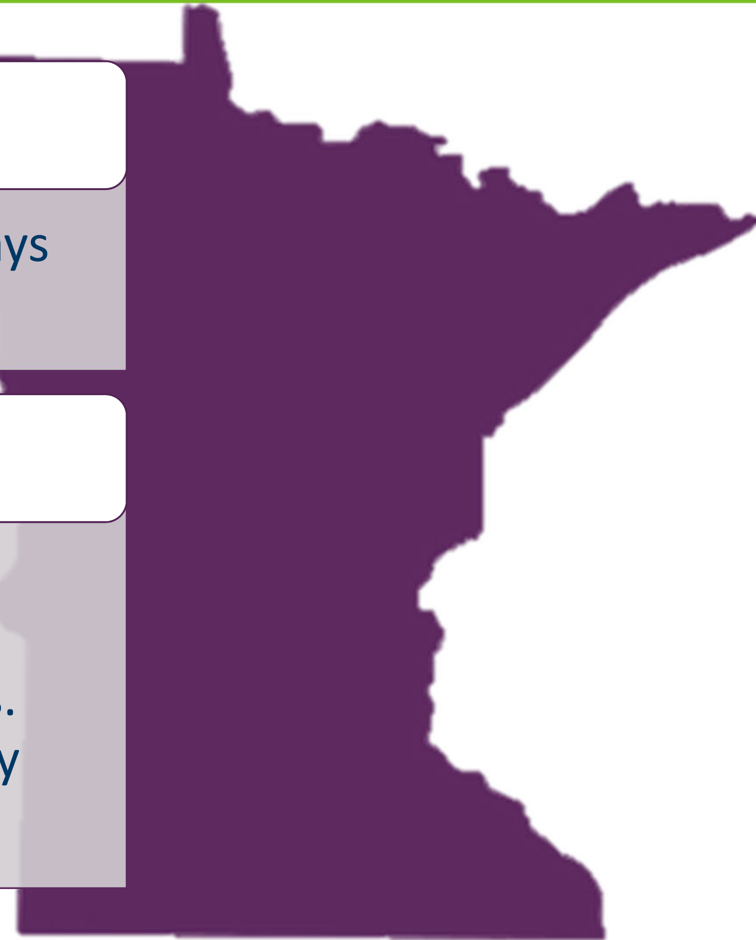
Managed Care

PJ Weiner| Manager, Alternate Purchasing

Health Care Administration

DEPARTMENT OF HUMAN SERVICES

How Minnesota purchases health care for enrollees



Fee for service (15%)

- DHS processes claims and pays providers directly

Managed care (85%)

- DHS pays managed care organizations (MCOs) to provide benefits to enrollees. MCOs process claims and pay providers.

Managed care organizations

The state contracts with managed care organizations to deliver

- Provider networks
- Payment arrangements
- Care coordination and disease management for complex cases

Who is covered through managed care?

Families and children

- 7 county Metro area: 643,056
- Greater Minnesota: 535,740

Adults with disabilities

- Statewide: 66,861

Seniors

- Statewide: 72,235

Managed Care Programs

- **Families and Children:**

  Parents, children, adults without children who are eligible for MA based on income.

  - MinnesotaCare is also covered through this contract.

- **Seniors:**

  People 65 and over, most of whom have Medicare coverage as primary.

  - Minnesota Senior Health Options (MSHO) product for dually eligible population enrolled in same Medicare and Medicaid plan.
  - Minnesota Senior Care Plus (MSC+) is an MA only plan.
  - Home and community-based services (HCBS - elderly waiver, PCA) covered in managed care.

Managed Care Programs *continued*

- **Special Needs BasicCare (SNBC):**

  People with disabilities ages 18-64, half of whom are also eligible for Medicare

  - Basic care services covered only.
  - Can opt out and be in fee-for-service.

Care Coordination and Disease Management

- MCOs required to provide initial screening of all enrollees to assess urgent or ongoing health needs.
- MCOs required to provide care management for their populations to ensure appropriate care is delivered and coordinated between settings and payers.
- MCOs provide disease management for people with chronic or complex illnesses such as heart disease, diabetes, asthma. They also must have a population health management strategy.
- Seniors and SNBC have enhanced care coordination activities due to the acuity of the populations served in the program.

Managed Care Flexibilities

- **In lieu of services:**
  Flexibility granted to health plans to cover an alternative service with the enrollee's agreement - IMD coverage, home modification for non-waiver, etc.

