



# ASPE

## ISSUE BRIEF

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### **Advancing Integrated Care: Lessons from Minnesota**

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There are 11.4 million individuals across the United States who are eligible for both Medicare and Medicaid.<sup>1</sup> These individuals, known as Medicare-Medicaid enrollees or dually eligible beneficiaries, often have complex health, social service, and long-term services and supports (LTSS) needs.<sup>2</sup> Although dually eligible beneficiaries have represented 20% of total Medicare enrollment and 14% of Medicaid enrollment, they have accounted for roughly one-third of Medicare and Medicaid expenditures (35% and 33%, respectively).<sup>3</sup> This is, in part, due to their complex care needs. Compared to other Medicare and Medicaid beneficiaries, those who are dually eligible are more likely to have conditions such as diabetes, heart disease, mental health disorders, and Alzheimer's/dementia, among others.<sup>4</sup>

Because Medicare is the first payer for all Medicare-covered medical and post-acute care services, dually eligible beneficiaries rely on Medicare for much of their acute and post-acute care services and Medicaid for services not covered by Medicare, such as LTSS. Dually eligible beneficiaries are more than twice as likely to use LTSS, as other Medicaid beneficiaries, and more than five times more likely than other Medicare enrollees.<sup>5</sup> Although dually eligible beneficiaries often have complex health care needs, they may receive services in separate unaligned and uncoordinated systems. This can result in potentially inefficient, duplicative, and poor quality care. In order to address long-standing problems with the alignment of Medicare and Medicaid Centers for Medicare & Medicaid Services (CMS) is funding a number of initiatives aimed at advancing integration of these historically siloed systems.<sup>6</sup> These initiatives include, but are not limited to: the Medicare-Medicaid Financial Alignment Initiative, and alternative approaches such as contracting with Medicare Advantage Special Needs Plans and Medicaid Managed Long-Term Services and Supports.

This brief will discuss how integrated care has taken shape in the State of Minnesota, highlight findings from a study of beneficiaries in the integrated care program in Minnesota, and discuss how the state is using demonstration authority to further build on this successful model.

## What is Integrated Care?

Integrating Medicaid and Medicare services may consist of seamlessly aligning benefits and administrative requirements for beneficiaries, and better aligning the financing between the programs; by integrating the administration, financing, and delivery of primary, acute, LTSS, and behavioral health services in the Medicare and Medicaid programs, integrated models have the potential to result in improved care for dually eligible individuals and increased cost effectiveness for Medicare and Medicaid. Person-centered care delivery models that offer the full range of medical, LTSS, and behavioral health services in an efficient and cost-effective integration model have the potential to address the current problems associated with the lack of coordination of Medicare and Medicaid benefits, financing, and incentives. However, there have long been barriers to developing and implementing Medicare-Medicaid integration models, including issues associated with sharing of cost savings across the Medicare and Medicaid programs. A number of integrated Medicare-Medicaid models rely on a capitated approach to provide a way to align Medicare and Medicaid benefits and financing at the health plan level. Currently, states use a range of capitated models, including capitation of limited Medicaid benefits, comprehensive Medicaid benefits, and comprehensive Medicare and Medicaid benefits. With the authorization of the Affordable Care Act (ACA) and the commitment of federal leadership to remove long-standing obstacles to integration and promote innovative Models of Care (MOCs) between Medicare and Medicaid, there is a greater opportunity for states to make real progress on improving care for dual eligible.<sup>7</sup>

## Integrated Care in Minnesota

Minnesota has been a national leader in innovation in health care delivery for elderly people and adults with disabilities. The state had an early (1981) Medicaid Section 1115(a) demonstration to expand the use of home and community-based services (HCBS) as an alternative to nursing facility care. Since that time, Minnesota has continued to move aggressively to expand the use of HCBS for people with disabilities and the elderly via Section 1115(a) waivers and, more recently, 1915(a) authority.

