Medica
PO Box 9310
Minneapolis, MN 55440-9310
952-992-2900

February 16, 2023

Representative Tina Liebling
Chair, House Health Finance & Policy Committee
477 State Office Building
St. Paul, MN 55155

Re: HF 693 Testimony – Opposed

Madam Chair and Committee Members:

My name is Kathy Albrecht, and I am the Director of Medicaid and Special Needs Plan Product & Strategy at Medica, which is a regional non-profit health plan based in Minnetonka. I welcome the opportunity to share my perspective on House File 693, which requires the state to administer Medicaid and MinnesotaCare through a third-party administrator.

I have dedicated my career to improving the lives of our most vulnerable populations through my work at Medica and previously in my work within the non-profit community in Minnesota and Area Agencies on Aging in the state of Iowa. I have worked as a Case Manager and Care Coordinator with the most vulnerable, and I understand how confusing the system can be for them. I understand the complicated and fragmented systems in place within the Medicaid and Medicare programs. A private managed care organization improves the health and wellbeing of these populations by integrating Medicare and Medicaid benefits, coordinating patient care, minimizing unnecessary and confusing paperwork, and working to address the specific, individual needs of each vulnerable person on the program.

Studies of our integrated care approach to vulnerable populations are numerous. Evidence of the positive impact these programs have had in the lives of seniors and people with disabilities is clear and established. For example, CMS recently contracted with RTI International to evaluate the state's Minnesota Senior Health Options (MSHO) program and the study found:

- "MSHO is widely considered a model of Medicare-Medicaid integration, with a high degree of integration and high enrollment."
- "A longitudinal study comparing it with [a non-integrated approach] found that MSHO enrollees had less hospital and emergency department use, and greater use of ambulatory care and home and community-based services."
- "MSHO plans have excellent Medicare Star ratings, indicating high performance and quality, and very good ratings in beneficiary experience surveys."

Inserted with my testimony is a page from this study showing recent examples of how managed care organizations have simplified MSHO for patients, health care providers, and government. Please read this sheet so you understand the positive impact Minnesota's private health plans are having on low-income seniors and what will go away if this bill passes. A TPA does not issue one insurance card that covers both

Medicaid and Medicare benefits. A TPA will not stop confusing and irrelevant Medicare bills and mailings. A TPA will not create an integrated appeals and grievance process. A TPA does not provide access to Bridging, so members moving out of homelessness can have access to household goods.

Do managed care organizations have room for improvement? Absolutely. However, in Minnesota we have always prided ourselves in taking an innovative, collaborative approach. When we attend national meetings, the Minnesota model is held up as a national leader. We are light years ahead of most states in how we serve low-income seniors and people with disabilities. Our state should not be moving backwards, while other states are striving to achieve what we have already accomplished.

I am testifying in opposition to House File 693 not due to the impact it would have on my company, but on behalf of the vulnerable people my team and I serve in Minnesota. Passage of this bill will create confusion, poorer health outcomes, and greater strife for them. Please do not enact this bill into law.

Thank you madam chair and members for the opportunity to testify.

Sincerely,

Kathy Albrecht
Director, Medicaid and SNP Product & Strategy

Table 1
Integrated features of Minnesota Senior Health Options as it operates under the Administrative Alignment Demonstration

Feature	Description
One plan for Medicare and Medicaid benefits, including LTSS	MSHO plans provide Medicare and Medicaid benefits, including LTSS and behavioral health services, so enrollees have one card and one care coordinator. Plans have MA contracts to operate D-SNPs, and Medicaid managed LTSS (MLTSS) contracts; contract dates are aligned. MSHO plans have been designated as FIDE-SNPs and expect to retain that designation in 2021.
No competition from non-Integrated D-SNPs	The State only signs State Medicaid Agency Contracts (SMACs) with Medicare Advantage plans that have Minnesota Medicaid managed care contracts. Without SMACs, plans cannot get Medicare contracts to operate D-SNPs in Minnesota.
Unique Medicare Advantage contract numbers ("H numbers")	Each MSHO plan operates under its own Medicare contract, rather than being one of multiple products under a larger Medicare contract, so each D-SNP has a unique contract number ("H number"). This allows plans to submit MSHO-specific beneficiary materials and models of care, and obtain data specific to MSHO from CMS. It also means CAHPS and Star ratings are based solely on MSHO performance.
Demonstration Management Team	A joint CMS-State team meets every other week to discuss topics related to MSHO, which helps State officials obtain information about Medicare changes and keep Medicare and Medicaid policies and processes aligned.
Integrated enrollment	• Enrollment materials are integrated. • Enrollment is voluntary and limited to full-benefit Medicare-Medicaid beneficiaries. Beneficiaries enroll in one plan for both sets of benefits, and enrollment dates are aligned. • The State functions as the enrollment Third Party Administrator (TPA) which helps keep enrollment aligned and reduces enrollment discrepancies. • Deemed enrollment helps retain enrollees and maintain continuity of care.
Network adequacy	Under the demonstration, CMS conducts annual network reviews for MSHO plans. The State provides input on local providers, geography, and patterns of care, which has greatly reduced the number of exceptions in remote areas.
SNP model of care	The State recommended additional elements related to the integration of Medicaid HCBS for the MOC template, which CMS added. The State reviews those elements of plans' submissions.
Integrated CAHPS survey	Plans conduct one integrated CAHPS survey annually. The State contributed some questions related to care coordination to the survey, and CMS shares data with the state.
Integrated grievances and appeals	MSHO has long been an innovator on integration of grievances and appeals. Appeal timeframes are aligned (previously 90 days, now 60 days) and integrated notices are used. The process will be even more integrated under the MA final rule for 2020 and 2021 (effective January 1, 2021), with integrated benefit determinations and more integrated notices for plans with aligned enrollment, such as MSHO plans (CMS, 2019).
Integrated claims adjudication	MSHO plans accept and process integrated claims from providers, so providers do not have to bill separately for Medicare and Medicaid services.
Medicare bid process	Minnesota requires MSHO plans to maintain zero Medicare premiums, to avoid a financial barrier to integrated care. The MOU allows MSHO plans to use a revised bid methodology if needed to maintain zero premiums.
Cost Plan Waiver	The Minnesota MOU includes a waiver that allows health plans to continue to operate cost plans in the state, while also operating MSHO plans. Plans are required to report shifts annually to deter gaming.