- **Additional benefits:**
  MCOs offer benefits they are not paid for under their capitation such as car seats, gym memberships, food programs and incentives.

- **COVID response:**
  MCOs can make program adjustments quickly in urgent situations such as the COVID response to with vaccine programs, outreach, transportation, and virtual visits.

MSHO and Integration

- MSHO is Minnesota's fully integrated special needs plan (FIDE SNP) for seniors eligible for both Medicare and Medical Assistance.
  - Requires approved model of care under which the SNP meets the need of each enrollee.
- The MSHO program integrates Medicare, Medicaid, pharmacy, acute care services, PCA, Elderly Waiver services, and coordination of care between acute medical services and long-term services and supports.
- Longitudinal study of the program demonstrated that MSHO enrollees fare significantly better than peers without the same level of coordination of benefits.
- Seniors that do not enroll in an MSHO plan enroll in MSC+ which also includes care coordination.

Procurement and Contracting

- Managed care contracts: grant contracts required to be re-procured at least every 5 years.
- Once the MCOs are selected through procurement, they enter into contracts with DHS. Contracts are renegotiated annually to address:
  - Legislative, federal, and other program changes.
  - Changes to capitation rates resulting from those changes in addition to utilization and trend assumptions.
- Contracts include federal requirements and requirements related to enrollment, payment, breach and contract termination, covered services, quality, grievance and appeals, program integrity, coordination of benefits, and reporting requirements – among others.

Procurement and Contracting *continued*

- In October 2022, DHS finalized managed care contracts for:
  - Families and children in 80 Greater Minnesota counties
  - Older adults and adults with disabilities statewide
- In October 2021, DHS finalized managed care contracts for the metro area Families and Children population
- The contracts are renegotiated annually and must be re-procured within the next 5 years

Procurement and Contracting *continued*

- Managed care plans operational as of 2023:
  - Blue Plus
  - HealthPartners
  - Hennepin Health
  - PrimeWest Health
  - Itasca Medical Care
  - Medica
  - South Country Health Alliance
  - Ucare
  - UnitedHealthcare Community Plan of Minnesota
- Final contracts end a 2-1/2-year collaboration with counties to design and implement a competitive procurement process.
- Procurements focused on goals established by DHS and counties to eliminate racial and geographic disparities, address social determinants of health, improve outcomes for all enrollees, establish greater county collaboration, improve provider relations and incentivize innovations in payment reform.

Enrollee Protections in Managed Care

- Federal managed care requirements include protections for people including:
  - Protections from coercive marketing or misleading communication
  - Right to privacy and respect
  - Protection from balance billing
  - Coverage of emergency and post-stabilization services from any provider
  - 2 level of appeals with the right to expedited appeals
- State law includes protections for people as required by HMOs including continuity of care provisions that allow enrollees to remain with their providers during health plan changes.

Managed Care Quality

- MCOs are involved in several initiatives to report quality of care, improve services, incentivize providers to improve care and report on enrollee satisfaction including:
  - **Performance withholds:** Contractually required targets aimed at improving enrollee outcomes
  - **Performance improvement projects:** 3 year projects dedicated to addressing specific topics (maternal and child health, comprehensive diabetes care for Seniors and people with disabilities)
  - **Managed care comprehensive quality strategy:** DHS' goals for continuous quality improvement and initiatives that will help us achieve those goals.
  - **Enrollee surveys and grievances**
  - **External Quality Review Annual technical report**
  - **HEDIS measures and quality assurance reports**
  - **Managed care program annual report** of the state's managed care monitoring system

MCO Oversight

- DHS Financial Oversight of MCOs:
  - MCOs submit quarterly financial reports which includes income statements.
    - Reviewed by the contracted actuary who raises any questions about information submitted on reports.
  - MCOs submit an annual MLR report which DHS verifies and submits to CMS.
  - MCOs submit copies of each claim received from providers, called encounter data.
    - DHS compares encounter data submitted and financial statements to confirm accuracy of financial data submitted.

MCO Oversight *continued*

- Ombudsman:
  - DHS offers services of the Ombudsman for State Managed Health Care Programs who help enrollees navigate care and advocate for fair, equal treatment by MCOs.
  - Ombudsman’s office works collaboratively with contract oversight team to identify trends or contract issues through MCOs’ work with enrollees.

MCO Oversight *continued*

- Contract Oversight of MCOs reports due to the state:
  - Grievance and appeals
  - Quality work plans and other quality improvement activities
  - Program integrity
  - Recoveries
  - Documentation of care management
  - Enrollee and marketing materials

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Questions?