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

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Presented to the Chairs and Ranking Minority Members,
Health and Human Services Legislative Committee

Executive Summary

The Minnesota Department of Human Services has contracted with Public Consulting Group to author the initial and final reports on the value of managed care for state public health care programs required by Section 31 of 2012 Sessions Law Chapter 247.

This initial report previews the approach PCG will take in authoring the final report, due July 1, 2013. Additionally, this report documents initial information PCG has identified in its early research that addresses the specific statutory criteria for evaluating the value of managed care, as compared to fee-for-service. These criteria include:

- the satisfaction of state public health care program recipients and providers;
- the ability to measure and improve health outcomes of recipients;
- 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 this 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.

This report begins with an introduction aimed at establishing an understanding of key concepts. These include "delivery system," the organizational approaches to providing and paying for health care that includes managed care and fee for service. The roles of delivery systems in Minnesota public health care programs will be discussed. Administrative elements such as delivery system rate setting and performance metrics will also be addressed.

Following the introduction, the next seven sections will each address the criteria for evaluating managed care identified in the statute that authorizes this study. Each section identifies the intended approach for evaluating each criterion by July 1.

In some of these sections, PCG's initial research has resulted in preliminary findings. This is the case in section two, related to consumer satisfaction. Here, PCG found that MHCP plans consistently perform among the highest-ranked managed care programs under nationally-

accepted measures of performance for timeliness, quality, and access to care. According to those same standards, MHCP plans also outperform the national average for commercial managed care in the majority of its service categories. Finally, enrollee switching between plans remains consistently below the State's self-imposed performance threshold. These findings suggest that consumers are generally satisfied with the level of service provided by Medicaid managed care in Minnesota.

Data presented in section four indicates that in 2011, the number of complaints per Medicaid recipients related to the lack of available providers increased. Between now and issuance of the final report, PCG will examine this data more closely to determine if this data represents real access concerns or is explained by other circumstances.

The work of this evaluation has just begun in most areas. Section six highlights the breadth of previous national research comparing managed care and fee-for-service cost. The results of this research points to the challenges of consistent conclusions. Sections seven and eight show the importance of delivery system alignment with state and federal health care reforms. The fluid nature of reform efforts, however, makes it difficult to align delivery systems with moving policy targets.

With the final report due July 1, this evaluation will provide Minnesota with a broad set of insights about the value it is already getting from its current delivery system, along with specific ideas about ways that value can be enhanced.

Section I. Background

Understanding Delivery Systems

Managed care and fee-for-service are examples of health care 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 is the engine that drives the form of the delivery system. 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:

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. Fee for service payments are

typically aligned with coding guidelines and rules (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.

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.

The MCOs are required to provide at least the same benefits as Medicaid fee-for-service.

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 fee-for-service 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.[1]

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 typically 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.[2]

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.

This past September, Minnesota submitted a State Innovation Model (SIM) initiative for the Minnesota Accountable Health Model. This model proposes to expand current Medicaid Accountable Care (ACOs) demonstrations, in alignment with similar models in Medicare and among commercial payers.

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.

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

In conclusion, 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 fee-for-service and managed care.

Delivery Systems and Minnesota Health Care Programs

Medicaid is the largest Minnesota Health Care Program, 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 now covers adults without children below 75% of the federal poverty level (FPL).

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. The MCOs are required to be non-for-profit by state law. As of January 2013, Minnesota had 613,520 individuals enrolled in Medicaid

