Report on the Value of Minnesota Health Care Programs (MHCP) Managed Care, as Compared to Fee-For-Service

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Executive Summary

The Minnesota Department of Human Services (DHS) contracted with Public Consulting Group (PCG) to author a report on the value of managed care for state public health care programs required by Minnesota Sessions Laws 2012, Chapter 247, Article 1, Section 31. Specifically, PCG was tasked with determining the value of managed care for Minnesota Health Care Programs (MHCP) in comparison with a Fee-For-Service (FFS) delivery system.

The state's managed care system encompasses services by Prepaid Health Plans and County-Based Purchasing plans for Medical Assistance and MinnesotaCare. The Legislation mandating the study calls for a comparative examination of the value obtained from these managed care products alongside the value evidenced by the FFS delivery system. The Legislation specifies seven distinct qualitative measures to serve as criteria for the evaluation. These measures include:

- the ability to measure and improve health outcomes of recipients;
- the satisfaction of state public health care program recipients and providers;
- the access to health services for recipients;
- the availability of additional services such as care coordination, case management, disease management, and after-hours nurse lines;
- actual and potential cost savings to the state;
- the level of alignment with state and federal health reform policies, including a health benefit exchange for individuals not enrolled in state public health care programs; and
- the ability to use different provider payment models that provide incentives for cost effective health care.

Further, the language also authorizes the evaluation to consider the need to continue the requirement for health maintenance organizations to participate in the Medical Assistance and MinnesotaCare programs as a condition of licensure under Minnesota Statutes, section 62D.04, subdivision 5, and under Minnesota Statutes, section 256B.0644, in terms of continued stability and access to services for enrollees of these programs.

Report Roadmap

Section I will introduce key terms and concepts related to the subject of health care delivery systems. It will also lay out in brief the existing state of the managed care and FFS delivery systems in Minnesota. Sections II-IV will assess the extent to which Minnesota's Managed Care Organizations (MCOs) have fulfilled the goals of the Managed Care Quality Strategy, evaluating their performance in quality of care, enrollee satisfaction, and access to services. The paper will not only address whether the MCOs are

compliant with current state and federal regulations, but will also determine whether they have demonstrated significant improvements toward the objectives presented in the programs' quality strategy. Section V will examine additional programs and services offered by the MHCP MCOs to assess the "value add" they provide in comparison to traditional FFS.

Section VI will examine cost as it relates to value, reviewing Minnesota's Medicaid health expenditures in comparison to other state programs and in relation to Minnesota's quality outcomes. Finally, Sections VII-IX will address the value of managed care in the context of specific state health regulations and policy initiatives, including state and federal health care reform efforts, other delivery reform opportunities, and the effectiveness of Rule 101.

What follows in this executive summary is a condensed synopsis of each of the qualitative measures reviewed by PCG, including major conclusions and data sources. Detailed analysis of each of these criteria can be found in the respective sections of the main report.

Value in Minnesota's Medicaid Program

Value is commonly defined as the intersection of quality and cost. Value represents the level of quality provided per unit of cost. More specifically, value is the measure of beneficial patient health outcomes achieved per dollar spent. When health care is value-driven, it is guided by a standard of performance improvement that evaluates and justifies costs in terms of the health outcomes they produce. As the measure of a relationship between quality and cost, value can be improved by changing either of these factors; value can be increased by achieving better outcomes at equivalent costs, or comparable outcomes at lower costs.

This report begins with a brief summary of the salient features that define managed care and traditional fee-for-service delivery systems. It offers an overview of the capitation methodology used to set payment rates to Minnesota's managed care organizations. It identifies the major eligibility groups within the state that receive care under each delivery system. It further describes the performance standards under which Minnesota's eight Managed Care Organizations operate, as well as their compliance requirements under Centers for Medicare & Medicaid Services (CMS) regulation and Minnesota statute. The quality metrics the state uses to monitor MCO performance are also described. The analysis also considers several delivery system alternatives to managed care and FFS that are gaining in use in other states.

In reviewing these two systems, PCG measured value by associating cost and quality outcomes. Three major conclusions emerged from our analysis:

1. Minnesota's managed care organizations (MCOs) exhibit a more developed level of care coordination, performance measurement, and quality improvement than the state's traditional fee-for-service system. Therefore, MCOs, as contrasted to traditional FFS, increase the state's potential for delivering high value health care. Alternative FFS delivery arrangements such as Minnesota's Health Care Home (HCH) initiative are exempted from this finding. Health care

homes depart from traditional FFS in significant ways, and their relatively recent implementation has not permitted direct performance comparison with the managed care system.

2. In practice, comparative analysis of the value of these two delivery systems in Minnesota is limited by the lack of common measurement standards. There are many elements of the two delivery systems for which no comparable measurement standards exist. This is due both to differences in the health status of members enrolled in managed care and FFS programs as well as the absence of effective FFS performance metrics.

3. While managed care increases the state's potential for delivering high value health care, as compared to traditional FFS, both systems appear high cost in comparison to other Medicaid programs nationwide. These higher costs are often associated with stronger quality outcomes for the program's major enrollee groups, especially for the state's high-utilization population of Seniors and Peoples with Disabilities (SPD). In the case of these enrollees, increased costs are driven for the most part by Minnesota's enhanced benefit set, which includes more expensive long-term care and home- and community-based services. One exception to this general association of cost and quality is child health, in which analysis revealed below average performance on a number of health indicators for children. These quality measures in need of improvement represent exceptions to otherwise high health outcome performance among the plans.

Measurement and Improvement of Health Outcomes

The most widely referenced and comprehensive basis for comparison between managed care and FFS system health outcomes is the Healthcare Effectiveness Data and Information Set (HEDIS). This is a nationally recognized performance metric developed and maintained by the National Committee for Quality Assurance (NCQA). HEDIS is widely employed throughout the United States, and can therefore be utilized not only to compare Minnesota's managed care and FFS systems to one another, but also to evaluate them against other states' Medicaid programs. HEDIS can also be used to measure Medicaid outcomes against the performance of commercial plans.

Although HEDIS is regularly used as the baseline for determining performance among delivery systems, HEDIS is in origin a tool developed primarily for measuring health outcomes using managed care encounter data and enrollment systems. The original managed care framework and population characteristics informing HEDIS measurements can create unique reporting challenges and methodological concerns when the tool is adapted for performance measurement of FFS populations.

In Medicaid, these challenges are compounded by the fact that, in most states, Seniors and Persons with Disabilities (SPD) have become the primary eligibility categories served under FFS systems.[1] Most other enrollment groups now fall under some form of managed care. This trend has resulted in a substantial

[1] Minnesota is relatively unique among state Medicaid programs in the high proportion of elderly (though not disabled) recipients enrolled in managed care rather than FFS.

divide between two disparate population sets with very different risk factors, consumer expectations, and utilization of services. The difficulty of comparing populations of different acuity was a repeated challenge throughout the report, but nowhere more so than in the comparison of health outcomes. (For a more thorough discussion of the scarcity of other comparison data, as well as the challenges of using HEDIS data for comparisons between FFS and MCO populations, see Section II.)

In 2011, DHS conducted a quality comparison of its managed care and FFS systems, using the 2010 HEDIS data available for comparable groups within both programs. While managed care outperformed FFS on the 19 key HEDIS rates under review, neither population performed strongly when contrasted to national Medicaid HEDIS rates. Of the 19 HEDIS measures reviewed annually in fulfillment of CMS requirements, Minnesota ranked below the national average in more than one-third of them (7 of the 19). The MHCP statewide average achieved the 90th percentile in only two of these 19 measures.

The report suggests that plan performance is probably stronger than indicated by these figures from DHS, on account of the fact that the state employs a conservative, "administrative methodology" when calculating HEDIS performance measures. This methodology has a known tendency to underreport services rendered if they are not reflected in administrative claims data. Alternatively, the HEDIS data self-reported by the health plans to the Minnesota Department of Health (MDH) utilize a "hybrid methodology," which is also NCQA-approved and supplements claims information with sampled medical records data. Calculations according to the hybrid approach indicated a stronger level of quality in the care delivered through the managed care system.

In some cases, significant variation exists between the two approaches. Whereas managed care appeared to be underperforming on 7 of the 19 measures according to the DHS methodology, only three of these measures indicated underperformance when calculated according to the hybrid methodology used by the plans. Plan performance improved in all of the measures in which a hybrid methodology was applied.

Importantly, though, the application of a hybrid methodology did not significantly improve health plan performance for the well-child care measures that serve as key indicators of children's health, raising questions as to whether the health plans are providing optimal value for this large group of Medicaid enrollees. The data available suggests that the MHCP health plans could be producing stronger health outcomes than they currently deliver for this population.

As one methodology of testing our findings, PCG reviewed other Minnesota healthcare quality studies for contrasting points of view. For example, the Commonwealth Fund Scorecard is a broad-based quality survey that combines performance indicators from commercial insurance populations in addition to public health care program recipients.

Although the Commonwealth Fund Scorecard recognizes Minnesota for its high quality of care, it does not isolate the performance of low-income groups or include performance data from HEDIS, due to the fact that HEDIS measures are not available for every locality or health system under review.

Studies which have either utilized HEDIS data or narrowed their scope exclusively to states' Medicaid populations have drawn more mixed conclusions regarding Minnesota Medicaid health outcome measures. One of the studies, conducted by the Mathematica Institute, and focused on the value of health care in Medicaid programs nationwide, also corroborated its HEDIS data with other information resources on children's health, including the National Survey of Children's Health (NSCH) and the National Immunization Survey (NIS). All of the studies examined by PCG are discussed in detail in the report.

Additional Measures of Quality: Satisfaction, Access, and Care Management Services

In addition to overall health outcomes, the report examines secondary measures of quality such as patient satisfaction and the availability and accessibility of care within each delivery system. This report also attempts to assess "value adds" derived from particular managed care services such as care coordination, case management, navigation assistance, and disease management. Each of these topics composes its own section in the full report.

Minnesota's MCOs rank exceptionally high in patient satisfaction, according to a number of independent indicators. The most important of these is the score of each plan on the Consumer Assessment of Healthcare Providers and Systems (CAHPS), a metric also maintained by NCQA. When compared to the national commercial and Medicaid CAHPS indicator averages for 2010, MHCP MCOs ranked above the national Medicaid HMO average in all measures, and exceeded commercial averages in all but one of the eight CAHPS indicators. Moreover, in six of the eight indicators the Minnesota statewide average MCO score placed above the 90th percentile nationally among Medicaid HMOs. Because CAHPS is administered exclusively to managed care organizations, as a requirement of NCQA HMO certification, equivalent data for services provided on a FFS basis is not available.

The absence of quantifiable patient satisfaction data for the FFS population illustrates many of the same difficulties of delivery system comparison evident in the examination of health outcome measures. There is a qualitative difference in the data available for managed care versus FFS. There are several reasons for this. The population under Minnesota's managed care system is roughly four times larger than the state's FFS population, which explains some of the increased attention managed care populations receive in comparison to FFS enrollees. Furthermore, Minnesota is obligated by federal managed care compliance requirements to devote greater customer service and oversight resources to its managed care program than its FFS system. Managed care is subject to more frequent and comprehensive quality reviews of patient satisfaction and access levels, and is required to establish a robust grievance reporting system.

Although the FFS system is also subject to periodic audit and review, the lack of statutory requirements means these measures are not equivalent to the comparable Managed Care processes. Where FFS requirements do exist, quality assurance activities are not conducted on a comparable scale.

The stability of provider networks serving the Medicaid program suggests relative provider satisfaction, as well as the adequacy of patient access to health services. PCG also interviewed county stakeholders and representatives from the provider community to assess overall support for Medicaid managed care.

These individuals all expressed satisfaction with the health plans overall, and many stakeholders indicated that managed care was perceived to be a more effective delivery system than traditional FFS. Stakeholders expressed a belief that strong MCO negotiating power has allowed plans to keep provider rates relatively low. However, none of the stakeholders interviewed raised major concerns about the overall level of provider satisfaction or the capacity of Minnesota Medicaid to provide access to quality medical services.

PCG surveyed a wide range of additional program materials and data sets in order to identify major quality differences between managed care and FFS systems. These include annual MCO compliance reports, FFS program audits, and grievance reports submitted by the State Managed Care Ombudsman. Deficiencies were found in individual service elements within each delivery system— lack of compliance in MCO grievance reporting, on the one hand, and underperformance in the state's FFS non-emergency medical transportation program, on the other. However, it is unclear whether any of these particular gaps indicates a qualitative difference in each system's ability to deliver quality services overall.

One area in which managed care appears to provide significant additional value to Medicaid is in case management and care coordination. The managed care model has the capacity to deliver patient-oriented case management and care coordination services that are otherwise absent from the traditional FFS system. However, it should be noted that Minnesota and some other states have attempted to supplement fee-for-service with care management under delivery models that do not fully capitate payment rates. Minnesota delivers these services to its FFS population through a health care home delivery system[2], while a number of other states have implemented primary care case management (PCCM) to provide these services. Although these care coordination alternatives are explored further in Section VIII, direct comparison between Minnesota's MCOs and its health care home initiatives is outside the scope of this study.

When surveying the spectrum of additional services offered by the MCOs, it becomes clear that these programs serve a range of objectives. While many additional services can be tied directly or indirectly to stronger quality outcomes, for some initiatives the relationship to increased value seems harder to demonstrate. Based on information collected from stakeholder interviews, it does not appear that DHS actively reviews program goals behind many additional services, nor does it evaluate their quality impact. Consequently, the report suggests that DHS can do more on the managed care side, and not just on the FFS side, to articulate the specific quality outputs expected from these efforts. DHS expects MCOs actively to develop new services that drive continuing quality improvement, but the Department has not specified a clear set of policy priorities for care coordination and integration or established a systematic process for evaluating the quality impacts of additional care management services.

Measurement of Actual and Potential Cost Savings

Examination of costs suggests that Minnesota's Medicaid program is expensive when compared to other state systems, both for its managed care and its FFS populations. In the case of managed care,

[2] Minnesota's Health Care Home initiative also encompasses eligible enrollees from the state's managed care population.

retrospective analyses of the capitation rates for Minnesota's MCOs have corroborated this conclusion, as do comparisons with Medicaid expenditures nationwide. For example, according to the CMS cost data available in the 2008 Medicaid Analytic eXtract (MAX)—the most recent year available for nationwide comparison—Minnesota ranked behind only the District of Columbia and New York in highest Medicaid expenditures per full-benefit enrollee.[3] When the two delivery systems are considered separately, each system proves to be high cost in comparison to other delivery systems of the same kind in other Medicaid programs across the nation.

Based on 2008 managed care data, Minnesota ranked 5th in the United States in capitated per member per month (PMPM) payments,[4] while the state's FFS system ranked 8th in overall expenditures per FFS enrollee. Significantly Minnesota ranked 4th in expenditures for the disabled population, which makes up the state's core FFS enrollment group. Managed care and FFS systems also both appeared to incur higher than average prices for secondary services paid on a FFS basis regardless of delivery service type. These service categories include expenditures for pharmaceuticals and certain laboratory and imaging services.

A high cost system does not necessarily signal poor value for money. In some cases, there are organizational factors, regional economic conditions, and unique state plan features that explain high expenditures for a given state without implying lesser value. In Minnesota's case, the state's extended benefit set appears to be the most important variable driving higher costs. Minnesota's Medicaid program offers a number of additional, high cost benefits such as long-term care, mental health, and home-and-community-based services (HBCS) that are considered optional benefits and so are not covered in many states.

In some cases, the high cost of Minnesota's managed care programs are reflected in quality outcomes that are also considerably higher than the national average, though not for all populations. Even if state expenditures per enrollee for the vulnerable Seniors and Persons with Disabilities (SPD) population are relatively high—reflecting this group's high utilization of Minnesota's expanded benefit set—the state's health plans can also boast strong performance in key health outcomes for this population. For example, seven of Minnesota's eight health plans rank within the HEDIS 90th percentile in Adult Preventive Visits (65+), a key health outcome for the state's elderly population.

By contrast, higher per enrollee expenditures for the Medicaid child population do not necessarily translate into better health outcomes. While Minnesota's health plans are above average nationally in HEDIS indicators for Child PCP visits, in other key children's health benchmarks, such as Well Child Care and Childhood Immunizations, most of the health plans performed at levels lower than the national Medicaid average. When paired with the population-specific costs of Minnesota's Medicaid program, these quality indicators raise questions about whether the state is receiving optimal value for its spending on children's health.

[3] The $8,481 spent per enrollee annually by the State includes both its managed care and FFS populations.

[4] It should be noted that the states which rank first and second restrict their managed care to Program for All-Inclusive Care for the Elderly (PACE) long-term care, which operates at considerably higher cost than other service populations.

More recently, the state has implemented major changes intended to provide stronger administrative oversight and financial accountability to MHCP. DHS has already identified and redressed reporting and accountability problems in several areas of suspected inefficiency in the managed care system. These changes have included:

- requiring increased transparency from MCOs in service and administrative cost reporting and performance measurement;
- establishing competitive bidding in the managed care sector;
- and implementing improved actuarial methodologies for future capitation rate-setting.

The final impact of these initiatives is not yet clear, although the state has already seen hundreds of millions of dollars in cost savings from these measures and from a 1% cap on the excess profit margins of the health plans. However, the existing managed care and corresponding state compliance structure at least lend themselves to the implementation of such programs and the reporting of necessary data. Minnesota's FFS system remains far more obscure when it comes to locating and eliminating system inefficiencies. For this reason alone, it is more likely that managed care rather than FFS is better positioned to deliver greater cost savings to the Medicaid program going forward.

Numerous comparative cost studies have pointed to the difficulties in identifying truly comparable measures of costs between managed care and FFS systems. Approaches to cost reporting and cost allocation diverge sharply between the two systems. For different reasons, neither delivery system easily captures the full range of health expenditures in a way that ties them to outcomes. This deficiency creates challenges for comparison, even when the costs incurred by the disparate enrollment groups are adjusted for acuity differences. Despite these caveats, though, the broad differences in cost and quality between the two systems is sufficiently discernible to conclude that the managed care system delivers higher value than traditional FFS as it currently exists in Minnesota Medicaid.

Alignment with State and Federal Health Reform

The report concludes that Minnesota's managed care system is positioned to assist the State in coping with many of the specific challenges posed by recent state and federal health reforms, including the sweeping reforms of the Affordable Care Act (ACA). Managed care has the capacity to make significant contributions to three major reform efforts identified in the report. These include:

- Recruiting adequate provider networks to maintain high quality levels of service under ACA Medicaid Expansion and its introduction of new, large populations of childless adults into the Minnesota Health Care Programs;
- Crafting Essential Health Benefit plans to ensure optimal alignment between commercial plans and state health programs;

- Coordinating plans offered on Minnesota's Health Insurance Exchange to guarantee smooth interaction between commercial insurance and the Medicaid system and mitigate the effects of "churn" between the two sectors.

First, managed care has an important role to play in mediating the inevitable disruptions caused by the influx of new enrollment groups into the Minnesota Health Care Programs. With substantial numbers of uninsured Minnesotans anticipated to become newly eligible, Minnesota's MCOs serve as a key resource in recruiting and stabilizing the requisite provider networks for serving this additional population.

Second, when it comes to the Essential Health Benefits (EHB) mandated for coverage by the ACA, Medicaid benchmark EHBs are not necessarily aligned with the EHBs featured in Qualified Health Plans (QHBs). MCOs can help smooth potential differences between these two EHB sets to assure member continuity of care when transitions to and from Medicaid and Exchange coverage occur.

Third, Medicaid MCOs hold the prospect of solving the problem of "churn," the various difficulties anticipated in transitioning individuals back and forth between Medicaid and plans purchased on the Exchange. Because commercial HMOs are required by the state to participate in the Medicaid program, these MCOs have an already developed plan infrastructure that overlaps Medicaid and the commercial market. This should allow for a relatively seamless transition of individuals in and out of Medicaid. The plan-based MCO system will align more smoothly with the plan-based structure of the Exchange.

