Managed Care in Medicaid and MinnesotaCare

Minnesota Council of Health Plans

In Minnesota, over 80% of Medicaid and MinnesotaCare members are enrolled in managed care

Managed Care is the National Standard

Managed care is the preferred delivery system for Medicaid programs in the United States, representing 72% of all Medicaid enrollees nationwide. As of July 2022, 41 states capitated managed care models to deliver Medicaid, with both North Carolina and Oklahoma moving their Medicaid programs to managed care in 2023[1]. States have turned to the use of managed care models to increase budget predictability, limit growth in Medicaid spending, and improve access to care and value for enrollees.

Minnesota Excellence

Minnesota moved to managed care in the 1980's to address severe provider shortages and an unpredictable budget. Since then, managed care in Minnesota has grown to cover additional populations and services, and was made a permanent fixture of Medical Assistance in 2001.

Minnesota has long been recognized as a national leader in delivering Medicaid, in partnership with the state's managed care organizations (MCOs).

In 2020, DHS and the MCOs formed a unique public-private partnership to reduce gaps in COVID-19 vaccination rates among public program enrollees in high-risk zip codes. The partnership also distributed over 500,000 masks to communities most in need.

·For the first time, the 2022 MCO contracts incorporated dedicated health equity metrics. Building on that, the 2023 contracts added incentives to address racial disparities in healthcare and adopt anti-racist principles. This work is considered a national model in how to use contracting as a lever for health equity.

Minnesota's MCOs are unique in collaborating together on performance improvement projects (PIPs). Currently, MCOs are working on improving care and outcomes for moms and babies under the Healthy Start PIP by focusing on areas with the most significant racial and ethnic disparities.

Case Study: Nation Leading Model

The Minnesota Senior Health Options (MSHO) program is a standard-bearer for fully-integrated special needs plans for dually-eligible seniors.

MSHO offered a new level of benefit coordination between Medicare and Medicaid, leading to stark improvements in how seniors accessed medical, dental, vision, transportation, pharmaceutical, case management and long-term care services seamlessly under one health plan and one benefit card.

Under the management of Minnesota's MCOs, the program is still considered a leading example of fully-integrated care.

[1] https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/

	Managed Care	Fee-for-Service (FFS)
Payments	MCOs receive a per member per month capitation payment. These payments cover expected utilization of covered services, administrative costs, and contribution to reserves and surplus. MCOs must meet an 85% medical loss ratio (MLR), meaning they spend at least 85% of their payment directly on medical care for members.	Providers bill for each service they provide and receive reimbursement for each covered service based on the Medicaid State Plan rate, typically set by the legislature and DHS.
State Budget	In a managed care payment system, prepaid health plans take on all of the risk of their members so the state can set a heath care budget and stick to it.	Under FFS, the state bears the risk for enrollees within a legislatively-approved budget. If program costs are unexpectedly high, the state has to absorb the additional cost and risk.
Rates	MCOs negotiate rates with providers. In some cases, MCOs must pay at least FFS rates and at times are required by legislation to pass through additional payments from the state directly to providers. In practice, MCOs often pay much higher rates than FFS.	Providers are paid at the set fee schedule rate. Rates are set by the Minnesota legislature and must be approved by CMS each year.
Benefits	MCOs not only cover state required benefits, but offer additional tailored benefits such as car seats, dental cleanings and fitness benefits. MCOs coordinate care for pharmacy, dental, transportation, and interpreter services to best meet the evolving needs of their members.	FFS cannot pay for benefits outside the required Medicaid benefit set.
Networks	MCOs use a variety of strategies to offer robust provider networks, including direct outreach to providers, financial incentives, uniform credentialing applications, and prompt payment policies. MCOs also pay for services from non-enrolled or out-of-network providers.	Members must receive care only from enrolled providers or in-network providers. DHS does not pay for services from non-enrolled or out-of-network providers and use limited alternative payment arrangements.
Social Drivers of Health (SDOH)	Managed care addresses social drivers of health. For example, MCOs can provide members access to support services such as meal delivery/food support, programs to reduce isolation for seniors, discharge support for members who are unhoused, and bringing care directly to members through mobile clinics.	FFS cannot reimburse for non-medical services.

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