Minnesota’s Approaches to Covering and Caring for People with Dual Eligibility

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Los Angeles CA
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Pamela Parker, MPA
Minnesota Department of Human Services
Minnesotaa Medicaid Managed Care

• Medicaid managed care since 1985, about 600,000 enrollees.

• Seniors enrolled since 1985, includes dual eligibles, began adding people with disabilities in 2001.

• States can do little to influence preventive, primary, acute care and post acute care for dual eligibles without partnering with Medicare. Decisions made by primary, acute and post acute care providers paid under Medicare also drive State Medicaid and long term care costs.


• 90% of seniors (49,000) enrolled in 8 managed long term care plans, all are also fully integrated FIDE-SNPs, includes behavioral health services. 76% of dually eligible seniors in managed care are enrolled in integrated SNPs.

• 43% of people with disabilities (37,000) enrolled in 5 managed care plans, 3 offer SNPs, long term care carved out, all behavioral health included. Only 3% in integrated SNPs.

• Now moving back to dual demonstration status with new CMS opportunities.
Options for Seniors

Minnesota Senior Care Plus (MSC+):

• Default program, mandatory enrollment, includes lock in but can move to MSHO. Same Medicaid services and payments under both options.
• Less intensive care coordination because Medicare is not integrated.

Minnesota Senior Health Options (MSHO):

• Integrated Medicare/Medicaid SNP based program, same Medicaid services but also includes Medicare including Part D.
• Voluntary alternative to MSC+ enrollment for dually eligible seniors. Can change plans each month and/or opt back to MSC+.
• 70% of all seniors enrolled in integrated SNPs. Average age of members is about 81, 70% need long term care services
• All members are assigned individual care coordinators. The State sets uniform standards, audit protocols and criteria for care plans, assessment and care coordination.
• Care coordination may be provided by SNPs, counties, Care Systems/Health Care Homes and community case management organizations.
• Aligned integrated full risk Medicare/Medicaid financing provides incentives for provider level payment and delivery reforms.
• State and local Stakeholders groups
<table>
<thead>
<tr>
<th></th>
<th><strong>MSHO (Statewide-87 counties)</strong></th>
<th><strong>MSC+ (Statewide-87 counties)</strong></th>
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<tbody>
<tr>
<td></td>
<td>1915 (a)(c)</td>
<td>1915(b)(c)</td>
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<tr>
<td><strong>Enrollment 65+</strong></td>
<td>Voluntary 35,800</td>
<td>Mandatory 12,800</td>
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<tr>
<td></td>
<td>Duals only</td>
<td>Duals and non duals</td>
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<tr>
<td><strong>Medicare Services</strong></td>
<td>All Medicare services including</td>
<td>Medicare A/B services through</td>
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<td></td>
<td>Part D drugs through Medicare</td>
<td>Medicare FFS.</td>
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<td></td>
<td>Dual Eligible Fully Integrated</td>
<td>Part D drugs through separate</td>
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<td></td>
<td>Special Needs Plan (FIDE-SNP)</td>
<td>Medicare drug plan</td>
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<tr>
<td><strong>Medicaid Basic Care Services</strong></td>
<td>Medicaid state plan services</td>
<td>Medicaid only plan provides</td>
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<td></td>
<td>(includes PCA) and remaining</td>
<td>state plan (includes PCA) and</td>
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<tr>
<td></td>
<td>drugs through same SNP</td>
<td>remaining drugs</td>
</tr>
<tr>
<td>**Medicaid Long Term Care</td>
<td>Elderly Waiver (EW) through</td>
<td>EW through same plan plus 180</td>
</tr>
<tr>
<td>Services**</td>
<td>SNP plus 180 days of nursing</td>
<td>days of nursing home care</td>
</tr>
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<td>home care</td>
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Options for People with Disabilities

Special Needs BasicCare (SNBC)