Alignment with Payment Reforms

The report also considers the value that Minnesota's MCOs can bring to further payment reforms. Considering the wide array of reforms currently in development in Medicaid and in health care more generally, PCG's perspective is that different delivery systems create different payment reform opportunities. No one delivery system has emerged as the definitive pathway to payment reform in the Medicaid space nationwide. Notably, as states innovate to test new payment reforms, delivery system models are proliferating, including Minnesota's own ongoing experiments with Accountable Care Organizations such as Hennepin Health, as well as other provider-led delivery system reform initiatives in development statewide. This trend indicates that no consensus has yet been reached on the one best delivery system to support payment reform.

The report briefly surveys the broad spectrum of payment reform options available, from primary care case management and episode-of-care based payments, to more sweeping organizational reforms, such as the formation of patient-centered health homes, Total Cost of Care (TCOC) payments, and Accountable Care Organizations (ACOs). In some cases, FFS systems allow for easy transition to episode-of-care reimbursement systems. However, it is possible to implement many of these types of reforms within an institutional framework of capitated managed care, and to craft a role for the managed care infrastructure within a broader set of reforms.

When it comes to many of these types of payment reform—especially those currently being pursued by DHS—it can be misleading to take a rigid, either/or approach with respect to the utility of capitated

versus FFS arrangements. Many of the most innovative kinds of payment reform blend different aspects of managed care and FFS structures, proving to be broadly compatible with either system. By the same token, neither arrangement is likely to be adequate in itself to support extensive reform.

It is possible to discuss each system's points of compatibility with the wider network of payment and delivery system reforms currently under development in Minnesota, but it may be inappropriate to assert that either an MCO-based or FFS system necessarily contributes more value than the other to these reforms. The state's health care home initiatives, TCOC contracts, and accountable care demonstrations are programs that operate concurrently with Minnesota's dominant managed care and FFS systems, but are designed to function independently of either payment methodology.

Assessment of the Requirement for HMO Participation in Medical Assistance

The report also recommends continuation of the state requirement for HMOs to participate in MHCP as a condition of their licensure. After interviewing multiple stakeholders within the managed care system, as well as state and county officials and representatives of provider groups, PCG found a few minor objections to the requirement as it currently stands, though none of the representatives questioned believed the requirement should be repealed. In particular, health plan representatives expressed dissatisfaction with the state's decision to implement a competitive bidding process without discontinuing its requirement that health plans respond to all RFPs for which they are eligible.

On the other hand, there is significant evidence that the requirement supports the law's intention to increase Medicaid recipients' access to strong provider networks. The additional requirement that health plans submit RFP proposals to provide services in any county where they have a sufficient presence also appears to support consumer choice. It serves Minnesota's consumer choice objectives to the extent that it prevents plans from maintaining Medicaid services only in a small area of the state in order to fulfill the minimal obligations of the statute, or from carving up the state's Medicaid space into a set of exclusive MCO territories.

Section I: Background

Understanding Delivery Systems

A "delivery system" is a specific organizational approach to the delivery of health care. Frequently, the method used by a payer to reimburse health care providers for the cost of services defines the nature of the delivery system. Managed care and Fee-For-Service are the most traditional examples. However, delivery systems have proliferated in recent years, and now include models that go beyond full capitation managed care and fee-for-service. The following is a summary of delivery system types, with a focus on their relationship with Medicaid systems.

Fee-For-Service

Fee-For-Service (FFS) is the traditional healthcare payment system in which providers receive a payment for each unit of service they provide. The amount paid for services is typically based on rates that have been determined by a formula or funding levels. FFS payments are typically aligned with coding guidelines and rules (e.g. ICD-9, CPT and DRG) that define what can be paid and billed for.

Medicaid FFS consumers can access services through any Medicaid certified provider of their choice. In Minnesota, the Department of Human Services (DHS) certifies Medicaid providers. Certified providers bill DHS directly for the services that each individual Medicaid enrollee receives. Claims are adjudicated and paid through the Medicaid Management Information System (MMIS). The provider may only bill the client for any co-payment that Medicaid has established for that service.

Managed Care

In Medicaid managed care, the state contracts with Managed Care Organizations (MCOs) that contract directly with a network of providers. Consumers in a Medicaid managed care program access services through providers under contract with the MCO (with provisional exceptions for emergency and out of network care). This model is most commonly found in more densely populated, urban areas because the capacity to spread risk across a higher volume of members makes "per member" costs more predictable.

In Minnesota, DHS contracts with MCOs to provide health care services to more than 600,000 Medicaid enrollees. Most non-aged, non-disabled Medicaid members are enrolled in an MCO. Federal law requires that some populations, such as Native Americans, be exempt from MCO enrollment requirements. Minnesota also enrolls about 80,000 elderly and disabled Medicaid recipients in managed care as well. The MCOs are required to provide at least the same benefits as Medicaid FFS.

DHS pays each MCO a monthly capitation rate for each enrollee. The MCOs are responsible for contracting with providers and establishing provider fee schedules. Providers bill the MCO for the services the patient receives. The reimbursement policies for providers under contract with MCOs may differ by MCO. The payment terms are defined in the contract document between the provider and the MCO.

Medicaid managed care has grown substantially over the past decade. Approximately two thirds of Medicaid enrollees are enrolled in managed care programs (either MCO or PCCM) nationally. With only a few exceptions, states with existing Medicaid MCOs are on the path to expand their risk-based managed care plans to new populations and areas of the state. There is significant variation among states in managed care program design, state selection methods of MCOs and provider networks. There has been a recent trend toward more intensive monitoring of MCO performance.

Primary Care Case Management

In Primary Care Case Management, members choose a primary care provider who is responsible for coordinating and monitoring their care. Under this model, the coordination efforts of the primary care physician are directly recognized by the payer. The PCPs receive a flat per member per month (PMPM) care coordination fee or an increase in preventive service fees to reimburse for the case management services they provide. Claims are otherwise paid on a FFS basis. This model is historically more common in rural areas where low patient volume makes full capitation rate models more difficult due to unpredictability of cost. Nineteen states are known to offer both PCCM and MCO options.[5]

Patient Centered Medical Home

A Patient Centered Medical Home (PCMH) is a model of care delivery usually focused on treating individuals with chronic health conditions or disabilities. The medical home uses a team approach, coordinating primary and specialty care under one provider umbrella for individuals with specific conditions. One way that it differs from the MCO model is that the medical home is typically provider-run.

Minnesota PCMHs, called Health Care Homes, were developed as a result of the state's health reform legislation passed in May 2008. Minnesota currently has 220 certified PCMHs throughout the state.[6]

Accountable Care Organization

Accountable Care Organizations are comprised of a group of health care providers who affiliate to coordinate patient care. The organization's payment is specifically tied to "shared savings" achieved through health care quality and efficiencies. This model was initially developed through Medicare. It is now expanding in many states to Medicaid and the private market.

In 2010, Minnesota's Legislature mandated DHS to develop and implement a demonstration testing alternative and innovative health care delivery systems, including accountable care organizations. In addition to the Hennepin Health ACO established in 2012 to serve Hennepin County's high-risk childless adult population, Minnesota's recent Health Care Delivery Systems initiative is experimenting with provider-led accountable care models, in which DHS negotiates with providers to provide services to a specified patient population according to agreed-upon risk and gain sharing payment arrangements.

[5] http://www.rwjf.org/content/dam/farm/reports/reports/2012/rwjf401106
[6] http://www.health.state.mn.us/healthreform/homes/index.html

Episode-Based Care Coordination

In a bundled payment model, reimbursement for multiple services is bundled into a single, comprehensive payment that covers an entire episode patient care. This model aims to control cost, integrate the care delivery system, and restructure primary care delivery by orienting the costs of service delivery towards specific patient health outcomes.

Delivery systems have proliferated as states have tested payment reforms. Because of this, as Minnesota continues to assess the value of health care service procurement options, it may be useful to broaden the evaluation of "value" beyond traditional FFS and managed care.

Delivery Systems and Minnesota Health Care Programs

Medicaid is the largest of the Minnesota Health Care Programs, providing coverage for more than 800,000 low income children and parents, adults without children, people with disabilities and seniors. In order to be enrolled in Medical Assistance, individuals must meet income limits that have been defined for specific populations. In addition, Minnesota Medical Assistance has covered adults without children below 75% of the federal poverty level (FPL) since January 2011, and will increase coverage up to 133% in January 2014.

MinnesotaCare was enacted in 1992, and provides health care coverage for non-aged, non-disabled and those who also have incomes too high to qualify for Medical Assistance. Enrollee premiums are determined on a sliding-fee scale based on income and family size.

Eligible individuals are enrolled in one of four coverage packages, listed below.

- Basic Plus- Parents
- Basic Plus One- Adults without children
- Basic Plus Two- Parents
- Expanded- Pregnant Women and Children

Minnesota also offers the following coverage packages for the elderly and/or disabled, which are listed below.

- Minnesota Senior Care Plus (MSC+)
- Minnesota Senior Health Options
- Special Needs Basic Care
- Preferred Integrated Network (subset of Special Needs Basic Care)

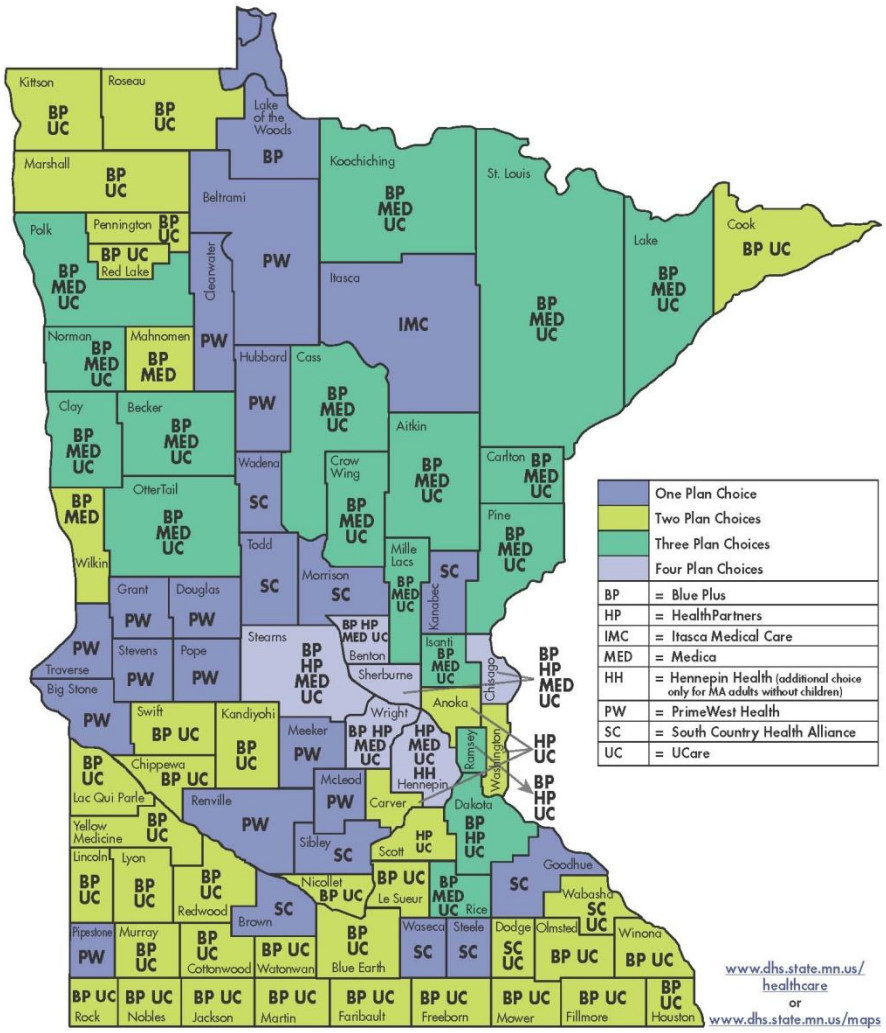
Managed Care has existed in Minnesota since 1985. MCOs are required to be not-for-profit by state law. As of January 2013, Minnesota had 613,520 individuals enrolled in Medicaid Managed Care.[7] Almost all Minnesota Medicaid members without a disability are enrolled in an MCO (federally required exemptions for Native Americans and other populations prevent 100% enrollment). More than 80,000 elderly and disabled individuals in Minnesota Medicaid are served by a managed care organization.

Minnesota currently has eight Medicaid MCOs. These include: Blue Plus, Health Partners, Itasca Medical Care, Medica, Metropolitan Health, PrimeWest Health, South Country Health Alliance, and UCare. The managed care organizations with the largest number of MA enrollees are UCare and Medica. Hennepin Health is a program administered by Metropolitan Health that specifically offers Medicaid Managed Care to those adults without children in the Medicaid expansion population.

Itasca Care, South Country Health Alliance, and Prime West are all County Based Purchasing (CBP) entities. Together, these entities represent 20 counties and over 26,000 enrollees.[8] CBP is a health plan operated by a county or group of counties which are primarily rural. The entity provides health care services for residents enrolled in public health assistance such including Medical Assistance (MA) and MinnesotaCare. CBP entities are required to meet most HMO requirements. The following page includes a map of the health plan choices by county, effective January 1, 2013. This includes all managed care organizations listed above.

[7] http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_141315

[8] http://www.health.state.mn.us/hmo/cbpinfo.htm



Consistent with the statutory direction provided for this study, PCG will examine the value these Medicaid managed care plans provide the State of Minnesota according to the specific criteria identified in the executive summary.

Managed Care Payment Methodology: Capitation Rates

Minnesota provides each of its MCOs with a prospective "per member per month" (PMPM) payment to cover the health care costs of each enrolled member. DHS adjusts capitation rates on an annual basis.

States differ in the methodologies they employ to set capitation rates. Federal rules do not prescribe a single method. Some states link their capitation rate directly to Medicaid FFS rates. For example, Wisconsin sets MCO rates in five regions of the state, and does so by pricing a 3-year set of "encounter claims" (records submitted by MCOs of the services they have provided to Medicaid recipients) consistent with rates. Assuming that the encounter claims set is accurate, the result is a "FFS equivalent rate." This indicates the amounts the FFS model would have paid for managed care claims.

Wisconsin further adjusts "FFS equivalent" rates for medical trends, state policy initiatives and MCO administrative costs, among other variables. Finally, rates are risk adjusted based on the medical acuity of the plan's enrollees.

Minnesota's capitation rates have been developed using plan cost data. These costs are then trended for the impact of legislative changes related to fees and benefits. The rates have historically yielded higher than targeted margins for the plans. The trends and high margins have been an area of scrutiny for DHS over the past two years.

DHS is beginning a process to review base FFS rates, which have not been maintained and are out of date with current cost data. Updating FFS rates can provide a more accurate basis for pricing managed care services. DHS is also working to update the risk adjustment process and has begun to utilize encounter data to set capitation rates.

Separate from PCG's broad evaluation of the value of managed care, DHS has commissioned an independent audit, completed in March 2013, of the rates it paid to Medicaid managed care plans from 2002 to 2011.

Performance Metrics

All states require their Medicaid MCOs to measure and meet specific performance metrics. Most states rely on the Healthcare Effectiveness Data and Information Set (HEDIS), developed and maintained by the National Committee for Quality Assurance (NCQA), and the Consumer Assessment of Healthcare Providers and Systems (CAHPS), to monitor the quality of service provided by each MCO.

HEDIS specifically measures performance of certain outcomes, focusing mainly on prenatal and post-partum care, child health, preventive care, disease management, and access to services. CAHPS is a survey used to measure patient experience. Many states require their own state specific quality metrics that MCOs are required to measure and report.

Some states require their Medicaid MCO health plans to be accredited by a nationally recognized accrediting organization, most commonly the National Committee on Quality Assurance (NCQA).

The eight MCOs in Minnesota are required to conduct Performance Improvement Projects annually. These projects focus on improving care and services for Medicaid enrollees. The 2012 performance improvement projects include:

- Reducing non-urgent emergency department use
- Increasing Colorectal cancer screening (CRC) for enrollees ages 50-75
- Increasing the use of spirometry testing for the diagnosis of Chronic Obstructive Pulmonary Disease (COPD)
- Increasing annual preventive and diagnostic dental services

- Breast cancer screening

Approximately one-fourth of states with MCOs and/or PCCM programs also monitor quality measurements in their FFS system.[9] The majority of those states use HEDIS measures in FFS. Some states use their own specific measures for FFS. In addition, many of these states administer the same patient experience surveys for their FFS population as they do for their MCO population.

MCO Quality Strategy

All Medicaid managed care programs are required by CMS to maintain a Managed Care Quality Strategy that outlines the state's quality of care and service compliance expectations for managed care organizations. Much of this strategy is dedicated to ensuring that participants in managed care programs receive sufficient quality according to defined metrics, such as network adequacy, timely access, and services offered. Collective program improvements brought about by successfully maintaining the quality strategy are anticipated to increase both provider and consumer satisfaction with the program.

The Minnesota Managed Care Quality Strategy indicates that the "best assessment…is not just in the measurement of compliance with state and federal requirements, but also in enrollee satisfaction and demonstrated improvements in the care and services provided to all enrollees."[10] In addition to outlining tools and processes for improving care outcomes, the strategy also lays a foundational framework for consumers to express levels of satisfaction with MCOs' provision of these services. These tools include a CMS-mandated grievance system overseen by the State Managed Care Ombudsman, and an appeals process operated through Minnesota's State Fair Hearing System

The state is responsible for providing information to each enrollee at least annually concerning a plan's service areas, benefits covered, cost sharing, and quality and performance indicators, including enrollee satisfaction.

[9] http://www.kff.org/medicaid/upload/8220.pdf p.32
[10] Managed Care Quality Strategy, p.6

Section II. Measurement and Improvement of the Health Outcomes

The Challenge of Health Outcome Measurement

Despite the crucial importance of health outcomes to any discussion of quality of care and overall value, there is remarkably little consensus on how best to measure and compare health outcomes.[11] The lack of appropriate quality standards has created difficulties in drawing meaningful comparisons between different kinds of health care delivery systems.[12] Further, there are special challenges specific to quality comparisons between Medicaid managed care and FFS systems. These must be properly acknowledged if such comparisons are to serve as the basis for informed policy decisions.

Many existing quality improvement efforts evolved in the context of managed care. They therefore depend on performance measurement tools specially adapted to the particular needs of MCO populations and reporting protocols. It is not always easy to adopt the same instruments, methods, or even quality criteria when evaluating FFS systems.[13] In Medicaid, these challenges are compounded by the fact that, in most states, only Seniors and Persons with Disabilities (SPD) continue to be served under FFS systems. Most other enrollment groups now fall under some form of managed care. This trend has resulted in a substantial divide between two disparate population sets with very different risk factors, consumer expectations, and utilization of services. The difficulty of comparing populations of different acuity was a repeated challenge throughout the report, but nowhere more so than in the comparison of health outcomes.

This is especially true in the context of Minnesota's Medicaid program, because of the state's long reliance on managed care and its relatively small remaining FFS population. Many of the performance measures in place to evaluate MHCP managed care do not exist for the FFS system. Minnesota has a well-developed quality improvement program for its managed care system, subject to extensive state and federal regulations and compliance requirements. Meanwhile, the state's FFS system receives neither the same level of oversight, nor the same level of resources devoted to quality assurance and performance improvement. This is another caveat that will recur throughout all comparisons between MCO and FFS systems.

For our analysis of health outcomes for the FFS and MCO populations of Minnesota Medicaid, PCG has relied in large part on the Healthcare Effectiveness Data and Information Set (HEDIS). This nationally recognized performance metric was developed and is maintained by the National Committee for Quality Assurance (NCQA). As a national measure, HEDIS can be used to compare Minnesota's managed care and FFS systems to one another. HEDIS data is also invaluable for drawing comparisons to other state Medicaid programs and commercial plans.