Health care and LTSS waiver services are provided to elderly people through managed care arrangements under the Minnesota Senior Care Plus (MSC+) or Minnesota Senior Health Options (MSHO) programs. The MSC+ program is mandatory for elderly Medicaid enrollees who do not enroll in the MSHO program. The MSC+ program originated from the earlier MSC program in the mid-1980s under which Minnesota required elderly Medicaid beneficiaries to receive all Medicaid state plan services (except state plan personal care assistance [PCA] services<sup>8</sup>) through managed care organizations, and LTSS on a fee for service basis. From 2005-2009 the state phased in managed LTSS waiver services to create MSC+. In July 2013, 11,147 dually eligible individuals were enrolled in MSC+ plans. MSC+ plans provide managed LTSS but are not required to coordinate or align with Medicare.

The MSHO program provides integrated acute care and LTSS to dually eligible individuals in Minnesota. Starting in 1997, Minnesota operated MSHO under a Section 1115(a) Medicaid waiver of the Social Security Act (SSA) and a Medicare payment demonstration waiver under

Section 402 of the SSA in selected areas of the state. MSHO expanded statewide in 2005. The Minnesota Department of Human Services reports that under the MSHO program nearly all enrollees have annual assessments, and individualized care coordination.<sup>9</sup> MSHO plans are at risk for nursing facility use up to 180 days, and then are reimbursed on a fee for service basis. They are also responsible for all Medicare skilled nursing facility stays. As of October 2016, 36,669 were enrolled in MSHO plans.

## **Impact of Integrated Care on Patient Outcomes 2010-2012**

The Office of the Assistant Secretary for Planning and Evaluation (ASPE) recently completed a study evaluating beneficiary outcomes in MSHO from 2010 through 2012, in which the experiences of MSHO enrollees were compared to the experiences of similar beneficiaries outside of MSHO. The study found:

***MSHO enrollees differed only slightly from those in the MSC+ program.*** MSHO enrollees tended to be older, female, to have more medical conditions and disabilities, were more likely to have died during the year, and were slightly more likely to live in rural areas of the state; but these differences were relatively minor except for age. The proportion of MSHO enrollees in the 65-69 age group was roughly half that of MSC+ enrollees (14.4% vs. 27.6%), and MSHO enrollees were more likely found in the 90+ age group (18.9% vs. 13.6%).

***MSHO enrollees had lower hospital and emergency department (ED) use, and greater use of primary care.*** Both before and after controlling for differences in observed individual-level and area-level characteristics, MSHO enrollees experience fewer hospitalizations and ED visits than MSC+ enrollees. The study found that MSHO enrollees were 48% less likely to have a hospital stay, and if so, had 26% fewer stays. MSHO enrollees were also 6% less likely to have an outpatient ED visit, and if so, had 38% fewer visits. These findings were in spite of MSHO enrollees being somewhat older and having somewhat greater prevalence of selected medical conditions and disabilities. At the same time, MSHO enrollees had a higher prevalence of primary care use. Although these analyses could not assess whether more frequent primary care use led to lower hospital-based care, it is consistent with the goal of connecting those who rely more heavily on inpatient and ED use to community-based providers as a strategy to reduce reliance on hospital-based care for care more appropriately provided in the community. MSHO enrollees, while having a greater prevalence of any primary care visits, if they had any, had 36% fewer total visits than MSC+ enrollees, and, for those with a specialist visit, 36% fewer specialist visits. One reason for fewer visits may be that the PCP and their affiliated staff were able to provide more comprehensive, coordinated care during each visit, resulting in the need for fewer visits over time. Conversely, dually eligible individuals in MSC+ may have elected that program to continue to see a greater number of specialists, or to have more visits with certain specialists with whom they had long-term relationships.

***MSHO enrollees were more likely to use home and community-based long-term care services.*** Compared to MSC+ enrollees, MSHO enrollees were more likely to use any HCBS but no more likely to have a long-term nursing facility admission and less likely to have any assisted living facility use. These findings took the greater age and slightly greater prevalence of medical

conditions and disabilities among MSHO enrollees into account. Potentially, the greater prevalence of HCBS and assisted living facility use helped prevent some long-term nursing home use.

