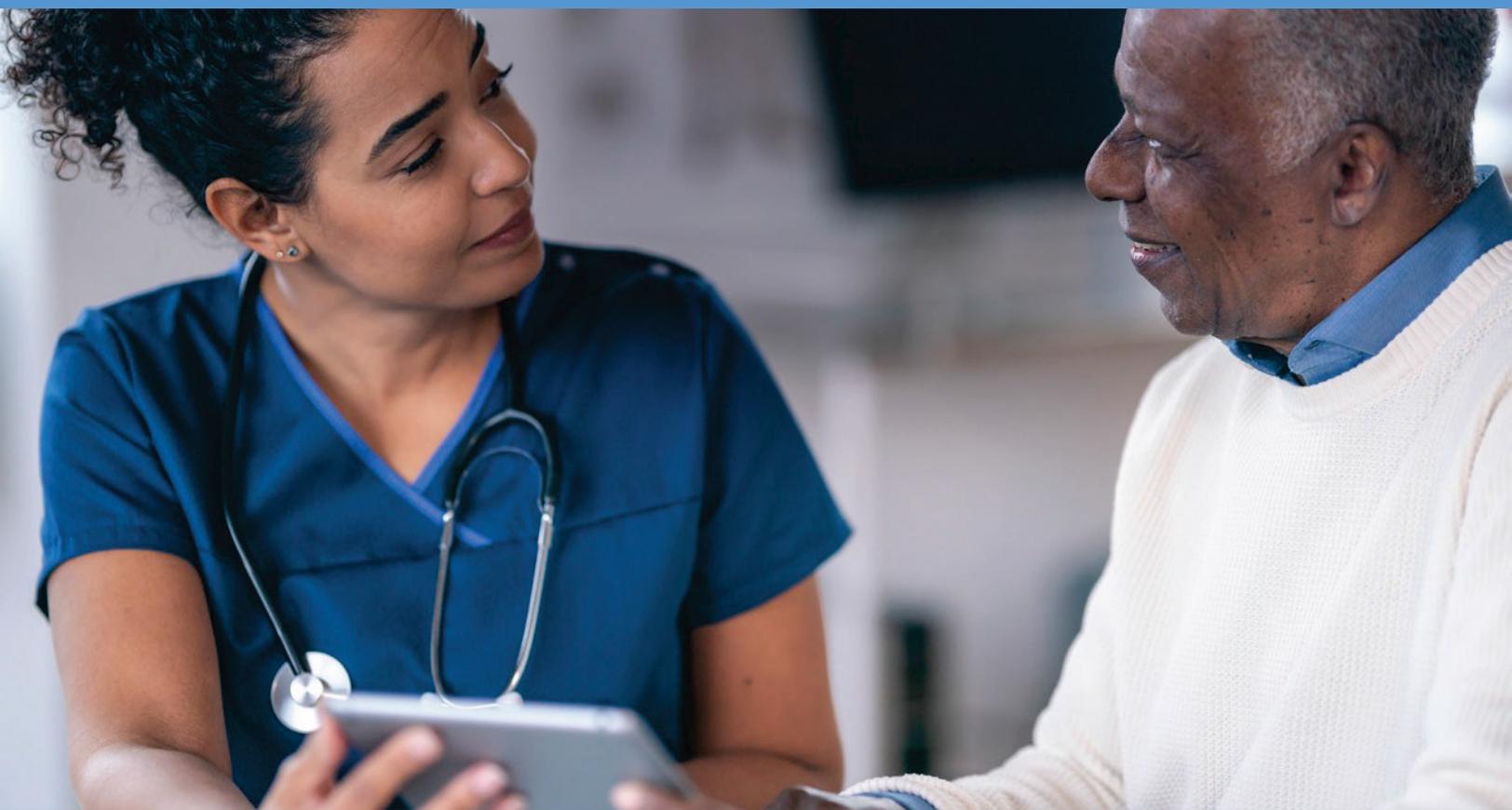


## FINANCIAL ALIGNMENT INITIATIVE

# Minnesota Demonstration to Align Administrative Functions for Improvements in Beneficiary Experience: Third Evaluation Report

Spring 2021



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FINANCIAL ALIGNMENT INITIATIVE  
MINNESOTA DEMONSTRATION TO ALIGN ADMINISTRATIVE FUNCTIONS FOR  
IMPROVEMENTS IN BENEFICIARY EXPERIENCE:  
THIRD EVALUATION REPORT

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## Glossary of Acronyms

|          |   |
|----------|---|
| CAHPS    | Consumer Assessment of Healthcare Providers and Systems |
| CMS      | Centers for Medicare & Medicaid Services                |
| DHS      | Minnesota Department of Human Services                  |
| DMT      | Demonstration Management Team                           |
| D-SNP    | Dual Eligible Special Needs Plan                        |
| FFS      | Fee-for-service   |
| FIDE-SNP | Fully Integrated Dual Eligible Special Needs Plan       |
| HCBS     | Home and community-based services                       |
| HMO      | Health Maintenance Organization                         |
| ICSP     | Integrated Care System Partnership                      |
| LTSS     | Long-term services and supports                         |
| MA       | Medicare Advantage                                      |
| MCO      | Managed care organization                               |
| MMCO     | Medicare-Medicaid Coordination Office                   |
| MMP      | Medicare-Medicaid Plan                                  |
| MOU      | Memorandum of Understanding                             |
| MSC+     | Minnesota Senior Care Plus                              |
| MSHO     | Minnesota Senior Health Options                         |
| NCQA     | National Committee for Quality Assurance                |
| PIP      | Performance Improvement Project                         |
| QIP      | Quality Improvement Project                             |
| SEP      | Special Enrollment Period                               |
| SMAC     | State Medicaid Agency Contracts                         |
| SNBC     | Special Needs BasicCare                                 |

|     |                           |
|-----|---------------------------|
| TPA | Third party administrator |
| TRR | Transaction Reply Reports |

# Executive Summary



The Medicare-Medicaid Coordination Office (MMCO) and the Innovation Center at the Centers for Medicare & Medicaid Services (CMS) have created the Medicare-Medicaid Financial Alignment Initiative (FAI) to test, in partnerships with States, integrated care models for Medicare-Medicaid enrollees.