[11] Porter ME. What is value in health care? N Engl J Med 2010;363:2477-81.
[12] Birkmeyer JD, Kerr EA, Dimick JB. Appendix F commissioned paper: Improving the quality of quality measurement. Performance Measurement. Washington, DC: National Academies Press; 2006:77-203.
[13] Lind, A., Berenson J., and Highsmith, N., "Performance Measurement in Medicaid: Emerging Best Practices," Center for Health Care Strategies (October 2010).

Although HEDIS is regularly used as a baseline for determining performance among delivery systems, HEDIS was originally developed primarily for measuring the health outcomes of relatively healthy MCO populations, using managed care encounter data and enrollment systems. While the outcomes measured by HEDIS have grown considerably in the past decade, the tool continues to be oriented to populations whose medical needs reflect the health characteristics of typical MCO populations, rather than the intensive health care needs of the Seniors and Persons with Disabilities (SPD) population. For example, a plan's HEDIS performance in Well Child visits might serve as an important indicator of quality in a managed care context, on account of the large proportion of children represented in the managed care population, as well as the relative healthiness of this population. However, the Well Child rate and other indicators of preventive care are likely to be less relevant for a FFS system whose resources are oriented primarily to serving elderly and disabled populations. HEDIS has yet to incorporate the full range of mental health and disability measures most useful for gauging the effectiveness of the FFS system in the role that it plays in Minnesota and in many Medicaid programs nationwide. Additionally, the significant churn between MCO and FFS populations, and the consequent difficulty in applying HEDIS continuous enrollment criteria to FFS populations, create unique reporting challenges and methodological concerns when the tool is applied in the context of a FFS system. Despite these caveats, HEDIS remains the only straightforward and readily available source of data for such comparisons.

Quality Comparisons in Minnesota's FFS and Managed Care Populations

In 2011, DHS conducted a quality comparison of its managed care and FFS systems, using the 2010 HEDIS data available for comparable groups within both programs. On the managed care side, the study used two voluntary demonstration programs—the former Minnesota Disability Health Options (MnDHO) and the Special Needs Basic Care (SNCB). These programs include adult populations whose special health care needs can be adequately served under a managed care delivery system. The FFS comparison population was composed of disabled individuals with a disability enrolled in a managed care organization. The study used a "continuous enrollment" criterion to strip the FFS comparison group of non-disabled Medical Assistance enrollees who are merely "waiting" on enrollment in an MCO.

The analysis was based on 19 standardized performance measures calculated by DHS, consistent with HEDIS 2011 Technical Specifications, and certified by an independent HEDIS auditor. The study focused on the same annual measures used to evaluate MCO strengths and weaknesses as required by federal Medicaid managed care regulations. The MCOs were evaluated with respect to quality, timeliness, and access. All measures were calculated on MCO submitted encounter data and FFS provider submitted claims data. With few exceptions, the FFS rates across the 19 measures were lower than the comparison and managed care benchmark populations. While acknowledging methodological limitations, the study concluded that "FFS rates are well below rates achieved in the managed care delivery system."

Managed Care MHCP HEDIS Performance

Interestingly, neither the FFS nor the managed care population performed exceptionally when evaluated against national Medicaid HEDIS rates. Of the 19 HEDIS measures reviewed annually in fulfillment of CMS requirements, average MCO performance ranked above the Medicaid 50th percentile in only 12

measures. The health plan with the lowest performance placed above the 50th percentile in only 10 of the 19 measures, while the strongest performer did so for 15 of the measures. The MHCP statewide average achieved the 90th percentile in only two of the 19 measures. Individual plans demonstrated exceptional performance in 3 to 5 measures. Although individual MCOs did better or worse on different measures, overall performance was relatively even among the health plans.

Health plan outcomes were least strong on children's health measures, including preventative measures such as well-child visits and immunization rates. In some cases, MCO performance was well below the 50th percentile. More than one MCO failed to take corrective action on weak scores over multiple years. The most recent External Quality Review Organization (EQRO) review noted that MCO HEDIS performance is consistently strongest in the realm of women's health (based on breast cancer and Chlamydia screening) and elderly care (based on senior preventative visits). These detailed observations of program quality strengths and weaknesses are important, because they align to some extent with similar conclusions drawn from two different comparative studies of Medicaid program quality throughout the United States, which will be discussed further below.

MHCP Managed Care Performance Comparison to Benchmarks, 2010 Annual Technical Report (calculated with Administrative Method)

Indicators	MCO Statewide Average	National Medicaid Average	MCOs above 50th Percentile	MCOs above 90th Percentile
Antidepressant Medication Management (Acute)	42.60%	50.74%	1	0
Antidepressant Medication Management (Continuous)	30.50%	34.44%	2	0
Appropriate Use of Asthma Medications (5-50yrs)	86.80%	88.37%	2	1
Chlamydia Screening	60.50%	57.47%	4	2
Adult Preventive Visits (20-44yrs)	89.60%	81.19%	8	6
Adult Preventive Visits (45-64yrs)	90.90%	86.04%	8	6
Adult Preventive Visits (65+yrs)	96.80%	83.66%	8	7
Child PCP Visits (12-24mos)	98.60%	96.09%	8	4
Child PCP Visits (25mos-6yrs)	92.60%	88.27%	8	2
Child PCP Visits (7-11yrs)	93.30%	90.22%	7	1
Child PCP Visits (12-19yrs)	93.20%	88.14%	8	6
Adolescent Well Child Care (12-21yrs)	35.60%	48.07%	0	0
Breast Cancer Screening	57.80%	51.35%	8	1
Cervical Cancer Screening	72.30%	67.19%	7	0
Childhood Immunizations (Combo #3-2yrs)	58.80%	69.94%	1	0
Comprehensive Diabetes Care (HbA1c Testing)	87.80%	82.03%	7	1
Comprehensive Diabetes Care (LDL-C Screening)	77.10%	74.71%	5	0
Well Child Care in First 15 mos. (6+ Visits)	55.20%	60.19%	1	0
Well Child Care (3-6yrs)	67.30%	71.89%	3	0

There are reasons to believe, though, that outcomes may be higher than the figures above suggest. Significantly, DHS's approach to measuring performance is based on data submitted to the health plans to claim reimbursement for each health care procedure performed. This is an NCQA-approved approach referred to as an "administrative methodology." Other legitimate methodologies exist in which claims information is used as a base, but is further supplemented with data collected from medical record reviews of randomly selected individuals. This alternative approach is called a "hybrid methodology," due to the employment of multiple data sources.

The NCQA allows each health plan to choose which method it uses to report performance data. A hybrid methodology that bases its results on a combination of claims data and medical records tends to show higher performance levels than a methodology based solely on claims data.[14] A hybrid method is generally considered more accurate than an approach relying exclusively on claims data, because it reveals some events that the claims data do not record.[15] For example, data submitted for claims purposes might show no record of a child's immunization. This is common for medical procedures where payment is minimal and providers do not file a claim with the health plan. Yet the child's medical record may indicate that the child was, in fact, immunized. A purely administrative methodology is unlikely to reflect these arrangements, so a hybrid methodology is often employed to capture this additional information.

It is important to consider, though, that Minnesota's health plans calculate their results according to hybrid methods that frequently yield higher results. Consequently, several of the MCOs have contested calls for corrective action based on poor performance when results have been calculated by the administrative method used by DHS. In response, they have cited their own performance results, as submitted to NCQA and reported to the Minnesota Department of Health (MDH), which are also validated by private audit firms certified by NCQA.

A review of MCO performance when measured according to a hybrid methodology shows considerably stronger performance among the plans. Statewide MCO averages score higher than the 50th percentile in 15 of the 19 measures reviewed, and rise above the 90th percentile in three of these measures. Health plan performance using the hybrid methodology is detailed below:

[14] Kerr, E.A. et al., "Comparing Clinical Automated, Medical Record and Hybrid Data Sources for Diabetes Quality Measures," *Journal on Quality Improvement* 28, no. 1 (October 2002): 555-565.
[15] Pawlson, G.L., Scholle, S.H., and Powers, A., "Comparison of Administrative-Only Versus Administrative Plus Chart Review Data for Reporting HEDIS Hybrid Measures," *The American Journal of Managed Care* (October 2007): 553-558.

MHCP Managed Care Performance Comparison to Benchmarks, 2010 (self-reported by health plans to MDH, calculated with Hybrid Method)				
Indicators	MCO Statewide Average	National Medicaid Average	MCOs above 50th Percentile	MCOs above 90th Percentile
Antidepressant Medication Management (Acute)	52.02%	50.74%	6	1
Antidepressant Medication Management (Continuous)	36.34%	34.44%	6	0
Appropriate Use of Asthma Medications (5-50yrs)	88.73%	88.37%	4	1
Chlamydia Screening	57.43%	57.47%	4	2
Adult Preventive Visits (20-44yrs)	89.15%	81.19%	8	5
Adult Preventive Visits (45-64yrs)	90.24%	86.04%	8	2
Adult Preventive Visits (65+yrs)	89.77%	83.66%	5	5
Child PCP Visits (12-24mos)	98.46%	96.09%	6	1
Child PCP Visits (25mos-6yrs)	91.65%	88.27%	6	1
Child PCP Visits (7-11yrs)	91.92%	90.22%	5	0
Child PCP Visits (12-19yrs)	92.05%	88.14%	7	2
Adolescent Well Child Care (12-21yrs)	40.40%	48.07%	0	0
Breast Cancer Screening	59.83%	51.35%	8	2
Cervical Cancer Screening	77.12%	67.19%	8	2
Childhood Immunizations (Combo #3-2yrs)	76.66%	69.94%	5	1
Comprehensive Diabetes Care (HbA1c Testing)	94.26%	82.03%	8	4
Comprehensive Diabetes Care (LDL-C Screening)	85.67%	74.71%	6	1
Well Child Care in First 15 mos. (6+ Visits)	60.67%	60.19%	5	0
Well Child Care (3-6yrs)	68.52%	71.89%	2	0

Because CMS does not accept self-reported performance data for purposes of official review, DHS performs its own calculations in order to meet federal requirements. DHS has chosen to use an administrative methodology. Although DHS is permitted to use either methodology, EQRO managed care reviews note that DHS has calculated the data with a claims-only method in order to ensure its consistency over time. Because NCQA guidelines grant MCOs discretion in the way they apply hybrid methodologies, Minnesota's health plans use hybrid approaches differently for each of the measures. For this reason, an administrative method also facilitates more consistent performance comparisons among plans within the state. Despite its potential for underreporting, PCG has noted the results derived from the DHS methodology, because this choice of methodology also renders managed care data more amenable to comparisons with FFS performance, whose performance calculations usually rely solely on claims data. However, it must be acknowledged that a purely administrative approach is likely to make the data less comparable to managed care programs in other states, where reported figures often reflect the use of hybrid calculation methods.

In some cases, significant variation exists between the two approaches. To take the most prominent childhood immunization example, under the administrative methodology, only one of the eight health plans ranks above the 50th percentile. However, five of the eight plans are above the 50th percentile under a hybrid approach, with one of the plans reaching the 90th percentile. While none of the other measures demonstrated the same dramatic differences, plan performance improved in all of the measures in which a hybrid methodology was applied.

Importantly, the application of a hybrid methodology did not significantly improve health plan performance for the well-child care measures that serve as key indicators of children's health, raising questions as to whether the health plans are providing optimal value for this large group of Medicaid enrollees.

Minnesota's Performance in Nationwide Quality Studies

Minnesota is frequently recognized for its excellent quality of health and for its health care system's overall high level of performance. However, it is important to note that nationwide health care studies frequently cited by DHS[16] and other stakeholders do not focus specifically on the Medicaid population. Neither do they incorporate HEDIS and other system performance data.

In order to contextualize Minnesota's overall quality performance among Medicaid programs nationwide, PCG analyzed four major comparative studies of health care systems nationwide:

- Commonwealth Fund Scorecard on Local Health System Performance (2007, 2009, 2012)[17]
- UnitedHealth Foundation's America's Health Rankings (2012)[18]
- Public Citizen Health Research Group's Ranking of State Medicaid Programs (2007)[19]
- Mathematica Policy Research, Inc., study on the Relationship between Medicaid Costs and Quality (2010)[20]

Each of the studies draws on a vast amount of health information from a variety of sources, using performance criteria that sometimes diverge substantially from the other studies. The first two studies

[16] See, for example, a presentation on Minnesota reform initiatives by Scott Leitz of DHS, at the National Academy of State Health Policy's 2012 Fall Conference, October 2012, which cites Minnesota's performance in the 2012 Commonwealth Fund Scorecard. Available at: http://www.nashpconference.org/wp-content/uploads/2012/presentations/leitz.12.using.accountable.care.pdf. Accessed June 14, 2013.
[17] Commonwealth Fund, *Scorecard on Local Health System Performance*, 2012. Available at: http://www.commonwealthfund.org/Publications/Fund-Reports/2012/Mar/Local-Scorecard.aspx. Accessed June 14, 2013.
[18] UnitedHealth Foundation, *America's Health Rankings: 2012 Annual Report*, 2012. Available at: http://www.americashealthrankings.org/. Accessed June 14, 2013.
[19] Ramirez de Arellano, A. and Wolfe, S. "Unsettling Scores: A Ranking of State Medicaid Programs," Public Citizen, 2007. Available at: http://www.citizen.org/medicaid. Accessed June 14, 2013.
[20] Lipson, D. et al. "Value for the Money Spent? Exploring the Relationship between Medicaid Costs and Quality," Mathematica Policy Research, Inc., August 2010. Available at: http://www.mathematica-mpr.com/publications/PDFs/health/medicaid_costs_quality.pdf. Accessed June 14, 2013.

give high marks to the Minnesota health system for quality. However, the last two studies reveal limited areas of underperformance in the state's health programs. Scope is of crucial importance in understanding Minnesota's performance in each of these studies. With very low rates of uninsured residents—the chief determinant of population health—Minnesota is bound to do well at the level of broad health trends and clearly continues to lead the nation in general population health.

For example, the first two studies include a wide range of population indicators drawn from census, public health and other demographic source data, none of which target Medicaid's low-income population explicitly. The Commonwealth Fund Scorecard, produced originally in 2007 and updated in 2009 and 2012, consistently ranks Minnesota among the top ten health systems in the nation. The UnitedHealth Foundation rankings are also regularly updated, with the state slipping gradually from 1st to 5th in the nation over the past half-decade. However, as criteria are narrowed more exclusively to the Medicaid program, the performance of Minnesota's state health programs can be distinguished and isolated from the state's strong overall health index scores and robust demographic quality indicators.

Minnesota also performs well in the PCHRG study, ranking 7th overall. Even so, its performance varies dramatically in individual categories relevant to the present inquiry. The study divides its evaluation criteria into four performance categories: 1) access, 2) scope of services, 3) quality, and 4) provider reimbursement. Although the PCHRG study draws on state health data that includes non-Medicaid populations, it nevertheless focuses on factors particular to the Medicaid program. These include Medicaid benefit sets and provider reimbursement rates for Medicaid services. Minnesota's Medicaid program performs well on issues of access (6th) and scope of services (2nd), which is unsurprising, given the state's generous eligibility standards and covered benefits. However, on the specific issue of quality of care, the state ranks 32nd. The study also ranks Minnesota only slightly above average on its Medicaid provider reimbursement (19th).

In contrast to the other quality studies included, the Mathematica study restricts its analysis solely to state Medicaid programs. It relies wherever possible on exclusively Medicaid health data or data identified predominantly with Medicaid populations. This study is the only nationwide comparison to incorporate HEDIS data in its quality analysis, along with data from Medicaid CAHPS surveys, the National Survey of Children's Health (NSCH), the National Immunization Survey (NIS), National Core Indicators (NCI), and Nursing Home Compare (NHC). Also unique to this study is an attempt to pair the quality data with Medicaid cost data mined from the Medicaid Analytic eXtract (MAX). As a result, the Mathematica study is a report on *value* and not merely *quality*.

Because of the complexity of the variables at issue, the Mathematica study opts to categorize states by tiers rather than individual rankings. Tier A represents states with high quality/low cost Medicaid programs. Tier B is made up of programs that are either high quality/high cost, or low quality/low cost. Tier C consists of low quality/high cost programs. The Mathematica study conducts specific analyses for each of the major Medicaid populations: children, adults, the elderly, and the disabled. Minnesota falls into Tier C for each of these populations except the elderly, which is grouped into Tier A.

The HEDIS data calculated by DHS reflects many of the same quality differences as those presented in the Mathematica analysis, with particular strengths in health outcomes for seniors, and weaker performance in children's health. Of relevance to the present report, the Mathematica analysis of children's health did not rely solely on HEDIS, but also drew its conclusions from performance data available from other sources, such as the National Survey of Children's Health (NSCH) and the National Immunization Survey (NIS). These sources also indicated unexceptional levels of preventative care for children, based on national Medicaid comparisons. Considering elevated expenditure levels on children's health (to be addressed in Section VI), these results suggest that state spending for this specific population has not generated optimal value.

Other Quality Measures

Aside from direct measurement of health outcomes available through HEDIS, the state also works to ensure quality health care by monitoring health plans' compliance with legal requirements. Through interagency agreement, MDH is responsible for ensuring compliance with statutes and rules, while DHS is responsible for ensuring compliance with state contracts. In addition to compliance requirements, health plans are subject to a variety of federal and state requirements mandating health care quality improvement projects. DHS also takes these quality improvement requirements a step further, by establishing a payment system that ties quality improvement to financial rewards and penalties.

First, in the case of MDH's quality assurance oversight, MDH reviews each health plan at least once every three years to determine whether it is compliant with state regulatory requirements. If MDH discovers problems, it requires the MCO to submit a "corrective action plan" and subsequently follows up to ensure that the problems were corrected. PCG examined the 2009-2012 quality assurance reports for each of the plans, noting a considerable number of individual areas of non-compliance for each plan. However, it was difficult to determine whether these deficiencies have a significant negative impact on health outcomes. It was rare for any of the health plans to persist in any particular deficiency, suggesting that the MCOs are responsive overall to agency oversight. Further, many of the deficiencies appeared to be procedural in nature, such as failing to provide plan enrollees or agency regulators with proper written notification of complaint decisions or plan changes. Many of the plans appeared to be non-compliant in regard to the grievance system and appeals process, as will be discussed in Sections III and IV at greater length.

Second, state rules also require managed care organization to prepare a written work plan annually. This work plan includes quality improvement activities they intend to pursue that year. The plan also sets a timetable for completion and specifies how initiated activities will be evaluated.[21] Federal regulations require that health plans administering public programs pursue performance improvement projects (PIP), which are targeted interventions, intended to improve outcomes of care.[22] These regulations further

[21] Minnesota Rules 2007, 4685.1130.

require states to conduct annual reviews of each health plan's quality improvement efforts, including PIPs.[23]

Health plans have maintained compliance with this directive. However, it is unclear how many of these quality improvement efforts are truly producing sustained impacts. Evidence exists that earlier initiatives were misaligned with state-level quality performance priorities and competing provider-level projects.[24] On the other hand, it appears from recent PIP annual summaries that the program has begun to foster more focused PIP collaborations among the health plans.

Third, DHS has developed a performance-based payment system to encourage quality improvement in the state's managed care programs. Since 2003, DHS has incorporated provisions into health plan contracts that tie service standards to a set of financial withholds and incentive payments. These provisions allow DHS to withhold a percentage of MCO capitation payments when certain administrative services are not completed satisfactorily.

Generally, MCOs have fared well on performance incentives in state contracts, although DHS limits the amount of funding at stake. State law allows DHS discretion to select and develop the performance areas for the payment withholds. It does require that the performance targets be "quantifiable, objective, measurable, and reasonably attainable."[25] Many of the performance measures are based on administrative functions. Some measures, such as the accurate claims reporting of provider identification numbers, are based on federal law.[26] DHS typically includes measures that focus on health-related services. However, these benchmarks have not always challenged plans to improve their performance over time. Moreover, some of the health-related measures have been suspended periodically, primarily due to deficiencies in the underlying data used to calculate performance.

