The Menges Group
Strategic Health Policy & Care Coordination Consulting

Learning Network with Pam Parker (MN)

Call Notes - September 9, 2014

Overview

Minnesota is a managed care state enrolling over 800,000 people in public programs enrolled in managed care, including about 49,000 seniors, both duals and non-duals. Twenty years ago, their program included families and children and seniors only - however, the seniors program did not include long term care. To address this gap, the State decided to add long term care into their managed care system and look at how Medicare impacts their overall costs and service delivery systems. Minnesota was the first state to be awarded a Medicare demo by CMS in 1995 which also included managed long term services and supports (MLTSS). A few years later, CMS transitioned this demonstration to the D-SNP platform for alignment with Medicare Advantage and Part D, and all enrollees were seamlessly enrolled through passive enrollment.

With this alignment, the State was able to provide both t Medicare and Medicaid to dual eligibles including long term care services and supports. The State had D-SNP Medicare plans serve seniors in both Medicare and Medicaid;

Minnesota runs two programs for seniors. There is a mandatory program called Minnesota Senior Care Plus (MSC+) and the Minnesota Senior Health Options program (MSHO) where enrollment is voluntary to go along with Medicare. Seniors will be automatically enrolled in the mandatory program but can choose MSHO instead. But if individuals don't want Medicare included, they will be returned to Senior Care Plus (MSC+, n=13,000) which also includes non-duals. About 90% of all full eligible dual seniors are enrolled in one of the two programs. The State enrolls in all settings and all levels of care; there are very few exclusions.

The State has not been able to achieve the same thing with people with disabilities due to a lack of Medicare options for people with disabilities and benchmark issues with health plans. But the state does have a large voluntary managed care programs for people with disabilities 18-64 that enrolls about 50% of that population. For the most part that program no longer includes Medicare and does not include long term supports and services.

Is there any reason people pick MSC+ and not MSHO?

Parker identified four reasons that people choose MSC+ over MSHO:

1. Primarily, because some seniors don't make a choice upfront and they are then defaulted to MSC+.
2. An immigrant bias that the State is trying to address by looking at communication issues and cultural issues.
3. It may also be driven by a few provider groups, which the State is also looking further into.
4. Also, when people come into Medicaid with an existing Part D plan, they choose MSC+ to not complicate their current Part D arrangement.

Medicaid services, rates, and LTC services are the same in both programs. There are a few, small populations that are excluded from both programs:

- Medical spend downs (not waiver obligations) (MSHO exceptions)
- People in an HMO that does not match their Medicaid plan (very few of these in Minnesota due to high Medicare Advantage premiums)
- Cost effective employer based coverage
- Partial duals
- SPMI with MH case management (about 300)
- ESRD prior to enrollment (MSHO only)
- Refugee assistance and torture victims programs
- Communicable diseases

MSC+ and MSHO plans also both include behavioral health. Health plans use BH contractors to provide services and are responsible also for providing chemical dependency. The State has some creative projects to integrate BH and primary care, but there is lesser utilization among seniors.

MSC+ does not include the Medicare component. MSHO has a much stronger care coordination model due to Medicare involvement and required primary care and MLTSS integration. The plans still try to run MSC+ with the same fundamentals, though it may be a bit more disconnected without control of Medicare.

Passive enrollment for the Medicare side was a one-time occurrence for MSHO related to Part D. Prior to 2006 MSHO had about 10-11,000 enrollees. But the majority of enrollees chose MSHO during the passive enrollment period so MSHO grew to about 33,000 and has stayed relatively stable at 35-36,000 since then. MSC+ was implemented at the same time as the Part D expansion but was phased in over several years by geographic area.

SNPs for the Physically Disabled Population

Minnesota is a high Medicare Advantage (MA) state, but its rates are low. The benchmarks are lower than other States (FL, TX, NY, etc.) Most of the State's plans that are MA are at-cost and are not full-risk. There is a feeling that it is risky with low-benchmarks. However, the state started a fully integrated Medicare Medicaid MLTSS program for people with disabilities in 2001 in the metro area with one large plan. This program stayed very small but was very popular with those who enrolled. However it was closed in 2010 due to cost issues (MLTSS for Medicaid and inadequate Medicare risk adjustment). In 2008 the state implemented a new program for people with disabilities (Special Needs Basic Care or SNBC) that started out fully integrated with Medicare D-SNPs statewide with 7 D-SNPs but did not include MLTSS. However all but two of the 8 total D-SNPs have dropped out since then due to issues with low Medicare payments and benchmarks which led to them having premiums that they were required to charge, Very few are enrolled for both Medicare and Medicaid in those two remaining plans.