Minnesota has implemented an alternative model demonstration that is testing approaches to improve administrative alignment between Medicare and Medicaid. The Minnesota Demonstration to Align Administrative Functions for Improvements in Beneficiary Experience is a statewide initiative intended to strengthen integration of the existing managed care plans participating in the long-running Minnesota Senior Health Options (MSHO) program, an integrated Medicare-Medicaid program that began in 1997.

Through a Memorandum of Understanding (MOU) signed by the State and CMS, the Minnesota demonstration

- authorizes a set of administrative activities designed to better align the Medicare and Medicaid policies and processes in the MSHO program; and
- formalizes certain prior informal agreements between CMS and Minnesota that allowed flexibility for the Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) participating in MSHO, because of the integrated nature of the program.

The demonstration does not change benefit packages, choice of plans and providers for beneficiaries, or the way in which the MSHO plans contract with either the State or CMS. Nor does it change the prevailing enrollment process for MSHO (MOU, 2013).

CMS contracted with RTI International to monitor implementation of the demonstrations under the FAI and to evaluate their impact on beneficiary experience, quality, utilization, and cost. The evaluation will include individual State-specific reports.

There were no major changes resulting from administrative alignment activities during the time frame covered by this report (July 2017 through December 2019, with relevant updates from 2020). However, there were some incremental improvements, new feedback on earlier improvements, and new challenges related to implementation of the CMS/Minnesota MOU provisions.

## Highlights

|                                      |  |
|--------------------------------------|--|
| <b>Demonstration Management Team</b> | <p>The Demonstration Management Team (DMT), composed of State and CMS staff, continues to be one of the most important components of the demonstration and has become more effective over time given its consistent membership. The DMT helped address changes at the Federal and State levels, such as changes in the Special Enrollment Period (SEP) for Medicare-Medicaid beneficiaries, the introduction of D-SNP look-alike plans, and changes in the Medicare guidelines for beneficiary materials.</p>                            |
| <b>Network Adequacy</b>              | <p>Implementation of new standards and processes for network adequacy reviews earlier in the demonstration resulted in very few exceptions<sup>1</sup> in 2017, 2018, and 2019.</p>  |
| <b>SNP Model of Care</b>             | <p>As a result of the MOU, the model of care (MOC) template was tailored to reflect the MSHO model. All of the plans received the maximum 3-year approvals of their SNP MOCs. Plans would like to implement coordinated MOC training to reduce burden and redundancy for providers, but implementation has not occurred. According to CMS, plans may be hesitant to adopt the joint training due to concerns that the joint process could reduce the MOC scores the plans receive from the National Committee for Quality Assurance.</p> |
| <b>Beneficiary Materials</b>         | <p>Changes in CMS guidelines for submission and review of member materials prompted the State to revise its processes to ensure its ability to review materials prior to finalization.</p>   |
| <b>Quality Measurement</b>           | <p>Implementation of a single integrated Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey continues to reduce the burden for plans and beneficiaries.</p>  |

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<sup>1</sup> “Exceptions” refer to instances where established network adequacy criteria are not met and a plan must request an exception to the criteria.

**Performance Improvement**

CMS removal of the Quality Improvement Plan (QIP) requirement eliminated the mechanism used by the State to meet both the Medicare QIP and Medicaid Performance Improvement Plan (PIP) requirements. The State quickly developed a State-based system, and plans collaborated to select an aligned and actionable PIP.

**Value-based Purchasing Program**

The State took steps to implement consultant recommendations to improve the value-based purchasing program for plans serving older adults and individuals with disabilities.

Both the State and plans said the MOU has been important for maintaining and improving the integrated nature of MSHO. The State and CMS negotiated a 3-year extension of the demonstration and expected the revised MOU to be signed in the fall of 2020.<sup>2</sup>

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<sup>2</sup> The MOU was subsequently finalized in fall of 2020.

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## SECTION 1

# Demonstration and Evaluation Overview



## 1.1 Demonstration Description and Goals

The Medicare-Medicaid Coordination Office (MMCO) and the Innovation Center at the Centers for Medicare & Medicaid Services (CMS) have created the Medicare-Medicaid Financial Alignment Initiative to test, in partnerships with States, integrated care models for Medicare-Medicaid enrollees.

Minnesota has implemented an alternative model demonstration, based on its Minnesota Senior Health Options (MSHO) program, which is testing approaches to improve administrative alignment between Medicare and Medicaid. The Minnesota Demonstration to Align Administrative Functions for Improvements in Beneficiary Experience is a State-Federal initiative to strengthen Medicare-Medicaid integration for plans participating in MSHO, which began in 1997. This demonstration (1) authorizes activities to improve alignment of Medicare and Medicaid policies and processes for the MSHO program; and (2) formalizes certain prior informal agreements between CMS and Minnesota that allowed flexibility for the Dual Eligible Special Needs Plans (D-SNPs) participating in MSHO.

The [First Evaluation Report](#) includes extensive background information about the demonstration. The [Second Evaluation Report](#) provides earlier implementation updates.

## 1.2 Purpose of this Report

CMS contracted with RTI International to monitor the implementation of the demonstrations under the Financial Alignment Initiative and to evaluate their impact on beneficiary experience, quality, utilization, and cost.

In this report on the Minnesota administrative demonstration we include qualitative evaluation information for the fourth, fifth, and sixth demonstration years (calendar years 2017, 2018, and 2019, respectively), with relevant updates from early 2020. We provide updates on administrative alignment activities authorized by the Memorandum of Understanding (MOU), and updates on projects that were funded by federal implementation funding to support demonstration activities.

## 1.3 Data Sources

We used a variety of data sources to prepare this report. See *Appendix A* for additional details.

