# Medicaid Managed Care

What this means for Idaho?

# Why now?

# The 2011 Idaho Legislature approved the "Medicaid Cost Containment and Health Care Improvement Act":

- The current fee-for-service health care delivery system of payment to Medicaid health care providers fails to provide appropriate incentives, and
- To improve Medicaid by incorporating managed care tools, including capitation and selective contracting, with the objective of moving toward an accountable care system that results in improved health outcomes.

### What product is expected?

A plan for Medicaid managed care that includes the following elements:

- Improved coordination of care (medical homes)
- Reduced costs and improved outcomes for high-risk, high-cost individuals
- Behavioral Health managed care that includes independent, standardized statewide assessment and evidenced-based benefits
- Elimination of duplicative practices that result in unnecessary utilization
- Contracts based on gain-sharing, risk-sharing or a capitated basis

### Why the interest in Managed Care?

When designed and implemented well, effective managed care programs can:

- Promote care management and care coordination
- Provide greater control and predictability over state spending; and
- Improve program accountability for performance, access and quality.

#### What is it?

- There is no "it" there are various managed care designs and various managed care tools
- Managed Care approaches range from no risk contracts to full risk contracts
- Most states use a range of managed care approaches that are tailored to their population needs:
  - Dense urban areas may include full-risk comprehensive managed care health plans
  - Remote locations may only be able to support primary care case management
  - Limited-benefit plans may be managed on a statewide basis for certain populations and for certain services

# Managed Care Definitions

- **Capitation**: A set fee paid per member (enrollee) per month that covers all benefits and services under the plan contract.
- Managed care entity: A Medicaid managed care organization or primary care manager.
- Medicare Advantage Plan: A type of Medicare plan offered by a private company that contracts with Medicare to provide Part A and Part B benefits.
- **Primary care case management:** A physician's contract with a state to provide case management services, coordination and monitoring of primary care. States can also contract with mid-level providers such as nurse practitioners.
- **Provider network**: The managed care plan establishes contracts with providers to ensure the right types and sufficient number of providers to serve the plan's enrollees.
- **Risk contract:** A contract under which the managed care contractor assumes risk for the cost of services covered and incurs loss if the cost of furnishing the services exceeds the payments under the contract.
- Special needs plans (SNP): Medicare Managed Care Plans that focus on certain groups of Medicare enrollees. There are three types of SNPs: one for duals, one for individuals with severe or disabling chronic conditions and one for institutionalized individuals.

### Medicaid Managed Care Designs:

#### Primary Care Case Management (PCCM):

Assures that enrollees have a primary care provider who receives a small monthly pre capita payment (an administrative fee) to coordinate each enrollee's care. All services are still paid on a fee-for-service basis. Nationally, 7.3 million Medicaid enrollees are in PCCM programs.

#### Limited-benefit plans:

Typically covers a single type of benefit, paid on a capitated basis. Nationally, 4.3 million Medicaid enrollees are in plans covering inpatient mental health services and 3.1 million are in plans with combined mental health & substance abuse benefits; 6.1 million enrollees are in plans that provided transportation services only; 1.2 million are in dental-limited benefit plans.

#### Comprehensive risk-based managed care:

Typically incorporates a health maintenance organization (HMO) model in which enrollees must use a network of providers. States pay on a capitated basis. Nationally, 23 million Medicaid enrollees are in comprehensive, risk-based plans.

### Primary Care Case Management

- Covers administrative non-face-to-face services and the commitment to be the enrollee's "medical home"
- Traditionally, a "gatekeeper" approach that requires enrollees to obtain referrals from their primary care provider before obtaining specialty care
- Primary Care providers sign a provider agreement (a type of Medicaid contract) with Medicaid. There is no limit on the number of providers who can participate
- Providers must agree to certain access and procedural requirements
- Will provide foundation for development into Patient-Centered Medical Homes, also called Health Homes

#### Limited-Benefit Plans

- Carve-out benefits, not comprehensive
- Two types of carve-out arrangements:
  - 1. Pre-paid Inpatient Health Plan (PIHP): among other services, includes institutional services and inpatient hospitalization. (comes with more stringent federal requirements)
  - 2. Pre-Paid Ambulatory Health Plan (PAHP): generally, a very narrow scope of service
- Delivered through a Health Plan (insurance carrier) that is paid a capitation amount per enrollee per month (must be on an actuarial sound basis)
- Delivered by a provider network established by the Health Plan through contracts. Payments to providers are typically made on a fee-for-service basis.
- Health Plan is at risk if spending on benefits and administration exceed payments.