Pam Parker said that if the State puts both populations together, it would take down the MSHO program and make it non-viable. The costs are too high for what Medicare will pay under their risk adjustment system.

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Provider Led Entities and Managed Care Entities

Minnesota is unique with its managed care contractor in a few ways:

1. Minnesota only allows non-profit HMOs or county based purchasing plans to operate to serve public programs. County based purchasing plans (CBPs) are defined as a group of counties who work together and purchase and sponsor a plan and take risk.
2. HMOs are required to participate in public programs if they want to serve public employees. This is called Rule 101, based in MN's statutes.
3. In order to integrate with Medicare, MN has required that all health plans serving seniors sponsor a D-SNP when wanting to serve seniors (MSHO).

Minnesota has eight plans serving seniors, four of which are county sponsored plans and three of those are CBPs, all have D-SNPs and there is statewide coverage. Minnesota re-procures their program contractors every 5 years, which requires a lot of coordination with D-SNPs.

Health Plans are regional or home grown, they are non-profit, and many are provider driven.
The state also has a separate but related Medicaid ACO initiative which works for families and children and non-duals disabilities population. The Medicaid agency has set up direct contracts with providers and uses an attribution model for members including people in Medicaid HMOs. The ACOs are in the HMOs network but have separate and different contracting relationships directly with the State and separately with the HMOs. The State has both risk based and non –risk based options, depending on the size and arrangements with the provider group. The state shares savings with the ACOs, with a formula set by the state. HMOs are required to pay a share of the savings to the ACO as calculated by the state in addition to anything they have already agreed to with the ACO. The program was approved through ae State Plan amendment. The HMOs themselves started relationships with the ACOs prior to the state deciding to get more directly involved. Later, the state wanted to be more directly involved to steer the arrangements and set up consistent measurement and savings calculations across plans and providers.

The State is now also doing something similar with the Seniors integrated MSHO program Pam warned that this is not easy to achieve because getting independent clinics and doctors to assume risk is new and difficult.

ACOs are all over the state with most of them in the metro area. There is HMO coverage statewide. Overall, there are four doors for someone to enter:

1. Medicaid ACO Initiative (Called Integrated Health Partnerships)
2. Medicare ACOs – a few of them, not yet proven effective
3. Health plans have developed contracting relationships with big provider systems – ACO type contracting arrangement with Health Plan and Provider System
4. Integrated Care Systems Partnerships (ICSPs) under the Seniors managed care programs – Since Medicare is primary; can't do payment reform without some involvement with Medicare. MN does this through requiring plans to sponsor a dual eligible SNP plan. In order to align with the Medicaid ACO initiative, the State contract requires each plan serving seniors to sponsor several Integrated Care System Partnerships (ICSPs) with providers. This helps leverage Medicare involvement. There is a wide range of relationships from small Pay for Performance projects to larger fully capitated total cost of care arrangements between providers and D-SNPs. The state

defined a set of measures to choose from, and a range of financial models that providers and D-SNPs can choose from. The difference between these arrangements and the IHPs for non duals in the broader Medicaid program is that the state does not contract directly with the ICSPs, those contracts are between the D-SNP and the providers but the plans have to send in proposals and measurement documentation etc. to track performance. They are also encouraged to include LTC providers. But without the D-SNPs we would not be able to do this, because it would not work with FFS Medicare.

Care Coordination

The State uses a lot of different types of entities to do care coordination. Many organizations do not want to take risk. Without a health plan to take the risk, the State is stuck with the risk. It is important to get a contract with someone that is overarching to help with risk.