## Data Sources



### KEY INFORMANT INTERVIEWS

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Site visit and key informant interviews

Quarterly monitoring calls with CMS and Minnesota Department of Human Services officials



### DEMONSTRATION DATA AND MATERIALS

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State Data Reporting System (SDRS) submissions

Demonstration policies, contracts, and other materials



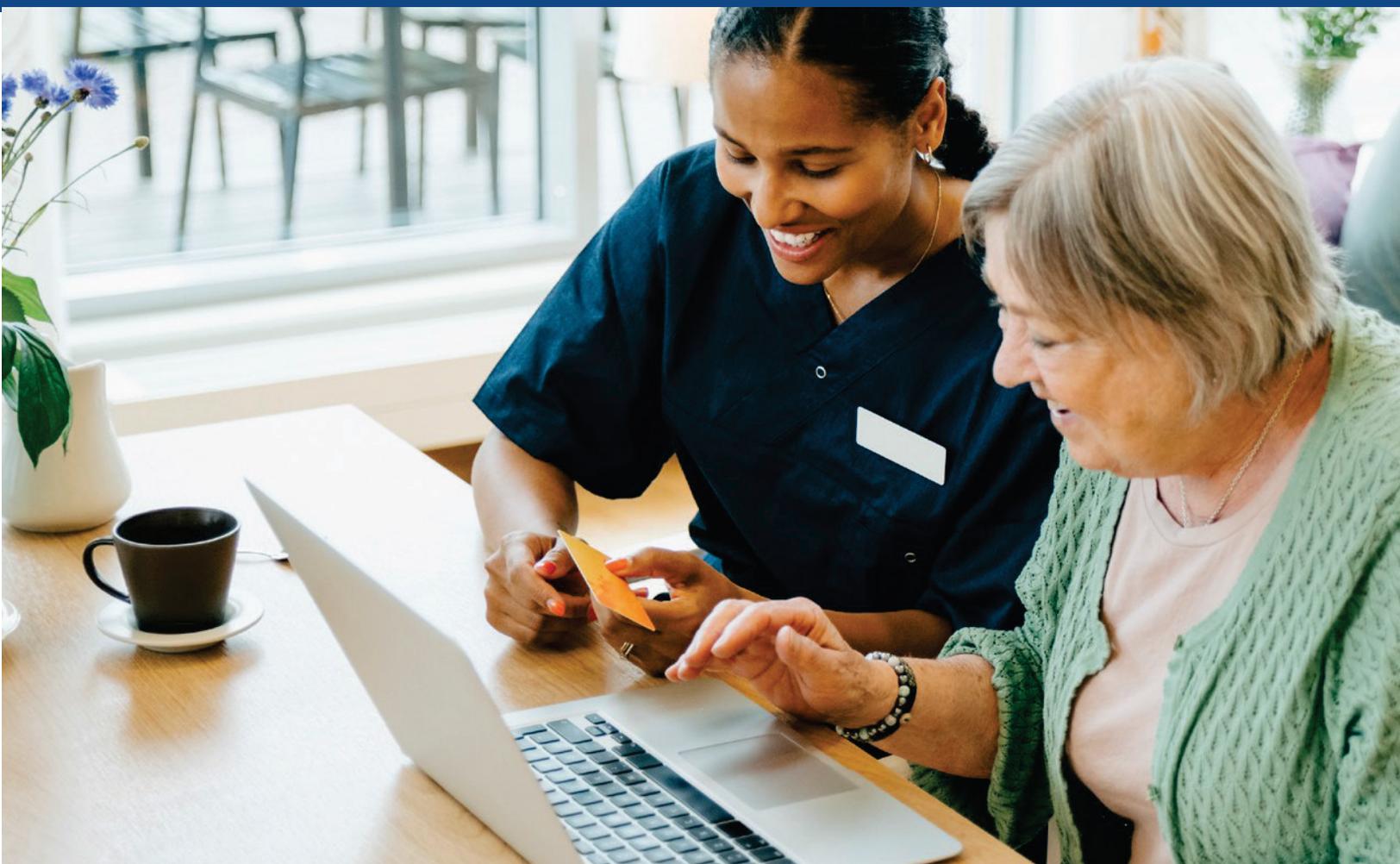
### BENEFICIARY SATISFACTION DATA

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Medicare Advantage Prescription Drug Plan Consumer Assessment of Healthcare Providers and Systems (CAHPS)

## SECTION 2

# Demonstration Design and State Context



## 2.1 Minnesota Senior Health Options and the Minnesota Administrative Alignment Demonstration

Minnesota has a long history of managed care and Medicare-Medicaid integration. Medicare-Medicaid beneficiaries have been required to enroll in Medicaid managed care since the mid-1980s. In 1997, the State launched MSHO to integrate Medicare and Medicaid. The seven MSHO plans operate as Medicare Advantage (MA) Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs), because they have Medicaid managed care contracts that include long-term services and supports (LTSS) and behavioral health services, as well as MA contracts.<sup>3,4</sup>

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 Minnesota's Medicaid-only managed LTSS program for dually eligible beneficiaries found that MSHO enrollees had less hospital and emergency department use, and greater use of ambulatory care and home and community-based services (HCBS) (Anderson, Feng, & Long, 2016; Howard & Baron, 2016).<sup>5</sup> MSHO plans have excellent Medicare Star ratings, indicating high performance and quality, and very good ratings in beneficiary experience surveys (see *Section 3.6, Quality Measures*).

We summarize the key integrated features of MSHO as it operates under the Administrative Alignment Demonstration in *Table 1*.

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<sup>3</sup> FIDE-SNPs are the most integrated form of Dual Eligible Special Needs Plans (D-SNPs).

<sup>4</sup> Long stays in nursing facilities are carved out of the capitation. Medicaid behavioral health services include Section 2703 behavioral health home services, as well as rehabilitative mental health services.

<sup>5</sup> The longitudinal data analysis may be accessed at: <https://aspe.hhs.gov/report/minnesota-managed-care-longitudinal-data-analysis>. An ASPE issue brief describing MSHO and summarizing the findings may be accessed at: <https://aspe.hhs.gov/basic-report/advancing-integrated-care-lessons-minnesota>.

**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                                       | <ul style="list-style-type: none"> <li>• Enrollment materials are integrated.</li> <li>• 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.</li> <li>• The State functions as the enrollment Third Party Administrator (TPA) which helps keep enrollment aligned and reduces enrollment discrepancies.</li> <li>• Deemed enrollment helps retain enrollees and maintain continuity of care.</li> </ul> |
| 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.  |

In 2013, CMS and the State signed an MOU for a demonstration to increase alignment between Medicare and Medicaid for MSHO, without making any major changes in the existing program.<sup>6</sup> We discuss demonstration activities in the remaining sections of this report.

Minnesota received an award of \$1.6 million to conduct demonstration activities. Although the funding ended in 2016, the State said the funded projects continue to bear fruit, as discussed later in this report.

