Innovations in Medicare-Medicaid Integration: Updates from Three State Pioneers

January 25, 2013

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CHCS Mission

To improve health care access and quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders, and racially and ethnically diverse populations experiencing disparities in care.

► Our Priorities

- Enhancing access to coverage and services
- Improving quality and reducing racial and ethnic disparities
- Integrating care for people with complex and special needs
- Building Medicaid leadership and capacity
Goals of Webinar

- Assist state policymakers who are considering how to integrate care for Medicare-Medicaid enrollees
- Review different state approaches to meet common goals of integration and alignment
  - Massachusetts: signed Memorandum of Understanding (MOU) with CMS for a capitated Financial Alignment Demonstration
  - Washington: signed MOU with CMS for a managed fee-for-service Financial Alignment Demonstration
  - Minnesota: pursuing an alternative strategy for improving Medicare-Medicaid integration
Massachusetts Duals Demonstration

January 25, 2013
CHCS Innovations in Integration Webinar
Presentation by Corrinne Altman Moore
Director of Policy, MassHealth
Agenda

- Overview of Massachusetts Duals Demonstration: Highlights of Final Proposal and MOU

- Stakeholder Engagement and Impact on Demonstration

- Timeline

- Advice for Other States
Why Do This?

- Demonstration provides opportunities to improve care for members and address other challenges in the current delivery system for dual eligible adults ages 21-64, including:
  - Fragmented care, especially for members with multiple and/or complex needs across medical, behavioral health, and long term services and supports (LTSS) domains
  - Existing fee-for-service structure focused on individual services, rather than a whole person approach focused on health outcomes
  - Misaligned incentives, encouraging acute service use instead of community-based alternatives
  - Confusion and administrative burden for providers
  - Cost-shifting between Medicare and Medicaid
  - Unsustainable cost increases in both Medicare and Medicaid
Eligible Population

- Target population: 111,000 dual eligibles ages 21-64 with full MassHealth and Medicare benefits

- To be eligible to enroll in the Demonstration, a person must be:
  - Age 21 to 64 at the time of enrollment;
  - Eligible for MassHealth Standard or CommonHealth;
  - Enrolled in Medicare Parts A & B and eligible for Medicare Part D;
  - Without other comprehensive insurance;
  - Not enrolled in a Home and Community-based Services (HCBS) waiver; and
  - Not residing in an Intermediate Care Facility (ICF/MR)

- MassHealth and CMS will continue discussions about inclusion of HCBS waiver participants in the Demonstration over time
Demonstration Covered Services

- Medicare Services: All Part A, Part B, and Part D services
- Medicaid State Plan Services*
- Additional Behavioral Health Diversionary Services, e.g.:
  - Community crisis stabilization, Community Support Program, acute treatment and clinical support services for substance abuse, psychiatric day treatment
- Additional Community Support Services, e.g.:
  - Day services, home care, respite care, peer support, care transitions assistance (across settings), Community Health Workers
- Additional services are meant as alternatives to advance wellness, recovery, self-management of chronic conditions, independent living, and as a means to avoid high cost acute and long-term institutional services

*Excluding certain services provided by other state agencies: Targeted Case Management, Department of Mental Health Rehabilitation Option, and Intermediate Care Facility services
Care Model and Delivery

- ICOs will provide for beneficiaries:
  - Person-centered planning, with integration across medical, behavioral health and LTSS needs
  - Individualized Care Plans directed by the enrollee, informed by comprehensive in-person assessment of medical, behavioral, and functional needs
  - Interdisciplinary Care Teams, with Care Coordinators and Independent Living and Long Term Services and Supports (IL-LTSS) Coordinators (see slide 15)
  - Integrated Medicare and MassHealth benefits

- ICOs will receive global payments, which increases their flexibility to authorize LTSS and community support services more broadly when doing so would prevent more expensive acute, inpatient, or institutional costs
Integrated Care Organizations (ICOs) will receive a prospective global payment to provide comprehensive, seamless coverage to enrolled beneficiaries.

Global payment will be paid as three capitation payments: two from CMS (for Medicare “portions” Parts A/B and Part D) and one from MassHealth (for Medicaid “portion”).

Adjustment for risk differences across ICOs:
- Medicaid – rating categories and high cost risk pools, ongoing development of robust risk adjustment methodology to include functional status
- Medicare – CMS-HCC risk adjustment for A/B, RxHCC for Part D

Risk corridors (for Medicaid and Medicare A/B combined) will be used to account for program uncertainties.

