DHS health care updates

House Health and Human Services Finance Committee

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Overview of topics covered

- Competitive bidding for MCO contracts
- Health Care Delivery System (HCDS) demonstration
- Dual eligibles demonstration
- Managed care for people with disabilities
- Healthy Minnesota Contribution program

Managed care organization competitive bidding

- The 2011 Governor's budget and 2011 HHS omnibus bill established a two-year competitive bidding pilot for the Twin Cities metropolitan area
- Populations in the pilot will be families and children and non-disabled adults under 65
- The pilot starts January 2012

Background on competitive bidding

- The implementation of competitive bidding was a change from past procurement processes
  - Traditionally, rates have been rate-set by DHS
  - Competitive bidding introduced market competition
- The five plans that served the Twin Cities metro area in 2011 participated in competitive bidding for 2012 contracts
- 2011 initiative competitively bid rates for seven-county metro for families with children
- Results: **$175 million in state savings for FY 2012**

Competitive bidding process

- RFP issued April 6, two components
  - Technical
  - Cost bid components
- Proposals submitted by current plans for each county were evaluated and scored; counties participated in scoring process
- Based on the bids submitted, letters of intent to contract were issued Aug. 30
- Negotiations began in September and are nearly final

Competitive bidding results

- HealthPartners and UCare scored highest (based on combined cost bid and technical bid) in all seven counties
- To ensure capacity of provider networks and plan administrative functions, Blue Plus added in Dakota and Ramsey; Medica added in Hennepin.
- Enrollees will have access to substantially the same providers, even if their current plan is not an option

Open enrollment/transition work

- Transition work is a high priority
- Approximately 78,000 enrollees will need to change health plans for January 2012
- DHS facilitated meeting with county staff and health plans for enrollee transition planning and open enrollment
- Plans preparing to send out member cards early so enrollees can access services January 1
- Collaborative work with plans and counties has been key to ensuring a smooth transition for enrollees

Health Care Delivery System (HCDS) demo

- The 2010 legislature authorized DHS to develop and issue an RFP for a Health Care Delivery System (HCDS) demonstration
- The demonstration will test alternative and innovative health care delivery systems
- It provides flexibility to encourage innovation and uses different levels and types of financial arrangements

HCDS demo goal

Impact the quality and total cost of care through new care models and strategies

- Provide the full scope of primary care services and coordinate care in a comprehensive and continuous manner, building off health care homes
- Engage and partner with patients and families
- Develop formal community partnerships to encourage integration with social services
- Allow providers to share in the risks and gains of designing care models that improve care and lower costs

HCDS demo - the model

- Multiple payment models allow participation of both small and large providers
- Duration of three years
- Flexible amounts of risk/gain for providers
  - First year is gain-sharing only
  - Risk phased-in during years 2 and 3
- Alignment of payment at the provider system level across FFS and managed care
- Future models will include additional providers and populations

HCDS process and timeline

- April 2011: RFI issued
- June 30, 2011: RFP published
- July-October: information sharing, Q and A with providers, feedback
- November 4, 2011: proposals due
- April 2012: demo projects begin (pending federal approval)

HCDS demo – quality and data

- Financial gains will be contingent on performance on a core set of measures in the areas of clinical quality and patient experience – already collected by MN Community Measurement
- Delivery systems can propose additional quality measures to demonstrate value to populations and communities
- DHS will provide timely and actionable data to participating delivery systems

HCDS current status

- DHS received nine proposals – diverse in geography and organization
- Decisions on intent to contract planned for early December
- Planning work under way
  - Actuarial services
  - Data analysis
  - Federal authority for fee-for-service population