## 2.2 Changes in Demonstration Design

The MOU for the Minnesota demonstration has been amended three times, and a fourth amendment was in progress when this report was written. The first amendment, in 2015, allowed the parent organizations of MSHO plans to continue operating Medicare cost plans while participating in the demonstration, and required monitoring of any shifts in enrollment from MSHO to cost plans (Minnesota MOU Amendment, 2015).<sup>7</sup> State and Federal officials said that without the waiver, health plans would have had to choose between giving up their cost plan business and dropping out of the demonstration. The second amendment, in 2016, extended the demonstration through December 31, 2018, and changed the appeals timeframe from 90 days to 60 days. Medicare and Medicaid appeals timeframes remained aligned, and the change aligned MSHO with Medicare and Medicaid managed care regulations. The third amendment, in 2018, extended the demonstration through December 31, 2020. The State and plans hoped to add Special Needs BasicCare (SNBC), another integrated managed care program, to the MOU in 2018, but CMS did not want to add plans serving a different population in the middle of the demonstration.<sup>8</sup>

The State said in early 2020 that it expected to sign an agreement with CMS extending the demonstration through December 31, 2023.<sup>9</sup> Unlike previous agreements, the names of the MSHO plans will not be listed in the new agreement. The State sought this change in order to make it possible for additional bidders to submit proposals for MSHO and Minnesota Senior Care Plus (MSC+) in the next procurement, planned for 2023.<sup>10</sup> State officials noted that in 2023 the demonstration will have operated for 10 years without any changes in plan participation. Accepting new bids would open the door for for-profit plan participation in MSHO for the first time, as discussed below.

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<sup>6</sup> The original MOU and extensions can be found on MMCO's [Minnesota demonstration webpage](#).

<sup>7</sup> Minnesota MOU Amendment dated January 21, 2015. <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MNMOUAddendum.pdf>.

<sup>8</sup> SNBC serves individuals with disabilities age 18 to 64. Four of the six SNBC plans are D-SNPs as well as MCOs. Five of the six health plans with SNBC products also have MSHO products. Several of those plans said it would be helpful to have the same Medicare-Medicaid alignment for SNBC as for MSHO.

<sup>9</sup> This MOU was signed in the fall of 2020.

<sup>10</sup> Minnesota operates two managed care plans for older adults: MSHO and MSC+. Enrollment in MSC+ is mandatory for Medicaid beneficiaries 65 and older who opt out of MSHO.

## 2.3 Overview of State Context

All of the health plans participating in Minnesota Medicaid managed care, including MSHO, are not-for-profit health plans. In 2017, Minnesota changed a 40-year-old law to allow for-profit health plans to operate Health Maintenance Organizations (HMOs) in the State (Montgomery, 2017). The new law allowed for-profit plans to offer HMOs in the MA market, but for-profit plans were still unable to offer D-SNPs because the State limits D-SNP participation to plans with Medicaid managed care contracts.

Instead, a few for-profit plans began offering D-SNP look-alike plans, and at least one expressed interest in bidding for Medicaid contracts.<sup>11</sup> State officials said that the D-SNP look-alike plans created some confusion for Medicare-Medicaid enrollees. To address concerns in Minnesota and across the country, CMS will not enter into contracts with new look-alike plans for contract year 2022, or with existing look-alike plans for 2023 (CMS, 2020).

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<sup>11</sup> D-SNP look-alike plans are regular MA plans that enroll, or seek to enroll, a high percentage of Medicare-Medicaid beneficiaries, but are not covered by CMS regulations for D-SNPs and are not required to coordinate Medicare and Medicaid benefits (Justice in Aging, 2019; MACPAC, 2020, pp.45-49).

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## SECTION 3

# Update on Demonstration Implementation



In this section, we provide updates on important aspects of the demonstration that have occurred since the [Second Evaluation Report](#). We include updates on administrative alignment activities authorized by the MOU, and an update on projects that were funded by federal implementation funding to support demonstration activities.

### 3.1 Demonstration Management Team

The Minnesota MOU established a Demonstration Management Team (DMT), consisting primarily of CMS Medicaid-Medicare Coordination Office staff, a CMS Regional Office representative, and Minnesota DHS representatives. Originally called the Contract Management Team in the MOU, CMS renamed it the DMT because CMS is responsible for management of the D-SNP contract, and the State manages the Medicaid contract. The DMT is responsible for model oversight, including:

- coordinating alignment activities,
- addressing barriers to increased integration of Medicare and Medicaid in MSHO, and
- helping to coordinate, rather than replace, existing oversight by CMS and the State.

During the reporting period, the DMT continued to meet every other week to communicate key Medicare updates to State officials, provide clarifications about programmatic updates, and help resolve any issues. The State reported that the DMT is still one of the most important pieces of the administrative alignment demonstration, and it has become a more effective communication and problem-solving vehicle over time due to its consistent membership.

State officials reported that the DMT helped the State navigate recent changes to the MA rules, including:

- review of member marketing and communications materials (see *Section 3.4, Beneficiary Materials*),
- elimination of the QIP requirement (see *Section 3.7, Performance Improvement*), and
- the change to the Special Enrollment Period (see *Section 4.1, Integrated Enrollment Systems*).

The DMT regularly facilitates communication between the State and regional CMS office to clarify discrepancies in member data found between the State and Medicare systems, clarify applicability of CMS regulatory updates, and provide subject matter expertise to address ad hoc questions from the State.

## 3.2 Network Adequacy

Per the MOU, annual Medicare network adequacy reviews were required for all MSHO plans, rather than triennial reviews as now required for MA plans.<sup>12</sup> Additionally, the MOU gives the State the opportunity to participate in the review of MSHO plans' Medicare network submissions and provide input to CMS on local health care delivery system considerations, as described in the [First Evaluation Report](#).

In 2018, the State noted that the network review process has become more streamlined over the course of the demonstration. In 2018 and 2019, MSHO plans and the State reported that there had been a sharp decline in the number of exceptions needed each year.<sup>13</sup> The State continued to play an active role in reviewing each plan's network adequacy exceptions identified by CMS. Plans indicated that having the State's support to address exceptions is one of the successes of the demonstration. They said they would rather not submit their networks annually; several said there are few changes in the network from year to year, and one described submitting plans as "busywork." However, the State and plans said those concerns are somewhat offset by the reduced burden of submitting exceptions.<sup>14</sup>

## 3.3 SNP Model of Care

The demonstration gave the State an opportunity to submit to CMS suggested language for incorporation in the D-SNP model of care (MOC)<sup>15</sup> matrix for MSHO plans to reflect MSHO requirements and processes. In 2014, CMS accepted the State's language. The elements added by the State allow MSHO plans to describe their role in coordinating Medicaid HCBS, conducting needs assessments, and developing care plans that address both Medicaid and Medicare services.