Payment model will include quality withholds and incentives.

Encourage ICOs to use alternative payment methodologies in provider contracts, including shared savings.
Enrollment

- Phased enrollment, to help ensure sufficient capacity to work with enrollees during the transition

- Enrollment will occur via voluntary, opt-out process
  - First self-selected enrollments will take effect July 1, 2013

- Auto-assignment of individuals who do not indicate a choice of ICO or to opt out
  - No auto-assignment of individuals in a PACE or Medicare Advantage plan
  - Two initial waves of auto-assignment enrollments will be effective Oct. 1, 2013 and Jan. 1, 2014
  - 60-day advance notice to members who have been auto-assigned

- At any time, enrollees may opt-out or transfer between ICOs, on a month-to-month basis.
Enrollment (cont’d)

- Process will be transparent, and reflect member choices
  - Eligible members will be notified about the Demonstration, at every stage, through clear, accessible information
  - Members will have at least 60 days to make an informed choice
  - MassHealth will confirm member’s choice before coverage begins

- Collaboration with CMS is ongoing to ensure members will experience seamless access to all Medicare benefits, including Part D, regardless of Demonstration enrollment status

- Independent enrollment assistance and options counseling will be available
Stakeholder Engagement

- Stakeholders have been consistently, highly involved in Demonstration design, including:
  - 32 open stakeholder meetings to date, including topical workgroups
  - A formal public comment process on draft proposal, with 2 public hearings and 152 written comments received
  - 4 member focus groups
  - Additional meetings with individual stakeholder organizations, including advocacy organizations, provider organizations, and unions
  - Email distribution list of >300 individuals
  - Dedicated website and email box

- Stakeholders have influenced many aspects of the Demonstration design and led to specific additions to or changes in the model

- Some examples are provided in the following slides
IL-LTSS Coordinator

- ICOs will be required to contract with community-based organizations to provide IL-LTSS Coordinators

- IL-LTSS Coordinator must have no financial interest in the determination of an enrollee’s type or amount of services

- IL-LTSS Coordinator is a member of the care team, at the enrollee’s discretion
  - ICO must make an IL-LTSS Coordinator available to all enrollees

- If enrollee has specific needs outside a given IL-LTSS Coordinator’s expertise, ICO will work with the enrollee to engage a more appropriate IL-LTSS Coordinator

- IL-LTSS Coordinator will work with enrollee to incorporate community-based services as appropriate into care plan
Assessment/Continuity of Care

- ICOs must perform comprehensive in-person assessment within 90 days of a member’s enrollment
- Individualized Care Plans (ICPs) will be developed for each enrollee based on needs identified during comprehensive assessment
- Continuity of care:
  - For the first 90 days, or until the ICO completes the assessment, the ICO must allow enrollees to maintain current providers at current rates and honor prior authorizations issued by MassHealth and Medicare
  - If the assessment is completed before 90 days and the enrollee agrees to the new care plan, the transition may occur prior to 90 days
  - Includes allowing enrollee access to current providers, even if they are not in ICO network
  - ICO will pay member’s current LTSS providers at the same rate such providers were receiving prior to Demonstration
- ICOs required to provide Single Case Agreements to out of network providers in certain situations
- ICOs encouraged to contract with providers currently serving individuals eligible for the Demonstration
ADA

- Demonstration will focus on assuring ADA compliance across the care delivery system
- Each ICO must have a designated ADA compliance officer and plan
- ICOs must reasonably accommodate persons and ensure that programs and services are accessible:
  - Provide flexibility in scheduling
  - Provide interpreters and/or translators
  - Provide accessible communications
  - Ensure safe and appropriate physical access to buildings, services and equipment
  - Provide home-based services where appropriate
- ICOs will be required to provide training in cross-disability awareness, self-direction, independent living and recovery philosophies, LTSS and communication skills to ensure staff competency
Implementation Council

- Developed at the request of stakeholders seeking a formal role for consumers in Demonstration implementation

- Composition:
  - Majority consumers (and/or family members)
  - Providers or trade associations, community orgs, union reps
  - Seeking diversity in geography, disability, race/ethnicity, etc.