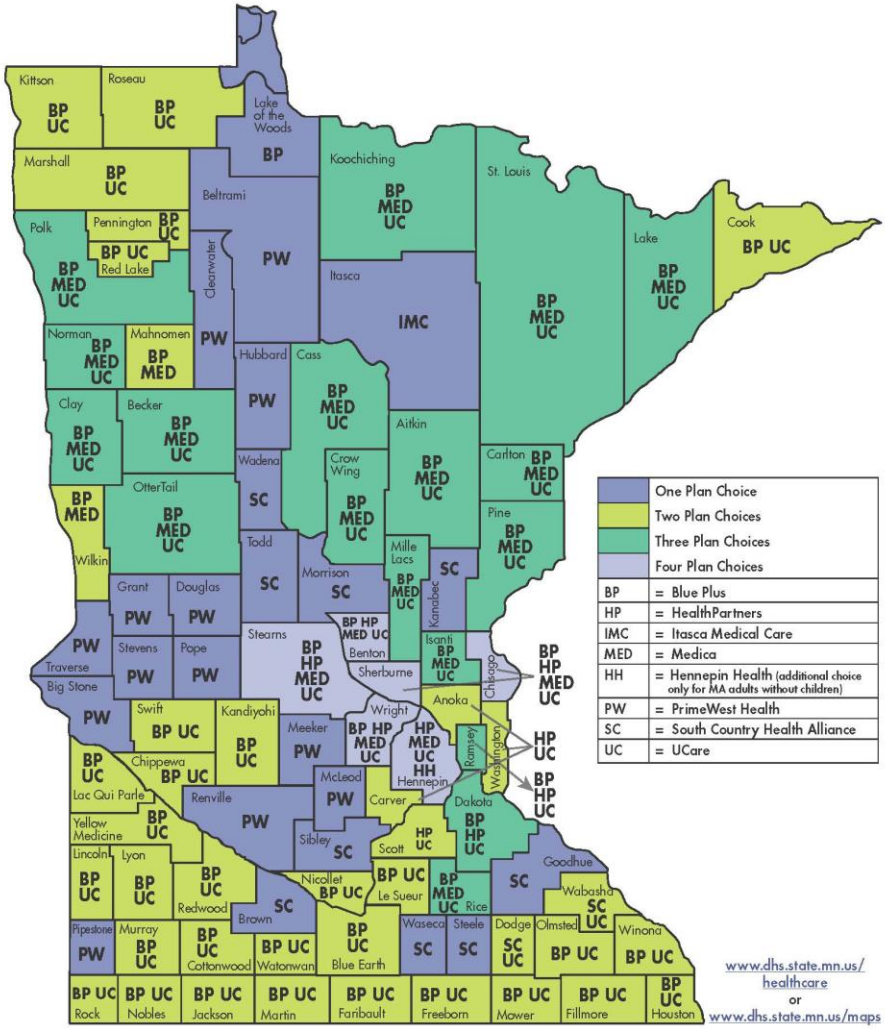
Managed Care.[3] Almost all Minnesota Medicaid members without a disability are enrolled in an MCO (federally required exemptions for Native Americans and other populations prevent 100% enrollment). More than 80,000 elderly and disabled individuals in Minnesota Medicaid are served by a managed care organization.

Minnesota currently has nine Medicaid MCOs. This includes Blue Plus, Health Partners, Itasca Medical Care, Medica, Metropolitan Health, PrimeWest Health, South Country Health Alliance, UCare, and Hennepin Health. The managed care organizations with the largest number of MA enrollees are UCare and Medica. Hennepin Health 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.[4]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.

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

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



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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 already identified in our introduction.

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 their fee-for-service 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 fee-for-service rates. Assuming that the encounter claims set is accurate, the result is a "fee-for-service equivalent rate." This indicates the amounts fee for service would have paid for managed care claims.

Wisconsin further adjusts "fee for service 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 intense scrutiny for DHS over the past two years.

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

Separate from PCG's broad evaluation of the value of managed care, DHS has commissioned an independent audit of the rates it pays to Medicaid managed care plans last year.

Managed Care Growth

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. All states with existing Medicaid MCOs, with the exception of a few, 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 trend toward more intensive monitoring of MCO performance.

Case Studies: Connecticut and Oklahoma

In our final paper presented by July 1, PCG intends to provide more information on delivery system changes in Connecticut and Oklahoma. These two states moved away from traditional Medicaid managed care to primary care case management (PCCM) programs. To help inform Minnesota's insights about the "value of managed care," PCG will assess how costs and quality outcomes have been affected by this change.

As initial background, Oklahoma moved away from full capitation managed care through a series of amendments to a §1115 Demonstration Waiver. 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. They 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 the 1115 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.

On January 1, 2012, Connecticut ended private insurer participation in the state Medicaid program. Kaiser Health News quoted the Connecticut Medicaid Director Mark Shaefer, stating 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.

Over the next several months, PCG will assess the initial outcomes of these changes in Oklahoma and Connecticut in an attempt to draw conclusions that may or may not be applicable to Minnesota.

MCO 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 nine 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

FFS Performance Metrics

About one fourth of the states with MCOs and/or PCCM programs also monitor quality measurements in their fee for service system.[5] 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.

[5] http://www.kff.org/medicaid/upload/8220.pdf p.32

The background information provided in this section is intended to inform the next nine sections of this paper. In each section, PCG will preview the approach it intends to take in assessing the value of Minnesota managed care, as compared to fee-for-service, according to the criteria provided in the statutory language that authorized this study. Further, PCG will document any findings that have emerged from our initial research that will shape the direction of the final paper.

Section II. Assessment of the Satisfaction of Recipients and Providers

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, but the collective program improvements brought about by successfully maintaining this 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."[6]

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.

