MCO Evaluation Report communications and outreach plan

The 2013 legislature mandated a MCO evaluation report on the value of managed care organizations vs. fee for service

The following are steps that should be taken

1. Draft talking points
    a. Main message
    b. Cost
        i. Old data
        ii. Doesn't include changes we've made since 2011
    c. Quality
        i. Barriers to accurate comparisons with FFS
        ii. Acknowledge disparities between MHCP enrollees and others. Point to MCM annual disparities report

2. Notify health plans

3. Notify legislators and OLA
    a) Committee chairs and minority leads: Huntley, Liebling, Lourey, Sheran, Abeler, Mack, Rosen and Benson
4. Notify Press
    a) Standing requests by Tom Scheck and Chris Snowbeck. We'd also give as a gesture of good faith to Jill Burcum and Paul Demko

Task	Timeline	Staff Responsible	Notes
Draft talking points		Jeremy	
Notify Legislators		Amy Dellwo	
Notify OLA		Chuck Johnson	
Notify plans		Katie Knutson	
Notify Press		Jeremy Drucker	
			Tab for additional rows

Talking Points

Main Message:

- This report confirms the wisdom of the direction the Department of Human Services is heading in improving its publicly funded health care programs by increasing quality and decreasing cost. Payment reform efforts at DHS have resulted in over a billion dollars in savings compared to pre-reform projections, and we have focusing efforts on increasing outcomes for our clients. While Minnesota scores highly on patient satisfaction, we are continuing to focus our attention on providing better outcomes for our enrollees. DHS recognizes the limits of the FFS program as outlined in this report. Many of the opportunities described in the report to improve the FFS program require significant resources to implement. DHS is committed to being an innovative leader in piloting new ways of purchasing and care delivery. We believe exploring opportunities in health care homes and HCDS' is the most efficient and effective use of our resources.

Cost:

- The data used to evaluate the cost of Minnesota's MA program dates from 2008, and over the last three years we have made significant progress in lowering these costs. Over the last 3 years we have **reduced** MCO rates overall by 1 percent, and through competitive bidding, a voluntary 1% cap on 2011 profits and better 2013 MCO contracts have saved over $1 billion dollars in compared to pre-reform projections. Compared to the last forecast under the previous administration the 2014-2015 HHS budget as whole is over $2 billion less.
- The Minnesota Medicaid benefit set is more comprehensive than is required by federal law. Past legislatures and the current legislative body have continued a commitment to low income Minnesotans to include coverage for prescription drugs, eyeglasses and inpatient psychiatric care. Those are just a few of the essential non-federally required benefits for enrollees.

Quality:

- Improving outcomes for enrollees in our public programs is a top priority for the agency, and is why our health reform efforts are prioritizing quality care and tying outcome measures more tightly to payment.
    - We made quality a big component of our competitive bidding process with 60% of the score dedicated to characteristics of improving quality of care
    - Our HCDS Medicaid ACOs are transforming our payment models so we are paying doctors to keep people healthy, not just for doing procedures.
    - In 2013 we tied payment increases in nursing facilities to quality of care and began the process of creating standards so we can do the same for our HCBS providers
    - In 2011 we reduced payments to organizations for unnecessary emergency room readmissions
    - DHS is in discussion with the MCO's to find a consistent way to record grievances

- For the last several years we have also partnered with Minnesota Community Measurement to produce an annual report on how we are doing providing care for clients in our publicly and where we need to focus our efforts.
    - Our biggest gains have been when we partner with the community, especially in areas like asthma, diabetes and cardiovascular care.

- We are also looking to revise our performance management standards with health plans to make those standards more meaningful. DHS wants to be intentional to selecting which outcomes we select to focus on. We

want to be more in sync with what is going on in the larger community including what providers are working on across programs.

- It is important to note that our reporting methodology tends to **underrepresent** the quality of our publicly funded health care. Right now we report quality based on administrative reporting (what services are billed), but a more accurate method would be to adjust that reporting with a sample of doctor records. (For example an administrative report would only show one immunization was given during a visit while the hybrid method may show three immunizations were given, providers only bill for one immunization because that is all they get paid for but in medical records an account of which immunizations were given is recorded)DHS has begun to undertake discussions with the MCO's on moving towards this hybrid methodology.

- It is also important to mention that there is no standardized way to measure quality. For example while this report finds Minnesota's publically funded health programs around average, the Commonwealth Fund recently ranked Minnesota 4th in nation for quality of care for low-income people.

Value:

Minnesota continues to push forward with reform initiatives to transform the health care system. The recently awarded SIM grant will help accelerate our efforts in increasing quality and lowering costs. In 2013 DHS was instructed by the legislature to begin laying the groundwork for continued evolution in MHCPs in preparation for the 2017 Innovation Waiver provided for in the affordable care act. The culmination of these efforts will allow Minnesota to maintain its reputation as a national leader in healthcare and provide us a substantial opportunity to improve quality and lower costs across our MHCPs.