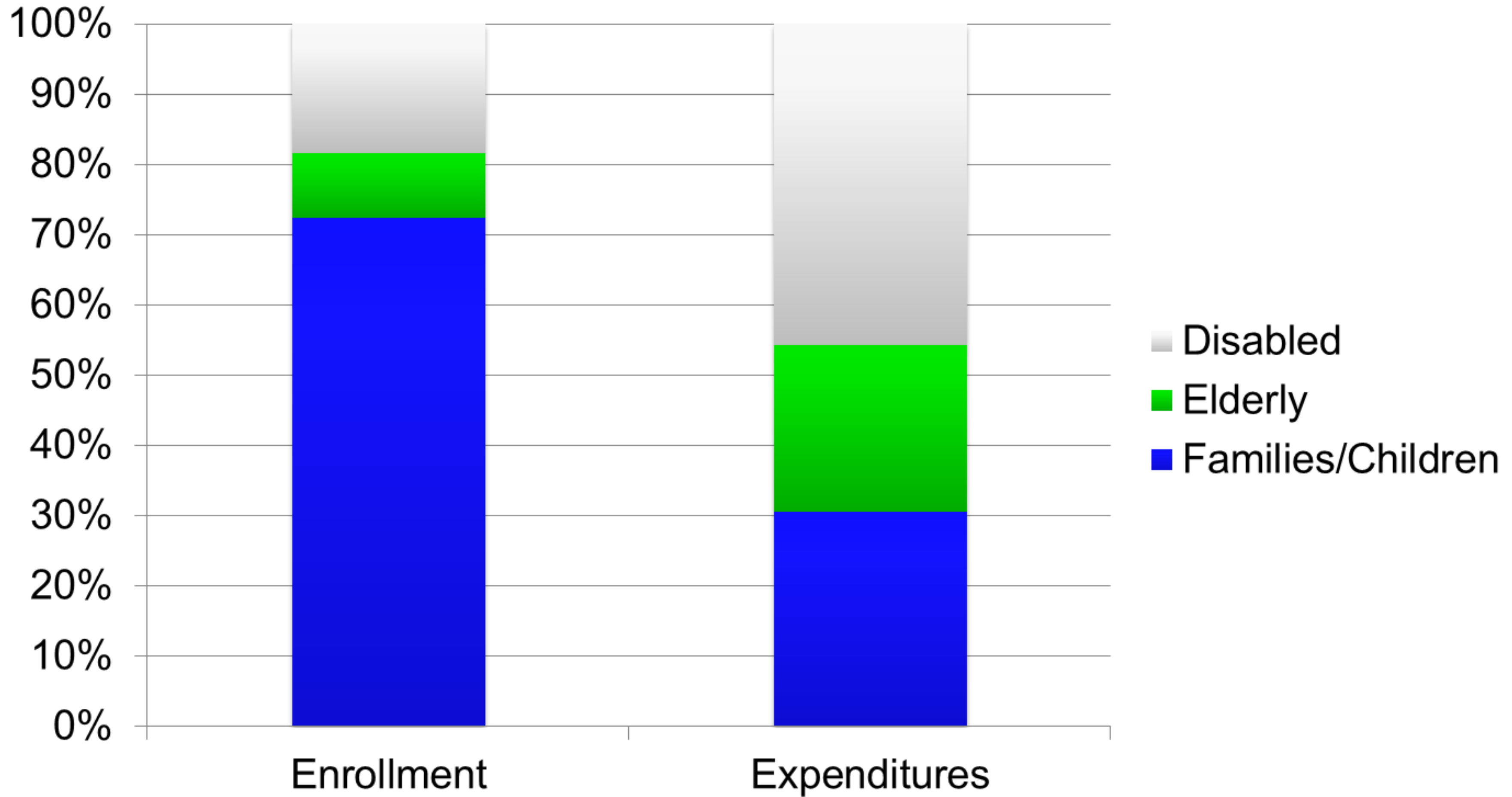
Dual eligibles overview

- Most Medicaid seniors and about 50% of people with disabilities in Medicaid are dually eligible
- Dual eligibles are among the sickest and poorest individuals with high needs for long-term care and mental health services
- Their care is fragmented and inefficient
- They must navigate two separate financing systems with conflicting information and payer and provider payment incentives
- State Medicaid innovations resulting in health care savings (physician, hospital) accrue to Medicare