Appendix B of Minnesota's quality strategy references 42 CFR 438.228, which 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.

[6] Managed Care Quality Strategy, p.6

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

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).

CAHPS System Survey Results

One tool regularly used by Minnesota to analyze consumer satisfaction is the annual Managed Care Public Programs Consumer Satisfaction Survey. The report utilizes data gathered from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey instrument to assess the satisfaction enrollees in managed care programs administered by DHS. 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.

Minnesota contracts with an External Quality Review Organization (EQRO) to conduct a "comprehensive annual review of the nine 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."[7] 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.[8] MHCP scores also exceeded national commercial MCO averages in all but one CAHPS indicator.

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. Both the volume of disenrollment as well as the reasons provided for switching from one plan to another can provide insights into levels of satisfaction among enrollees, both with individual plans and with managed care as a whole.

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 remain

[7] MPRO 2010 Annual Technical Report, p.i
[8] MPRO 2010 Annual Technical Report, p.73

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. In cases where disenrollment has occurred, reasons for plan selection changes do not necessarily represent 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.[9]

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

Conclusions

PCG's review of consumer satisfaction data in Minnesota suggests key points to consider in this program evaluation. First, the State maintains methods built into its quality strategy for consumers to voice concerns regarding managed care. This grievance and appeals system holds MCOs accountable to the consumers, and consumers are notified of plans performance on a regular basis.

Second, MHCP consistently performs among the highest-ranked managed care programs under nationally-accepted measures of performance for timeliness, quality, and access to care. According to those same standards, MHCP also outperforms the national average for commercial (private) managed care plans in the majority of its service categories. Finally, the rate of enrollee switching between plans remains consistently below the performance targets established by the State.

These findings suggest that consumers are generally satisfied with the level of service provided by managed care in Minnesota. In preparation for our final paper, PCG will consider additional information obtained through interviews with key MHCP stakeholders regarding levels of satisfaction. We will compare the information gathered to the data presented in this first draft.

[9] 2011 Voluntary Changes in MCO Enrollment Report

Appendix A: Comparison between MHCP Statewide Averaged and National Commercial Averages

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%

Section III. Measurement and Improvement of the Health Outcomes

PCG understands that a goal of this evaluation is to determine if an MCO or FFS delivery model would better support the state's capacity to measure and improve the health outcomes of recipients. Our understanding is that the evaluation will further support insights on which delivery models may yield better health outcomes.

PCG has reviewed the existing managed care outcomes data that Minnesota has assembled and made available online at the Minnesota Department of Heath website. Initiatives such as the Performance Improvement Projects demonstrate each plan has made progress in particular health focus areas. A 2011 report compares managed care and fee for service health outcomes for select populations in 2010, noting the limitations of comparability.

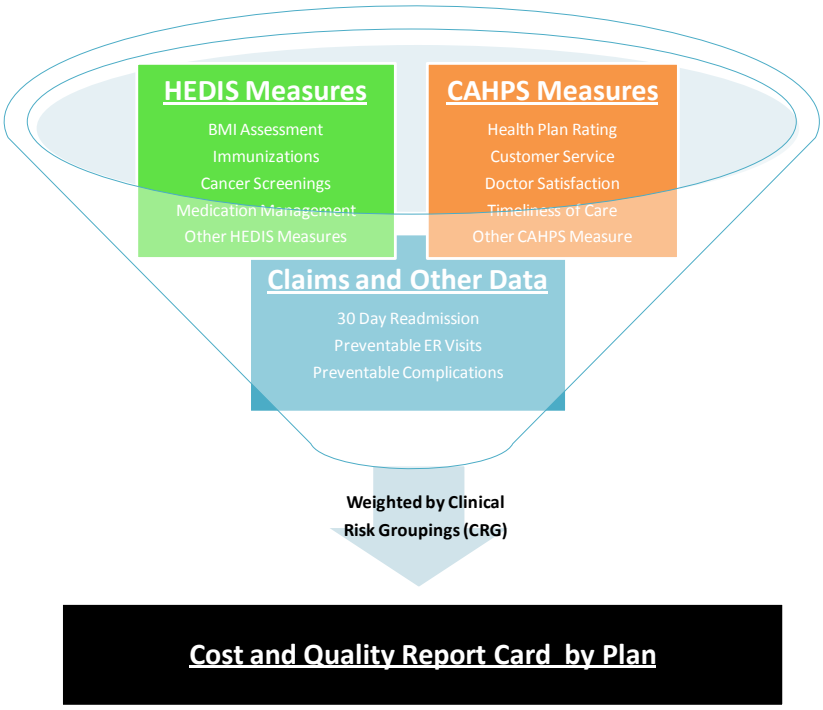
These and other reports demonstrate the increased efforts DHS has commenced to determine managed care health quality outcomes. In the months between this initial report and our final report, PCG intends to build on this analysis to construct, as much as will be possible, a more comprehensive presentation of healthcare quality benchmarks under the current managed care delivery model.