In past years, DHS also gave MCOs an opportunity to earn additional monies, up to 5% of their capitation amount, for achieving benchmarks on measures of clinical performance. These incentives emphasized preventive care activities, requiring the health plans to work with their provider networks on implementation. Many of these initiatives focused on improving the accessibility of health care to children. These included immunizations, primary care visits, and mental health screenings. Other measures focused on screening adults for particular diseases or monitoring individuals diagnosed with chronic conditions such as diabetes. After recent legislative changes, DHS no longer retains the authority to approve MCO incentive payments, though the system of withholds remains in place.

Virtually none of these broad types of quality assurance mechanism exist within the FFS system. In the FFS system, it is impossible to find the same systematic scale of performance measurement or programs for accomplishing quality improvement. DHS routinely analyzes key performance measures such as Ambulatory Care Sensitive Conditions (ACSC) for its managed care populations. It does not conduct

[22] 42 CFR sec. 438.240(b)(1)
[23] 42 CFR sec. 438.240(e)
[24] Minnesota Office of the Legislative Auditor, *Financial Management of Health Care Programs*, 2008.
[25] *Minnesota Statutes* 2007, 256B.69, subd. 5a(c), and 256L.12, subd. 9(c).
[26] 42 U.S. Code 1396b(m)(2)(A)(xi).

similar studies for its FFS enrollee outcomes at a comparable scale to its managed care programs. Some evidence suggests that managed care performs more strongly than FFS in important ACSC outcomes, such as reducing unnecessary hospital admissions.[27] However, FFS performance in these measures has not been systematically reported and analyzed in a manner that would facilitate straightforward comparison.

Overall, FFS care has been subject to minimal external oversight of quality and health outcomes. While managed care organizations are subject to numerous internal and external quality assurance reviews, there are no such reviews for FFS care. Although DHS conducts periodic performance comparisons between FFS and managed care programs, FFS quality outcomes in themselves are not subject to regular review.

Such shortcomings in FFS quality assurance are not unique to Minnesota. Medicaid FFS systems were developed primarily as mechanisms for processing provider payment claims. They were not designed initially to address quality of care issues. Consequently, rigorous quality measurement in the FFS setting is exceedingly difficult, to say nothing of quality improvement.

Apart from limited measures focused on FFS care coordination efforts[28], performance measurement and quality improvement measures in the FFS model trail its managed care counterpart substantially.

Conclusions

PCG's comparative analysis of health outcomes has yielded three major observations:

1. The traditional FFS system appears limited in its ability to report health outcome performance, relative to the capacities for performance measurement in the managed care system.

2. Where FFS and managed care outcomes have been measured in comparable populations, FFS performance has lagged behind outcomes in the managed care system. While MCO outcomes are possibly less than optimal, managed care outstrips FFS in all available measures.

3. Minnesota's FFS performance measurement and quality improvement infrastructure is underdeveloped in comparison to the programs in place for managed care. Given all of these quality differences between the two systems, it would appear that managed care is able to deliver stronger health outcomes, and therefore stronger potential value, than what can be expected from the FFS system.

[27] Bindman, Andrew B. et al. "The Impact of Medicaid Managed Care on Hospitalizations for Ambulatory Care Sensitive Conditions," Health Service Research 40:1 (February 2005), 19-37.
[28] A more extensive discussion of the state's efforts towards FFS case management can be found in Section V.

Section III. Assessment of the Satisfaction of Recipients and Providers

Satisfaction, Quality, and Value

Consumer satisfaction is one major criterion for distinguishing the relative value of managed care in comparison to FFS models. It also plays a major role in Minnesota's Managed Care Quality Strategy. PCG has evaluated the existing managed care satisfaction data assembled and made available on the Minnesota Department of Human Services website. We have gained from this analysis a robust portrait of recipient satisfaction with the state's managed care program. PCG's assessment incorporates a variety of direct and indirect indicators of consumer satisfaction.

These include a review of survey results from Minnesota's annual Managed Care Public Programs Consumer Satisfaction Survey, responses from recipients voluntarily changing their plan enrollment, and reports of consumer grievances collected by the managed care ombudsman.

Patient satisfaction can be an important indicator of health care quality. However, patient satisfaction has multiple meanings in value measurement, with varying degrees of significance for determining value. Patient satisfaction measurement can be a vehicle for measuring both patient compliance and, most important, health outcomes, *as perceived by the patient*. Surveying patients on outcomes is often essential to understanding functional status, pain, anxiety, and other factors that the patient is best equipped to judge and for which biologic or other markers may be unavailable.

Other satisfaction measures have an only indirect connection to health outcomes. Patient satisfaction with care processes is the focus of most patient surveys, which cover hospitality, amenities, friendliness, and other aspects of the service experience. While a consumer's experience with service delivery is not itself a health outcome and should not be the only focus of quality measures, it can contribute indirectly to good outcomes.

PCG has also engaged representatives from the Minnesota provider community in order to gauge the experience of providers with the plans. PCG interviewed the managed care ombudsman to understand the context of the state's grievance program and the character of consumer grievances. Provider satisfaction also plays an indirect role in the measurement of value.

Provider satisfaction can impact the quality of health care in a number of ways. Strong provider satisfaction is an important indicator of the strength of provider networks in the Medicaid system. Recipient access to a greater number of high quality providers is a positive quality outcome. Provider support for the Medicaid program is critical to ensuring that enrollees receive an equitable level of care in relation to patients insured through Medicare and commercial plans. Finally, provider satisfaction can be a measurement of provider responsiveness to health care innovations, such as the state's service delivery reform efforts.

CAHPS System Survey Results

One tool regularly used by Minnesota to analyze consumer satisfaction is the annual Managed Care Public Programs Consumer Satisfaction Survey. Data is gathered from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey instrument, and used to assess enrollees' satisfaction with their managed care programs. CAHPS data measures overall satisfaction with care received as well as specific ratings of the doctors and specialists, provider communication and health plan customer service.

Importantly, the FFS system lacks an equivalent to the CAHPS assessment. Because CAHPS is administered exclusively through the managed care system as a requirement of NCQA HMO certification, equivalent data for services provided on a FFS basis is not available. While CAHPS data cannot be used to compare FFS quality with MCO performance, it is a useful metric for gathering a general picture of managed care quality. At the same time, the fact that the FFS delivery system lacks such tools for tracking and improving consumer experience is an inherent difference in quality between the two models.

Minnesota contracts with an External Quality Review Organization (EQRO) to conduct a "comprehensive annual review of the eight MCOs to evaluate each organization's performance in relation to the quality of health care, timeliness of services, and accessibility to care for MHCP enrollees."[29] In the 2010 EQRO report by the Minnesota Peer Review Organization (MPRO), MHCP indicators were compared to the national commercial and Medicaid CAHPS indicator averages. As seen in this comparison, MHCP's statewide average score on CAHPS measures ranks above the national Medicaid average for all performance indicators. Minnesota places above the 90th percentile among Medicaid HMOs nationally for six of the eight indicators.[30] MHCP scores also exceeded national commercial MCO averages in all but one CAHPS indicator.

Indicators	MHCP Statewide Average	Nat'l Commercial Average	Nat'l Medicaid Average
QUALITY:			
CAHPS: How People Rated Their Personal Doctor	71.61%	67.45%	61.10%
CAHPS: How People Rated Their Specialist	66.26%	66.43%	61.34%
CAHPS: How People Rated Their Health Care	56.36%	53.64%	48.75%
CAHPS: How People Rated Their Health Plan	62.72%	47.30%	54.69%
CAHPS: How Well Doctors Communicate	95.00%	93.86%	87.84%
ACCESS:			
CAHPS: Getting Needed Care	87.10%	85.48%	75.95%
CAHPS: Health Plan Customer Service	86.00%	85.80%	79.74%
TIMELINESS:			
CAHPS: Getting Care Quickly	86.50%	85.70%	80.56%

[29] MPRO 2010 Annual Technical Report, p.i
[30] MPRO 2010 Annual Technical Report, p.73

Plan Change and Disenrollment Reasons

Enrollee satisfaction with managed care plans can also be measured by reviewing the reasons provided when a recipient voluntarily changes MCOs. The volume of disenrollment as well as the reasons provided for switching from one plan to another are both useful measures. This data can provide insights into levels of satisfaction among enrollees, both with individual plans and with managed care as a whole. No corresponding measure exists for the FFS model.

Published in June of 2012, the most recent report concerning disenrollment covers the 2011 calendar year. The 2011 data indicates that the statewide change rates from 2005 to 2011 remained consistently below the 5 percent threshold set by the state. These change rates indicate that, in general, many consumers in managed care are satisfied with plan selections. Furthermore, plan selection changes do not necessarily reflect dissatisfaction with the present MCO. Common reasons for plan changes include:

- General desire to change plans (not necessarily due to dissatisfaction);
- Absence of desired services or providers;
- Difficulty obtaining referrals to specialists or approvals for tests;
- Difficulty obtaining dental services;
- Difficulty scheduling appointments;
- Perceived as unable to provide all needed services, with another plan offering more comprehensive benefits; and
- Case management not meeting the perceived benefits.[31]

The disenrollment rates witnessed in Minnesota suggest that the plans provide services, in their respective regions, that are satisfactory to consumers.

Complaint and Grievance Reporting

Appendix B of Minnesota's quality strategy references 42 CFR 438.228. This federal regulation requires MCOs to maintain a grievance system and access to an appeals process through Minnesota's State Fair Hearing system. MCOs are required to assist enrollees in completing forms and navigating the grievance and appeal process. Each grievance and appeal must be resolved according to time frames specified in each contract, and records of these incidents must be maintained and transmitted to the state according to contract provisions.

Each MCO must provide, on a quarterly basis, information relating to each notice of action to the Managed Care Ombudsman Office, which reviews the information and tracks trends in the MCO's

[31] 2011 Voluntary Changes in MCO Enrollment Report

grievance system. At least once every three years, the Minnesota Department of Health (MDH) audits MCO compliance with state and federal grievance requirements.

In 2010 DHS conducted the 2010 Triennial Compliance Assessment (TCA), in conjunction with the Minnesota Department of Health's (MDH) quality assurance examination of the MCHP health plans. It was discovered that a number of MCO written policies were not in compliance with the terms of their Medicaid contracts. The noncompliant health plans developed corrective action plans. They also devoted additional resources to developing accurate Policies and Procedures and providing more accurate identification of grievances. Health plan participation in the grievance reporting process has improved considerably since the compliance assessment. However, the Ombudsman's Office has reported that the grievance system is still facing challenges. Foremost among these is the appropriate categorization of grievances, which is necessary for accurate and consistent reporting across all the plans. The Ombudsman's Office has observed considerable "over-reporting" from at least one of the plans. For this reason, at first glance the record of reported grievances can be misleading.

The table below illustrates grievance reporting trends among the health plans since 2009.

Grievance Reporting Trends: 2009-2012	2009	2010	2011	2012
Grievances Reported*	3,125	4,275	5,393	5,892
Managed Care Enrollment Population**	513,082	554,131	580,834	619,647
Percentage of Growth of Grievances	--	36.8%	26.2%	9.3%
Percentage of Growth of Enrollees	--	8.0%	4.8%	6.7%
Ratio of Grievances to Enrollees	1:164	1:130	1:108	1:105

** Source: 2011 Managed Care Grievance System Information Summary (2009-11), Ombudsman Communications (2012)*
*** Source: DHS, Managed Care Enrollment Figures, December 2009-2012*

The grievance reporting data shows a growth in the number of grievances that exceeds enrollment growth for the plans. This trend has slowed in recent years, although the growth rate in the number of grievances continues to be higher than the growth rate of the managed care program. There is only a 3% difference in growth in 2012, in comparison to the sharp rise in grievances in the years prior. The steady rise in grievances has begun to taper off, and the rate has begun to track more closely the rise in enrollment. The Ombudsman's Office believes, and PCG concurs, that this reflects a heightened level of MCO participation in grievance reporting, rather than a spike in enrollee dissatisfaction.

In some cases, particular MCOs have reported disproportionately higher increases, especially in key quality categories such as access to services. In these cases, the Ombudsman Office has investigated the nature of the grievances. The Office has determined that in many cases these trends are due to transition challenges resulting from major policy or service changes that create temporary disruption and dissatisfaction. For example, one plan had reported significant access grievances. However, 33-66% of their grievance volume in 2010-2011 was related to ID card changes and Primary Care Clinic (PCC) changes, which caused delays in scheduling appointments and created administrative difficulties in

obtaining pharmacy services. Such challenges are inevitable as plans roll out changes. In such cases, the Ombudsman observed that health plans always responded in a timely and an appropriate manner.

Another factor is over-reporting or miscategorization of grievances. It is unclear that grievances related to ID card and PCC changes should be categorized as access issues, rather than an administrative difficulty. DHS is in discussion with the health plans to determine how grievances can be consistently and appropriately logged across all plans.

The Ombudsman Office also operates a call center for directly receiving managed care enrollee complaints. The log of these call complaints are an important supplement to the MCO grievance reports, and help to corroborate many of the issues reflected in the grievance reports. Together, these two sources of information about recipient experience provide a composite picture of any significant quality concerns arising within MHCP managed care.

Top Ten Types of Complaints Reported Annually to Ombudsman				
Complaint Type	2010	2011	2012	Overall
General Inquiry	1	2	1	1
Pharmacy Service	2	1	4	2
Personal Care Attendant (PCA) Services	4	3	8	3
Eligibility Status	6	5	5	4
Enrollment/Change of Health Plan	7	7	2	4
Professional Medical Services	3	4	NR	6
Transportation Services	8	10	3	7
Professional Medical Service Billing	9	6	NR	8
Dental Services	5	NR	NR	9
MinnesotaCare	NR	NR	6	10
Billing	10	NR	NR	NR
County Complaints	NR	9	10	NR
General Complaints	NR	8	NR	NR
Provider Complaints	NR	NR	9	NR
Restricted Recipient Program	NR	NR	7	NR
Complaint types not listed by the Ombudsman in a particular year are designated "NR."				

The major reasons for complaints tend to shift depending on particular events or major administrative changes on the part of the plans, without consistent patterns emerging For example, in 2010 and 2011, pharmacy services were a major source of customer complaints. This reflected a number of policy changes among the plans which affected how pharmacy services are delivered. One of the plans reported that 46% of its access grievances were related to changes in pharmacy formulary and quantity limits. A change in vendor from Walgreens to CVS left many enrollees unhappy to be unable to use their familiar pharmacy. Therefore, the Ombudsman Office call statistics reflect a high number of pharmacy-related complaints in that year. However, such temporary issues do not seem to reflect any serious problems with either access or satisfaction.

Despite these sorts of acute short-term issues and the continuing challenges of plan participation in the grievance system, the Ombudsman's perspective is that Medicaid enrollees are generally well-served by the managed care system. Health plans are generally responsive to enrollee grievances and take proper corrective action when it is warranted.

Significantly, Minnesota Medicaid's FFS system lacks a comparable apparatus for registering consumer complaints. Complaints from FFS enrollees are handled by a DHS-operated help desk line, currently staffed by approximately eight representatives. By contrast, each of the health plans maintains its own customer service center for addressing consumer grievances. This is in addition to the Ombudsman Office, which independently registers enrollee complaints and provides oversight of the managed care grievance system. Further, each county in Minnesota maintains a Managed Health Care Advocate who works at the local level to represent enrollee interests and ensure appropriate access to services.

FFS users do have access to the same appeals process as managed care recipients, and can take their appeals to the state's "fair hearing" process. However, overall FFS enrollees appear to have less recourse than managed care enrollees when they have service concerns. Although the Medicaid managed care population is four times larger than the state's FFS population, this fact in itself does not entirely explain the extreme differences in scale between each system's customer service efforts. Overall, it would appear that customer service resources are disproportionately available to serve the managed care population. This gives the managed care plans an increased ability to track and improve satisfaction levels.

Other Stakeholder Perspectives

PCG also met with representatives from the Minnesota Medical Association (MMA) and county social services agencies throughout the state. The purpose of these interviews was to understand how managed care performance was perceived by other stakeholders within the MHCP system and obtain additional perspectives on customer satisfaction levels. They were also valuable in offering community and provider-level views of the health plans.

In general, stakeholders expressed support for the managed care system as it currently exists in Minnesota. Many of the officials interviewed also believed that it delivered better value than a purely FFS system would allow. County social service managers indicated that providers are generally happy with managed care and prefer it to the FFS system, which reportedly has a stigma attached to it. The managed care system also appeared to be more purpose-driven, with audits and regulations to establish appropriate goals and training in the system. They felt that FFS did not seem to exhibit the same level of direction or guidance.

County representatives also called attention to the partnerships that the health plans over time have developed with the counties, vastly improving service delivery. They reported that the health plans appeared to operate with a "community perspective," and not merely a "service perspective." The county-based purchasing (CBP) organizations participating in MHCP were especially commended for their ability to create productive relationships with area providers and county social services by leveraging

local knowledge. There is also a perception among providers that CBP reimburses providers at a higher rate than the private health plans.

Overall, all stakeholders indicated that providers are basically satisfied with the managed care system and committed to serving the Medicaid population.

Conclusions

PCG's review of consumer satisfaction data in Minnesota suggests key points to consider in this program evaluation:

1. MHCP consistently performs among the highest-ranked managed care programs under nationally-accepted measures of consumer satisfaction with program quality, timeliness, and access to care. In fact, by those same standards, MHCP also outperforms the national average for commercial (private) managed care plans in the majority of its service categories.

2. The rate of enrollee switching between plans remains consistently below the performance targets established by the state.

3. The state maintains methods for consumers to voice concerns regarding managed care. These methods are built into the state's quality strategy. This grievance and appeals system holds MCOs accountable to the consumers, and consumers are notified of plans' performance on a regular basis. The managed care system is also equipped with a robust customer service and patient advocacy infrastructure for addressing recipient dissatisfaction.

By contrast, the FFS system does not appear to exhibit the same satisfaction assessment capabilities, nor does it possess the same level of resources for responding to recipient dissatisfaction. It also seems clear that the managed care system currently enjoys greater "buy-in" among other actors within the system, including providers and county social service agencies. These facts should be considered when contemplating a systemic transition to a predominantly FFS state system.

Section IV. Evaluation of Access to Health Services

Minnesota's Managed Care Public Programs Quality Strategy designates access standards as one of its core quality strategy components. According to 42 CFR 438.206, "Each State must ensure that all services covered under the State plan are available and accessible to enrollees of MCOs, PIHPs, and PAHPs."[32] Each MCO must also provide assurance to the state and supporting documentation that it has the capacity to provide services in a manner consistent with the state's standards for access to care. This includes the capacity to serve the expected enrollment in its service area, as well as the capacity to meet the needs of the anticipated number of enrollees in the service area.

Availability of Services

Availability of services includes both the size of the delivery network and the furnishing of services. MCOs are required to maintain a provider network sufficient to provide adequate access for members to all services covered under the contract. Provisions of these network requirements include rules for distance or travel time, timely access, and reasonable appointment times. Additional requirements grant access to female specialists, second opinions, and out-of-network providers. Regarding furnishing of services, enrollees have the right to timely access to care and to receive services in culturally competent manner.

MCOs agree, through contracts with the state, to provide the same or equivalent substitute services as those provided under FFS, and may also provide services that surpass this threshold. These benefits include physician services, inpatient and outpatient hospital services, dental services, behavioral health services, therapies, pharmacy, and home care services.[33] In a FFS delivery model, the availability of specialty providers is limited by the decisions of individual providers whether or not to participate in the Medicaid program. The burden falls to the state to establish a FFS provider network that can support adequate access.