***MSHO enrollees rarely opted out of the program once enrolled, while MSC+ enrollees were increasingly likely to enroll in MSHO over time.*** Very few of those who were enrolled in MSHO in January of a given year ever switched to MSC+ during that year, but 12.8% of those who were enrolled in MSC+ in January of a year switched to MSHO by the end of the year. Although MSHO enrollees can disenroll from MSHO and elect MSC+ effective at the beginning of the next month, the finding that almost none do suggests high satisfaction with services received under MSHO. Conversely, switching to enrollment in MSHO from MSC+ increases with age, which suggests that dually eligible individuals may become more aware of the potential choice of MSHO or place more value on the benefits available under MSHO relative to MSC+ as they get older, particularly after attempting to coordinate care between Medicare and Medicaid themselves.<sup>10</sup>

## **Advancing Integrated Care in Minnesota, Building on Success**

MSHO has made great strides in increasing access to care, delivering person-centered care, and promoting independence in the community. However, opportunities remain to improve beneficiary experience by strengthening administrative integration of the Medicare and Medicaid programs. MSHO plans provide an integrated option for Medicare-Medicaid beneficiaries, as they are enrolled with a single MSHO plan that delivers both Medicare and Medicaid benefits. This is possible, in part, because MSHO plans must operate simultaneously as Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) to administer the Medicare benefit and as Medicaid managed care plans contracted with the state to administer the Medicaid benefit. This creates challenges for communications with beneficiaries as well as administrative inefficiencies for health plans.

On September 13, 2013, CMS and the State of Minnesota launched the Minnesota Demonstration to Align Administrative Functions for Improvements in Beneficiary Experience, a partnership to test new ways of improving MSHO enrollees' experience of care by better aligning certain Medicare Advantage and Medicaid managed care requirements.

The authority for the Minnesota Demonstration was established by Section 1115A of the SSA (as added by Section 3021 of the ACA). The Minnesota Demonstration also does not change the benefits available to MSHO enrollees, nor does it affect the MSHO enrollment process or payments to the MSHO plans. Rather, the Minnesota Demonstration aims to support the existing MSHO integrated care model by simplifying information and processes for enrollees and their families, and generating administrative efficiencies for the MSHO plans that, in turn, may help them to continue to offer the integrated benefit.

CMS and the State of Minnesota identified a set of administrative activities for testing under the new initiative, as outlined in the Memorandum of Understanding (MOU) for the Demonstration.<sup>11</sup> Over the past three years, CMS and the state have implemented a number of

these activities while also encountering some challenges and continuing to look for additional opportunities for improvement. Key activities include:

***Demonstration Management Team.*** As one of the first activities completed under the Demonstration, CMS and the State of Minnesota created a Demonstration Management Team (Team) comprised of federal and state staff to jointly conduct MSHO contract management activities related to ensuring access, quality, program integrity, and program compliance. Before the Demonstration, the state and CMS typically conducted routine Medicare and Medicaid oversight activities separately. The state, CMS, and the plans consider the Team to be an important and highly successful vehicle for resolving challenges related to Medicare-Medicaid misalignment as well as day-to-day plan oversight issues.

***Model of Care.*** Under the Medicare Advantage program, D-SNPs are required to have MOCs that provide the structure for care management processes and systems that will enable the plan to provide coordinated care for enrollees. The National Committee for Quality Assurance (NCQA) reviews and approves D-SNPs' MOCs based on standards and scoring criteria established by CMS. Under the Demonstration, for MOCs beginning in 2015, Minnesota added state requirements to the existing MOC elements. The state's additions include elements related to the coordination of Medicare and Medicaid benefits, including managed LTSS. For the first time, the state also had the opportunity to review the MSHO plans' MOC submissions concurrently with NCQA and provide feedback to the plans. Previously, the process was bifurcated, with the state providing limited feedback through offline responses to the plans. In the past, the plan shared their MOCs with the state but the state review was not incorporated into the overall response from CMS. The current integrated and joint review process also helps avoid issues that previously arose when plan audits only reflected the Medicare-only process as identified in the D-SNP MOC, and not the integrated process that the plan was actually using.