Healthcare Effectiveness Data and Information Set (HEDIS) Assessment

First, PCG will analyze the Healthcare Effectiveness Data and Information Set (HEDIS) data made available by the state.

HEDIS is a tool used by more than 90 percent of America's plans to measure performance on important dimensions of care and service. HEDIS consists of 75 measures across 8 domains of care that address important health issues. HEDIS is also one component of NCQA's accreditation process. According to the NCQA Medicaid Managed Care Toolkit (2012 Health Plan Accreditation Standards), Minnesota Medicaid has adopted NCQA and HEDIS standards (as of February 2012). 34 states collect or require NCQA's standard HEDIS data making it possible to compare performance across states on an "apples-to-apples" basis.

However, despite efforts to compare Medicaid FFS and managed care systems, most states find it difficult to achieve comparability within states. A 2010 report conducted by the Center for Health Care Strategies indicated that states have a very difficult time comparing the MCO and



FFS systems. They identified difficulties with financial and human resources to support medical record extraction at the provider level for the FFS programs and comparability of the data because of differences in the population acuity covered by managed care versus FFS. Managed

care plans often treat healthier populations whereas FFS programs are focused on the sickest long term care, disabled, and mental health clients in the system.

The evaluation will identify any gaps in the HEDIS reporting for the FFS and MCO system and apply a risk adjustment to the scoring to ensure we account for difference in population health. We will then report HEDIS measures across the FFS and MCO plans for comparison purposes.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Assessment

This report has already addressed CAHPS reviewing recipient satisfaction. It is equally relevant here for another reason.

The evaluation will also analyze the Consumer Assessment of Healthcare Providers and Systems (CAHPS) data. CAHPS is a survey which measures members' satisfaction with their care in areas such as claims processing, customer service and getting needed care quickly. Data collection relating to the CAHPS 4.0 survey must be conducted by an NCQA-approved external survey organization. To assist PCG, Minnesota will make available CAHPS satisfaction survey results, HEDIS and Ambulatory Care Sensitive Conditions (ACSC) performance measures, the managed care quality strategy, EQRO annual technical and other available PMQI reports, and care system and county care system reviews, care plan audit protocols, and care plan audit reports.

NCQA Medicaid Managed Care Toolkit Assessment

PCG will utilize and consult with the NCQA Medicaid Managed Care Toolkit as well. In 2006, NCQA created its first Medicaid Managed Care Toolkit in consultation with the Centers for Medicaid and State Operations in response to numerous inquiries from state Medicaid programs. The toolkit explains how states can take advantage of the federal authority to streamline oversight of Medicaid managed care plans through the use of private accreditation for health plans. Using accreditation for oversight reduces unnecessary duplication in the oversight process. The toolkit highlights the areas where NCQA's evaluation standards and performance measures can be used to supplement and, when considered applicable, serve in lieu of relevant Medicaid requirements and complement the mandatory EQRO activities. PCG will look to leverage the NCQA toolkit for assessments across both MCO and FFS systems.

Medicaid Claims (FFS) and Encounter (MCO) Assessment

Lastly, PCG will identify differences in health status across the FFS and MCO population utilizing claims and encounter data. Health claims data risk grouping is the fundamental platform for performing population-based risk-adjusted analytics. Risk groupings predict resource consumption at the person level and allow for patient and provider analysis on an

"apples-to-apples" basis, comparing patients with the same disease burden and resource requirements. This is necessary for any care, population, or provider management.

Claims data provides much valuable information to the market. We can identify average lengths of stay, payment to charge ratios, and Per Member Per Month (PMPM) cost by users. However, claims data alone is limited in that it does not identify the underlying illness burden of each unique member by plan. Applying population-based health status indicators onto claims helps regulators make more accurate decisions on disparities in health and cost across the system.