Prior to their MLTSS system, Minnesota also had counties doing care coordination. They didn't want to throw those counties out from providing this service, so many health plans chose to contract with the counties to continue to do care coordination for them. But Minnesota also welcomed other entities including ACOs (sponsored by clincs and health systems) to do care coordination. The care coordination requirements are standardized and go through audits, so everyone is responsible for the same basic activities even though their sponsoring organization may vary.

The State is somewhat flexible in its care coordination models though staff have to meet the same credentials. There are several different models employed:

- Counties: many health plans contract with counties to provide care coordination required for SNPs and for MLTSS. This is usually not integrated with primary care.
- Care Systems or Health Care Homes: primary care clinics (independent or part of hospital systems using physician extenders, nurses and social workers) provide primary care, conduct MLTSS assessments, and provide all care coordination across primary, acute and MLTSS services.. Some of them are fully sub-capitated, taking risk and even sharing gains with long term care providers.
- Some models include capitation to clinics just for care coordination and primary care (includes Medicare and Medicaid and MLTSS)
    - Many of these are tied to a P4P mechanism. Only at risk for primary care services, not at hospitals but are rewarded for reducing utilization.
    - Difficult to conduct P4P with duals under MSC+ because Medicare is FFS, but it works well in MSHO.
- Care Management Organizations, community organizations. Some of them are behavioral health organizations, family service organizations, or religious charities. Also, some are provider driven entities that only do care coordination. These types of organizations can be good with cultural groups.
    - Mostly do community care management as they would for regular waiver services, but with a different model due to their relationship with SNPs, they put more emphasis on medical conditions than waiver county case management. The State has them do care coordination not just for waiver population, but other seniors outside of in nursing homes and the so-called "community well" who aren't getting waiver services. The counties or care management organizations get a payment for this and are also discovering a lot of

people that have never been involved with county services or have never been screened but need assistance.

- Some Health Plans also provide direct care coordination, one is a fully integrated health system which has its own clinics, hospitals and specialists, Other plans fill in rural areas of the state by hiring local care coordinators and two plans sponsor their own "care systems" with a group of care coordinators assigned to certain clinics. The care coordinators have a lot of clinical back-up and training in these systems.

Care Coordination contractors are held to a lot of standards and monitoring drive times, ethnic background, language, culture are big issues in Minnesota. As such the State has not set specific case load ratios, however, each plan is required by contract to have an adequate number of care coordinators, who are individually assigned to each MSHO member. Plans have to establish their own care coordinator ratios based on a set of criteria in the contracts, and have to show how they are meeting that criteria and their ratios.

Pam noted that in her experience, most individual counties have a weaker connection with the medical system versus when a clinic based care system or health care home is contracted to provide care coordination. Initially very few of counties wanted to take on risk for MLTSS, most of they did not want to share risk so having a variety of approaches/contractors has worked for the State. However, counties that became CBPs took on risk are still viable and strong. In Itasca County which is a county based plan (CBP) they have an arrangement for the primary care providers to take all the risk. There are two other county systems that are about 13 counties each. And, there is one county that sponsors an HMO.

Program Enrollment

Minnesota enrolls all populations, not just LTC. A person can come in at 65 due to poverty or at 85 after breaking their hip and needing LTSS to stay at home.

- If they are entering Medicaid due to poverty, for example when they turn 65, the county will determine the financial eligibility and the beneficiary will be placed in a health plan and the health plan assesses to see what the individual needs. If, they are found to need MLTSS, they will be assessed by the health plan and put into a rate cell that covers those appropriate services (through a one-step documentation).
- When people come into Medicaid because they need LTSS related to a hospitalization or an illness (and it is their first time entering the system), they would have received both financial eligibility and an MLTSS assessment through the county. The individual will choose or be assigned to a health plan but it may take a month or two for enrollment to be final. The county will setup a care plan and transition information to the health plan when enrollment is complete.

Program Models and Features

The disabled population is about double the size of seniors and about half of them are dually eligible. About half of the disabled population are enrolled voluntarily in a special Medicaid managed care program designed for people with disabilities called Special Needs Basic Care (SNBC). The State developed this program with disability stakeholders, and it is not a MLTSS program. It is a voluntary

program and was built this way because stakeholder voiced that they did not want to be thrown in with the seniors.

