## Parsons, Ken V (DHS)

**From:** Leitz, Scott D (DHS)
**Sent:** Wednesday, June 05, 2013 11:19 AM
**To:** Marquardt, Julie A (DHS); Hudson, Mark J (DHS); Zimmerman, Marie L (DHS)
**Cc:** Golden, James I (DHS)
**Subject:** RE: MA FFS v MCOs

Julie, thanks.

On your last point, is there anything that actually prevents us from not contracting with certain providers?

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I couldn't say for sure whether access as a whole would drop off, but it seems we would lose some advantages that we gain through managed care contracting. One is the flexibility to have differing rates with providers through contracts. The plans, through their provider contracts have flexibility we don't have to negotiate rates, change rates if circumstances arise that require it, and can include things like utilization targets that may impact payment to the provider. A second thing is the ability to require the designation of a primary care provider, which provides an avenue for management of appropriate utilization. In FFS, a recipient can go see any provider (except those where an order or referral is explicitly required) including a specialist if they wish without first going to a primary care provider to assess the patient's condition and determine whether more conservative treatment means are available. In managed care, they usually must go through the primary care provider in order to ensure appropriate conservative means of treatment are exhausted before specialty care is initiated. MC also has the ability to establish a network of providers that they choose to contract with, particularly in areas of the state where there are large numbers of providers. In some areas of the state, they can select some providers they believe do a "better" job and contract with them while not choosing to contract with those they think are not as "good". It's possible they may leverage their commercial networks as well. I don't know to what extent each MCO currently utilizes these areas of flexibility, but at least it is available to them.

Just my two cents…

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> **From:** Leitz, Scott D (DHS)
> **Sent:** Monday, June 03, 2013 3:45 PM
> **To:** Hudson, Mark J (DHS); Marquardt, Julie A (DHS); Zimmerman, Marie L (DHS)
> **Cc:** Golden, James I (DHS)
> **Subject:** MA FFS v MCOs
>
> Cindy asked an interesting question today:
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> In meeting with UCare last week, they stressed (again) the fact that they bring us access to services for our Medicaid clients, and without MCOs we wouldn't get that same access.
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> Leaving dental aside (where neither mcos or ffs get us the access we need in my opinion), what's our assessment of the claim that, absent the plans networks, we would see a drop-off in access if folks were enrolled in MCOs?

It seemed to me that at the point we made a large movement to MCOs, we had a smaller Medicaid population. We didn't have as much expansion, and MinnesotaCare was either just getting started or didn't really exist. I can see an argument where providers might decide it's not worth it to participate with a small population of poorer paid clients. However , we now cover a lot more people under MA/MNCare, so I'm curious if we even think the same rationale exists under "access."

Any thoughts on this?

Scott Leitz
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