MassHealth Matters

Overview of Minnesota LTSS delivery
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Minnesota Medicaid Special Needs

- Total Medicaid seniors 65 and older: 59,000
- Total Medicaid people with disabilities: 125,000
- Full benefit Medicaid –Medicare dual eligibles: 56,000 seniors; 62,000 people with disabilities
- Partial benefit Medicaid-Medicare dual eligibles (Medicare cost sharing): 10,000
- Medicaid expenditures for seniors and people with disabilities:
  - Seniors: $1.817 Billion (19.3% of all Medicaid)
  - Disabilities: $3.981 Billion (42.3% of all Medicaid)
  - Elderly/Disabled Total: $5.79 Billion (61.6 % of all Medicaid)

*Data: Average monthly enrollment FY 2104 Reports and Forecasts

Strategy: Managed Care Programs for Medicaid Seniors

- Required to enroll managed care; 48,000 (about 80%) enrolled at any given time.
- 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), in all settings and levels of care. Two managed care options:
  - Minnesota SeniorCare Plus (MSC+): 13,000 enrollees, mandatory enrollment. Provides Medicaid services only, 85% dually eligible.
  - Minnesota Senior Health Options (MSHO): 35,000 enrollees, integrated with Medicare, voluntary enrollment for dually eligible seniors as an alternative to MSC+.

Strategy: Leveraging Medicare Involvement

- Decisions made by primary, acute and post acute care providers paid under Medicare also drive State Medicaid and Long Term Services and Supports (LTSS) costs.
- Without coordination with Medicare, States can do little to impact preventive, primary, acute care and post acute care and costs for their largely dually eligible Medicaid populations.
- Combining Medicare/Medicaid primary, acute and LTSS financing in capitated aligned contracts can create incentives for partnerships at State, plan and provider levels that can improve care and costs across both financing sources.
- The CMS Medicare Medicaid Coordination Office (MMCO) now sponsors an integrated Financial Alignment demonstration in 12 states; Minnesota has a unique D-SNP Administrative Alignment demonstration for MSHO.

Strategy: Medicare-Medicaid Integration through MSHO

- Minnesota Senior Health Options (MSHO) provides integrated Medicare and Medicaid benefits through Medicaid contracts with 7 Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs).
- All D-SNPs must have Medicaid contracts with state approval to operate. About 336 D-SNPs now serve nearly 1.7 million duals in 38 states.
- Medicare and Medicaid contracts and payment remain separate but services and finances are coordinated or integrated at the plan and provider level. Opportunity to insert state model of care, care coordination and LTSS assessment priorities into Medicare
- MSHO's integrated models of care, assessment and individual care coordination of all members, care plans, waiver of 3 day hospital stays and other operational features enable a focus on management of chronic care conditions and improved outcomes across both Medicare and Medicaid.

Strategy: Value Based Purchasing

- Leverage Medicare involvement in value based purchasing arrangements that can combine payments and risk and gain sharing across primary, acute and LTC settings tied to performance measurement
- DHS VBP Initiative facilitates Integrated Care System Partnerships (ICSPs) between D-SNPs and network providers.
- State contract requirements for MSHO/MSC+ managed care programs allow ultiple financial models tied to a range of quality metrics developed by D-SNPs, clinical experts and DHS for triple aim goals including:
  - Improved health outcomes and choice of care setting
  - Long-term care provider involvement
  - Increased coordination of physical and behavioral health

Strategy: HCBS for Frail Pre-Medicaid Seniors

- Alternative Care is a state funded program started in 1980 to help seniors 65+ who require nursing home level of care and are not financially eligible for Medical Assistance, but whose income and assets are insufficient to pay for 135 days of nursing facility care.
- The program connects high-need seniors with modest income and assets to community services earlier. It diverts them from nursing facilities and slows spending into Medicaid eligibility.
- In state fiscal year 2013, the AC program served 4,490 people and spent $26.6 million. The average monthly cost per enrollee was $772.
- Available services include: adult day service, chore, companion, home-delivered meals, homemaker, home modifications, supplies and equipment, personal care, respite, caregiver supports, and transportation.
- DHS successfully sought Federal match from Medicaid which was approved and began November 2013.
- No change in eligibility criteria or services for participants.

Rebalancing the System for Seniors

- **Rebalanced System:** From 63% NF and 9.5% community waivers in 1996 to 23% NF and 41% community waivers in 2014. Fewer seniors spend into Medicaid through long nursing home stays. Average length of stay was reduced to less than 150 days per stay.
- Factors include:
  - LTC industry role in creating assisted living and other housing alternatives to meet changing consumer preferences
  - DHS Aging leadership on nursing home bed management
  - Universal assessment and quick access to Medicaid LTSS through MSHO/MSC+
  - DHS Aging Return to Community and Moving Home Minnesota Initiatives

Strategy: Extend Integrated Options to People with Disabilities

- Managed Care for People with Disabilities 18-65: Adults with disabilities can voluntarily enroll in managed care.
- Special Needs BasicCare (SNBC), currently enrolls nearly 50% of adults 18-65 with disabilities. (SNBC does not include Medicare or LTSS but includes all behavioral health and other Medicaid services). SNBC was designed with the assistance of disability stakeholders.
- About 50% of SNBC members are dually eligible for Medicare. About 300 non-duals change to Medicare each month after the waiting period for Medicare eligibility ends.
- SNBC includes two small integrated D-SNPs, but in general the D-SNP option has not proved viable for this population. Medicare risk adjustment payment has been less than fee for service Medicare. Changes in Medicare risk adjustment may make this option more attractive to D-SNPs.

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