The State also had started a MLTSS program for people with disabilities in 2001 but it was closed down due to its high cost. The State then began SNBC which was embraced well. Though the Medicare part of it has diminished – everyone likes the coordination and navigation and behavioral health services it provides.

The personal care program: Minnesota has a large Personal Care Assistance (PCA) benefit under the Medicaid State Plan. About 8,000 seniors in managed care and a few children in the families managed care programs get PCA and it is paid through the health plan. However, most children and adults with disabilities are receiving PCA under fee for service. While SNBC enrolls 50% of Medicaid people with disabilities age 18-64, personal care and most other long term services and supports are carved out and paid outside of the managed care rate.

Minnesota also has 5 different home and community based waiver programs for different populations including: IDD, traumatic brain injury, people with other disabilities, seniors and people at a hospital level of care. Many people in these waivers receive PCA under the State Plan along with other waiver services under one of these options. For seniors, both the personal care and the other waiver services are covered under managed care. For people with disabilities, both PCA and waiver services are carved out of managed care and are paid fee for service.

Return to Community Program: Under this program, every private pay and Medicaid person that goes into a nursing home is looked at with MDS data within first two days. If it is determined that they are or are not a long term stay person, they are contacted and provided assistance and information to help them leave the nursing home when they are ready. There is extensive follow up to track what happens. Most are private pay and are not eligible for additional services, but do leave the nursing home. If they are on MSHO or MSC+ they are referred to the care coordinator to assist them to get out. .

- The State also has an Alternative Care program which provides a variety of community based services to individuals who need community based services and are within 6 months of Medicaid eligibility if they were to go into a nursing home and didn't have the resources to remain in the community. We recently were able to get FFP for this program through a new waiver.
- Return to Community is separate. If they found a MSHO client, they would refer them to their care coordinator.
- The state also participates in the Money Follows the Person demonstration (MFP) which also is part of MSHO/MSC+ though very few people have been enrolled in that as yet.

Once in Medicaid, the health plans have incentives to keep community members out of nursing homes. In fact, they get more payment if a member stays in the community and no added payment and a smaller capitation payment if they go into the nursing home. The State pays an additional PMPM on every person in the community to cover the risk for a set amount of expected Medicaid nursing home admissions (including the State's share of Medicare) and average days per year to cover stays up to 180 days. So plans are at risk if they exceed that set amount of admissions and days or don't pay their fair share through Medicare. An edit is put into the system to lock out any FFS nursing home payment. When the 180 days of plan payments has been exhausted (this may take 180 days or 10 years!) the edit is lifted.

Nursing homes send documentation to the state to confirm when the 180 days is up so that the edit can be lifted and then Medicaid will start paying the NF under FFS, but the person remains enrolled in the plan. The 180 day liability can recur if the person leaves the nursing home and returns to the community. People who are already in the nursing home when they enroll are not included in that payment, but they are also in the plan and get a smaller PMPM and the state pays for the NF under FFS. Minnesota finds that this is working. In Minnesota, nursing facilities are paid Medicaid per diem unless NF agrees to different contract rated. Most are contracted to pay for Medicare at blended rates and plans pay SNFs for in lieu of hospital days and waive the three day stays, many also have ICSP arrangements with pay for performance.

Provider community service development (Assisted Living) and Return to Community efforts have had a substantial impact on marketplace.

Quality performance metrics

Minnesota has performance withholds on:

- Licensing repeat deficiencies
- Care Plan audits
- Initial health risk screening timeliness on non EW (EW is already required through required input to system)
- Stakeholder group reporting documented responses to issues

The State collects general HEDIS, CAHPS and HOS data. The MSHO program defers to Medicare for specific measures. Minnesota also collects and analyzes ICSP measures. There are active PIP/QUIP collaboratives on many topics, but are now dictated more by CMS. Minnesota does not have specific MLTSS measures, but financial and system performance is tracked.

Key Lessons Learned

- Time needed for evolution
- Use existing resources (must trade off neatness sometimes!)
- Primary care communications with care coordinators is challenging, may have to “chase the docs”
- Guidance and training to plans and CCs
- Must listen and learn from the plans -- collaborate
- State should lead coordination between plans to standardize processes
- Reduce complexity for member
- Keeping focus on the members’ view point can resolve conflicts