***Network Adequacy Standards.*** CMS, in coordination with the State, is testing new Medicare provider network review standards and a new annual network review for all MSHO plans. CMS developed the network adequacy standards currently being tested by leveraging the current Medicare Advantage methodology to ensure that the providers within MSHO plan networks are accessible to enrollees within certain time and distance standards. Unlike Medicare Advantage, however, the standards themselves are based on geographic location of the Medicare-Medicaid population rather than all Medicare beneficiaries. The state also has the chance to participate in the review of Medicare network submissions and provide input to CMS on local delivery system considerations. The new standards and collaborative CMS-state review began in 2015. MSHO plans' feedback about the review has been mixed given that Medicare Advantage does not require annual reviews. MSHO plans are currently undergoing the 2016 annual review and appear to have adapted to the process. While the annual reviews represent an increased burden for MSHO plans, the plans have indicated that they agree the standards better reflect the population they serve.

***Written Materials for Beneficiaries.*** Medicare and Medicaid beneficiaries receive numerous types of written materials about their health care. Many materials are difficult to understand, especially among populations with lower levels of health literacy or English proficiency. The

challenge is compounded for dually eligible beneficiaries, because they receive written materials on both programs.

For years, MSHO plans have tried to make written materials more understandable for beneficiaries by integrating Medicare and Medicaid information through agreements with the CMS regional office. While ultimately beneficial to enrollees, the process was long and cumbersome, and did not allow for concurrent review by the state and CMS. With the Demonstration, this process has been modified to allow MSHO plans to use model written materials developed for the Financial Alignment Initiative that integrate Medicare and Medicaid benefits information, resulting in both a smoother process for submission and review as well as additional integrated materials. These integrated materials include:

- The Summary of Benefits, which provides a brief overview of benefits and cost sharing information and describes important aspects of enrolling in the plan.
- An integrated comprehensive formulary (List of Covered Drugs) that includes drugs and over-the-counter products covered under both the Medicare Part D and Medicaid pharmacy benefits available through the MSHO plans.
- A provider and pharmacy directory; an Annual Notice of Change and Evidence of Coverage (Member Handbook); an enrollment form.
- A document known as the “LIS Rider” that includes information about Part D cost sharing.

In 2015, CMS made a system modification to allow for a concurrent joint review of written materials by CMS and state staff in the CMS Health Plan Management System. The concurrent review process reduces the time needed to get final approval of materials and allows plans to begin printing and mailing materials by required deadlines. Both the state and plans have indicated that they are pleased with the change because it streamlines the review process.

***Appeals and Grievances.*** CMS and the state have added new features to simplify communications with MSHO enrollees and their families. The state is using a new simplified, integrated model notice for appeals explanations, developed and approved by CMS for Medicare Advantage organizations, including D-SNPs. The state and CMS also aligned the timeframes for MSHO enrollees, their authorized representatives, and providers to file Medicare and Medicaid appeals. Under the Demonstration, CMS formally extended from 60 to 90 days the timeframe for MSHO enrollees file an appeal related to either Medicare or Medicaid benefit coverage. Aligned appeals timeframes simplify the appeals process for MSHO enrollees who receive both coverage of both Medicare and Medicaid benefits under the plan and ensure that appeals for services that overlap the Medicare and Medicaid benefits are not dismissed because the appeal missed the earlier deadline applicable to Medicare benefits. These timeframes will change in 2018, when new federal Medicaid managed care regulations will require a 60-day period for enrollees in Medicaid managed care plans to file an appeal related to Medicaid services. At that time, CMS will restore the Medicare appeal timeframe under the Minnesota Demonstration to the standard 60-day period, to maintain Medicare and Medicaid alignment.

The Demonstration terms allow for testing of additional administrative alignment steps, including new quality measurement approaches, which CMS and the state continue to explore.

For example, in partnership with the state, CMS is testing the option of adding another language to the Medicare Health Outcomes Survey to determine if conducting the survey in additional locally prevalent languages increases response rates. Also, CMS will be sharing data from the Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey with the state in lieu of the state including the MSHO population in the Medicaid-only CAHPS survey, with the goal of reducing survey fatigue for beneficiaries.

## Looking Forward

MSHO is one of the longest-standing programs designed to integrate Medicare and Medicaid benefits for Medicare-Medicaid enrollees. As demonstrated by the ASPE report, MSHO has made significant progress in improving enrollee experience and shifting utilization patterns toward lower-acuity settings.