This enhanced data is used to identify variation within the population by provider or other organizational affiliation to design and implement payment policy initiatives and manage programs designed to reduce variation and improve overall cost and quality. Specifically these data provide:

- The ability to stratify populations by illness burden, enabling us to predict resource consumption at the person level providing programmatic support to care management programs and the foundation for risk adjusting the population.
- The ability to establish risk-adjusted outcome measures including cost and utilization reports at the population level (e.g. PMPM costs utilization).
- Member-centric reporting that is actionable at the provider level. Developing a member centric approach calculates population illness burden at the patient level – as opposed to episode level.
- Creating data that is meaningful and actionable to the front line providers.
- Outcome metrics that focus on events such as admissions, readmissions, ER visits, high cost testing and complications. These outcome measures highlight the greatest opportunities for improving both cost and quality.

Developing a Report Card by Plan

Once data has been grouped and tagged, PCG can calculate risk-adjusted expected values, which are used to compare dissimilar populations with HEDIS, CAHPS, and claims metrics. PCG will be able to create report cards for cost and quality across MCO and FFS plans in the Minnesota MHCP 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.[10]" Each MCO must also provide assurance to the State and supporting documentation that it has the capacity to service the expected enrollment in its service area in accordance with the State's standards for access to care, and to meet the needs of the anticipated number of enrollees in the service area.

Availability of Services

Availability of services entails both the size of the delivery network and the furnishing of services. Network requirements dictate that each MCO maintains a provider network sufficient in size to provide adequate access for members to all services covered under the contract. Provisions 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 fee-for-service, 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.[11]

Timely Access

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 available to commercial or Medicaid fee-for-service 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

[10] 42 CFR 438.206
[11] Minnesota Managed Care Public Programs Quality Strategy, June 2012, p.11

accepted practice parameters."[12] For both primary care and specialty physician services, access must be available 24 hours per day through:

- Regularly scheduled appoints during normal business hours;
- After hours clinics;
- Use of 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.[13]

Geographic Accessibility

MCO geographic access requirements are judged according to Minnesota statute 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.[14]" 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]." [15]

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. Nevertheless, interactions between multiple payers and provider systems 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 to coordinating care for all enrollees.[16] 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."[17]

Complaints Concerning Access

[12] Minnesota Administrative Rules 4685.1010 Availability and Accessibility, Subpart 6(A)
[13] Minnesota Administrative Rules 4685.1010 Availability and Accessibility
[14] 2012 Minnesota Statutes 62D.124, Subd 1
[15] 2012 Minnesota Statutes 62D.124, Subd 2
[16] 42 CFR 438.206 (b)

[17] Minnesota Managed Care Public Programs Quality Strategy, June 2012, p.16

The Minnesota 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. While grievances have increased in this area, several factors may contribute to this. The increases may be attributed to an overall increase in the population of managed care enrollees. Alternatively, the increase in grievances can arise from restructuring coverage areas or plan enrollments, which can produce failures to maintaining continuity of care. While access grievances attributed to continuity issues are legitimate, complaints relating to enrollment or coverage changes tend are transitional in nature and tend to decrease over time.

In order to discern whether grievance increases can be attributed to enrollee number growth, PCG has indexed these two variables against one another for the most recent three years. This index can be seen in Appendix 2. This analysis indicates an increase of grievances related to access over enrollee population growth between 2010 and 2011. Between these two years, enrollee growth increased by only 4.85 percent, while the number of complaints related to access increased by 20.49 percent. This comparison indicates that enrollment does not appear to be the cause of the spike in access complaints. However, a final determination of the cause of this increase requires further study by PCG and will be a focus of the final June 2013 version of this report.

Conclusions

Access to care is an essential component of value when analyzing a State's managed care program. There are many ways that differences in fee-for-service and managed care payment structures can impact access to care. Most notably, they can impact provider participation in MHCP.

Although data-driven analysis and contract monitoring is essential for ensuring that MCOs maintain frameworks capable of supporting enrollee care, the most telling information concerning access remains whether consumers are satisfied that their needs are being met. Data

provided in Minnesota's most recent external quality review included an analysis of CAHPS performance indicators , and found that MHCP outperformed national averages for patient satisfaction with both Medicaid and commercial MCOs. However, the data analyzed in most recent EQRO report does not extend past 2010. PCG observed that, between 2010 and 2011, the number of grievances brought against plans has increased, both in quantity and as a percentage of enrollees.