- Nominations from stakeholders were received by MassHealth in December 2012; announcement of selection will be issued shortly

- Responsibilities will include
  - Examining ICO quality and access to services
  - Monitoring grievances and appeals, and ombudsperson reports
  - Assessing use of peers, community health workers, IL-LTSS Coordinators, and
  - Assisting development of public education and outreach campaigns

- MassHealth will support the Council, including providing accommodations, stipends, state staff time
Ombudsman

- MassHealth will work with stakeholders to establish an ombudsman role for the Demonstration

- Development of this role will be a major focus for the newly formed Implementation Council

- Ombudsman’s roles and responsibilities are expected to include both individual advocacy for enrollees and working with MassHealth and all stakeholders to address systemic issues

- MassHealth is requesting implementation funding support from CMS to help establish this position
<table>
<thead>
<tr>
<th>Event</th>
<th>Date</th>
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<tbody>
<tr>
<td>ICO Selection Announcement</td>
<td>November 2, 2012</td>
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<tr>
<td>3-Way Contracts</td>
<td>March/April 2013</td>
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<td>Learning Collaboratives</td>
<td>March 2013 - Ongoing</td>
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<td>Implementation Activities</td>
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<td>- Stakeholder Workgroups</td>
<td>Dec. 2012 - Ongoing</td>
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<td>- Implementation Council</td>
<td>Feb. 2013 - Ongoing</td>
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<td>- Ombudsperson</td>
<td>May 2013 - Ongoing</td>
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<tr>
<td>Public Awareness Campaign</td>
<td>April 2013 - Ongoing</td>
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<tr>
<td>Member Outreach Activities</td>
<td>May 2013 – Ongoing</td>
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<td>(Members can begin to select ICOs for effective date July 1, 2013)</td>
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<tr>
<td>Self-Selected Enrollments Begin</td>
<td>July 1, 2013</td>
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Advice for Other States

- Engage with and learn from your stakeholders as much as possible
- Set timelines, but be willing to move them if more time becomes necessary
- As you approach implementation, think about how you will raise public awareness and understanding of the demonstration (consumer-oriented language, branding, outreach, etc.)
For More Information

Visit us at www.mass.gov/masshealth/duals

Email us at Duals@state.ma.us
WA’s Original Proposal

Three phases:

• Implementation of intensive care coordination for high cost/high risk clients receiving long term services and supports
• Include duals in state’s transition to financially capitated medical services
• Financial capitation model in limited geographic regions
MFFS Strategy for Integrating Care

• Embed robust delivery of health home services in all systems using section 2703 of the ACA
• Act as a bridge to coordinate across all systems of care
• Integrate service delivery at the local community level where beneficiaries receive health care and social services
• Recognition that health and social services are inter-related
Sources that Inform WA’s Health Home Model

• Federal law – Section 2703, Affordable Care Act
• State law – SSB 5394 (passed in 2011)
• Stakeholder feedback during “Duals” planning
  – Integrate across medical and social services to improve coordination and align incentives
  – Create a single point of contact and intentional care coordination for beneficiaries
  – Build on what’s working while improving, including flexibility to allow for local variances based on population need and provider networks
Service need and risk factor overlaps among high risk DUAL ELIGIBLE Aged or Disabled clients

STATE FISCAL YEAR 2009

GRAND TOTAL
ALL HIGH RISK DUAL ELIGIBLES (Dotted Outline) = 44,608

Shaded Area Between Dotted Outline and Circles = 4,228

9%

TOTAL LTC = 35,411
79%

LTC ONLY = 25,296
57%

TOTAL DD = 2,608
6%

DD ONLY = 877

TOTAL SMI = 12,390
28%

LTC + SMI = 7,985
18%

LTC + SMI + DD = 138
<1%

LTC + DD = 329
1%

LTC + AOD = 834
2%

LTC + AOD + SMI = 816
2%

AOD + SMI = 844
2%

LTC + AOD + SMI + DD = 641
1%

TOTAL SMI + DD = 1,356
3%

TOTAL AOD = 3,191
7%

LTC + SMI + DD = 138
<1%

LTC + SMI ONLY = 1,208
3%

SMI ONLY = 1,356
3%

LTC ONLY = 25,296
57%

LTC + SMI = 7,985
18%

LTC + SMI + DD = 138
<1%

LTC + DD = 329
1%

LTC + AOD = 834
2%

LTC + AOD + SMI = 816
2%

AOD + SMI = 844
2%

LTC + AOD + SMI + DD = 641
1%

TOTAL SMI + DD = 1,356
3%

TOTAL AOD = 3,191
7%

LTC + SMI + DD = 138
<1%

SOURCE: DSHS Research and Data Analysis Division, Integrated Client Database, January 2012.
Health Home Services: The Washington Way

• A new set of services targeted to high cost/high risk clients who could benefit from intensive care coordination
• Will not duplicate or take the place of other case management services provided through Medicaid
• Focus on working with beneficiary on setting personal health action goals
• Make changes to improve beneficiaries’ ability to function in their home and community and manage chronic conditions
Health Homes Services: The Washington Way (cont.)