• Designed with ongoing large disability stakeholders group, good support and buy in, operating since 2008
  – Each MCO has local stakeholders group
• Enrollment for ages 18-64, voluntary with opt-out and auto-assignment, recent expansion led to enrollment of about 43% of all eligibles
• Provided through 5 MCOs, 3 offer SNPs
• Where there are SNPs there are 2 enrollment options, integrated and non-integrated
• Only about 3% are enrolled in the integrated SNP option, not marketing
• Most long term care carved out, behavioral health all in
• Emphasis on increased access to primary care and integration of physical and behavioral health
• Each enrollee has a care coordinator or care navigator
• 71% of members have behavioral health diagnoses
• Preferred Integrated Network (PIN) behavioral/physical health partnership in one service area, deep care coordination for SPMI
• Medicare rates not viable for this population in MN, started out fully integrated with SNPs statewide in 2008, since then 4 plans have dropped 5 different SNPs and 9 counties due to bid premiums.
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<thead>
<tr>
<th></th>
<th>SNBC with Medicare</th>
<th>SNBC Medicaid</th>
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<tbody>
<tr>
<td><strong>Enrollment 18-64</strong></td>
<td>Voluntary Duals Only</td>
<td>Voluntary with Opt Out/Assignment Duals and Non-Duals</td>
</tr>
<tr>
<td><strong>Medicare Services</strong></td>
<td>All Medicare services including Part D drugs through Medicare Dual Eligible Special Needs Plan (SNP)</td>
<td>Medicare A/B services through Medicare FFS. Part D drugs through separate Medicare drug plan</td>
</tr>
<tr>
<td><strong>Medicaid Basic Care Services</strong></td>
<td>SNP provides all Medicaid state plan services and remaining drugs through SNP (except for PCA and Private Duty Nursing)</td>
<td>Medicaid only plan provides all state plan services and remaining drugs (except for PCA and Private Duty Nursing)</td>
</tr>
<tr>
<td><strong>Medicaid Long Term Care Services</strong></td>
<td>100 days of nursing home through SNP. PCA, PDN waiver and remaining institutional through FFS</td>
<td>100 days of Medicaid nursing home through MCO. PCA, PDN, waiver and remaining institutional through FFS</td>
</tr>
</tbody>
</table>
Integrated SNPs in Minnesota

Non Integrated SNP Features

- Separate assessments and Models for Care for Medicare and Medicaid
- Misaligned enrollments
- Two enrollment forms to sign
- Separate accretion and deletion dates
- Two cards and sets of member materials, provider directories, etc.
- Separate reviews of member materials, State vs RO
- Two sets of notices (likely misleading)
- Separate PIPs and QI
- Typically must have Medicare denial or appeal before Medicaid service picks up
- May handle claims twice, once for Medicaid, once for Medicare
- Providers normally bill twice
- Two different member service responses
- May have conflicts between Medicare and Medicaid networks

MN Integrated SNP Features

- Integrated person centered care coordination, assessments and Model of Care
- Same enrollment requirements for both programs (State as TPA)
- One integrated enrollment form
- Same accretion and deletion dates for all Medicare and Medicaid services
- Coordinated member materials review with State, SNPs and RO
- One card and EOC, member materials, directories, etc.
- One set of integrated notices
- Integrated PIPs and QI
- Integrated coverage decisions and coverage flexibility for Medicare and Medicaid, waivers of 3 day hospital stays, in lieu of hospital days, etc.
- Integrated provider billing
- Integrated member services
- Integrated provider networks
Results for MSHO Seniors

• Have retained most integrated operational features under current SNP and State policies without additional authorities (despite constant challenges requiring State, SNP and CMS cooperation and intervention)

• **98% of MSHO seniors** have annual primary care visits.