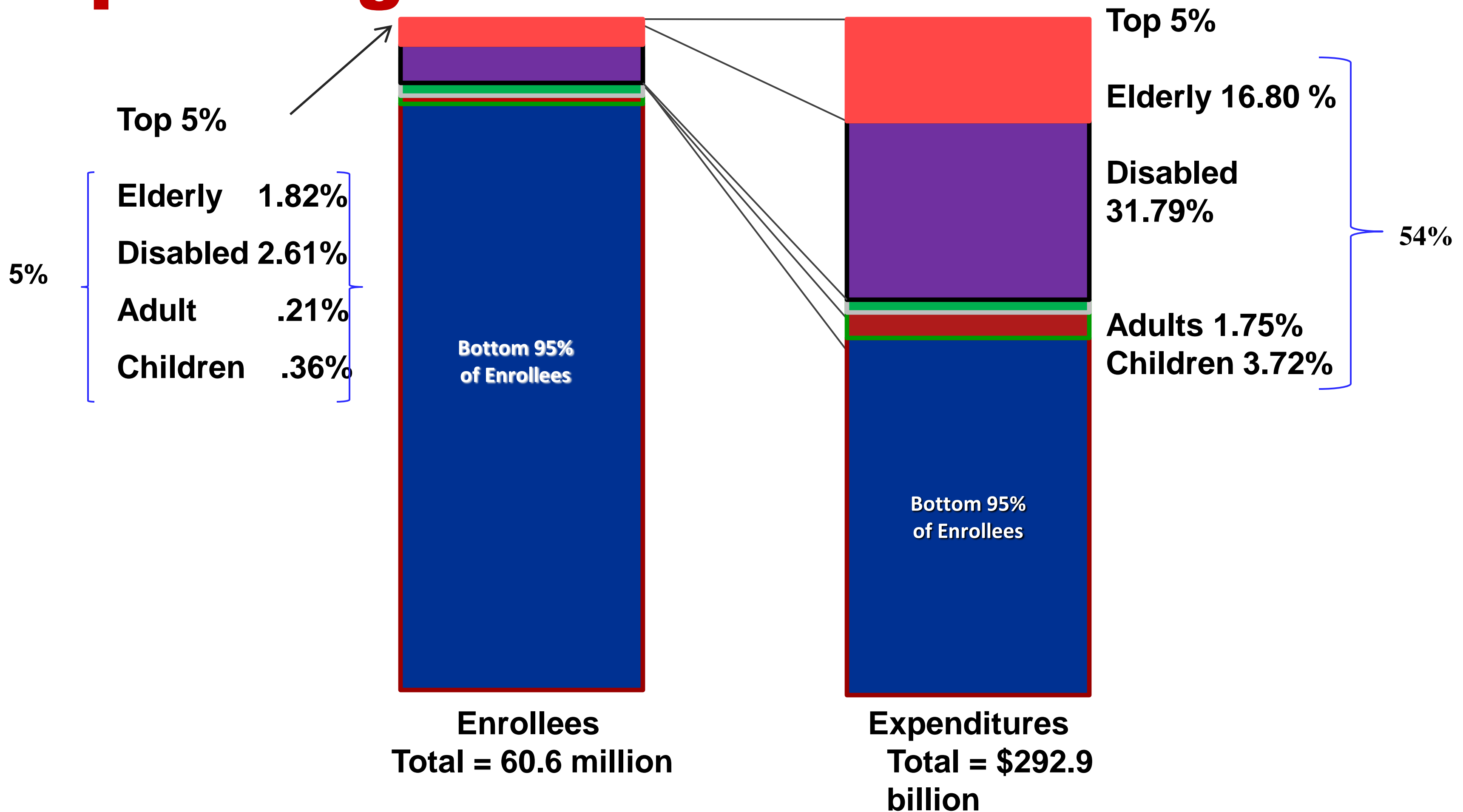
Dual eligibles overview

- Dual eligibles – about 39% of Medicaid spending; 15.3% enrollment nationally
- In Minnesota, about 106,600 fully dually eligible people with Medicaid spending of about $2.8 billion in FY 2010
- Minnesota was first state to develop a statewide integrated model for care and financing for dual eligibles in 1995 (Minnesota Senior Health Options)
- Great interest in improving the quality and efficiency of care for dual eligibles through expansion of similar models

Medicaid expenditures are concentrated with elderly and disabled



Top 5% of enrollees account for more than Half of Medicaid spending



Source: FY MSIS 2008, FY MSIS 2007 for AZ, NC, ND, HI, UT, VT, WI

Dual eligible demonstration

- Two new CMS initiatives for more efficient integrated models of care for dual eligibles
  - 15 states (including MN) given contracts with CMS to develop integrated service and payment models for dual eligibles
  - CMS invitation for integrated financing models; MN one of 38 states to submit letter of intent to pursue further discussion
- CMS expects models with full integration of Medicaid and Medicare services, as well as integration of medical care, behavioral health, long-term care and community services
  - Builds off existing Medicare-integrated programs for seniors and people with disabilities
  - Allows states to share in savings to Medicare
  - Builds on health care home and HCDS models

Managed care for people with disabilities

- The 2011 HHS omnibus bill required enrollment of people with disabilities into managed care, with an opt-out provision
- The enrollment of people with disabilities from MA fee-for-service to managed care is being phased in starting Jan. 1, 2012
- Those eligible for enrollment will be asked to join a health plan participating in Special Needs BasicCare (SNBC) but may opt out of enrollment.

Managed care for people with disabilities

- SNBC is offered by five health plans and currently has 6,000 enrollees
- SNBC has been operating since 2008
- An estimated 78,200 adults and 11,500 children with disabilities will be asked to enroll