The Managed Care Ombudsman reported few significant recipient complaints about access to providers. According to communication with the Ombudsman, the office "could find no evidence that the managed care plans have inadequate provider networks, that enrollees are unable to access covered services through their health plans, that enrollees have difficulty or are unable to obtain referrals or medical information, or that the networks lack available special services."[34] This evidence corroborates evidence provided by county stakeholders and provider organizations that the provider networks within the managed care system are robust and adequate to the needs of the managed care system.

Federal requirements for timely access under managed care can be found in 42 CFR 438.206(c)(1), which defers much responsibility for defining and overseeing timeliness requirements to states. The federal regulation explicitly requires that MCO network providers offer hours of operation no less than those

[32] 42 CFR 438.206
[33] Minnesota Managed Care Public Programs Quality Strategy, June 2012, p.11
[34] Stakeholder interview with the managed care ombudsman.

available to commercial or Medicaid enrollees, and that services are available 24 hours a day, 7 days a week when medically necessary.

Minnesota Administrative Rule 4685.1010 states that covered services must be accessible to enrollees in accordance with "medically appropriate guidelines consistent with generally accepted practice parameters."[35] For both primary care and specialty physician services, access must be available 24 hours per day to:

- Regularly scheduled appointments during normal business hours;
- After-hours clinics;
- A 24-hour answering service with standards for maximum allowable call-back times based on what is medically appropriate to each situation;
- Back-up coverage by another participating physician; and
- Referrals to urgent care centers, where available, and to hospital emergency care.[36]

There are many ways that differences in FFS and managed care payment structures can impact access to care. Most notably, they can impact provider participation in MHCP. Although providers and MCOs are both subject to Rule 101 provisions guiding participation in Medicaid, the health plans are especially well-positioned to leverage their commercial networks to bring providers into the Medicaid system. These "take one, take all" policies require providers who want access to commercial MCO enrollees to also provide services to Medicaid patients.

Non-Emergency Medical Transportation

The state's non-emergency medical transportation program is an important component in ensuring overall access to services for the Medicaid population. The Managed Care Office of the Ombudsman reported a spike in transportation-related grievances for one of the health plans in 2012. Grievances were due to members dissatisfied with the vendor or driver, failing to be picked up on time, and long hold times on plans' transportation telephone lines and same day rides. The health plan noted the high number of transportation grievances during the period and initiated a corrective action plan, increasing staff and additional training.

While medical transportation is the responsibility of the health plans in Medicaid managed care, DHS retains responsibility for medical transportation within the FFS system. In 2011, the Minnesota Office of the Legislative Auditor (OLA) reported that the FFS medical transportation program was deficient in certain key areas of access. The report found aspects of the program administratively inefficient and noted weak oversight on the part of DHS. The report also asserted that DHS's "special transportation" service, which offers the most costly and highest levels of service, was administered in an ad hoc fashion.

[35] Minnesota Administrative Rules 4685.1010 Availability and Accessibility, Subpart 6(A)
[36] Minnesota Administrative Rules 4685.1010 Availability and Accessibility

Specifically, DHS ignored rulemaking procedures and failed to develop formal policies or notify the public about changes in service. These problems substantially diminished the reliability of the service for users. Moreover, OLA claimed that DHS, through its broker, frequently limited recipients' eligibility for special transportation to very short time periods—often one day—in a manner inconsistent with contract language.

Geographic Accessibility

MCO geographic access requirements are judged according to Minnesota Statutes, Section 62D.124, which states that, "Within the [MCO's] service area, the maximum travel distance or time shall be the lesser of 30 miles or 30 minutes to the nearest provider of…primary care services, mental health services, and general hospital services.[37]" Subdivision 2 of the statute expands the maximum distance or travel time to "the lesser of 60 miles or 60 minutes" to provide alternative services including "specialty physician services, ancillary services, specialized hospital services, and all other health services not listed [elsewhere in the statute]."[38]

Recent audits of Minnesota's health plans have found all of the plans in compliance with federal and state requirements concerning this statutory requirement. Comparable information for the FFS population was unavailable.

Coordination and Continuity of Care

The capitated payment structure of managed care incentivizes more efficient coordination of care, reducing repeated tests and discouraging unnecessary procedures. Interactions between multiple payers and provider systems can leave MCOs exposed to administrative errors that prevent patients from having access to necessary services. Under 42 CFR 438.208, MCOs are responsible for ensuring that each enrollee has access to a primary care provider and for coordinating care for all enrollees.[39] Required coordination services include "primary care and all other covered services to…enrollees [to] promote and assure service accessibility, attention to individual needs, continuity of care, comprehensive and coordinated service delivery, culturally appropriate care, and fiscal and professional accountability."[40]

Recent audits of Minnesota's health plans have found all of the plans in compliance with federal and state requirements concerning coordination and continuity of care. Although Minnesota's health care homes provide care coordination within the FFS system, comparable information for these populations was unavailable.[41]

[37] 2012 Minnesota Statutes 62D.124, Subd 1
[38] 2012 Minnesota Statutes 62D.124, Subd 2
[39] 42 CFR 438.206 (b)
[40] Minnesota Managed Care Public Programs Quality Strategy, June 2012, p.16
[41] It should be noted that Minnesota's health care homes do not serve the FFS system exclusively, but are available to eligible groups in managed care as well as the FFS system.

Access Grievances

As discussed in detail in Section III, DHS publishes regular reports containing information on complaints received by its MCOs. These complaints can relate to several areas of interest to the state, and assist DHS with monitoring plan performance and identifying opportunities for improvement. Complaints or grievances regarding access to care can be brought forth for several reasons, including:

- Delays in obtaining service;
- Excessive wait times;
- Excessive wait times;
- Inadequate geographic options;
- Delays in appointment scheduling;
- Inability in obtaining referrals;
- Inability to obtain medical information; and
- Lack of availability of special services.

According to DHS reports, the number of grievances relating to access has increased in the past three years. Some of this increase may be attributed to an overall increase in the population of managed care enrollees. Restructuring coverage areas or plan enrollments can also produce failures in maintaining continuity of care. While access grievances attributed to continuity issues are legitimate, complaints relating to enrollment or coverage changes tend to be transitional in nature and decrease over time.

However, as discussed in depth in the previous section, the State Managed Care Ombudsman has explained that the apparent rise in access complaints is due largely to better reporting from the plans and standardization of the procedures by which MCOs process consumer grievances. Until 2011, MCO participation in the grievance program varied, creating large disparities from plan to plan in the number and types of registered complaints. Since 2011, the health plans have more or less begun to participate appropriately, but the plans still have different protocols for assessing the nature and significance of consumer complaints. These differences continue to produce disparate reporting rates among the plans.

In general, the Ombudsman observed the health plans to be responsive to the concerns of their enrollees.

It does not appear that FFS enrollees have the same level of recourse to express their grievances or the same level of state oversight in preventing wrongful denials of service. FFS enrollees must take their concerns to the DHS “help desk.” This service has far fewer resources to address broad, system-level issues than those available for managed care. FFS enrollees can report service concerns to the DHS Surveillance and Integrity Review Section (SIRS), which serves both managed care and FFS enrollees. However, this unit’s main focus is on legal compliance, fraud and abuse issues.

Federal regulations require health plans to send notifications of service denials, reductions, or terminations to their enrollees. While FFS enrollees are notified when services requiring prior authorization are denied or reduced, there is no stipulation that enrollees be notified of denials or reductions for other types of services. Furthermore, enrollees in managed care programs receive detailed descriptions outlining eligible benefits. FFS enrollees often receive far less information about available services, which potentially affects their likelihood of initiating appeals.

Data-driven analysis and contract monitoring ensures that MCOs maintain frameworks capable of supporting enrollee care. Information about consumer satisfaction with MCO service access is also closely tracked. Parallel monitoring and compliance structures do not exist for the FFS delivery model. Where comparisons are possible, managed care appears to outperform the FFS delivery system. The same limitations that make direct comparisons between FFS and managed care difficult also create difficulties in tracking and improving access issues for the FFS system at all.

Section V. Impact of Additional Services Provided by MCOs

Additional Services: An Intrinsic Benefit of Managed Care

One recognized benefit of the Managed Care delivery system is that MCOs approach patient care from a more holistic perspective, rather than the fragmented, episodic nature of a FFS program. This allows MCOs to institute additional services for their members beyond the specific interventions sought out by the consumer. Such services are intended to improve health outcomes in the long term, improve access for consumers who would not otherwise have sought out services, and target disparities and other gaps in access or care. While some of these additional services, such as patient transportation programs, are required by the state, other programs are innovations initiated by the plans in order to meet state targets for cost-effectiveness, access and outcomes. Where possible, we have noted which programs were created in response to state mandates or incentives. Additionally, in a competitive managed care marketplace, managed care plans may compete to offer value-added services to consumers who have a choice between different plans.

Survey of Additional Services Offered by MCOs

PCG conducted a survey of additional services offered by MCOs, requesting information from each of the health plan representatives interviewed. In some cases PCG also followed up with a request for additional data about individual programs some time later. The information sought by PCG included the name and nature of additional services, the implementation dates of these services, the number of patients served, and the health outcomes achieved by these programs.

All but one of the MCOs reported their additional services, though plan response was varied. Some plans supplied a great deal of information, tying programs to specific health outcomes and responding to a follow-up data request with a tight turnaround. In a few cases this included Return-On-Investment data linking outcomes to costs. Others were able to supply nominal descriptions of their programs, with only minimal descriptions of program impacts. (One plan reported simply that they do not measure plan outcomes, but that initiatives support measureable public health goals.) In some cases, commercial MCOs found it difficult to separate results for the Medicaid population from the results for all enrollees.

For organizational purposes additional services have been split into six categories. These categories are merely thematic and are not strictly defined. There may be some overlap between categories, or different components of an individual program spread across the appropriate categories. The purpose is merely to organize the wide range of programs into broad service areas, and to provide a simplifying framework that facilitates comparison among different individual programs.

Case Management

Case management is often highlighted as a key benefit to implementing managed care. Providers, plans, and advocates often express support for the idea that managed care has the potential to improve care coordination for Medicaid beneficiaries. This care coordination can range from basic measures—such as health risk assessments or reminders sent out for preventive care such as mammograms, immunizations

and prenatal check-ups—to intensive care coordination and case management. The state has heavily incentivized such programs, as discussed in the analysis of pay-for-performance measures in Section II.

Since 2008, DHS and the Minnesota Legislature have made some progress in coordinating care for FFS enrollees, initiating a number of projects with the goal of improving FFS care coordination. First, the Legislature authorized "provider-directed care coordination" for FFS enrollees with "complex and chronic medical conditions."[42] The Legislature authorized DHS to pay providers an additional $50 per enrollee per month for care coordination. Related laws required DHS to develop care coordination pilot projects for several subgroups of the FFS population with complex health care needs, paving the way for the Health Care Home (HCH) initiative by which the state has begun to test and implement health care home reforms in Minnesota. Today, HCH encompasses eligible populations both in FFS and the managed care system.

Plans tend to have more resources at their disposal than the state (e.g. nurses, data analysts, and community outreach workers to work with individual Medicaid beneficiaries, especially those at risk, to improve their health and health behaviors. Plan case managers can counsel those with chronic illnesses to receive necessary preventive care and adhere to medications. They can assist with poverty-related issues that interfere with patients' medical appointments. They can use data analytics to identify outliers such as frequent emergency room utilization or preventable 30-day readmissions. Many of the other categories found below are more specific permutations of the broader category of case management. However, a few specific examples of broader case management are given here:

Medication Therapy Management

Recently, multiple plans have begun to offer some form of medication management service, limited either to dual eligible Medicaid/Medicare patients or to other qualified Medicaid patient groups. Medication Therapy Management (MTM) is a case management service focused on providing care coordination for patients who use multiple medications. Particularly because medications may have been prescribed by different providers, assisting such patients in managing their medication and wellness is an important goal. Patients who fall into categories particularly at risk for drug reactions and interactions may be contacted by a special medication management service provider. This provider performs an initial consultation and follows up with the patient going forward. Innovations in MTM consist of using videoconferencing for the enrollee's convenience and involving pharmacists more fully in the process. The results reported by one plan indicate that while this service had growing participation and relatively high rates of satisfaction, outcomes data over the last three years revealed only modest gains. Other plans offering MTM did not include outcomes data, in at least one case because participation fell below the plan's reporting threshold. On the FFS side, Minnesota also provides some level of MTM through additional payments to pharmacists to perform these services.

ED Utilization Reduction

Minnesota Statutes section 256B.69, subdivision 5(g), requires all managed care organizations to reduce ED utilization by 25% over a five year period beginning in 2011 for members enrolled in

[42] *Laws of Minnesota* 2007, chapter 147, art. 15, sec. 16.

Prepaid Medical Assistance and MinnesotaCare. In response, plans have designed programs specifically targeted to bring down emergency department visits or readmissions, steering their patient populations to preventive care in advance of emergency needs and providing follow-up case management for those who are admitted to the emergency room, ensuring they don't wait until another crisis to engage their health care needs again. Outreach to patients and follow-up care can significantly decrease emergency department (ED) utilization, which is the most expensive way for Medicaid patients to engage their health care. In this way, individual case management can be the solution to a larger demographic problem.

For instance, one plan uses Health Coaches assigned to frequent ED users to help advise and direct patients to more appropriate locales, and to institute preventive care that prevents emergency room utilization. Since 2011, these and other ED utilization-lowering measures by the plan have reduced inpatient admissions per 10,000 member months by 50%, and ER visits per 10,000 member months by 44%. A restricted recipient program identifies frequent ED users and places stricter controls on their allowed utilization, directing these consumers to non-emergency services when appropriate. This effort has led to a 48% drop in ED utilization and 57% drop in costs. Certain demographic populations are also targeted for home visits by community health workers, with dramatic differences between participating and non-participating members (65.2% decrease in ED utilization versus 10.3% for non-participants).

While the plan discussed in detail was the most forthcoming with quantitative data supporting its utilization management efforts, as noted above all plans are required by the state to have a program in place to drive down emergency room utilization. Most programs follow a similar model, with additional efforts focused on addressing a lack of urgent care facilities to absorb non-emergency health care needs. Use of online and phone services to coordinate care and manage aftercare is also common.

Targeted Health Populations

In addition to case management focusing on the long-term health of a specific consumer, managed care organizations also have taken the opportunity to implement population-based initiatives. These focus on specific illnesses, conditions, and trends within specific patient population. These initiatives target patients who have undergone procedures or experienced illnesses with a serious and permanent impact on their health. This allows MCOs to reduce re-admission and relapse, and deal with new health events sooner rather than later, improving outcomes in the long-term.

Disease Management can have significant positive effects on patient wellness, and creates verifiable, concrete data on outcomes. For instance, one plan was able to demonstrate a 58% reduction in hospital readmissions for patients enrolled in their asthma action plan program. Other outcomes demonstrate a positive return on investment for the program, such as a 26% reduction in missed work days per patient per month. Programs for COPD, heart failure, diabetes, coronary artery disease and many other health demographics can report similarly strong results. Most of these programs are five years old or older.

A ready example of this kind of case management is the special attention and care given to expectant mothers. In health plans that have established such programs, an expectant mother enrolled in Medicaid is reminded to attend appointments, provided with pre-natal vitamins, and given access to specialized support for the duration of her pregnancy. The MCO engages the pregnancy as a holistic event and guides the consumer from beginning to end. This kind of care ensures better outcomes and long-term savings, as proper pre-natal care can reduce risk of future illness for mother and child.

Another program, targeting heart failure, uses home-based technology to monitor the health indicators of heart failure patients and track their progress towards weight loss goals. Case management is also particularly valuable for consumers with special needs, who require greater guidance to make sure they maintain their health. For example, one plan's case management system uses proprietary algorithms to review claims data to identify patients in need of intensive case management, who would otherwise be at risk of hospitalization or other high cost interventions. Similar programs identify behavioral health patients, as well as chronic medical conditions that require ongoing disease management. Such patients receive a higher level of supervision and case management.

Programs specifically targeting developmental and other disabilities are also in place, steering these patients into sub-plans that provide more comprehensive engagement with case management needs. For instance, some plans offer Care Navigators to steer members to primary care options and enroll members in disease management programs. For members with a high level of need, Care Coordinators are available to provide regular supervision and design a plan of care.

Community Outreach and Targeting Disparities

Similarly, MCOs can also target health disparities within the Medicaid population, improving access in a targeted way for subpopulations that would otherwise slip through the cracks. This focuses on continuing to improve access when general access concerns have largely been addressed, but specific groups lag behind the rest of the population in terms of access or targeted health concerns.

One example of this type of program was instituted in 2009, focused on reducing health disparities for minority-populations. In many cases this effort required focusing on providing information about services and their availability to populations for whom English is not the primary language. A few examples of disparities targeted include:

- Increasing pediatric immunizations for children from East African immigrant families.
- Improving diabetes outcomes for patients of Ethiopian extraction.
- Improving colorectal cancer screening rates among communities of color.
- Increasing breast cancer screening rates and decreasing readmission rate for minority patient populations and patients with limited English proficiency.

Outcome and access data exists demonstrating that since these programs were instituted, rates of relevant measures have improved to be comparable to the mainstream patient population. For instance, according

to materials provided by the plan, a 15% disparity in breast cancer screenings for women of color vs. white patients in 2006 had dropped to 3.5% by the first quarter of 2012.

MCOs also engage these communities by offering interpreters services and community outreach, working with community organizations to increase visibility and awareness of available Medicaid services. While some of these services (for example, translation services) have been in place for decades, in the past year innovative initiatives are being tried in the area of community outreach and partnerships. In 2012, one plan reported 797 families educated about where to seek health care for a sick child through its partnership with HeadStart.

Another recent example of community outreach is a home visitation program focused on certain populations with advanced ED utilization, including training on using phone services on the second visit. Plans work with community organizations among different immigrant and ethnic populations to offer training, outreach, follow-up, wellness, and transportation services.

Member Rewards: Incentives and Preventive Care

Examples of these types of programs include waiver of nominal FFS co-pays to take away potential barriers to care, or gift cards offered as incentives for preventive examinations, immunizations, or pre-natal care. Smoking cessation services, home health kits provided to patients, discounts for fitness organizations, and youth camps for young patients with specific health needs also fall under this umbrella.

Incentive programs of various kinds have been a staple of managed care organizations over the last decade, with the specific targets and incentives adjusted in light of shifting health priorities and legislative pressures. For instance, annual incentive drives to facilitate lead screening take aim at a DHS-determined goal of 80% testing rate for children ages 9 to 30 months.

Access: Transportation and Online and Phone Services

All MCOs are required to have a transportation plan in place to arrange non-emergency transport for patients who have difficulty accessing health care. MCOs also target access problems by developing online and 24/7 telephone services that allow consumers to contact health professionals or access information about health care options from home. Consumers have the ability to engage their own health care on their own schedule without needing to arrange transport to a health care provider.

Many of the case management services discussed below, such as nurse navigators, are available by phone and online services. Other innovative solutions to problems of access have been enacted by the plans. In response to a shortage of Medicaid-eligible dental providers, one MCO instituted a mobile dental clinic program that has performed more than 40,000 dental procedures for more than 8,000 members.

These services are mostly well-established, in some cases dating back to the 1980s. However, online services are more recent innovations, and also subject to continuous improvement. Online member services in 2013 are far removed from the state of such programs when they were first implemented ten years ago. One plan offers an “online clinic” for consultation on common conditions and was able to report dramatic increases in consumption of online services over the last three years. Based on first

quarter data (273 patients served), the plan estimates online services will serve nearly as many patients in 2013 as were served from 2010 to present (990).

Alternate Payment Models

Alternate payment models have allowed managed care organizations to incentivize providers to raise the quality, access and cost-effectiveness of their services. Of the five plans surveyed, one in particular uses its payment model to reward physicians whose patients reach various health milestones such as immunization or preventive care. Rather than targeting the consumer directly, this MCO negotiates with providers to set performance and quality benchmarks that are aligned with providers' increased financial reward and financial risk. These innovative payment models illustrate that it is possible for MCOs to incentivize providers to take greater responsibility for quality outcomes.