The revised matrix has been used by all plans for submissions made since 2015, and the State has reviewed and provided input to CMS on the plans' MOCs. In 2017, the MOC approval period for all but one of the plans expired. These plans resubmitted their MOCs based on CMS and State requirements, and CMS approved the MOCs for the maximum 3-year period. The remaining plan resubmitted its language in 2018 and was also approved for three years.

MSHO plans have not had any problems with MOC audits since incorporation of changes under the MOU. The plans proposed joint MOC provider training and attestation in 2019 to help reduce provider burden and streamline collection of attestations. CMS approved the proposal promptly, but according to CMS, the plans have not implemented joint training due to concerns about whether the joint process could affect plans' MOC scores from the NCQA.

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<sup>12</sup> The change to network adequacy reviews every 3 years occurred in 2018 (Gorman Health Group, 2018).

<sup>13</sup> The term "exception" is used to indicate a plan does not meet network adequacy standards.

<sup>14</sup> CMS announced in August 2020 that MMPs and MSHO plans will now submit signed attestations of network adequacy, rather than submitting their networks for annual review. This change is effective in September 2020. Further details are available in this [CMS memo](#).

<sup>15</sup> A model of care outlines how a SNP will meet the needs of its enrollees. It provides information about processes as they relate to care management, care coordination and quality. Section 1859(f)(7) of the Social Security Act requires that every SNP have a model of care approved by the National Committee for Quality Assurance (NCQA). Further details are available on the [CMS Model of Care web page](#).

### 3.4 Beneficiary Materials

The demonstration requires MSHO plans to use integrated materials developed for capitated plans participating in the Financial Alignment Initiative or adapt those materials with CMS and State approval. Since many of the FAI model materials were based on earlier MSHO integrated materials, this provision has worked well for the plans and the State. Under the demonstration, CMS became part of Minnesota’s annual process to adapt and review materials for MSHO. In 2018, State officials made changes in the review process in response to updates in the Medicare marketing guidance; some materials are now submitted directly to the State, and reviewed only by the State, which reviews all materials that plans distribute to current and prospective enrollees.

An MSHO Plan Member Materials Workgroup that includes representatives from all of the plans, the State, and the CMS Regional Office reviews and adapts CMS model materials each year to create MSHO model materials. The process allows materials to be tailored to MSHO while ensuring consistency across plans.

After the MSHO model materials are finalized, each plan adds its own logo, contact information, and other plan-specific information such as supplemental benefits, and submits the materials for review. During the early years of the demonstration, CMS and the State developed a concurrent review process, with plans submitting materials through the Health Plan Management System, a web-based information system for MA plans. CMS and the State review the materials concurrently, then meet to decide whether to accept or reject specific items.

In 2018, independent of the demonstration, CMS streamlined review and approval of member materials as part of the “Patients Over Paperwork” initiative, consistent with Federal efforts to cut red tape.<sup>16</sup> The new Medicare Communications and Marketing Guidelines were issued to replace the Medicare Marketing Guidelines (CMS, 2018a). According to the State, approximately 18 documents were reclassified from marketing documents (requiring CMS review) to member communications. This allowed plans to use some materials without submission to CMS, and to submit and use other materials without prospective CMS approval. The new guidance also allows plans to post electronic copies of some voluminous Medicare materials, rather than mailing hard copies to all enrollees.

The State said in 2018 that these changes late in the annual cycle (July 2018) led to the development of a new submission and review process so that it could review materials in time for plans to disseminate them in time for Medicare open enrollment. In addition to the materials no longer being reviewed by CMS, CMS added some new member materials, and eliminated the tracking codes for documents that it no longer required plans to submit.

These changes created additional challenges for the State. The State had to quickly devise tracking codes and a new process for submission of some materials, and prepare a grid to inform plans how each document should be submitted. The State said that the option to publish materials

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<sup>16</sup> For more information about this CMS initiative, see the [Patients Over Paperwork website](#).

electronically helped plans complete the process on time in 2018, despite the challenges. In 2019, the State said the member materials were completed earlier than in the past.

In 2019, one plan said the changes to the review process the previous year had been very positive for them, but had caused confusion between DHS and CMS about how the process would work. Another plan said it “would love to go back to just having one submission path for materials,” with concurrent review by both CMS and the State.

### 3.5 Value-Based Payments

The MOU authorized MSHO plans to participate in value-based purchasing agreements with providers as part of a State initiative called Integrated Care System Partnerships (ICSPs). In 2014 and 2015, plans implemented more ICSP agreements than required by their contracts (Minnesota DHS, 2018). In 2016, consultants reviewed the plans’ existing ICSPs and prepared a series of reports to State officials. Their final report summarized their findings and provided recommendations for strengthening the program (Bailit Health Purchasing, 2016).

The State said in 2019 that it had implemented a number of the consultants’ recommendations, such as:

- providing guidance to plans about what is considered a value-based model,
- focusing ICSPs on LTSS and behavioral health, and
- standardizing ICSP reporting by implementing a reporting template and process.

ICSP implementation has not required collaboration with CMS.

In 2018, two plans said that a majority of their members received care under some form of value-based payment arrangements, though not all of those arrangements were reported to the State as ICSPs. MSHO members were most likely to be covered under pay-for-performance arrangements, with a smaller percentage in various forms of risk arrangements.

### 3.6 Quality Measures

The MOU included a provision to conduct one integrated CAHPS survey annually, rather than separate State and CMS CAHPS surveys, to address MSHO plans’ concern about duplication of quality measure requirements. That provision was implemented in 2016. Six questions prepared by the State were added to the CMS survey, and CMS shares beneficiary-level data with the State.

The State and plans said in 2018 and 2019 that the single integrated CAHPS survey has reduced the burden on plans and beneficiaries, and helps to ensure a good response rate by reducing confusion among beneficiaries, who previously might have received two different CAHPS surveys around the same time. One plan cited this as one of the demonstration’s major successes.

MSHO plans perform well on CAHPS in comparison to MA plans nationally.<sup>17</sup> In 2019, the most recent year with final results:

- an average of 72 percent of MSHO enrollees gave their plan a 9 or 10 rating, compared to 66 percent for MA plans nationally, and
- 73 percent rated their plans 9 or 10, compared to a national MA average of 64 percent.