• Annual assessments and individualized care coordination for all members increases access to HCBS, care coordinators assist in monitoring chronic medical conditions

• Rebalanced Medicaid long term care for seniors since the start of managed LTC programs (Sources: 1996 Medicaid Forecast, July 2012 Medicaid enrollment by living arrangement). #1 on AARP Scorecard for HCBS Access.
  - Nursing home admissions average about 7% across the senior programs with an average length of stay of about 150 days per year
  - About 41% of nursing home admissions return to the community.
  - About 60% of all EW expenditures are for Assisted Living which is by far the largest single EW service expenditure

• MSHO SNPs have average Star ratings of 4.0 Stars (2012)

• MSHO satisfaction scores are the highest among all of the state managed care programs, disenrollment is < 2%.
Results for MSHO Seniors

• Integrated financing has resulted in creative “Care System” (mini-ACO like) subcontracts for integrated service delivery and payment reforms across Medicare, Medicaid, primary acute and long term care with a range of arrangements such as:
  – Shared incentive pools or enhanced payments with LTC providers
  – Combined Medicare and Medicaid care coordination PMPM payments
  – Combined Medicare and Medicaid primary care and care coordination PMPM payments
  – Total cost of care sub-capitations or virtual sub-capitations with shared performance pool

• Despite much higher chronic disease rates, acute care hospital admits/episode rates for community seniors by risk categories are lower in MSHO than for regular Medicare members. (Source: JEN iMMRS-MN Dual Data Base)

• SNPs and providers rely on integrated benefit determinations and the flexibility provided in Medicare Advantage to provide additional care coordination, waive 3 day hospital stays, provide in lieu of days, substitute services and support increased use of physician extenders in order to obtain these results.

• State goal is to increase these purchasing and delivery reforms for dual eligibles, cooperation of Medicare SNPs is key to that goal.
Enrollment by Setting of Care 1996 and 2012

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<tr>
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<th>1996</th>
<th>2012</th>
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<tbody>
<tr>
<td>Community</td>
<td>14,837</td>
<td>19,023</td>
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<tr>
<td>Nursing Facility</td>
<td>30,104</td>
<td>14,459</td>
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<tr>
<td>Elderly Waiver</td>
<td>4,726</td>
<td>21,565</td>
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Total 1996: 49,667
Total 2012: 55,047
Percent of Population enrolled in Minnesota Medicare with Chronic Diseases, 2009 and 2010

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<th>2009</th>
<th>2010</th>
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<td>Diabetes</td>
<td>34.79%</td>
<td>35.59%</td>
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<td>Congestive Heart Failure</td>
<td>27.06%</td>
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<td>MN Medicare FFS</td>
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<td>MN Medicare HMO</td>
<td>7.40%</td>
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<td>Total Population</td>
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Minnesota Medicare Percent of Enrolled Months by Frailty Score*
2009 and 2010

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<tr>
<td>High Risk</td>
<td>35.74%</td>
<td>33.68%</td>
<td>7.76%</td>
<td>1.86%</td>
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<tr>
<td>Medium Risk</td>
<td>41.88%</td>
<td>40.35%</td>
<td>27.19%</td>
<td>9.35%</td>
</tr>
<tr>
<td>Low Risk</td>
<td>22.38%</td>
<td>25.97%</td>
<td>65.05%</td>
<td>88.79%</td>
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* Defined using JEN Associates, Inc. Frailty score, an annual flag based on likelihood of a future nursing home admission.
Acute Hospital Episodes per 1000 Member Months for Minnesota Medicare Enrollees Residing in the Community with No Long Term Care Services, 2010
MN Dual Demo Proposal

- One of 15 Original Dual Demo states
- Huge stakeholder involvement effort for refocusing dual programs over past 18 months
- Submitted proposal for both FAD and Original Demo
- Withdrew FAD in June, 2012 with CMS understanding and support
  - FAD savings not viable due to 15 year history of integration
    - low utilization,
    - low Medicare benchmarks,
    - high SNP penetration,
    - high MLRs
    - SNP loss of revenue,
    - Part C rebates used to buy down Part D premiums
- Already high SNP enrollment, not reliant on passive enrollment for seniors
- Many FAD features already modeled after current MN programs
- Much integration possible through SNP model, but still “half a bubble off” so let’s keep working on it!
Alternative “Rules for Duals” Demo