- Reduce avoidable health care costs
- Ensure access to after hours assistance to help with health care decisions during evenings or weekends when the health home coordinator is not available
- Slow the progression of disease and disability
- Access the right care, at the right time and place
- Successfully transition from hospital to other care settings and get necessary follow-up care
After Health Home

- My Health Home Coordinator
- Lead Entity

Before

Primary Care
Mental Health
Chemical Dependency
Treatment
Stooling Plan
Long Term Care
Community Integration
Managed Care Organization
Community Services

My Health Home Coordinator
HHC: Long Term Services and Supports
LE: Mental Health Provider

The Empowered Beneficiary
Washington’s MFFS MOU

- Integrated health home networks
- Use of web-based clinical decision support application (PRISM)
- Evaluation design
- Core, process and state measures
- Performance payments
Tips

• Be flexible and know where you can and are willing to make changes
• Build extra time and contingencies into work plans
• On-going communication is essential
• Acknowledge and celebrate accomplishments
Resources

Websites:
http://www.hca.wa.gov/health_homes.html
http://www.integratedcareresourcecenter.com/
http://www.adsa.dshs.wa.gov/duals

Bea Rector rectobm@dshs.wa.gov
Minnesota’s Alternative Dual Eligible Demonstration

CHCS Webinar
January 25, 2013

Pamela Parker, MPA
Special Needs Purchasing
Minnesota Department of Human Services
Pam.parker@state.mn.us
Integrated Programs for Dual Eligibles in MN

- Medicaid managed care since 1985, about 600,000 total enrollees.
- Seniors enrolled since 1985, includes dual eligibles, began adding people with disabilities in 2001.
- 90% of seniors (49,000) enrolled in managed long term care, includes all home and community based and behavioral health services. 70% of seniors enrolled in FIDE SNPs. Average age 80. 70% eligible for LTSS. Two options:
  - Minnesota SeniorCare Plus (MSC+): 12,500 seniors in same 8 Medicaid MCOs, mandatory enrollment unless enrolled in MSHO, Medicare FFS.
  - Minnesota Senior Health Options (MSHO): 36,500 dual seniors in 8 fully integrated Medicare/Medicaid FIDE SNPs, voluntary alternative to mandatory enrollment in MSC+
- 43% of people with disabilities (36,500) enrolled in Special Needs BasicCare sponsored by 5 Medicaid MCOs, LTSS carved out, all behavioral health included. Only 3% in 3 integrated SNPs, 5 other SNPs dropped Medicare for disability group.
- MSHO now moving back to Dual Demonstration status under new CMS options.
## Typical SNPs vs. Integrated SNPs

### Non-Integrated SNP Features
- Separate assessments and Models for Care (MOC) 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 MOC
- 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, directories, materials,..
- One set of integrated notices
- Integrated QA, 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 Indicators for MSHO Seniors

- **Contract Requirements for Care Coordination:** All members are assigned individual care coordinators. The State sets uniform standards, audit protocols and criteria for assessment, care plans and care coordination. Audit reports, independent onsite reviews and corrective actions are used to follow up.

- **Encounter Data Analysis:** Shows annual assessment and individualized care coordination has increased access to HCBS.

- **Payment Incentives:** Contracts include significant payment withhold tied to timely assessment as well as carefully designed financial incentives for provision of HCBS.

- **AARP Scorecard:** MN has been #1 for HCBS Access. Medicaid long term care for seniors has been rebalanced since the start of managed LTC programs (Sources: 1996 Medicaid Forecast, July 2012 Medicaid enrollment by living arrangement).

- **HEDIS:** 98% of MSHO seniors have annual primary care visits.

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

- **STARS:** MSHO D-SNPs have had average Star ratings of 4.0 Stars (2012)

- **CAHPS:** MSHO is highest rated Medicaid program. Includes care coord. questions

- **Disenrollment Rates:** Despite voluntary enrollment, MSHO disenrollment is < 2%.
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 and Integrated Care System Partnerships (ICSPs):** SIM/HCDS aligned relationships for provider payment and delivery reforms for dually eligible enrollees within DE-SNPs.
SNPs provide MSHO care coordination directly or through contracts with counties, Care Systems/Health Care Homes or community case management organizations. Unlike typical HCBS case management, care coordination models include clinical support for care coordinators to increase monitoring of chronic medical conditions.