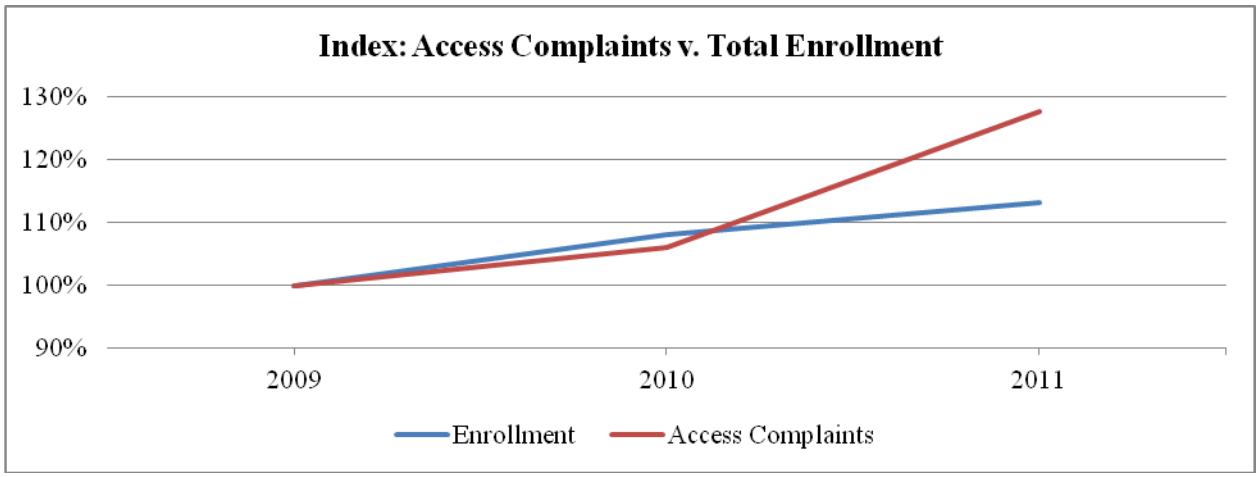
These findings must be substantiated through additional analysis of complaints data and through conversations with Minnesota stakeholders, including providers, MCO representatives, and State officials responsible for interactions with consumers.

In the period between the issuance of this preliminary report and the final report published in June 2013, PCG will continue its analysis of access to care. PCG will investigate MCO compliance with access standards found in contracts, state law, and in federal regulations to identify opportunities for improvements in patient access and satisfaction.

Access Complaints can include: delay in obtaining service, excessive wait times, inadequate geographic options, delays in appointment scheduling, inability in obtaining referral, inability to obtain medical information, and lack of availability of special services.[18]

	Total		Indexed	
	Enrollment	Access Complaints	Enrollment	Access Complaints
Year-End 2009	513,082	929	100.0%	100.0%
Year-End 2010	554,131	984	108.0%	105.9%
Year-End 2011	580,834	1,185	113.2%	127.6%

[18] 2011 Managed Care Grievance System Information Summary



Enrollment data for calendar years was retreived from the December enrollment report for that year. For example, enrollment data for 2010 was gathered from the State's December 2010 enrollment summary. [19, 20]

Section V. Impact of Additional Services Provided by MCOs

Some MCOs offer services, beyond what is offered or can be reimbursed under FFS models, to incentivize members to enroll. That may include greater use of social workers or use of specific MCO care coordination models or waiver of nominal FFS co-pays to take away potential barriers to care. In other cases MCOs offer other incentives, such as free baby strollers or diapers to new mothers, to enroll in their plan. PCG has begun work to document the additional services offered by the MCOs and request that each MCO provide information on utilization rates of these "add-on" services. This would include any outcomes MCOs can document related to the provision of these care management tools.

Case management is often times 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. Plans have more resources at their disposal than the state (e.g. nurses, data analysts, and community outreach workers) who can 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.

[19] 2011 Managed Care Grievance System Information Summary
[20] Minnesota Department of Human Services, Managed Care Enrollment Figures, December 2009, December 2010, December 2011

Done effectively, these initiatives could both improve the quality of care and reduce its cost. If the Minnesota plans are contractually required to hire case managers, conduct health risk assessments for new members, and develop a care plan for members with special health care needs, then these services need to be evaluated. Work has begun to document each plan's strategy and try to quantify the cost and benefits of each program.

Section VI. Measurement of Actual and Potential Cost Savings

"Value" is the intersection of cost and quality. While cost analysis will not solely determine if Minnesota would receive better value from fee-for-service or managed care, it is a critical component.

In initial interviews with PCG, DHS staff indicated their interest in improving agency access to cost data that would enhance their ability to manage health care costs. This would include re-basing fee-for-service rates so that they more accurately represent recent provider cost experiences. Fee for service rate rebasing would provide more options for linking capitation rates to managed care rates.

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

DHS has made efforts to reduce managed care contract costs. In 2011, Minnesota implemented a competitive bidding procurement pilot process for the five plans in the Twin Cities metropolitan area. The pilot started in January 2012. In the past year, this competitive bidding process helped keep actual program costs below initial budget estimates.