- State proposing alternative “Demonstration to Align Administrative Systems for Improvements in Beneficiary Experience”
  - Builds on current SNP platform along with some FAD parameters
  - No new procurement/applications needed
  - Current SNP and Medicaid financing and rates
  - Phase 1: Seniors enrolled in MSHO SNPs implementation to start in 2013
  - Phase 2: People with Disabilities enrolled in SNBC, ongoing discussions for 2014
- Goals
  - Preserve/enhance integrated administrative and operational features to support State delivery reforms for dual eligibles as developed through stakeholder efforts
  - Reduce reliance on informal CMS Medicare SNP policy agreements which can change and increase disintegration
- Provide learning laboratory for CMS efforts to improve D-SNP administrative efficiency and alignment for beneficiaries
Proposed Demo Alignment Areas

- **Enrollments**
  - Retain State TPA role, ensure facilitation of integrated enrollment forms and dates
  - Medicaid eligibility verification needed before Medicare enrollment is complete

- **Networks**
  - Coordinate Medicare and Medicaid network adequacy standards
  - State involvement in exceptions process

- **Models of Care and Assessment**
  - Assure continued integration
  - Reduce duplication between MOCs and S&Ps
  - (Also working with NCQA to test feasibility of new integrated measures for duals)

- **Member Materials**
  - Retain integrated EOCs, member notices and communications, use new models from FAD where possible

- **Quality Oversight**
  - Test more targeted duals outcome measures
  - Test alternative Stars Measures
  - HOS languages relevant to populations served
  - Consolidate CAHPs reporting with shared analytic data with state
Proposed Demo Alignment Areas

- Retain Integrated Benefit Determinations and Provider Billing
  - Slight modifications of bid audit instructions

- Premium Protection for beneficiaries
  - Allow small increase in de-minimus premium levels
  - Waive Part D co-pays

- Integrated Appeals and Grievances
  - Align State and CMS timelines (using FAD rules)
  - Simplify member materials

- MOU in drafting stage, want final before end of 2012
  - Currently amending SNP contracts to prepare for demo

- Implementation to start in 2013
  - Requests numerous elements from FAD model parameters
  - Ongoing discussions with CMS Medicare on key elements
  - Other elements to be worked out in next few months for implementation in 2014

- Phase 2: People with disabilities in SNBC, ongoing discussions for 2014
  - Get Medicare back? Focus on physical/behavioral health integration
MN Payment/Delivery Reform Initiatives

- **Health Care Home (HCH):** Medicaid benefit provides additional payments to clinics and practitioners certified by MDH.

- **Multi Payer Advanced Primary Care Practice (MAPCP) Demo:** 8 state demo providing added Medicare payments to HCH for FFS patients including duals.

- **Private Sector and Medicare ACOs:** History of HMO/Provider ACO type subcontracting, also 3 Medicare Pioneer ACOs.

- **Health Care Delivery System (HCDS):** Primary/acute Medicaid ACO like delivery models operating in and outside of managed care.

- **State Innovation Model (SIM):** State’s CMS proposal builds on above models to improve care coordination, population health, patient experience and costs.