Other MCOs have similar innovative payment models in place, including paying for care coordination, pay-for-performance measures, risk- or gain-sharing, total cost of care and other payment models. Some of the MCOs have only established TCOC contracts with providers for their commercial populations, but not their public programs. However, representatives from these plans expressed the view that their Medicaid populations also benefit at least indirectly from these payment reforms, since the service delivery redesign initiated by providers to serve the commercial populations necessarily also impacts their Medicaid clients.

These payment models are also available to Minnesota for payment reform enacted directly by the state, and some have already been implemented through the state's health care home and HCDS initiatives. Either channel for reform is likely to have its own benefits and drawbacks. On the one hand, because many MCOs are affiliated with commercial insurance plans, payment reform implemented through the managed care system would be able to leverage the parent organizations' wider network of relationships with local providers to institute payment models that reward desired outcomes. Lacking the same leverage in the commercial sector, the state may not be able to achieve the same results dealing directly with providers. On the other hand, the state's direct engagement with providers would create more opportunities to leverage the Medicaid population as a whole to drive quality improvement, instead of dividing these populations across multiple MCOs with different outcome goals and incentive structures. These issues and their relevance to the value of recent innovative payment models, particularly Total Cost of Care initiatives, are discussed more extensively in Section VIII.

Innovation

These programs are frequently described as "innovative" insofar as they are designed and piloted by the plans themselves to improve access and outcomes. The survey above attempts to track the introduction and age of existing initiatives. As discussed above, many of these services such as smoking cessation services, health-risk assessments and special maternity care are now standard for any health care organization or insurance provider. Online and phone services have been available for many years. Other services, such as transportation and programs aimed at reducing ED utilization, were mandated by the state.

It is indisputable that managed care organizations have innovated and brought into being benefits that did not exist under traditional FFS models. More recent innovations are more comprehensive and more targeted. Plans have moved away from broad-based reminders and incentives, and increased focus on specific health outcomes and disparities in demographic populations. Yet even in these areas, it is clear that the pace of innovation has slowed over the last three to five years.

Conclusions

Many of the services described here are not available under a FFS model. Where comparable services do exist in FFS, it is not yet clear how effective they are relative to a managed care delivery system. Data received from the plans indicate high degrees of customer satisfaction with care coordination services and care plans. These findings accord well with the generally high level of satisfaction seen in CAHPS data and other measures. (However, it must be repeated that customer satisfaction is not always a clear measure of improvement in access, outcomes, or cost-effectiveness, and that not all plans were able to contribute comprehensive quality data for their initiatives.)

Because these programs are considered innovations on the part of the plans, most of them are not directly measured or evaluated by the compliance-oriented reporting currently in place. It is not always clear whether outcomes or access have truly improved, or if so, how much these improvements cost in the end. While incentivizing innovation and additional services may often be in the best interest of the state and the consumer, it is important that these innovations be measured using concrete and well-described institutional definitions of value, to determine whether the additional services are truly cost-effective, and whether innovations are continuing. Currently, no standard model for reporting additional services or evaluating their results is in place with DHS.

PCG understands that documenting these services has been a frequent point of contention between DHS and the plans. The plans feel that the state is not sufficiently aware or supportive of innovative services. Meanwhile, the state has encountered frequent resistance to gathering hard data on such services from the plans, who voice that their reporting burden is already outsized and that DHS is not successfully capturing all services. Yet additional services are expected to be one of the key advantages of managed care over the FFS delivery model. Without a clear picture of all additional services available and their quality and cost-effectiveness, DHS will not be able to garner a clear picture of the value of the managed care program going forward.

Section VI. Measurement of Actual and Potential Cost Savings

Having completed a thorough discussion of the outcomes produced by Minnesota's health care delivery systems, we turn now to the topic of costs. This section seeks to evaluate the cost impact of Minnesota's managed care system as compared to the FFS delivery model. The section focuses both on the actual difference in costs between the two systems as they currently exist, as well as the differing potential of the two models for producing value and cost-savings.

As discussed throughout the report, value can only be measured as an intersection of costs and outcomes. Short-term cost-cutting measures can have results that also diminish outcomes, reducing value overall. This can potentially lead to greater costs in the long run. Unhealthy patients seek more services to treat conditions that could have been effectively controlled or eliminated with earlier interventions. Preventive care, such as wellness exams and immunization programs, offers a classic example of how additional costs upfront can avert costly hospitalizations or emergency department utilization in the long term.

Cost Comparison Challenges

Over the last twenty years, states have overwhelmingly shifted to a managed care delivery system. However, realistically most health care delivery systems combine the two delivery models in various ways. This can range from using FFS structures for specific populations or subsidiary procedures, to managed care structures that provide patient case management and other services but still pay doctors on a volume-based methodology. In states like Minnesota, FFS has not been the dominant delivery model for decades, creating vastly disparate populations of enrollees for the two different systems.

Even beyond the acuity differences that complicate all such comparisons, the comparison of costs between the two systems is particularly problematic. Truly comparable measures of cost and value are rare, because the two models have different approaches to providing care and allocating costs. It can be difficult to capture the full set of expenditures in a managed care program with many different programs and additional services in a way that ties them appropriately to outcomes. Such costs are generally allocated according to organizational units such as departments, rather than allocated around specific health events with specific outcomes. On the other hand, the FFS structure is "volume-based", tied to individual procedures which rarely have a quantifiable outcome, obstructing the measurement of value.

The Cost of Care in Minnesota

Minnesota is one of the many states that have shifted their Medicaid enrollment overwhelmingly to a managed care delivery model, partly in search of the potential cost savings discussed above. CMS has repeatedly renewed the waiver underwriting the managed care system. This indicates that the current system meets at least the minimum compliance standards for cost-effectiveness, when compared with the prior FFS model. However, the rate-setting process used to determine Medicaid capitation payments in Minnesota has been subjected to intense criticism. Concerns have been raised about the cost-effectiveness of the program as well as the value of services received for the expenditure. Scrutiny of Minnesota managed care costs and rates has only intensified in the wake of a recent retrospective rate-setting analysis conducted by The Segal Company. Its report concluded that capitation rates from 2002-2011 left

plans with a greater than intended operational margin, reflecting costs for the state that are higher than targeted.[43] One of the primary concerns of DHS in this examination of the current managed care system was the need to control costs and set rates more accurately.

A survey of nationwide Medicaid rates shows Minnesota among the highest rates in the country. This analysis is based on cost data available in the 2008 Medicaid Analytic eXtract (MAX), the most recent date for which data are available for national comparison. According to this data, Minnesota's average Medicaid expenditures per full-benefit enrollee was $8,481, third only behind New York and Washington DC.[44] Minnesota is 5th in the nation in capitated per member per month (PMPM) payments. (Further, two of the states with higher PMPMs use managed care only for elderly populations.)[45] In overall expenditures per FFS enrollee, Minnesota is 8th, but for the disabled population that constitutes the majority of the Minnesota's FFS enrollment, the state is 4th in expenditures. Secondary services paid on a FFS basis (whether under the FFS model or for a primarily-managed-care system) are also higher than average, including spending for pharmaceuticals and laboratory or imaging services.[46]

These costs are not benefit-adjusted, to the extent that the figures do not account for differences in levels of expenditure based on the range of benefits offered by different states, which would help to explain some of the cost disparities among different states. In fact, Minnesota's Medicaid program offers a number of long-term care, mental health, and home-and-community-based services (HBCS) that are considered optional benefits and so are not covered in many states. Some of these services, especially long-term care, are high cost services that increase program costs considerably. Several other factors that drive high state Medicaid costs do not appear to apply to Minnesota. Higher Medicaid costs in the state do not seem to be attributable to high payment rates to providers or to a high cost of living. Discussions with the Minnesota Medical Association (MMA) indicated that perceived low provider rates are a frequent source of complaints from Minnesota providers, and the Geographic Pricing Cost Index factors used to adjust Minnesota's Medicare provider rates reflect generally average geographical costs for Minnesota physicians.

In some cases, the high cost of Minnesota's managed care programs are reflected in quality outcomes that are also considerably higher than the national average, though not for all populations. Even if state expenditures per enrollee for the vulnerable Seniors and Persons with Disabilties (SPD) population are relatively high, the state's health plans can also boast strong performance in key health outcomes for this population. For example, seven of Minnesota's eight health plans rank within the HEDIS 90th percentile in Adult Preventive Visits (65+), a key health outcome for the state's elderly population. By contrast, higher per enrollee expenditures for the Medicaid child population do not necessarily translate into better

[43] The Segal Company, "Actuarial Review of Medicaid Managed Care Rate Setting," MN DHS, 2013. Available at: https://edocs.dhs.state.mn.us/lfserver/Public/DHS-4569-ENG. Accessed May 14, 2013.
[44] Borck, Rosemary et al. *Medicaid Analytic Extract 2008 Chartbook*, p. 29. Washington, DC: U.S. Department of Health and Human Services, CMS, National Health Statistics Group, 2012.
[45] Borck, Rosemary et al. *Medicaid Analytic Extract 2008 Chartbook*, p. 38. Washington, DC: U.S. Department of Health and Human Services, CMS, National Health Statistics Group, 2012.
[46] Borck, Rosemary et al. *Medicaid Analytic Extract 2008 Chartbook Appendix Tables*, Table A3.19, Table A3.21, Table A4.6. Washington, DC: U.S. Department of Health and Human Services, CMS, National Health Statistics Group, 2012.

health outcomes. While Minnesota's health plans are above average nationally in HEDIS indicators for Child PCP visits, in other key children's health benchmarks, such as Well Child Care and Childhood Immunizations, most of the health plans performed at levels lower than the national Medicaid average. When paired with the population-specific costs of Minnesota's Medicaid program, these quality indicators raise questions about whether the state is receiving optimal value for its spending on children's health.

It must be acknowledged that the financial data available for nationwide comparison do not reflect recent cost containment efforts by DHS and its increased scrutiny of health plan costs since 2010. Evidence suggests that such efforts have already exerted a significant impact on lowering managed care rates. For example, while PMPM rates for the state's PMAP increased annually by 10.1% on average, and 8.6% for its MinnesotaCare rates, from 2007 to 2010, the state placed a 1% cap on health plan annual profits, dramatically reversing this trend.[47] Indeed, PMPM rates for all of these programs decreased or remained flat in each subsequent year after 2010. Total spending for these programs in CY 2012 was $336.9 million lower than the costs originally forecasted in 2010, and the state expects even greater savings in CY 2013. For 2011, Minnesota was also able to reclaim an additional $75.2 million in excess profits, due to provisions in the state's MCO contracts requiring health plans to return to the state any profits in excess of the 1% cap.

PCG was unable to examine the assumptions behind DHS' 2010 PMPM projections; however, the contrast between pre- and post-2011 rate trends is clear, indicating the effectiveness of the state's heightened vigilance in cost containment. Specific strategies employed recently by Minnesota to control costs are discussed throughout the remainder of this section. Whether these measures have improved the cost of care in Minnesota relative to the performance of Medicaid programs nationwide will not be understood until more data is released in years to come.

Managed Care and Costs

One of the primary reasons states have overwhelmingly shifted their Medicaid programs to a managed care delivery model over the last twenty years is the promise of better value, both through improved outcomes and through lowered costs. Indeed, the potential for savings under managed care is clear:

> "Savings opportunities in Medicaid managed care are largely created by the inherent structural challenges of coordinating care and containing costs in the FFS setting. The FFS model is an unstructured system of care that creates incentives to provide as many services as possible, while doing little to encourage providers to manage the mix and volume of services effectively. Managed care organizations (MCOs), on the other hand, combine within one entity the responsibility for both the financing and delivery of health care and thus have strong incentives – and means—to coordinate care and, in turn, reduce the costs of inpatient and other expensive categories of health care services, where Medicaid spending is concentrated."[48]

[47] It should be noted that the 1% cap has been removed from the state's post-2011 MCO contracts.

[48] The Lewin Group. "Medicaid Managed Care Cost Savings – A Synthesis of 24 Studies." March 2009. http://blogs.chicagotribune.com/files/lewinmedicaid.pdf

Medicaid managed care plans have opportunities to achieve savings through a number of mechanisms. Many of these mechanisms have short-term costs which are expected to be off-set by long-term improvements in the health of the Medicaid population, driving down future costs. Such mechanisms include but are not limited to:

- Improving access to preventive and primary health care;
- Investing in enrollee outreach and education initiatives;
- Providing coordinated care using a primary care physician to refer patients to the appropriate specialist (as opposed to relying on patient self-referrals to coordinate care);
- Providing individualized case management services and disease management services;
- Using lower cost services and products where such services and products are available and clinically appropriate; and
- Enhancing provider accountability for quality and cost effectiveness.[49]

There are challenges to the managed care delivery system as well. These include:

- FFS rates are already so low that it is hard to get additional price discounts. More generally, Medicaid already is a low-cost program, with a lower rate of per capita cost growth than either commercial insurance or Medicare.
- States can use prior authorization, utilization review, and other similar tools, which mirror some of the efficiency methods of managed care.
- Federal law limits the level of co-payments on Medicaid beneficiaries, thereby making it more difficult to incentivize beneficiaries to change care-seeking behavior.
- The cost-savings created must be weighed against the increase costs of care coordination and other administrative costs.

In practice, the savings potential of managed care is not always fulfilled. A review of research literature leads swiftly to the conclusion that managed care does not consistently reduce cost:[50]

[49] The Lewin Group. "Medicaid Managed Care Cost Savings – A Synthesis of 24 Studies." March 2009. http://blogs.chicagotribune.com/files/lewinmedicaid.pdf
[50] Sparer, Michael. "Medicaid managed care: Costs, access, and quality of care." Robert Wood Johnson Foundation. September 2012. http://www.rwjf.org/content/dam/farm/reports/reports/2012/rwjf401106

Authors	States Studied	Model Studied	Data Years	Cost Savings	Detail of Findings
Duggan & Hayford	United States	MCO and PCCM	1991-2003	No cost savings	Nationally, shifting from FFS to MCO does not reduce overall Medicaid expenditures. States that did reduce costs had relatively high prior FFS reimbursement rates.
Alker & Hoadley	FL	MCO	2011	No clear evidence	Insufficient data to assess cost implications.
The Lewin Group	CT, DE, IL, IN, IA, MO, NE, NY, OH, TN, TX, UT, WV, WI	MCO		Project cost savings	States with pharmacy carve-outs are projected to save $11.7 billion within a 10 year period (2012–2021) upon adopting pharmacy "carve-in" model.
Herring & Adams	United States	MCO	1996-2002	No cost savings	Implementation of commercial HMOs or Medicaid HMOs did not result in decreasing health expenditures.
Burns	United States	MCO	1996-2004	No cost savings	Compared prescription, medical, and dental care costs between FFS and MCO counties for adult SSI beneficiaries.
The Lewin Group	AZ, KY, MI, NM, OH, WA, PA, WI	MCO	Update of 2004 Study	Cost savings	MCOs can yield savings of 1% to 20%. These savings result from: (1) enrolling SSI Medicaid beneficiaries, (2) decreasing preventable hospitalization utilization (3) reduced drug costs in MCOs relative to FFS.
The Lewin Group	NY	MCO	2005-2007	Cost savings	HIV SNP program attributed to $4.2 million savings for Medicaid.
Verdier et al.	AK, IN, NC, OK, PA	PCCM	2008	Cost savings	Cost savings in both per-member expenditures and total state expenditures.
Sparer	NY	MCO	2007	No clear evidence	Concludes that (1) it is difficult to conduct accurate comparative analysis between MCO and FFS spending and (2) must take into account high expenditure factors such as high administrative and marketing costs under health plans as well as costly administrative state requirements.
Aizer et al.	CA	MCO	1999-2000	No cost savings	The lack of cost savings was attributed to poor access to prenatal care resulting in higher NICU costs.
Momany et al.	IA	PCCM	1989-1997	Cost savings	Iowa's PCCM program resulted in $66 million (3.8%) savings to the state over 8 year period. Cost savings attributed to improved care coordination and reduced unnecessary medical utilization.
Kirby et al.	United States	MCO	1987 & 1997	Modest cost reductions	Increasing Medicaid HMO enrollment led to fewer hospital visits, thus modestly lowering overall Medicaid expenditures.
Duggan	CA	MCO	1993-1999	Costs increased	Shifting enrollees from FFS to MCO increased overall costs by 12%. The author speculated that the increased costs resulted from higher payments to providers, higher administrative costs, and inclusion of "normal level" HMO profits.
Holahan et al.	AL, CA, CO, FL, MA, MI, MN, MS, NJ, NY, TX, WA, WI	MCO and PCCM	-	Project cost savings	States hope for 5%–10% savings from implementing MMC programs—mainly by controlling provider payments and reducing utilization.

Findings	Total
No cost savings	4
Cost savings	4
No clear evidence	2
Projected cost savings	2
Costs increased	1
Modest cost reductions	1

The findings from these studies yield conflicting conclusions in terms of cost savings.

As discussed in Section VIII, with the uncertainty of managed care cost savings, some states have begun to show preferences for alternative models. However, reverting to a purely volume-based delivery system is relatively rare, because of the inefficiencies and potential for perverse incentives inherent in paying physicians per procedure, without additional safeguards focusing on case management and long-term outcomes. Programs that cost less but provide lower quality of outcomes only create greater costs over time, through readmissions, untreated ailments that become emergencies,

and other complications. As noted above, volume-based delivery systems can also obscure the true measurement of value by fragmenting the care and treatment of a disease into arbitrary procedural units not tied to specific outcomes.

One of the major advantages of a delivery model oriented around case management and patient care as opposed to volume of services is that long-term wellness of patients can be monitored and pursued, driving down costs over the long-term and creating better value for costs. Although capitated managed care does not always deliver on this promise, it is a step in the right direction towards truly value-driven health care. In the remainder of the section, PCG discusses initiatives that have already been adopted by Minnesota's managed care system to lower the state's high cost of care, as well as additional efforts that could realize the cost-saving potential of capitated models. These could also serve as a bridge to larger payment reforms as discussed in Section VIII.

Effective Procurement Strategies

In initial interviews with PCG, DHS staff indicated their interest in improving agency access to cost and payment data that would enhance their ability to manage health care costs. This would include re-basing FFS rates so that they more accurately represent recent provider cost experiences. In Minnesota, Medicaid MCO provider reimbursement rates are frequently derived from state FFS rates.

Further, DHS staff expressed an interest in improving access to cost and payment information that would rapidly identify cost drivers. This is especially true in the remaining FFS budget, where rapid identification of individual benefit line cost trends (hospital, pharmacy, etc.) could enhance the agency's ability to successfully manage them.

States use different methods for procurement and capitation rate setting of MCO services. States may use actuaries, negotiate with the managed care plans, or go out to competitive bid. The table below shows which methods some states were using as of 2010.

State	Administrative Rate Setting Using Actuaries	Negotiation	Competitive Bid Within Rate Ranges	Competitive Bid
AZ	x		x	x
CA	x			
CO	x	x		
CT		x		x
DC	x	x		
DE	x	x	x	x
FL	x			
GA	x			
HI		x	x	
IL	x			
IN			x	
KS			x	
KY	x			
MA		x	x	

MD	x			
MI	x			
MN	x	x		
MO		x	x	x
MS	x			
NE	x			
NJ	x			
NM			x	
NV	x	x	x	x
NY	x			
OH	x			
OR	x			
PA	x	x		
RI	x			
SC	x			
TN	x		x	
TX	x			
UT		x		
VA	x			
WA	x			
WI				
WV	x			
Total	27	11	10	5
36	75.00%	30.60%	27.80%	13.90%

Of the 36 states that responded to Kaiser's 2010 survey[51], 75% use actuaries to set administrative rates. Also, 12 (33%) of the states have used multiple methods in capitation rate setting, including Minnesota. Along with using actuaries to set rates, Minnesota DHS conducts negotiations with managed care plans in the state and has also initiated a competitive bidding process.