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				

State	Administrative Rate Setting Using Actuaries	Negotiation	Competitive Bid Within Rate Ranges	Competitive Bid
WV	x			
Total	**27**	**11**	**10**	**5**
36	75.0%	30.6%	27.8%	13.9%

Of the 36 states that responded to Kaiser's 2010 survey[21], 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.

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		

[21] 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

State	Capitation Withhold	Bonus	Shared Savings	Other
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	33.3%	27.8%	2.8%	16.7%

Of the 36 states that responded to Kaiser's 2010 survey[22], 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, incentive 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.

[22] 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

The results of past studies comparing managed care and fee-for-service costs have not generated consistent results.

The savings potential under managed care are 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."[23]

Medicaid managed care plans have opportunities to achieve savings through a number of mechanisms, including but not limited to the following:

- 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 the patient's ability to self-refer appropriately)
- 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
- Enhancing provider accountability for quality and cost effectiveness[24]

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

- Fee-for-service 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.

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

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

- 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.

Although states overwhelmingly have shifted to a managed care delivery system, a review of research literature does not consistently support conclusions that it reduces cost.[25]

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.

[25] 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
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.

Authors	States Studied	Model Studied	Data Years	Cost Savings	Detail of Findings
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.

The findings from these studies are split in terms of cost savings.

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

With uncertainty managed care cost savings, some states have begun to show preferences for alternative models. Connecticut has recently transitioned from a Medicaid managed care program to a care coordination case management model. State officials indicated that the managed care system was no longer saving the state money and that health outcomes were insufficient. In January 2012, Connecticut ended its MCO contracts and began directly reimbursing providers. Other states are turning to care management organizations that are typically provider led, including health homes and accountable care organizations (ACOs).

Determining whether a state is paying "too much" or "too little" is a subjective measure. This question needs to be considered against the goals of a managed care program. However, it is clear, and DHS staff agrees, that the additional use of data analytics and rate updates will greatly enhance the agency's ability to control its own costs in its role as a health care payer.

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 managed care and/or fee-for-service.

State Innovation Model

In September 2012, Minnesota submitted their State Innovation Model (SIM) Initiative to implement the Minnesota Accountable Health Model. The model aims to close the current gaps in health information technology, secure exchange health information, quality improvement, and workforce capacity needed to provide team based coordinated care.[26] The model aims to expand the state's current Medicaid Accountable Care Organization (ACO) demonstrations while incorporating the existing models in Medicare and the commercial market. By 2016, the model is expected to impact 190,000 Medicaid enrollees in Medicaid ACOs. As part of this model, the state will invest in developing service delivery models that integrate health care, behavioral health, long term care, and prevention services within the community. The savings resulting from the implementation of this model is expected to be around $111.1 million over a three year period, with $90.3 million of that savings in Medicaid.[27]

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. It is estimated that approximately 168,000 uninsured Minnesotans will be newly eligible for Medicaid with the expansion.[28] The Federal Government will cover 100% of the cost for the "newly eligible" for calendar years 2014 through 2016, and will decline slightly from 2017 on, remaining at or above 90% through 2020.

[26] Health Reform Minnesota- Executive Summary P. 2
[27] Health Reform Minnesota- Executive Summary p. 3
[28] http://www.cbpp.org/files/healthtoolkit2012/Minnesota.pdf

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. Specifically, if the MCOs are fully responsible for covering this new population, they will have to insure 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 an effort to ensure that MCOs are able to take on this increase in volume, some states are considering broadening their standards on plans for the required size of their networks.

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" which consist of ten service coverage categories. States are given the ability to define their essential health benefits by selecting a "base benchmark plan" for which 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, and the additional option to select a plan outside of these options pending 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 habilitative 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 essential health benefits 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, or base for the rest of the health insurance market.

Managed Care Organizations will be responsible for providing at least the benefits covered in the benchmark plan. Some of these benefits, now required, may have been leveraging tools for MCOs to gain enrollees. For example, MCO's may have offered "additional benefits" from the Medicaid plan that attracted individuals to enroll. Now that all MCOs will be required to offer the array of benefits, MCOs may have more trouble differentiating themselves in the market. MCOs may need to readdress their marketing strategies in order to assure continued enrollment and participation.

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.

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. Therefore, Minnesota may want to consider including some plans on the Exchange that are very similar to those plans offered in Medicaid. Given that MCOs make up the majority of the Medicaid market currently, Minnesota should actively work to engage the MCOs in offering plans on the Exchange. This may help with providing seamless transitions for individuals. It is predicted that there will be a variance between Medicaid and Exchange regulatory requirements, as well as separate rate setting and underwriting issues, which will provide further challenges for the state and those plans that offer coverage in both the Medicaid population and the Exchange. In addition, the Exchange will have different rules for marketing and collection of premiums that will need to be adhered to.

