



Minnesota Department of **Human Services**



Minnesota MSHO Longitudinal Analysis: Lessons Learned

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June 27, 2016

The Challenge

- Over one million, or 1 in 5 Minnesotans rely on Medical Assistance and MinnesotaCare for access to health coverage and care. The quality, health outcomes and long-term sustainability of these programs is of paramount concern.
- State spending for Medical Assistance and MinnesotaCare is approximately \$5.0 billion for 2016 (approximately \$4.9 billion projected for Medical Assistance and \$162 million for MinnesotaCare)
- Medical Assistance is projected to be approximately 21% of the State general fund budget in 2016, with annual cost growth of approximately 6%.
- Approximately 70% of the state Medical Assistance spending is on health care and long term care for the elderly and individuals with disabilities.
- Financing should encourage reducing cost and improving quality.
- Care should be centered around patients and their families.



Minnesota Landscape: Medicaid Managed Care

- Medicaid managed care for families, children, adults: 647,019
- MinnesotaCare: 76,702
- 90% Medicaid seniors enrolled in managed care under two options:
 - Minnesota SeniorCare Plus (MSC+): 13,677 enrollees (coordinates Medicare, enrollment mandatory)
 - Minnesota Senior Health Options (MSHO): 35,291 enrollees (integrates Medicare, enrollment voluntary)
- Special Needs BasicCare (SNBC): Over half of adults with disabilities (50,150) voluntarily enrolled, all behavioral and physical health, home health aide and skilled nurse visit, 100 days NF, carve-out for PCA and HCBS waiver services



Minnesota Medicaid managed care for seniors

- Most Medicaid enrolled seniors are required to enroll managed care
- Goal is to focus on improved management of chronic conditions, appropriate utilization of services and control of costs.
- Services provided include all Medicaid services including Long Term Services and Supports (LTSS), HCBS waiver services, 180 days nursing facility care, in all settings and levels of care
- Minnesota Senior Care Plus (MSC+) is the default mandatory managed care for seniors; Medicaid services only
- Seniors may opt into Minnesota Senior Health Options (MSHO) which integrates Medicare allows coordination of benefits across programs. Combines Medicare (including Part D) and Medicaid services using contract requirements and enrollment process.



MSHO features

- Aligned capitated financing supports innovation and payment reform
- Integrated member materials, one enrollment form, aligned enrollment dates, one card for all services
- State MLTSS assessment tool integrates Health Risk Assessment (HRA) into assessment process
- All members are assigned individual care coordinators. The State sets uniform standards, audit protocols and criteria for care plans, face to face assessment and care coordination
- Flexible care coordination delivery models
- High degree of collaboration among SNPs and State on member materials, PIPs, care coordination, benefit policy, demo decisions, etc. through multiple joint workgroups



Minnesota Demonstration

- “Demonstration to Align Administrative Systems for Improvement in Beneficiary Experience” signed September, 2013 – Not a Financial Alignment Demo (FAD)
- Charts a new path for improving States’ ability to work with Medicare Advantage Dual-Eligible Special Needs Plans (D-SNPs)
- Builds on current D-SNPs platform for MSHO seniors along with key FAD features; SNPs remain SNPs, not MMPs
- Current SNP and Medicaid financing and rates; integrate Medicaid priorities including value based purchasing
- No new procurement/applications needed, seamless transition to demo status for current and new members



Making the most of integration

- Demographic and cost challenges require joint CMS/State/Plan/Provider efforts toward Triple Aim goals especially designed for Medicare-Medicaid beneficiaries.
- Decisions made by primary, acute and post acute care providers paid under Medicare continue to drive State Medicaid and LTSS costs.
 - Combined Medicare/Medicaid primary, acute and LTSS financing is just the first step:
 - Align service delivery arrangements across primary, acute and long term care services
- Create provider level practice and payment incentives



MN Integrated Care System Partnerships

- Minnesota state VBP initiative for seniors and people with disabilities in integrated D-SNP and Medicaid managed care programs:
 - Expands and builds on long standing MN D-SNP/Provider VBP contracting arrangements and experience in Minnesota Senior Health Options (MSHO)
 - D-SNP platform leverages Medicare involvement
 - Combined Medicare and Medicaid financing provides opportunity for VBP across primary, acute and LTSS
 - MCOs/provider partners develop arrangements and submit proposals to state
 - Multiple financial and delivery models tied to a range of defined quality metrics developed by D-SNPs, clinical experts and the state for triple aim goals results include reducing re-hospitalizations, ED use, and costs of care.