DHS has already made efforts to reduce managed care contract costs. A shift to competitive bidding for county managed care contracts was instituted in 2011, and managed care plans now compete in terms of both price and quality for the right to provide Medicaid services in a given area. This bidding process has been controversial among the plans, and some 85,000 enrollees were forced to change plans and providers due to shifts in plan availability. (Plan complaints are exacerbated by the legislative requirement to bid on RFPs, a topic discussed more fully in section IX.) However, the change generated $175 million in cost-savings in 2012, with an additional $175 million saved in the program's federal share.[52]

[51] Gifford, Kathleen, Smith, Vernon K., Snipes, Dyke, and Paradise, Julia. Kaiser Commission on Medicaid and the Uninsured. "A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey." September 2011. http://www.kff.org/medicaid/upload/8220.pdf

[52] Edwards, Jennifer. "Health Care Payment and Delivery Reform in Minnesota Medicaid," Commonwealth Fund pub. 1667, vol. 12 (2013), p. 9

The state has also made efforts in recent years to increase transparency about administrative expenses, to properly define an administrative cost, and to define what level of administrative costs is acceptable as a factor in managed care rates. These efforts are aimed at curtailing excess and improving cost-effectiveness. Stakeholder interviews indicated that administrative costs vary widely between health plans that seem to be providing equal services, a clear indicator of inefficiencies.

Incentive Payments and P4P

Within contracts with MCOs, states may include incentive payments, which can affect costs. Under federal managed care rules, approximately 5% of a capitation rate can be tied to incentive payments. These performance based elements may include withholding a portion of the capitation payment, making a bonus payment to the MCOs, or sharing the cost savings with the MCO. The table below shows what states included in their MCO contracts in 2010 related to incentive payments.

State	Capitation Withhold	Bonus	Shared Savings	Other
AZ				
CA				
CO				
CT				
DC	X			
DE				
FL				
GA				
HI	X			
IL	X	x		
IN	X			
KS				
KY				
MA	X	x		
MD	X	x		
MI	X	x		
MN	X	x		
MO	X			X
MS				
NE				
NJ				
NM	X			
NV				

NY				X
OH		x		
OR				
PA		x		
RI		x		
SC				X
TN	X	x		
TX			x	X
UT				X
VA				
WA				
WI	X	x		X
WV				
Total	12	10	1	6
36	33.30%	27.80%	2.80%	16.70%

Of the 36 states that responded to Kaiser's 2010 survey[53], 19 (52.8%) different states with managed care responded that they include at least one pay-for-performance aspect in their payment method. Some states, including Minnesota, reported including multiple performance based components. Elements included in the "Other" column were: auto-assignment preference, enhanced capitation, or incentives for reporting encounter data; extra premium if MCO exceeds savings target for inpatient hospital costs; and one percent of premiums placed at risk in a pool for which plans can compete based on performance measures. Ideally, incentive payments improve outcomes while raising costs, at least in the short-term. Therefore the state must exercise caution and analyze results carefully, in order to set high-value targets with an appropriate return on investment.

As noted above, Minnesota has instituted some incentives based on quality targets. Most recently, these incentives have targeted optimal care for diabetes, vascular issues, acute myocardial infarction, heart failure and pneumonia. Efforts to align and streamline such measures statewide are ongoing, while the state's incentive programs are increasingly shifting from payers to providers. The incentives reward progress towards goals as well as hitting specific targets. These efforts have also involved the development of an all-payer claims database to improve reporting transparency and facilitate a better understanding of health care utilization in the state. This also includes a risk-adjustment methodology in order to accurately measure and compare the price of services. This database and methodology are very

[53] Gifford, Kathleen, Smith, Vernon K., Snipes, Dyke, and Paradise, Julia. Kaiser Commission on Medicaid and the Uninsured. "A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey." September 2011. http://www.kff.org/medicaid/upload/8220.pdf

recent developments, and the methodology so far has not been released publicly.[54] Their eventual impact on cost-savings for the managed care program is yet to be seen.

Connecting Costs to Outcomes

Minnesota can apply techniques and lessons-learned from its own cost containment attempts and from the nationwide perspective explored above to its ongoing efforts to reform the current managed care system. Expanded use of data analytics to inform more frequent provider rate updates will allow the state to control its own costs in its role as a health care payer. Increased transparency in reporting would improve the state's ability to set goals and cut costs. However, even additional cost information would only give part of the picture. To effectively contain costs, it is necessary to measure and prioritize not just the costs of programs but their value. To identify value, it will be necessary to have greater access not just to cost information, but to information concerning outcomes, and to properly group and synthesize this data to make meaningful judgments. This is central to the "Total Cost of Care" payment reforms discussed in Section VIII, and PCG has examined the challenges involved in this form of value-driven cost analysis more fully in that section.

[54] Edwards, Jennifer. "Health Care Payment and Delivery Reform in Minnesota Medicaid," Commonwealth Fund pub. 1667, vol. 12 (2013), p. 8

Section VII. Alignment with State and Federal Health Reform

At a time when the pace of both state and federal health reform efforts quickens, the capacity of delivery system alignment with these reforms is a critical component of its value. What follows is a look at recent and pending state and federal reforms, and their potential capacity to align with the current Minnesota health care delivery system, especially as compared to a FFS model.

Medicaid Expansion

In 2011, the State expanded coverage for adults without children with incomes at or below 75% FPL. The State has decided to move forward with the Medicaid Expansion provision of the Affordable Care Act, which would expand Medicaid coverage to those at or below 133% FPL. The Federal government will cover 100% of the cost for the "newly eligible" for calendar years 2014 through 2016, and will decline slightly by 2017, remaining at or above 90% through 2020.

There is an expected enrollment growth in MCOs nationwide as a result of the large number of new Medicaid enrollees. The increase in enrollment in Medicaid is likely to cause a strain on the current systems of delivery. In order to maintain access and quality of services, states will need to ensure that there are enough plans and providers to accommodate this new influx of patients. However, the growth of Minnesota's Medical Assistance program will be less dramatic than in other states, due to the fact that many new eligibles are already enrolled in the state's MinnesotaCare program, and will merely be transferred between the two programs as a result of the expansion. While up to 110,000 former enrollees of MinnesotaCare are predicted to be transferred to Medical Assistance, DHS anticipates that only 45,000 new individuals will enter into the system as a result of the Medicaid expansion. As a result of the Expansion, the eligibility rules for MinnesotaCare will also change, with new enrollees into the program expected to be as high as 162,000.

Specifically, if the MCOs are held fully responsible for covering these new populations, they will have to ensure that their current providers have the ability to treat more individuals, that the coordination of care remains seamless, and that the administrative functions continue to operate efficiently. In a FFS model, the burden would fall to the state to attract and enroll more Medicaid-eligible providers. The partnership between Managed Care Organizations and the state will be more vital than ever as Medicaid coverage expands.

Essential Health Benefits

The Affordable Care Act requires all plans in and outside of the Health Insurance Exchange to cover the defined "essential health benefits" (EHBs) which consist of ten service coverage categories. States are given the ability to define their essential health benefits by selecting a "base benchmark plan." All services included in that plan must be covered by all individual and small group plans both inside and outside of the Exchange (with the exclusion of large group plans and grandfathered plans). States were given three specified benchmark plan options. The option to select a plan outside of these options is also available, dependent on approval by the Secretary of HHS. Minnesota defaulted to the largest small group plan, *The Health Partners Small Group PPO* for their benchmark plan. This plan includes mental health

services and rehabilitative services, but does not include coverage of pediatric vision and dental, which are required essential health benefits. The coverage of pediatric dental and vision is supplemented through the FEDVIP benefit.

The ACA requires states to select an alternative benchmark plan for the Medicaid Expansion population which must also cover all ten EHBs or provide supplemental coverage for any benefit not included. Medicaid plans are required to cover periodic screening, diagnostic, and treatment services for children, so states will not need to supplement these benefits. The above ACA requirements will provide a greater consistency in services offered, regardless of the service delivery method. The introduction of benchmark plans will provide a foundation for the rest of the health insurance market.

If the state actively works to engage the MCOs in offering plans on the Exchange, the existing managed care structure could provide valuable scaffolding for introducing comparable plans for the Exchange. Existing relationships between the MCOs and the state would facilitate adaptation to the new structure and ensure an optimal alignment of benefits between commercial plans and state health programs.

Health Insurance Exchange

Minnesota was recently granted conditional approval for the development of a state based exchange, and expected to have a fully functioning exchange up by October 2013. The introduction of a state based exchange will bring on many changes to the market.

The state will need to ensure that there are an appropriate number of plans interested in providing coverage through the Exchange. Minnesota will need to determine the method of selection of plans, whether it be through a competitive request for proposal or an application process. The goal should be to attract as many plans as possible, while not flooding the market. While these plans may face many of the challenges described above, they may greatly increase their market and provider networks in participating in the Exchange. As individuals are predicted to move from Medicaid to the Exchange, and vice versa, sometimes referred to as “churn”, the state will need to plan for seamless transitions between the two. Working with the MCOs provides the state with the opportunity to create a smooth transition experience for consumers moving between Medicaid and the Exchange. A FFS delivery model would require patients moving between the two to pivot back and forth patients between entirely distinct delivery models.

In general, recent State and Federal Health Care Reform has been moving away from the volume-based payments of a FFS model and towards value and performance-oriented payment mode. If Minnesota’s Medicaid program were working under a FFS model currently, health care reforms such as the ACA would require a continued transformation of the delivery model, in many ways recreating innovations and practices used in the current MCO structure.

Section VIII. Alignment with Payment Reforms

As discussed throughout the report, improving value requires aligning specific health outcomes with all costs that go into producing them. Real value for the patient is created not by any single intervention, but by the combined efforts of all organizational units providing care to the patient. This is often defined as an "episode of care."

Minnesota's experience, along with the experience of other Medicaid programs nationwide, suggests that FFS or capitation by themselves are unlikely to meet the challenge of providing this kind of value. FFS systems focus on isolated procedures, while traditional capitated systems are oriented towards covering all services for a broad population, with little differentiation of patient needs. However, these two systems each provide their own opportunities as well as challenges as a starting point for payment reform.

Numerous payment models have emerged in the attempt to connect costs more productively with episodes of care. PCG has discussed several of these options below, beginning with incremental reforms to the existing system and gradually increasing the scale of the reforms required. At every stage we have attempted to relate the reform to the opportunities and challenges of the existing models of Minnesota Medicaid service delivery.

Incremental Payment Reform: Episode-of-Care, Incentive Payments

States under a predominantly managed care system may contractually require MCOs to implement payment reforms, either generally or specifically. States can also use capitation payment reforms to shape health outcomes. In Wisconsin, for example, state contracts with MCOs include pay for performance provisions that target specific health outcomes, such as increased immunization rates for children.

As a part of its recent managed care procurement for Milwaukee County and surrounding areas, Wisconsin modified the way it paid MCOs for births. Wisconsin asked its MCOs to offer health home solutions for high risk pregnancies that changed the way providers were paid for these services. The new agreement effectively withholds full payment until all benchmarks for pre-natal care and a healthy birth outcome are met.[55] Because health plans and providers in Minnesota are also experienced with incentive payment programs in the state health care system, greater use of incentive payments could be an attractive route to implementing more ambitious performance initiatives. Some Minnesota MCOs are already using incentive payments to shift or share responsibilities for case management and health outcome targets to providers, as discussed briefly in Section V.

Under a FFS model, because states pay provider claims directly they can directly change payment terms to elicit care reforms. Arkansas, for example, is one of the few states to maintain FFS as its primary Medicaid delivery system. This has provided Arkansas with the opportunity to directly commence an episode-based payment model to its Medicaid certified providers. Arkansas is currently implementing an episode of care Payment Improvement Initiative in a primarily FFS system. The goals are to control cost

[55] A limitation on these sorts of methods is that the state may not direct MCO payment methodologies to such a degree that the capitation payment is no longer considered risk-based.

growth and improve quality of care for beneficiaries across payers. This statewide initiative also features collaboration between the state and private health insurance companies.

There are criticisms of "episode of care" payments that have not yet been fully answered. Foremost among these is the concern that such payments create delivery systems that are "disease-centered" rather than truly "patient-centered." Other challenges include the difficulty of defining the boundaries of an episode of care, the lack of mechanisms to incentivize disease prevention or reducing unnecessary care, and the lack of reliable safeguards to protect high-risk patients whose needs may exceed average episode payments. Despite these obstacles, episode-of-care payments are increasingly common, and play a role in many of the reforms discussed below.

Primary Care Case Management

A primary care case management (PCCM) form of managed care would require something of a shift in policy direction for the reform of Minnesota's Medicaid system. However, such a shift remains feasible within the bounds of traditional FFS and capitation systems. Several states dissatisfied with their Medicaid capitation systems have transitioned from risk-based systems to the modified FFS delivery characteristic of PCCM. Oklahoma and Connecticut are the primary examples of this reform trend. Their separate experiences potentially hold lessons for Minnesota.

Oklahoma experimented with PCCM and capitated models simultaneously before deciding to move away completely from its full capitation system of managed care. In 1995, the State implemented a full capitation MCO model in urban areas (SoonerCare Plus). In 1996, Oklahoma implemented a PCCM partial capitation model in rural areas (SoonerCare Choice). Budget pressures led the Oklahoma Health Care Authority (OHCA) to undertake a study of the two models. The agency estimated that a PCCM model could operate in urban areas as well with significantly lower staff levels and costs than a full capitation MCO model. In early 2009, Oklahoma submitted an amendment to its §1115 Demonstration Waiver to fully replace traditional managed care with a PCCM model. Under this model, OHCA contracts directly with primary care physicians throughout the state. The physicians receive a monthly care coordination fee for each enrollee, based upon the services provided at the medical home. All other medical services are on a fee-for-service payment schedule.

More recently, Connecticut opted to make similar moves. On January 1, 2012, the state ended private insurer participation in the state Medicaid program. Kaiser Health News quoted the Connecticut Medicaid Director Mark Shaefer, who stated that "there has been a diminishing confidence in what [MCOs] are providing" in the state's fifteen year history with managed care organizations. According to Shaefer, firms did not fulfill their promise of lowering cost and providing better care in Connecticut. Last year, Connecticut contracted with Community Health Network to provide care coordination services to recipients of Medicaid and the state's other public health care programs. Community Health is paid a monthly case management fee for each member, while the state retains responsibility for paying medical claims.

Minnesota has a reputation as a leader in service delivery reform, and its technical infrastructure is well-developed to support significant innovation. The state is probably prepared for service delivery reforms more ambitious than the "tweaks" to traditional FFS offered by PCCM, and in fact Minnesota has already begun, through its health care home initiative, to implement more intensive care coordination efforts for its FFS population as well as its managed care population. However, there may be good reasons to pursue PCCM reforms as a transitional stage, in order to prepare providers for more substantial future reforms. PCCM may also be useful as a way to pay for care in regions of the state that have not yet developed the technical infrastructure necessary to support more substantial reforms.

Health Homes

Minnesota already benefits from a highly integrated provider community: in 2012, 85% of the state's providers were concentrated in 53 medical groups.[56] The state has sought to take advantage of this integration by encouraging providers to organize into health care homes (HCH), which would allow for more comprehensive care coordination practices than those typically available from a basic PCCM program. By 2008, the state had enacted legislation requiring medical homes for patients in FFS Medicaid who had complex conditions and established a plan for a broader multi-payer health care home program that would involve privately insured patients, Medicaid enrollees, and state employees. The HCH initiative involves a multi-payer payment methodology that reimburses certified practices for care coordination, including a requirement that certified health care homes be reimbursed for all eligible MHCP enrollees. The initiative includes eligible enrollees in the state's managed care system, as well as the FFS population.

Many of the care coordination services available through the HCH initiative have already been discussed in Section V. While the introduction of a payment methodology for care coordination is a significant reform of FFS in itself, the development of these capacities within a health care home infrastructure could transform the FFS system in fundamental ways if implemented widely, creating a delivery system that can no longer meaningfully be called "fee-for-service," even if the majority of services continue to be paid to providers on a FFS basis.

Not only does the additional technical infrastructure needed for health care home implementation allow providers to benefit from stronger data analytics, but state certification requirements for HCH participation will also permit the state to take a more committed approach to oversight and performance measurement than is feasible in traditional FFS systems. These measurement capacities and reporting requirements will eventually foster a feedback loop in which the state will be able to make outcomes data available to health care homes so that providers can compare their performance with peers. Once fully implemented, these additional data analytics functionalities will bring the FFS system into greater alignment with further payment reforms, by making it possible for the state to establish more extensive

[56] National Governors Association. "Minnesota Expands Health Care Homes." National Governors Association Case Study. 2012. http://statepolicyoptions.nga.org/sites/default/files/casestudy/pdf/Minnesota%20-%20Health%20Care%20Homes.pdf.

risk- and gain-sharing contracts with providers and systems that will hold them accountable and reward them for cost and quality outcomes.

Total Cost of Care Contracting

It is likely that some form of Total Cost of Care (TCOC) contracting will present itself as the predominant solution to Minnesota's payment reform dilemma. Innovative payment reform initiatives already explored by the state point in this direction. TCOC uses "global" or "comprehensive care" payments based on a longer period of case management and care. This combines the strengths of episode-of-care payments and traditional capitation, while addressing many of the deficiencies associated with these systems.

TCOC is similar to traditional capitation in a number of ways. It involves a single payment for the full range of health care services required by a specified group of people for a fixed period of time. Unlike traditional capitation, however, TCOC methodologies rely heavily on sophisticated risk adjustment techniques. Such methodologies are subject to stronger quality measurement and performance standards, and limit to the risk exposure transferred to providers. TCOC arrangements are less likely than traditional capitation to restrict consumer access to certain providers. Under this model, payers also provide more information support to providers, while providers benefit from a more robust infrastructure to manage population health.

TCOC utilizes mechanisms similar to conventional episode-of-care payments to incentivize integrated service delivery and provider coordination. Episode-of-care payments are not always appropriately scaled to discourage unnecessary future episodes or complications. However, TCOC contracting encompasses payments for all services over longer periods. This promotes efforts to minimize future episodes and reduces unnecessary hospitalizations and re-admissions. By measuring outcomes and costs for attributed patients over the entire year, TCOC encourages participants to coordinate services over more productive intervals.

TCOC contracting changes the conventional negotiation paradigm between payers and providers which has focused on negotiating unit price increases over two to three year periods. TCOC models involve negotiating the limits to annual rates of increase, using three to five year contracts. This gives payers greater budget predictability and stronger cost controls. At the same time, providers are given the opportunity to share savings. Incentive payments are activated if cost growth is held below negotiated benchmark target growth rates. In many cases, during the transition to a TCOC system, previous payment contracts are allowed to remain in place, but with additional or reformed incentive payments. These payments are based on a comparison between the rate of growth in total health care expenditures for attributed patients versus the growth in total cost of care for patients attributed to a network provider.

TCOC contracting was initially launched in 2009 and 2010 by private insurance companies and provider organizations in Massachusetts, Minnesota, and Illinois. In 2009, Blue Cross Blue Shield of Massachusetts (BCBSMA) drafted its Alternative Quality Contract (AQC) as a statewide effort involving a diversity of providers. In Minnesota, HealthPartners, Medica, and Blue Cross Blue Shield signed TCOC

contracts in 2009 and 2010, focused on the four major health care systems in the metropolitan Minneapolis market. Similar agreements followed in Chicago in 2011.

All three markets are different in terms of their size, levels of consolidation, and costs. The Minnesota and Illinois programs are focused on metropolitan and suburban markets, respectively, while the Massachusetts program is a statewide initiative. Due to BCBSMA's Boston market share, the AQC experiment very quickly achieved a critical mass and was able to demonstrate its value to the wider Massachusetts health care community. The State of Massachusetts has since adopted BCBSMA's AQC as a part of its own health care reform efforts. Massachusetts is now attempting to gradually replace all non-managed care FFS Medicaid payments with these "global rates" over a period of several years.