MSHO plans' scores on members' rating of health care quality were slightly below the national average, at 62 percent compared to 64 percent for all MA plans. The overall survey response rate for MSHO plans was 36 percent in 2018, and 33 percent in 2019 (Health Services Advisory Group, 2018 & 2019).

No progress has been made on an MOU provision to develop and test new measures of integrated care that could be incorporated into MSHO-specific MA Star ratings. Performance on Star ratings is linked to Medicare bonuses. State officials and plans have long voiced concerns that D-SNPs are at a disadvantage in the MA Star ratings because they serve populations that are typically older, sicker, and lower income than enrollees in other MA plans.

Despite the well-documented challenges all D-SNPs face in achieving high Star ratings, MSHO plans typically perform well. For 2020, five of the seven MSHO plans had overall Star ratings of 4.5 (out of 5), and another earned a 4.0 rating. The remaining plan had insufficient data for an overall rating. One plan said it had earned a 4.5 rating for 8 years in a row.

MA plans were not required to submit CAHPS and Healthcare Effectiveness Data and Information Set data in 2020 due to the COVID-19 pandemic, according to CMS. CAHPS surveys had already been mailed to members of some MSHO plans, but normal follow-up efforts were suspended.

### **3.7 Performance Improvement**

Through 2017, MSHO plans were required to conduct Medicare Quality Improvement Plans (QIPs) and Medicaid Performance Improvement Projects (PIPs). Under the MOU, MSHO plans were able to use their Medicare QIPs to meet the Medicaid PIP requirements. Effective January 1, 2018, CMS eliminated the QIP requirement for all MA plans. As a result, the reporting mechanism for Medicaid PIP that had previously been used was inadvertently eliminated.

In 2018, State staff said that the Medicare QIP elimination required them to develop their own State-run reporting mechanisms and processes, and the plans had to quickly develop and submit their PIPs for Medicaid system submission. According to the State, the DMT helped navigate the shift from QIPs to PIPs.

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<sup>17</sup> Health Services Advisory Group, Inc. analyzed CAHPS data from the CMS surveys and prepared the reports under a contract with the State; the results may not match reports prepared by CMS (Health Services Advisory Group, 2019).

In 2018, MSHO plans began implementing their new PIPs. The plans chose to collaborate on a 3-year project with other MCOs in Minnesota to reduce the rate of chronic opioid use among the State Public Programs population.<sup>18</sup> One MSHO plan said that picking a topic for the PIPs was a collaborative activity that brought all the plans together to identify the best option for alignment and meaningful outcomes. In 2019, the State reported that MSHO plans continued to make progress with their PIPs.

### 3.8 Medicare Bid Process

The demonstration authorizes MSHO plans to use a revised bid methodology if needed to maintain zero premiums. State officials have long held that it is important to maintain zero premiums for D-SNPs, because the beneficiary population cannot afford premiums. A Minnesota program for individuals with disabilities was terminated after losing a majority of its D-SNPs when their bids resulted in premiums that posed a barrier to enrollment. The State and MSHO plans said the revised bid methodology has not been triggered since the demonstration began.

### 3.9 Implementation Funds

The State received \$1.6 million in Federal implementation funds to support activities associated with implementation of the MOU. The funding was used for several projects, including an integrated Medicare and Medicaid claims database, actuarial analysis of MSHO data, a care coordination conference, cultural diversity grants, and staff positions. State officials said in 2019 that these projects continue to produce results, even though Federal funding ended in 2016. For example:

- The cultural diversity project informed outreach to beneficiaries in ethnic minority groups, including Lao, Hmong, Somali, and African American beneficiaries, who had experienced barriers to enrollment and participation in MSHO. The findings helped the State and plans address health disparities and communicate the advantages of integrated care more effectively (Minnesota DHS, 2017).
- The State held a care coordination conference in 2014 using implementation funds. The event was well received, and the plans provided funding for two more conferences in 2016 and 2018. The 2018 conference was attended by 450 care coordinators and another 400 participated by webinar.

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<sup>18</sup> See <https://stratishealth.org/toolkit/health-plan-performance-improvement-projects-pips/> 

SECTION 4  
MSHO Functions Formalized with  
the Demonstration



The MOU formalized some integrated features of MSHO as they existed before the demonstration—the enrollment system, grievances and appeals, and claims adjudication—without any changes. However, in response to Federal changes, Minnesota adjusted its enrollment, grievance, and appeals systems during the reporting period.

#### 4.1 Integrated Enrollment System

MSHO’s integrated enrollment system helped the State achieve a high enrollment rate before the MOU was signed, and helped to maintain it during the demonstration. In December 2019, 70 percent of eligible Medicare-Medicaid beneficiaries were enrolled in MSHO plans; disenrollment has been uncommon. Although enrollment in Medicaid managed care is mandatory in Minnesota, enrollment in MSHO is voluntary and beneficiaries must opt in. The State acts as third party administrator (TPA) for enrollment for six of the seven plans, which helps keep Medicaid and Medicare enrollments aligned. Other enrollment features are outlined in *Table 1*.

Although the MOU did not make any changes to the enrollment system, some recent Federal changes have posed challenges and provided a new opportunity. For example, the shift in the Special Enrollment Period (SEP) for Medicare-Medicaid beneficiaries greatly affected MSHO enrollment. Initially, the open-ended monthly SEP allowed beneficiaries to enroll, disenroll, or change plans in any month. Effective 2019, this was reduced to one change per calendar quarter.

State officials and plans said in 2018 that they did not support this change, because MSHO did not have a problem with enrollees switching plans, and the new policy was challenging to explain and implement. The State also feared beneficiaries would be discouraged from enrolling on a trial basis because it would be harder to disenroll or change plans. The State’s request to CMS to waive the new requirement for MSHO was denied. One plan said that although MSHO plans function like MMPs, they were not granted an exemption whereas MMPs were.

In 2019, the State and plans still cited the SEP change as an implementation challenge and a barrier to beneficiary choice. The State said the change made it difficult for it, as TPA, to determine the proper codes for SEP enrollment changes. The TPA had to deny many plan selection requests that arrived after the end of the Annual Election Period in December, and advise those beneficiaries to resubmit their requests the following quarter, because the SEP only applies in the first three quarters of the year. Similarly, the TPA had to deny requests from beneficiaries who had accidentally enrolled in non-integrated plans and wanted to switch to MSHO plans that they needed to wait until the next quarter. State and plan officials said it is often challenging for MSHO enrollees to remember to follow through weeks or months later.