Next steps

- Medicaid-Medicare data integration in-house to allow further study of impacts of MSHO vs. MSC+
- Study ICSPs and develop next phase
- Back to basics: Continue building on successes in integrated materials and operations
- Evaluate enrollment and education processes
- Look ahead to integration for people with disabilities under age 65; moving seniors with disabilities to MSHO

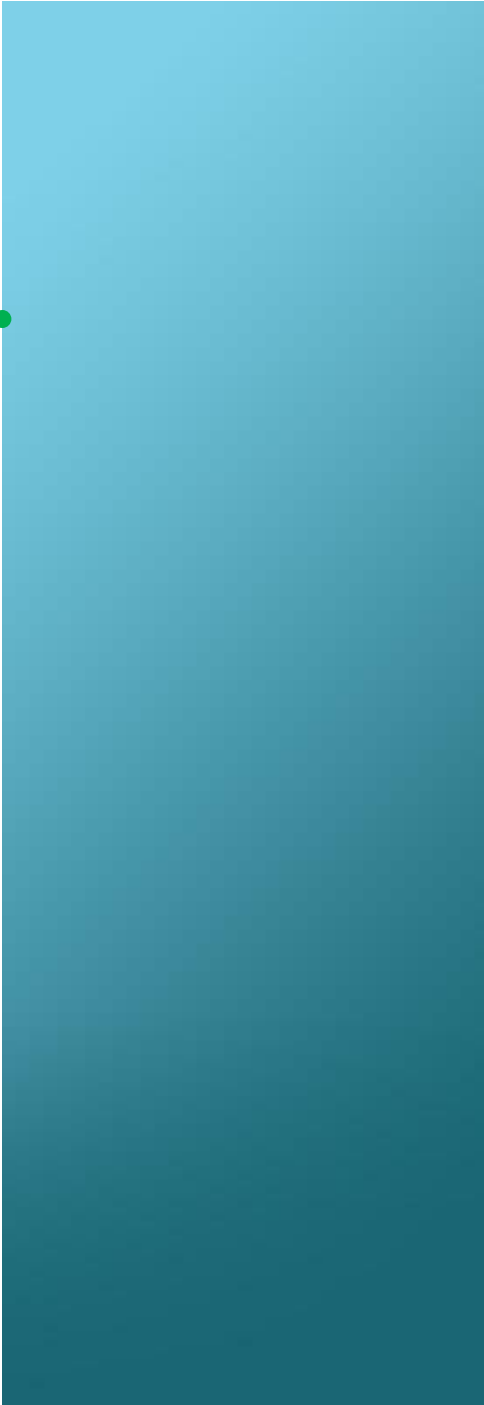


Thank you!

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Impact of Minnesota's Managed Care Programs for Seniors on Utilization Outcomes

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Purpose of Study

- Analyze differences in enrollment and service use for
 - Minnesota Senior Health Option (MSHO) program
 - Medicare/Medicaid integrated services program
 - Minnesota Senior Care Plus (MSC+) program
 - Medicaid program that may coordinate with Fee-for-Service Medicare
 - No integration of Medicare/Medicaid payments to managed care plans
 - Both MSHO and MSC+ programs have managed long-term services and supports (LTSS) components.

- Almost all Medicaid beneficiaries aged 65 and older in MN are enrolled in MSHO or MSC+.

Enrollment Analysis Highlights

- Relative to MSC+, MSHO enrollees tended to be older, female, to have more medical conditions and disabilities, to have died during the year, and to live in rural areas of the state. *These differences were controlled for in the multivariate regression analyses.*
- Very few MSHO enrollees ever switched to MSC+ during a year, but 12.8 percent of MSC+ enrollees switched to MSHO after the beginning of a year

Multivariate Analyses Highlights

- Controlling for differences in observed individual- and area-level characteristics, MSHO enrollees were:
 - 48 percent less likely to have a hospital stay, and if so, had 26 percent fewer stays than if in MSC+
 - 6 percent less likely to have an outpatient ED visit, and if so, had 38 percent fewer visits than if in MSC+
 - No more likely to have a long-term nursing home admission than if in MSC+
 - 2.7 times more likely to have a primary care physician visit, but if so, had 36 percent fewer visits than if in MSC+

Multivariate Analyses Highlights (cont'd)

- Controlling for differences in observed individual- and area-level characteristics, MSHO enrollees were:
 - No more likely to have a specialist visit, but if so, had 36 percent fewer visits than if in MSC+
 - 13 percent more likely to have any home and community-based services than if in MSC+
 - 16 percent less likely to have any assisted living services than if in MSC+
 - 9 percent more likely to have any hospice care use in last year of life than if in MSC

Conclusion

- This study found that one type of capitated model, as represented by the MSHO program, has great potential for improving health care outcomes for dual eligibles
- Findings suggest that additional initiatives that use fully integrated care models similar to the MSHO program may have merit for other States
- CMS and twelve states (including Minnesota) are currently participating in the Financial Alignment Initiative
- Future efforts to test the MSHO model in other States would help assess its generalizability beyond Minnesota