Minnesota MSHO Longitudinal Analysis: Lessons Learned

Gretchen Ulbee
Manager, Special Needs Purchasing, Health Care Administration
Minnesota Department of Human Services

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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.

Fiigures from the 2015 Health Care Financing Task Force final report.

Medicare plays an important role

- In 2014: Roughly 891,000 Minnesotans receive coverage through Medicare
- Full benefit dually eligibles: 118,000 (56,000 seniors 62,000 PWD)
- Total Medicaid seniors 65+ : 59,000 (95% dual)
- Total Medicaid people with disabilities: 125,000 (50% dual)
- Partial benefit Medicaid (Medicaid covers only Medicare cost sharing): 10,000
- So even though seniors and people with disabilities make up 17% of enrollment and have primary coverage through Medicare, they still account for 58% of Medical Assistance program expenditures

Fiigures from the 2015 Health Care Financing Task Force final report.

Seniors clinical challenges

- On average our dual senior population is older and has 4.6 chronic conditions. *Overall, 19% are under age 70, 38% are aged 70 to 79, 28% are aged 80 to 89, and 15% are 90+ years old.*
- *82% rate of high blood pressure*
- *52% rate of high cholesterol*
- *42% rate of depression*
- *37% rate of arthritis*
- *32% rate of diabetes*
- *30% rate of heart disease*
- *22% rate of Alzheimer's/dementia*
- *16% rate of osteoporosis among seniors enrolled in MSHO or MSC+.*

Adults with disabilities clinical challenges

- The average SNBC enrollee has 5 + chronic conditions
- 54% rate of depression
- 41% rate of generalized anxiety disorder
- 32% rate of seizure disorder
- 24% rate of substance use disorder
- 19% rate of bipolar disorder, and 16% schizophrenia
- 34% high cholesterol
- 27% rate of asthma
- 26% rate of obesity
- 24% rate of arthritis
- 21% rate of diabetes
- 16% heart disease
- 17% rate of PTSD
- 14% rate of personality disorder

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

Minnesota Managed Care Analysis

- *Minnesota Managed Care Longitudinal Data Analysis*, prepared by Wayne L Anderson, PhD and Zhanlian Feng, PhD of RTI International and Sharon K. Long, PhD of the Urban Institute
- Published by HHS on June 16, 2016
- Compares service delivery patterns among elderly dually eligible enrollees in Minnesota Senior Care Plus (MSC+) and Minnesota Senior Health Options (MSHO)
- Studies seniors enrolled in either program during 2010-2012
- Data included fee for service claims, managed care encounters, enrollment data, and Minimum Data Set nursing home assessments

links

- Link to the CMS blog:
- 2016_06_16_CMS Blog for better outcomes for dually-eligible-older-adults-through-integrated-care

- Link to the report itself:
- https://aspe.hhs.gov/report/minnesota-managed-care-longitudinal-data-analysis

Findings

- MSHO enrollees tended to be older, female, have more medical conditions, have died during the year, and likely to live in rural areas
- Very few MSHO enrollees ever switched to MSC+, but 12.8% of MSC+ enrollees selected MSHO during the year
- MSHO enrollees were:
  - 48% less likely to have a hospital stay, and if so, had 26 % fewer stays than if in MSC+
  - 6% less likely to have an outpatient ED visit, and if so, had 38 % fewer visits than if in MSC+
  - 2.7 times more likely to have a primary care physician visit, but if so, had 36 % fewer visits than in MSC+

Fiigures from the 2015 Health Care Financing Task Force final report.

Findings, cont

- MSHO enrollees were:
- No more likely to have a specialist visit, but if so, had 36 % visits than in MSC+
- No more likely to have a long term nursing home admission than in MSC+
- 13% more likely to have any HCBS than in MSC+
- 16 % less likely to have any assisted living services than in MSC+
- 9 % more likely to have any hospice care use

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!

Gretchen Ulbee

Gretchen.Ulbee@state.mn.us

(651) 431-2192