- People are being given the opportunity to opt out prior to enrollment in a plan

Managed care for people with disabilities

- People may opt out of managed care enrollment or disenroll at any time and return to fee-for-service
- Budgeting for the law assumed enrollment would be phased in between January and July 2012 and that 50% would choose to opt out
- The goal of SNBC is to promote access to primary and preventive care, including coordination with Medicare benefits
- Under SNBC, most long-term care services continue to be provided through MA FFS

Managed care for people with disabilities

- Information will be mailed to potential enrollees 40-60 days before enrollment date
- Letters sent to the first group Nov. 7-14
- DHS is working closely with stakeholders and counties to ensure a smooth transition for those joining health plans
- Stakeholder meetings are being held to discuss implementation
- Additional Information is available on the DHS website: **www.dhs.state.mn.us/SNBC**

Healthy Minnesota Contribution program

- Established by 2011 HHS omnibus bill
- Replaces current MinnesotaCare program for enrollees who are adults without children with income at or above 200% FPG
- As of July 1, 2012, they will receive a monthly defined contribution to purchase coverage under a private health plan or the Minnesota Comprehensive Health Association (MCHA)
- Approximately 3,500 people will qualify

Healthy Minnesota Contribution program

- MinnesotaCare eligibility requirements continue to apply
- The contribution is calculated on a sliding scale based on age and household income
- Eligible applicants and enrollees must be referred to professional insurance agent associations (broker associations)

Healthy Minnesota Contribution program

- A joint DHS/Commerce project team is working to implement the legislation
- Stakeholder meetings with broker associations, health plans and MCHA are planned to discuss implementation issues
- Other project issues
  - Notifying enrollees, broker referrals and premium payment in June to avoid coverage gaps
  - Agreement by DHS and health plans on an enrollment and premium payment process
  - System changes and worker training