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. 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.

Section VIII. Alignment with Payment Reforms

Managed care and fee for service delivery systems each provide their own opportunities for payment reform. Under a fee-for-service model, states are directly paying provider claims, and, therefore, can directly change payment terms to elicit care reforms. Arkansas is one of the few

states that maintains fee-for-service 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.

Alternatively, states may contractually require MCOs to implement payment reforms, either generally or specifically. Indirectly, states can use capitation payment reforms to shape health outcomes. In Wisconsin, state contracts with MCOs included pay for performance provisions that targeted specific health outcomes, such as increased immunization rates for children. A limitation on this method is that the state may not direct MCO payment methodologies to such a degree that the capitation payment is no longer considered risk-based.

Wisconsin also completed managed care procurement for Milwaukee County and surrounding areas, Wisconsin asked its MCOs to offer health home solutions for high risk pregnancies that changed the way providers were paid for these services. Wisconsin modified the way it paid MCOs for births, effectively withholding full payment until all benchmarks for pre-natal care and a healthy birth outcome were met.

Other state payment reforms have also reflected the context of their delivery system.

Arkansas is currently implementing an episode of care Payment Improvement Initiative in a primarily FFS system. The goals are to control cost growth and improve quality of care for beneficiaries across payers. This statewide initiative features collaboration between the state and private health insurance companies. The goal is to change the payment model from bundled payments to episode-based payments for certain types of conditions.

Global fees are the primary payment methodology that Massachusetts is attempting to use to replace all non-managed care FFS Medicaid payments. This will be done over a period of years, but the state is utilizing Global Rates as it implements a first-in-the-nation Integrated Care Organization (ICO) model to manage 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, are expected to utilize a global rate arrangement with the patient centered medical homes that they will contract with to coordinate the care. Innovative payment models and provider incentives are being encouraged throughout the system, all in an effort 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.

In launching its own payment reform last year, DHS initiated the Health Care Delivery System (HCDS) demonstration. This model is a departure from both traditional managed care and fee-

for-service. Under HCDS, DHS contracts with providers to coordinate care. HCDS incentivizes providers to improve care efficiency by allowing them to share in savings they generate.

Based on this, PCG's initial perspective on these criteria 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. This trend indicates that no consensus has yet been reached on the one best delivery system to support payment reform.

For the final paper, PCG will examine HCDS demonstration progress and provide comparisons to Minnesota managed care.

Section IX. Assessment of the need to continue the requirement for HMOs to participate in MHCP as a condition of licensure under Minnesota Statutes, section 62D.04, subdivision 5, and Minnesota Statutes, section 256.0644, in terms of continued stability and access to services for MHCP enrollees.

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 through Medicaid. Specifically, Minnesota passed the following statutory language, which remains in effect today:

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

For the July 1 final report, PCG will use the following approach to assess the merit of continuing these requirements:

- Compare rates of HMO participation in Minnesota's Medicaid managed care to the Medicaid participation rates of HMOs in states that do not have similar requirements.

- Compare the prevalence of HMOs in the Minnesota insurance market to the prevalence of HMOs in states that do not have similar requirements.

- Consider the future role of qualified health plan (QHP) certification requirements in the Minnesota Health Insurance Exchange as a new factor that affects broader decisions about MCO involvement in Medicaid. (The Minnesota Exchange could seek federal approval to require qualified health plans to participate in Medicaid managed care. Alternatively, Minnesota could seek federal approval to require Medicaid managed care plans to offer Exchange qualified health plans. This new dynamic could redefine the scope of requirements of private plans to also participate in Medicaid.)

- It is possible that plans wishing to successfully capture market share across both the Exchange and Medicaid will initiate innovations to create bridge products. These products are intended to retain members when changes in income or life circumstances modify eligibility from Medicaid to the Exchange and vice-versa. PCG will consider if these changes create incentives sufficient enough to eliminate the current provisions of Minnesota state law.

- Gather input directly from HMOs and consumer advocates to identify and analyze leading arguments and supporting data justifying continuation or change in these policies.

The work of this evaluation now continues until issuance of the final report due July 1, 2013.

As stated in the executive summary, an ongoing goal of this evaluation will be to provide Minnesota with a broad set of insights about the value it is already getting from its current delivery system and specific ideas about ways that value can be enhanced.

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