An MA reporting change at the Federal level created another challenge for the TPA. Previously, the TPA received Transaction Reply Reports (TRRs) to verify enrollments, and other reports (such as financial reports) were sent directly to each plan. In 2019, CMS began sending all reports to a single point of contact for each plan. As a result, the State began receiving all reports intended for MSHO plans, rather than just the TRRs.

To address this change, the State and plans arranged to have all reports sent to the plans, who then forwarded the TRRs to the State, thus requiring an extra file transfer of protected health information. State officials said the change disrupted their TPA operations and delayed many MSHO enrollments. In early 2020, State officials were working with CMS on a more efficient solution.

In 2018, CMS provided an opportunity for D-SNPs when it reintroduced default enrollment, effective for 2019 (CMS, 2019).<sup>19</sup> Under the new guidance, only health plans operating both a Medicaid MCO and an integrated D-SNP in the same area may apply to use default enrollment, with State approval.

All of the MSHO plans meet the criteria for default enrollment and would like to implement it. The State supports default enrollment, but implementation has been delayed by staff turnover in the State's TPA unit and challenges with SEP changes and CMS file transfers. The State intended to ask CMS to allow the TPA—rather than the plans—to send default enrollment notices to beneficiaries. The TPA mails other enrollment notices as part of its TPA contracts, which helps ensure that only beneficiaries who meet Medicaid criteria for MSHO are invited to enroll.

## 4.2 Integrated Grievance and Appeals System

The MSHO appeals process became more integrated under the MOU, with the plans using integrated notices developed for the FAI, and appeals timeframes aligned at 90 days for both Medicare and Medicaid services. In 2017, the State and plans implemented provisions of the Medicaid managed care rule by changing the appeals timeframe from 90 days to 60 days and requiring enrollees to use the plan's appeals process before requesting a State fair hearing.

Effective January 2021, CMS will require FIDE-SNPs and Highly Integrated Dual Eligible Special Needs Plans (HIDE SNPs) to implement a unified grievance and appeals process. This provision is part of a CMS rule issued in April 2019 to increase Medicare and Medicaid process integration. MSHO plans will be able to use more integrated model notices, tested by CMS in MSHO member interviews in 2019. The State and plans revised the State Medicaid Agency Contract, also known as a MIPPA<sup>20</sup> agreement, during the first half of 2020 to incorporate the new requirements. State officials said the new process will allow subtle improvements in the integrated appeals process for MSHO, and will allow beneficiaries to continue any Medicare services they are appealing during the appeals process.

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<sup>19</sup> Default enrollment allows a health plan to transition enrollees in an affiliated Medicaid MCO into a D-SNP operated by the health plan in the same area when the beneficiary become newly eligible for Medicare (CMS, 2018b). Default enrollment was previously known as seamless conversion; a moratorium on new proposals for seamless conversion was in effect from October 2016 until October 2019 (CMS, 2016).

<sup>20</sup> The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008, as amended by the Patient Protection and Affordable Care Act (Affordable Care Act) of 2010 as well as the promulgation of regulations, seek to improve Medicare and Medicaid benefit integration. MIPPA requires MA organizations to have a fully executed MIPPA agreement with the applicable Medicaid agency in the state in which they want to offer a D-SNP.

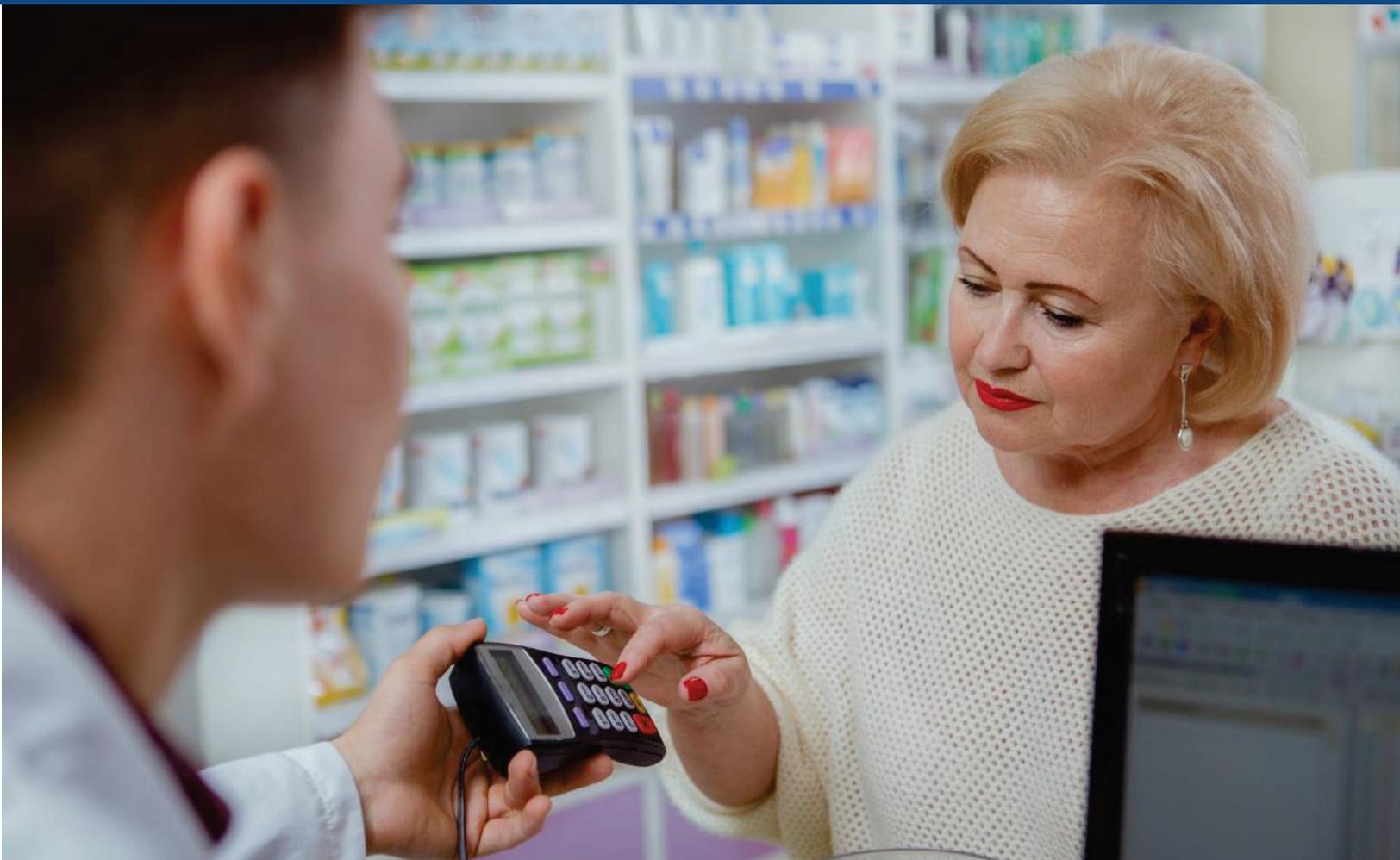
### **4.3 Integrated Claims Adjudication**