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.

Under MSHO, 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 performance based payments with LTC providers
- Combined Medicare and Medicaid care coordination PMPM payments
- Combined Medicare and Medicaid primary care, Health Care Home and care coordination PMPM payments
- Total cost of care sub-capitations or virtual sub-capitations with shared performance pools across all services

State goal is to increase the use of these payment and delivery reforms

Cooperation of Medicare SNPs and the Dual Demo are key to that goal.
Integrated Care System Partnerships

- New contract provisions for SNP/MCOs participating in MSHO/MSC+/SNBC
- Builds from current MCO/Provider “Care System” contracting arrangements (current providers may convert to ICSPs)
- Combined Medicare and Medicaid financing provides incentives for provider level payment and delivery reforms stimulating new subcontracting arrangements and affiliations across services.
- All models to incent improved health outcomes and choice of care setting
- Seniors: Encourages involvement of long term care providers under shared pooled incentives or payment reform models
- People with Disabilities: Encourages coordination of physical and behavioral health for people with disabilities in SNBC
- Tied to a range of quality and financial performance metrics
  - Clinical workgroups developing quality measure options
- Financial metrics to be proposed according to broad State parameters
- SNP/MCO/Provider proposals due July 2013, review of proposals by State, implementation of new arrangements no later than January 2014.
- All proposals subject to State contract requirements for care coordination, quality metrics, financial performance measurement and reporting
MN Alternative Dual Demo Proposal

- One of 15 Original Dual Demo states
- Huge stakeholder involvement effort for refocusing dual programs over past 18 months
- Stakeholder groups at State level and at each plan level required
- 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 Medical Loss Ratios
    - SNP loss of Medicare revenue,
    - Part C rebates already used to buy down Part D premiums
- Already high SNP enrollment, not reliant on passive enrollment for seniors
- Many FAD features already similar to 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
  - Improved platform for dual eligibles to align with and support State Payment and Delivery Reforms as developed through stakeholder efforts
  - Provide State a clearer joint role with CMS in Medicare SNP oversight in order to preserve/enhance integrated administrative and operational features and reduce reliance on informal CMS Medicare SNP policy agreements which often change and threaten disintegration

- Provide learning laboratory for State and CMS efforts to improve integrated 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

• **Member Materials**
  – Retain integrated EOCs, member notices and communications,
  – Use new models from FAD where possible

• **Quality Oversight**
  – Test more targeted duals outcome measures (also working with NCQA on this)
  – 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**
  - Clarify bid audit instructions

- **Premium Protection for Beneficiaries**
  - Exploring mechanisms such as increasing in de-minimus premium levels (CMS objecting thus far)
  - Waive Part D co-pays as under FAD (no response from CMS on this yet)

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

Status of Alternative Demo

- MOU in drafting stage, promised a full draft soon
  - SNP contracts amended to prepare for demo and ICSPs, further amendments likely

- 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: Still considering what to do for people with disabilities
Thoughts to Share

• Measurement and evaluation will be much more difficult than you think, be careful what you promise!
  – Savings and outcomes are very hard to prove
  – Very hard to get doctors to change practice patterns for a relatively small proportion of their patients
  – Many accepted measures/benchmarks are not appropriate for some sub-populations (e.g. nursing home members, memory care members, certain disabilities)
  – The wide range of risk between dually eligible sub-populations makes fair measurement more difficult
  – Risk adjustment systems are needed for measurement as well as payment

• Aligning the financing does not equal aligning the service delivery
  – Demo plans need to integrate operations to support integrated benefit determinations and service delivery, make sure this is really happening and they aren’t just using old Medicare or Medicaid procedures when a new procedure is what’s needed

• Collaboration among plans is important for learning and consistency across providers—you need to help that happen!

• Bottom Line: Impact on beneficiary is the unifying force for achieving agreement between disparate interests, guiding principle should be will they understand, how will it work for the member?
## 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
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Deb Maruska, Project Manager, Dual Demo/Disability Managed Care
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651-431-2516

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

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

To submit a question please click the question mark icon located in the toolbar at the top of your screen.

Your questions will be viewable only to CHCS staff and the panelists.

Answers to questions that cannot be addressed due to time constraints will be posted online after the webinar.
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