Notably, the MSHO program achieved these accomplishments even before the start of the Minnesota Demonstration, in a system where differences between Medicare and Medicaid processes at times made that progress more difficult. While CMS and the state do not expect the Minnesota Demonstration itself to directly impact service utilization, clinical quality, or Medicare and Medicaid costs, the Minnesota Demonstration aims to enhance the already robust MSHO integrated care model and improve beneficiary experience by introducing processes that support integrated care and reduce administrative obstacles.

CMS and the state recently effectuated a two-year extension of the Demonstration through December 31, 2018, to provide additional time for CMS and the state to obtain and review Demonstration results. CMS and the state will closely monitor the performance of the MSHO plans through the plans' participation in Medicare Advantage reporting and the Medicare CAHPS survey. CMS has also contracted with RTI International to conduct an independent evaluation of the Minnesota Demonstration, which will examine the extent to which the Demonstration is achieving its goals. CMS will publicly release each annual evaluation report for the Demonstration, and is releasing the first annual report for Demonstration Year 1 (September 2013 - December 2014) together with this brief. In collaboration with the MSHO plans and other stakeholders, CMS and the state look forward to using those results to identify approaches to combine service and administrative integration that might benefit not only the MSHO program but managed care models more broadly.

In the meantime, the Minnesota Demonstration is a prime example of a CMS Innovation Center initiative that builds upon an existing, successful program. Health policy observers are likely familiar with the Innovation Center as the sponsor for testing completely new MOCs, such as Pioneer Accountable Care Organizations and for other Advanced Alternative Payment Models under the Medicare Access and CHIP Reauthorization Act of 2015. These new initiatives are a central part of CMS efforts to improve quality while lowering Medicare and Medicaid spending. Alongside these new initiatives, however, are opportunities to identify and further improve upon programs already advancing the quality and value of care delivery. With considerable evidence of MSHO success, including the 2016 ASPE report, the Innovation Center has invested in the Minnesota Demonstration to strengthen the MSHO program and enhance beneficiary experience.

## Endnotes

1. Centers for Medicare & Medicaid Services, Medicare-Medicaid Coordination Office. Accessed at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Analytics.html>.
2. Ibid.
3. Ibid.
4. Ibid.
5. Congressional Budget Office. (June 2013). Dual Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies. Accessed at: [https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/44308\\_DualEligibles2.pdf](https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/44308_DualEligibles2.pdf).
6. People Enrolled in Medicare and Medicaid. (April 2016). Medicare-Medicaid Coordination Office Fact Sheet. Accessed at: [https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO\\_Factsheet.pdf](https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO_Factsheet.pdf).
7. Anderson, W., Feng, Z., Long, S. (March 2016). Minnesota Managed Care Longitudinal Analysis. Accessed at: <https://aspe.hhs.gov/report/minnesota-managed-care-longitudinal-data-analysis>.
8. PCA services were not provided under managed care arrangements until the mid-1990s.
9. The Minnesota Department of Human Services conducts triennial compliance assessments of each of the MSHO participating health plans. As of 2016, all MSHO plans reported conducting annual assessments and individualized care coordination for nearly all members. The results of these assessments can be found at: <http://www.health.state.mn.us/divs/hpsc/mcs/quality/>.
10. Anderson, W., Feng, Z., Long, S. (March 2016). Minnesota Managed Care Longitudinal Analysis. Accessed at: <https://aspe.hhs.gov/report/minnesota-managed-care-longitudinal-data-analysis>.
11. MOU between CMS and the State of Minnesota Regarding a Federal-State Partnership to Align Administrative Functions for Improvements in Medicare-Medicaid Beneficiary Experience, September 12, 2013. Accessed at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MNMOU.pdf>.

This Issue Brief, authored by Jhamirah M. Howard and Jennifer Baron, presents information on integrated care in the State of Minnesota. For additional information about this subject, visit the DALTCP home page at <https://aspe.hhs.gov/office-disability-aging-and-long-term-care-policy-daltcp> or contact the ASPE author at HHS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201; [Jhamirah.howard@hhs.gov](mailto:Jhamirah.howard@hhs.gov).