Under the MOU, providers file integrated claims for services. Plans pay claims without differentiating between Medicare and Medicaid, and then determine how to allocate expenditures. There have been no changes in this process since the demonstration began.

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## SECTION 5

# Conclusions



## 5.1 Implementation-related Successes, Challenges, and Lessons Learned

Minnesota's MSHO program has long been a model of Medicare-Medicaid integration based on D-SNPs, providing integrated experiences for beneficiaries, high quality health care, and good outcomes. The Minnesota alignment demonstration focuses on reducing the challenges of Medicare-Medicaid misalignment for MSHO plans. The MOU signed in 2013 formalized some existing agreements between CMS and the State, and authorized new alignment activities and the DMT, a mechanism for communications and collaboration between CMS and the State.

During the timeframe of this report (2017–2019), some changes implemented earlier in the demonstration continued to benefit plans, and the DMT coordinated responses to some new challenges. State participation in Medicare network adequacy review has greatly reduced the number of exceptions needed, all plans received maximum approvals of their SNP models of care, and the single integrated CAHPS survey continued to reduce the burden on beneficiaries and plans. The experience over the 3 years also demonstrated the value of collaboration between the State and CMS to address emergent challenges, such as changes in the SEP for Medicare-Medicaid beneficiaries, and the appearance of D-SNP look-alike plans in the MA market. While the demonstration did not insulate MSHO plans from these changes, the DMT helped the State and CMS respond to them.

State and plan officials were generally pleased with their close collaboration with CMS, but had some reservations. They were displeased with the change to the change in the Medicare Advantage SEP for Medicare-Medicaid beneficiaries, independent of the demonstration, which they said was complex to administer and limits beneficiary choice. The State asked CMS to waive that requirement for MSHO, but that request was not approved—even though States with capitated model demonstrations under the FAI were able to waive it. Additionally, the State and plans had hoped to add SNBC plans to the administrative alignment initiative in 2018, so those plans could enjoy the same flexibilities as MSHO. That request was not approved, either.

State officials and MSHO plans have been pleased with the demonstration overall, and State officials said in 2020 that they were negotiating a 3-year extension with CMS.<sup>21</sup> Now that SNPs have been permanently authorized as part of the MA program, States pursuing Medicare-Medicaid integration using D-SNP models may want to look more closely at the lessons that can be learned from MSHO and the Minnesota demonstration.

MSHO has already influenced the capitated model demonstrations under the FAI and some of its best practices have been disseminated to other D-SNP states. Valuable features of the Minnesota administrative model for consideration by CMS and other States include a State role in Medicare network adequacy and SNP model of care reviews, the DMT, and an integrated enrollment process. States interested in adopting some of these features may need demonstration authority to implement them.

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<sup>21</sup> The extension was executed in an MOU signed in the fall of 2020.

## 5.2 Next Steps

As noted previously, Minnesota requested an extension from CMS to continue the demonstration, which will provide further opportunities to evaluate the demonstration's performance.<sup>22</sup> The RTI evaluation team will continue to collect information such as enrollment statistics and updates on key aspects of implementation on a quarterly basis from Minnesota officials through the online State Data Reporting System. We will continue to conduct annual virtual site visit calls with the State and demonstration stakeholders, and quarterly calls with the Minnesota administrative alignment demonstration State and CMS staff. RTI will review the results of any evaluation activities conducted by CMS or its contractors, as well as any written reports or other materials from the State related to administrative alignment activities.

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<sup>22</sup> The extension was executed in an MOU signed in the fall of 2020.

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Appendix A  
Data Sources

**Key informant interviews.** The RTI evaluation team conducted remote site visits in Minnesota in 2018 and 2019. The team interviewed individuals from the State, health plans, and CMS. To monitor demonstration progress, the RTI evaluation team also engages in periodic phone conversations with the Minnesota Department of Human Services (DHS) and CMS. These might include discussions about new policy clarifications designed to improve plan performance, quality improvement work group activities, and contract management team actions.

**Surveys.** Medicare requires all MA plans, including Dual Eligible Special Needs Plans (D-SNPs) such as the MSHO plans, to conduct an annual assessment of beneficiary experiences using the Medicare Advantage and Prescription Drug Plan CAHPS survey instrument. In addition, the Minnesota Department of Human Services added six questions as part of its agreement with CMS to field one integrated CAHPS survey each year. In this report we discuss survey results for a subset of the 2019 survey questions, and compare results for MSHO plans with results for all Medicare Advantage plans.

**Demonstration data.** The RTI evaluation team reviewed data provided quarterly by Minnesota through the State Data Reporting System (SDRS). These reports include eligibility, enrollment, opt-out, and disenrollment data, and information reported by Minnesota on its integrated delivery system, care coordination, benefits and services, quality management, stakeholder engagement, financing and payment, and a summary of successes and challenges.

**Demonstration policies, contracts, and other materials.** The RTI evaluation team reviewed a wide range of demonstration documents, including demonstration and state-specific information on the [CMS website](#); and other publicly available materials on the [Minnesota administrative alignment model website](#); and the [MSHO website](#). The RTI evaluation team also reviewed the ASPE longitudinal analysis on MSHO (Anderson, Feng, & Long, 2016), a report on a value-based payment initiative (Bailit Health Purchasing, 2016), various news articles, and summaries of Medicare Advantage regulations.

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