Parsons, Ken V (DHS)

From: Ghita Worcester <[redacted]>
Sent: Monday, July 29, 2013 3:01 PM
To: Hudson, Mark J (DHS)
Cc: Stephanie Schwartz; Ghita Worcester
Subject: UCare comments on the MCO Report
Attachments: 20130729 MCO report - UCare Edits, Comments.pdf

Mark,
There are a couple of "editorial comments" that I will list first and then a few more substantive comments. I am listing the page numbers for the specific editorial comments.

Page 33, paragraph that starts with "Third, DHS has developed"….. in the next to last sense of that paragraph there is a reference to certain administrative services related to the withhold. DHS has both administrative and clinical withholds in place and both should be noted.

Page 34, in the paragraph that starts with "Virtually" – in the first sense the word mechanism should be mechanisms.

Page 37, in the third paragraph it notes that the 2010 EQRO report is done by the Minnesota Peer Review Organization (MPRO), it was in fact that Michigan Peer Review organization.

Page 39, there is a reference to the 2010 DHS TCA as though all of the MCO's were reviewed that year. That is not accurate as all plans were not reviewed in the 2010 DHS TCA cycle.

Page 48, the section with complaints, grievance access to care has the same description for both #3 and #5.

Page 72, in the fourth paragraph, the word insure should be ensure.

Page 74, in the fourth paragraph, last sentence the word patients should be removed as it is already included earlier in the sentence.

Page 77, in the third paragraph, the sentence that starts with "PCCM may also be serve to pay for care" – needs editing. As written the sentence doesn't make sense.

Page 79, in the third paragraph, the sentence that starts with "The ICOs, in turn, contract with patient centered medical" needs to have "home" inserted after medical.

Page 86, the wording of "Medicaid-only" MCO should be modified to "Government program only" MCO as the products offered are more than Medicaid-only.

Page 87, in the first paragraph we have concern about the last sentence. We think that the words "could be" more attractive is more accurate given the experience in the state with beneficiary choice of plans and the differences in selection that has occurred. Member choice/selection differs by geography/county. Also, it is an organizational choice to offer only certain products and the sentence saying "that can offer only Medicaid patients" we think should be modified to "an MCO that has chosen to focus only on government programs".

General Report Comments

- Finding that MN Medicaid program is more expensive per enrollee than in most other states.
  Comment: From what I can tell, the PCG does not factor into account that MN likely has a more generous benefit package than many states. We know for a fact that MN has an extensive list of

optional services that exceed other states, and the legislature this session just added more, including a new and expensive autism benefit. Shouldn't it be noted that a comparison of PMPM Medicaid costs across states, without looking at benefit packages, is a significant flaw in the conclusion that MN is more costly?

- Strong MCO negotiating power has allowed to plans to keep provider rates relatively low. **Comment:** The state fee structure is more of a factor in keeping the provider rates relatively low, than the MCO negotiating power on its own. There is no data in the report pointing to the MA cuts the legislature has made over the years (except this past session, where they did make some modest increases). The Council has the data to back up the cumulative cuts to MA over the past several years if that would be helpful.

- Page 88. Re; competitive bidding. *The plans can also point to a disruption in service for 85,000 beneficiaries who had to change plans as a result of the competitive bidding policy*. **Comment:** this statement should not be attributed to all of the Plans, because it was probably made by the plans that lost out. More importantly, a change in plan as a result of comp. bidding is not necessarily a "disruption in service" i.e. access to, and able to receive medical care. As currently written, this statement is biased from the perspective of the plans who lost out in the comp. bidding process. I doubt if UCare or HP said there was a major disruption in services, and certainly, we have not heard of an outpouring of complaints from members as a result of changing plans.

- Page 57,*Where FFS delivery models reward quality of care*….**Comment:** Not sure what is meant here as most of the discussion preceding this statement has documented the lack of data in the FFS system.

- Page 63, *a review of research literature leads swiftly to the conclusion that managed care does not consistently reduce cost*. **Comment:** Again, a biased statement. Why not acknowledge where Managed Care has documented significant savings. Maybe they reached their conclusion "too swiftly."

- The case for the SIM/HCDS model is being made in advance of any evidence that it has accomplished anything , clearly too soon to document the value. This report focus should be comparison to information where there is data or research and not to programming too knew for that information to be available.

Please call me if you have any questions on this feedback.

Ghita

Ghita Worcester

Senior VP Public Affairs and Marketing

UCare

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