

Program Integrity

Health Plans have dedicated staff utilizing the latest technology to detect and prevent fraud

Managed Care is the National Standard

Managed care is the preferred delivery systems for Medicaid programs in the United States, with more than 40 states utilizing the model to ensure private sector efficiencies and best practice technology is utilized in management of public programs. Managed care organizations (MCOs) contract with the State to provide oversight resources the State otherwise lacks—dedicated staff utilizing the latest technology to proactively detect and prevent fraud.

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

Provider Enrollment and Validation.

MCOs review credentials of providers to verify they are who they claim to be and qualified to deliver the service. Reviews track and collect Disclosure of Ownership, business transactions, social security number validation and cross-checks against the excluded provider list.

Pre-Payment Validation.

MCOs validate information before a service is provided to make sure a service meets recognized standards for care, including monitoring inpatient and high-dollar services to validate appropriateness.

Post-Payment Audits.

MCOs scrutinize bills and medical records to validate that billed services were delivered, documented, and compliant with medical standards.

Case Study:

Housing Stabilization Services

In 2020, Minnesota became the first state to offer state program coverage for housing stabilization services. The benefit was projected to cost \$2.6 million annually.

- Unlicensed providers.
- State policy bypassed MCO review of provider credentials and network development.

The program grew to more than \$100 million before being shuttered due to widespread fraud.

Structural Integrity

Benefits should be launched only after a formal process to develop standards, including licensing of providers.

Empower Oversight

Utilize proven MCO methods: network development, pre-service reviews, pre-payment validation, and post-payment audits.



SOLUTIONS

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 the risk of their members so the state can set a health 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.