- **Dual Demo Integrated Care System Partnerships (ICSPs):** SIM/HCDS aligned proposals for provider payment and delivery reforms within DE-SNPs.
  - Combined Medicare and Medicaid provides incentives for provider level payment and delivery reforms stimulating subcontracting arrangements across all services.
  - Encourages involvement of long term care providers under shared pooled incentives.
  - Tied to quality and financial performance metrics.
  - Tied to proposed MSHO contract requirements, proposals due July 2013.
**Revised Dual Demo Original Design Model Special Needs Plan/Medicare Medicaid Integrated Care Organizations**

**Joint CMS/State Memorandum of Understanding (MOU) for Medicare and Medicaid Managed Care**

- Demo under Medicare Advantage Special Needs Plan (SNP) platform and payment structures
- Includes Medicare, Part D, current Medicaid State plan and LTSS (seniors) starting 2013
- MOU to outline State/CMS oversight roles
- CMS acknowledgement of State payment and delivery reform goals
- “Rules for duals” supports features needed to continue and improve integrated operational features including quality and outcomes measurement and integrated benefit determinations, provider billing and protection from premiums for enrollees

**Acronyms**
- CD=Chemical Dependency
- CMS=Centers for Medicare and Medicaid
- FFS=fee for service
- HCH=Health Care Home
- HH=Health Home
- LTSS=Long Term Services and Supports
- MMICO=Medicare Medicaid Integrated Care Organization
- MSC+=Minnesota SeniorCare Plus
- MSHO=Minnesota Senior Health Options
- NF= Nursing Facility
- PAC=Post Acute Care
- SNBC=Special Needs BasicCare
- SNP=Medicare Advantage Special Needs Plan
- SMI=Serious Mental Illness
- TCOC= Total Cost of Care
<table>
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<tr>
<th>Model Features</th>
<th>ICSP Models 2 and 3 Payment Options</th>
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<tbody>
<tr>
<td></td>
<td>Payment Type A</td>
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<tr>
<td>Performance rewards: performance pool or P4P</td>
<td>Payment Type B</td>
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<tr>
<td>Primary Care/Care Coordination Payment Reform (PMPM or partial sub-capitation for primary care and care coordination)</td>
<td>Payment Type C</td>
</tr>
<tr>
<td></td>
<td>Sub-capitation or Virtual Capitation for Total Costs of Care Across multiple defined services including primary, acute and Long Term Care</td>
</tr>
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<td></td>
<td>Payment Type D</td>
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<tr>
<td>Alternative Proposals</td>
<td></td>
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- **MCO manages various provider contracts with LTC providers and/or Primary Care Providers designed to incent improved health outcomes and consumer choice of community and institutional settings.**
  - X
  - X
  - ?

- **MCO contracts with primary care under primary care payment reform models that include care coordination and health care home or health care home alternative payments.**
  - X
  - X
  - ?

- **MCO delegates care management to Provider Care System/Collaborative (primary care providers with long term care providers) using risk/gain/performance payment model across services.**
  - X
  - ?

- **MCO contracts with providers to provide financial and/or performance incentives for Chemical and Behavioral Health coordination or integration can include HCH or Health Homes(mainly for SNBC).**
  - X
  - X

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<tr>
<th>Care Coordination</th>
<th>X</th>
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<tr>
<td>Quality Metrics</td>
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<td>Financial Performance</td>
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<td>DHS Review</td>
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<td>Reporting Requirements</td>
<td>X</td>
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STAY TUNED!
We’ll know a lot more by next year!
## Participating Health Plans

### MSHO SNPs/MSC+ MCOs*

- Blue Plus
- Health Partners
- Itasca Medical Care
- Medica
- Metropolitan Health Plan
- Prime West
- South Country Health Alliance
- UCare Minnesota

*All plans offer both MSHO SNP and MSC+ Medicaid plans

### SNBC SNPs/MCOs

- Medica
- Metropolitan Health Plan *
- Prime West *
- South Country Health Alliance *
- UCare Minnesota

* Offers Dual Eligible SNBC SNP
Contact Information:
Special Needs Purchasing
Minnesota Department of Human Services

Pamela Parker, MPA, Manager
pam.parker@state.mn.us
651-431-2512

Dual Demo Stakeholders Website:
www.dhs.state.mn.us/DualDemo

Disability Managed Care Stakeholders Group
www.dhs.state.mn.us/SNBC