While this is in progress, Massachusetts is already utilizing global rates in its implementation of a first-in-the-nation Integrated Care Organization (ICO) model. The ICO manages the care of dually eligible (Medicare-Medicaid) beneficiaries. The state and CMS are collaborating to pay ICOs a global rate for the 115,000 eligible beneficiaries. The ICOs, in turn, contract with patient centered medical to coordinate care, also using global rates. Innovative payment models and provider incentives are being encouraged throughout the system. The goal of this program is to reduce inpatient hospital admissions for this population, as well as increase access to long-term support services, other community based services, and improved quality outcomes.

Although TCOC contracting is at the center of health care reform in Massachusetts, its development in Minnesota is perhaps even more advanced. All of the major health plans and providers in the metropolitan Minneapolis market are now involved in some form of TCOC contract.[57] On the commercial side, TCOC agreements now cover a significant share of the contracted commercial revenue for the major providers.[58] At this point, TCOC contracting has not spread deeply into the Medicare and Medicaid sectors. However, strong interest exists in expanding the TCOC concept to include Medicare and Medicaid patients more broadly. TCOC payment systems feature heavily in the State of Minnesota's broader agenda for Medicaid delivery reform.

As the model has developed in the commercial sector so far, TCOC appears to be applicable both to MCO and FFS populations. The Minneapolis and Chicago TCOC experiments deal primarily with PPO patients, but the Massachusetts AQC contracts focus entirely on BCBSMA's HMO and POS service. Where TCOC has been implemented, the patient attribution process has varied depending on whether FFS or managed care arrangements predominate. In Massachusetts, patients were already assigned to a specific

[57] See Dudley Morris and Bill Eggbeer, "Total Cost of Care Contracts: Early Lessons" *BDC Advisors, LLC* (2011), p. 10. Available at: http://bdcadvisors.com/. In November 2010, BCBSMN signed TCOC contracts with Allina Hospitals and Clinics, Essentia Health, Fairview Health Services, and Health East. In a March 2013 TCOC white paper, HealthPartners reported that two thirds of its membership is currently linked to providers paid on TCOC shared savings agreements (see "Total Cost of Care and Resource Use White Paper," available at http://www.healthpartners.com/ucm/groups/public/@hp/@public/documents/documents/dev_057649.pdf).
[58] *Ibid*., p. 11.

provider group responsible for managing their care and related costs, simplifying the challenge of patient attribution.

However, MCO-style patient assignment protocols are not necessary for TCOC implementation. In PPO populations like those currently under TCOC arrangements in Minnesota, contracts rely primarily on claims history to attribute patients to providers. DHS employs a similar method with its HCDS initiative and has not encountered any major attribution challenges. TCOC arrangements are flexible enough to be built on top of FFS, full capitation or performance-based structures. The "right" system depends on local factors: the level of provider experience with each payment structure, as well as provider preferences regarding cash flow and interim payment needs.

Contracts have been signed with a broad range of provider organizations, including large multi-specialty groups, independent and employed physician practice organizations, smaller physician practices, and physician-hospital organizations. TCOC contracting is most likely to promote successful reform among providers in advanced markets, where strong technical infrastructure and data analytics capacities already exist to take advantage of payment reform incentives. Provider organizations must have the data warehousing capabilities necessary to identify and attribute patients to participating providers, along with timely and accurate data received from payers. The providers' staffs must also be sufficiently organized, clinically, to accept contracts and provide comprehensive care management. Other organizational factors that determine success are strong leadership and commitment to change, experience in quality improvement programs, advanced care management procedures for chronic illness, and appropriate market incentives. The use of robust risk adjustment methodologies, experience with quality and performance measurement, and the ability to conduct utilization management activities are all essential to the success of TCOC contracting. Many managed care organizations in Minnesota already have these capabilities in place, already leveraged to support their commercial TCOC initiatives.

On the other hand, these technical requirements need not impose a barrier to the state's current efforts to broaden and deepen its direct relationships with Minnesota providers. DHS has already made important strides in building its own in-house analytic capacities. Although DHS continues to contract out risk adjustment to an outside vendor, it is able to deliver data reporting to its HCDS providers beyond the level of health plan data analytics for many measures, especially in the agency's ability to provide patient-level data to providers.

Proponents of TCOC initiatives in Minnesota have also expressed that there are equally good reasons for the state to assume greater payer responsibilities, suggesting that deeper cost savings could be achieved if the state gained the critical mass to coordinate attributed patients and costs across plans. Unlike the current managed care system, in which each health plan has data for its own plan members, DHS has the capacity to analyze the full data stream and to target areas for quality improvement that require more overarching system coordination. Furthermore, continued state investment into this structure is more likely to encourage smaller providers to participate in the Medicaid program, especially providers such as FQHCs that do not participate widely in the commercial health sector.

Managed Care, ACOs, and the Health Care Delivery Systems Demonstration

In addition to the TCOC experiments, DHS recently initiated the Health Care Delivery Systems (HCDS) Demonstration. This model is a departure in many respects from both traditional managed care and FFS service delivery. The initiative's core concept is a provider-led delivery system akin in many ways to the more familiar Accountable Care Organization (ACO) model. As Minnesota's model is currently implemented, DHS contracts directly with provider-led organizations to hold them accountable for their performance on total cost of care and quality for a defined patient population across managed care plans and fee-for-service. The state incentivizes providers to improve care efficiency by allowing them to share in the savings they generate while transitioning them over the three-year period of the Demonstration to assuming greater risk for losses. This could allow providers to achieve even stronger health outcomes while bearing responsibility for the total cost of care of their patient populations.

Many proponents of Medicaid ACOs believe that they can give providers greater incentives than traditional MCOs to deliver the innovations that will keep people healthier. They also see ACOs as better able to integrate care across settings. Minnesota's other accountable care initiative includes an MCO contracted with Hennepin County to function as a safety net ACO. The Hennepin Health initiative is building a county-integrated service model across its providers and county service structures to address the intensive health and social service needs of the single adult population targeted by the plan. The county began enrolling low-income, childless adults in January 2012. Separately, the state solicited bids from throughout Minnesota to participate in a Medicaid HCDS demonstration.

Six other ACOs became operational in January 2013. Three more are negotiating with Minnesota Medicaid to start later this year. They will serve an initial attributed population of approximately 100,000 Medicaid beneficiaries. The participants include several integrated systems with experience in care coordination. In order to meet cost and quality performance goals, these organizations may have to tailor their services to the needs of Medicaid patients, as well as conduct performance measurement and improvement or introduce new cost-management activities, including coordination and integration activities with other providers. In February 2013, CMS awarded Minnesota a State Innovations Model (SIM) Initiative grant to test and implement a multi-payer accountable care model for the state.

The boundaries between traditional risk-based managed care and ACOs can be difficult to discern in Medicaid. In some instances, MCOs coordinate with ACOs or simply act as the ACOs. Models vary from state to state.

- **Utah**, which previously converted most of its insurer- and provider-led health plans from full-risk to partial- and no-risk arrangements, is now planning to return to risk-based contracting. The same organizations will operate as ACOs charged with managing care delivery and bearing financial risk.

- **Colorado**'s ACO initiative, the Accountable Care Collaborative, allows for the continuation of existing managed care contracts with Kaiser Permanente as an exception that limited to the initial stage of the initiative.

- **Oregon** is implementing an ACO initiative based around Coordinated Care Organizations that will strengthen Medicaid requirements for community and provider engagement. However, the structure allows existing Medicaid MCOs to apply to participate and gradually transition to meet the new requirements.

- In **New Jersey**, the legislature authorized a grassroots provider-based ACO initiative. The state envisioned that its extensive network of risk-based MCOs would contract directly with the ACOs. However, the legislation did not address the structure of these contractual relationships in detail. The state expects that the intensive case management envisioned in ACOs will be attractive to at least some MCOs, but their participation in the initiative remains voluntary.

When surveying peer states, it is evident that other states have evolved different solutions for meeting this challenge.

- In **Colorado**, for example, beneficiaries residing in state psychiatric institutions or nursing facilities were initially excluded from enrollment in the Accountable Care Collaborative.

- **Utah** specifically excludes mental health services, substance abuse treatment services, nursing facilities, and emergency transportation from its ACO program. These exclusions remain in place under the ACO initiatives.

In other cases an ACO initiative may be viewed as an opportunity to integrate services previously carved out from managed care.

- **Oregon** plans to use the ACO program to merge previously separate medical care and behavioral health care risk arrangements, ultimately also folding in risk for dental care.

- **Colorado** uses five regionally-based Behavioral Health Organizations to operate a state-funded mental health program. These geographic areas were used as a starting point for the development of the seven Regional Care Collaborative Organizations (RCCOs) within the Medicaid ACO program. To date, all RCCOs are required to coordinate and collaborate with the existing local Behavioral Health Organizations and with most regional Managed Service Organizations handling substance use disorders.[59]

[59] Advancing Colorado's Mental Health Care. "The Status of Behavioral Health Care in Colorado: 2011 Update." December 2011. Available at: http://www.coloradomentalhealth.org/sites/all/themes/acmhc/ACMHC_StatusReport.pdf

Section IX. Assessment of the Requirement for HMO Participation in Medical Assistance

Minnesota took strong measures in past years to assure that managed health plans doing business in the state participated in serving low-income families, children, elderly and disabled populations through Medicaid. Specifically, Minnesota has passed the following statutory language:

Section 62D.04, Subdivision 5:

Health maintenance organizations shall, as a condition of receiving and retaining a certificate of authority, participate in the medical assistance, general assistance medical care, and MinnesotaCare programs. A health maintenance organization is required to submit proposals in good faith that meet the requirements of the request for proposal provided that the requirements can be reasonably met by a health maintenance organization to serve individuals eligible for the above programs in a geographic region of the state if, at the time of publication of a request for proposal, the percentage of recipients in the public programs in the region who are enrolled in the health maintenance organization is less than the health maintenance organization's percentage of the total number of individuals enrolled in health maintenance organizations in the same region. Geographic regions shall be defined by the commissioner of human services in the request for proposals.

Section 256B.0644:

A vendor of medical care, as defined in section 256B.02, subdivision 7, and a health maintenance organization, as defined in chapter 62D, must participate as a provider or contractor in the medical assistance program and MinnesotaCare as a condition of participating as a provider in health insurance plans and programs or contractor for state employees established under section 43A.18, the public employees insurance program under section 43A.316, for health insurance plans offered to local statutory or home rule charter city, county, and school district employees, the workers' compensation system under section 176.135, and insurance plans provided through the Minnesota Comprehensive Health Association under sections 62E.01 to 62E.19. The limitations on insurance plans offered to local government employees shall not be applicable in geographic areas where provider participation is limited by managed care contracts with the Department of Human Services

In short, the rule requires a health maintenance organization that wishes to operate in the state of Minnesota to facilitate the delivery of Medicaid services through the plans they offer. Without the rule, it would still be allowable for commercial HMOs to also offer Medicaid-oriented plans. Repeal of the rule would merely offer these HMOs the freedom to *not* serve the Medicaid population, if they wished. The rule also requires any medical vendor that wishes to serve state or municipal employees, the workers' compensation program, and other state and local government insurance must also serve the Medicaid population as a Medicaid managed care organization.

Finally, the Medicaid HMOs in operation are required to respond to Requests for Proposals to be a local Medicaid provider in any county where they have a sufficient presence (as defined by the statute). This

secondary requirement ensures customer choice and prevents several unintended consequences of the main rule, such as plans maintaining Medicaid services in a small area while growing their commercial services statewide, or plans carving up the state's Medicaid space into a set of mutually exclusive monopolies. This component of the rule has become more important, and more controversial, with the introduction of competitive bidding.

Impact of the Rule on the Delivery of Medicaid Managed Care

Analysis of 2010 Medicaid enrollment data shows that among Minnesota's managed care population, approximately 88% of patients are enrolled with a "commercial" Medicaid managed care plan, opposed to 11% enrolled in a "Medicaid-only" Medicaid managed care plan. This represents a very high share of Medicaid managed care patients enrolled in commercial MCOs, but is also comparable to some other states without the same rule. While mandatory participation has certainly encouraged the role of "commercial" MCOs in Minnesota's managed care program, Minnesota is not extraordinary in terms of commercial involvement in the Medicaid space.[60]

	Medicaid Managed Care Population	Commercial MCO		Medicaid-only MCO		Other forms of Managed Care	
Location	Enrollment	Enrollment	%	Enrollment	%	Enrollment	%
West Virginia	172,476	163,131	94.58%	0	0.00%	9,345	5.42%
Minnesota	468,437	413,155	88.20%	55,282	11.80%	0	0.00%
Wisconsin	713,959	586,710	82.18%	95,180	13.33%	32,069	4.49%
California	4,559,445	3,211,912	70.45%	788,220	17.29%	559,313	12.27%
Hawaii	255,213	179,015	70.14%	76,184	29.85%	14	0.01%

It's important to remember that in reality, these "commercial" MCOs are still **non-profit** health management organizations. They are distinguished from "Medicaid-only" MCOs in that they offer additional commercial plans, also run on a non-profit basis, and because they may be set up by or in some way affiliated with commercial insurance providers. In Minnesota, a "Medicaid-only" MCO generally takes the form of a county-purchasing agent.

Concerns have been raised about the role of commercial MCOs in the Medicaid space, particularly relating to their administrative costs and their sometimes-contentious relationship with the state, and these are valid issues that deserve the attention of DHS and the legislature. In a stakeholder interview, the Minnesota Medical Association shared some anecdotal provider concerns with PCG. These included contentions that commercial MCOs sometimes lagged behind the county-based purchasing entities,

[60] The Kaiser Family Foundation State Health Facts, "Medicaid Enrollment in Managed Care by Plan Type." Data Source: Medicaid Managed Care Enrollment Report, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, November 2011. Accessed 6/6/2013, http://kff.org/medicaid/state-indicator/enrollment-by-medicaid-mc-plan-type/

particularly in payment reform innovations. Providers also felt that county-based organizations are more embedded in the fabric of the community and more concerned about a holistic approach to county services where they intersect with Medicaid.

However, in other ways commercial MCOs have significant advantages in the delivery of Medicaid services. Commercial MCOs operate from a position of improved leverage over "Medicaid-only" MCOs when contracting with providers. As attested by provider representatives, this can lead to lower rates for providers, who find themselves with virtually no leverage to negotiate for higher reimbursement. Because MCOs enforce a policy of "take one, take all" with their provider networks, the mix of Medicaid and commercial patients enrolled in commercial MCOs distributes the Medicaid population throughout Minnesota's system of providers. This prevents the evolution of a two-tiered system of care, with Medicaid population effectively segregated from the rest of the patient population in terms of provider access.

Because commercial MCOs are often pre-existing multi-state entities experienced in the delivery of Medicaid managed care, they bring to bear efficiencies of scale and expertise in case management and other managed care intricacies. Lessons learned from the commercial health care space can be cross-fertilized into Medicaid service delivery. At the same time because Medicaid patients are known to suffer generally worse health outcomes and pose other risks for providers, a mix of commercial and Medicaid patients is more attractive to a prospective provider than an MCO that can offer only Medicaid patients.

For example, as noted in Section V, one of the managed care plans currently in operation administers an internal incentive program that shares the burden of risk and case management with providers, essentially passing on many of these responsibilities to their providers through their contracts. It would be difficult for a Medicaid-only MCO to extract similar concessions from providers.

Impact of the Rule on the Minnesota Health Insurance Exchange and Medicaid

The health exchanges created under the ACA will rely on certified "qualified health plans" (QHPs) to provide medical services to patient populations who previously fell into the gap between Medicaid coverage and access to commercial insurance through an employer or other organization. With or without legislative prompting, the existing penetration and strong provider networks enjoyed by the existing Medicaid managed care organizations make it likely that existing MCOs will move into the Exchange space.

This has advantages not only for the plans but for consumers. As discussed in Section VII, the "churn" of patients moving between Medicaid and the Exchange is an issue that could impact access for some consumers. One way this issue can be addressed is through the presence QHPs in the Exchange that also deliver Medicaid services or are affiliated with MCOs that do.

Such plans could initiate innovations to create bridge products intended to smoothly transition members from Medicaid to the Exchange or vice versa. The opportunity to successfully capture market share across both the Exchange and Medicaid incentivizes plans to protect access for patients as they move through the

different levels of the health care system. It seems both likely and beneficial that many of the QHPs operating in the Exchange will also provide Medicaid services or be affiliated with an MCO currently working in the Medicaid managed care system. The existing rule can be adapted to further encourage this.

Stakeholder Voices

In interviews with PCG, the managed care plans repeatedly brushed aside the idea that revoking the requirement for HMOs to participate in Medicaid would lead to an exodus from the Medicaid space. The consensus expressed was that with or without the rule, their role and reason for existence was strongly tied to the delivery of Medicaid services. However, the plans expressed dissatisfaction with the component of the rule requiring MCOs to respond to county RFPs. In the past, every plan was required to submit a proposal if their provider network in the county was sufficient; however, they had the assurance that any plan that submitted a valid proposal would be accepted as a Medicaid vendor for the county. Recently Minnesota moved to a system of competitive bidding that does not guarantee acceptance. The plans feel that required RFP response, when combined with the new competitive bidding methodology, results in a constant flow of wasted work on proposals that will be rejected.

The plans have argued strongly that if the competitive bidding methodology remains in place, they should be reserved the right to decide to which RFPs they will respond. The plans can also point to a disruption in service for 85,000 beneficiaries who had to change plans as a result of the competitive bidding policy. However, this must be weighed against the $175 million in cost savings that competitive bidding produced in 2012.[61]

As noted above, the Minnesota Medical Association (MMA) shared with PCG some provider concerns about the role of commercial MCOs in the Medicaid delivery system. These concerns touched on the ability and willingness of commercial MCOs to enact payment reforms and interact with other community services, as opposed to the corresponding ability and willingness of county-based purchasing agents. The MMA also shared provider concerns about low rates of reimbursement stemming from the powerful leverage commercial MCOs enjoy.

However, the MMA also expressed doubt that changing this particular set of requirements would impact these issues, mirroring the opinion of the plans that the current system is held in place by more than the requirement for HMOs to participate in Medicaid. The MMA also expressed the belief that there is value in distributing the Medicaid population throughout the entire provider network, as encouraged by the requirement.

Conclusions

PCG believes that in the interest of continued stability and access to services for enrollees of these programs, there is no harm and potential advantage in continuing the requirement in some form, although the exact structure of the legislation may change to reflect evolving situations.

[61] Edwards, Jennifer. "Health Care Payment and Delivery Reform in Minnesota Medicaid," Commonwealth Fund pub. 1667, vol. 12 (2013), p. 9

The complaints of the MCOs about the current competitive bidding system should also be considered, but carefully weighed against the benefits of competitive bidding and the requirement to participate. It may be possible to ease MCO complaints about the administrative burden of mandatory participation by simply streamlining and standardizing the county RFP process.

It may appear on the surface that the rule is not purely necessary in the status quo. Based on stakeholder input, under the current framework the plans will continue to operate as they have operated, with or without it. However, this current framework cannot be considered as permanent. In addition to the sweeping changes under ACA, Minnesota is currently considering various reforms to the Medicaid program, including new payment models and changes to the rate assessment framework as well as increased scrutiny of plan transparency, outcomes, and cost-effectiveness. It is difficult to predict how these transformations would impact the willingness of MCOs to continue working providing Medicaid services if the legislative requirement is removed. The rule has benefited the State by encouraging a diverse Medicaid managed care space that is well-positioned for the transition to the Exchange and other changes under ACA. It will continue to be of value as Minnesota moves through this period of unprecedented change to the Medicaid health care space.

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