#### Capitation risk-based managed care

- Covers all or most current Medicaid-covered services
- Paid a capitation rate, which pays a fixed amount per member per month to cover a defined set of services for a given population
- Can also include incentive payments for meeting certain performance standards
- Capitation payment must be made on a actuarially sound basis (use of data and adjustment factors to predict enrollees' use of health care services)
- Plans are at financial risk if spending on benefits and administration exceed payments

# Issues Affecting Enrollees

ISSUES	S DECISIONS/CONSIDERATIONS	
Voluntary vs. Mandatory Enrollment	Can exempt certain populations; can allow for voluntary enrollment (opt-in and opt-out provisions; can mandate enrollment	
Outreach & Enrollee Education	Transition from fee-for-service may be challenging; may want to use enrollment brokers to assist with transition	
Roll-out	Ensure adequate time for systems development and transition process	
Plan choice and auto- assignment	For risk-based plans, there usually are at least two plan choices; if enrollees don't choose, autoassignment is made and aligns with existing enrollee-provider relationships	
Continuity of Care	Can require plans to allow a transition period to avoid treatment disruption	
Fluctuations in eligibility	High eligibility turn-over needs to be managed for the non-disabled population	

### Provider participation requirements

Fee-For-Se	rvice	Comprehensive risk-based Plans	Primary Care Case Management	Limited-benefit Plans
Any willing provider lice by the state agrees to accommodate may ment in participate.	ensed who ccept ites as full can	Plans must meet network size and location standards. Plans are permitted to limit the number of providers in their network and generally must credential providers before accepting them into the network.	PCCM programs may have to meet additional state requirements and agree to certain service policies.	Plans contract with a network of providers, similar to the process for comprehensive risk-based managed care plans, and may also need to meet network requirements.

### Enrollee care-seeking rules

Fee-for-Service	Comprehensive Risk-based Plans	Primary Care Case Management	Limited-benefit Plans
Typically, enrollees may receive care from any participating provider.	Plans set the rules on nonemergency referrals and care management, subject to state requirements and oversight. Services must be received from participating network providers, except in emergencies.	Enrollees may need referral by the primary care provider (PCP) to see various kinds of specialists, except in emergencies.	Plans set the rules on nonemergency referrals and care management, subject to state requirements and oversight. Services typically must be received from participating network providers, except in emergencies.

### Navigation support for enrollees

Fee-for-Service	Comprehensive Risk-based Plans	Primary Care Case Management	Limited-benefit Plans
Open access; enrollees may or may not have rules or guidance on how or where to seek appropriate, available services.	Plans typically must provide enrollees with a member handbook and conduct an initial health assessment to determine enrollee needs. Many also provide disease management and care coordination services.	PCCM programs may provide additional navigation support and ways of identifying appropriate providers.	Depending on the type of services provided, plans may provide navigation support for enrollees similar to comprehensive risk-based plans.

# **Quality Requirements**

Fee-for-Service	Comprehensive	Primary Care Case	Limited-benefit
	Risk-based Plans	Management	Plans
Provider accountability for outcomes for individual enrollees is not typically formalized. For example, most states do not require providers to report HEDIS data.	Plans must conduct external quality reviews and must report specific performance data (e.g. HEDIS) and undertake specific quality improvement activities. Some states require external accreditation.	Same as FFS; potentially specific metrics associated with monitoring PCCM performance.	Pre-paid Inpatient Health Plans must conduct annual external quality reviews, may be required to report performance data applicable to the services delivered, and undertake specific quality improvement activities. External accreditation may be required.

#### Idaho's existing Managed Care products:

#### Healthy Connections

Primary Care Case management: "medical homes" for every Medicaid enrollee. Pays primary care providers a case management fee in addition to fee-for-service to coordinate all care.

#### Idaho Smiles

Limited benefit plan: a carve-out of all dental benefits administered by a single statewide contractor who is paid a capitated rate.

#### Medicare/Medicaid Coordinated Plan

Special Needs Plans paid a capitated rate for certain wrap-around Medicaid benefits for dual eligibles.

#### American Medical Response

Selective contract for transportation, contractor is paid a capitated rate.

#### Idaho's development activities

- The Idaho Legislature funded an actuarial analysis of Idaho Medicaid populations in order to identify current costs and opportunities.
- The Idaho Legislature funded project staff to support the Governor's Multi-Payer Medical Home Collaborative which is intended to assist medical practices become more "patientcentered," improve outcomes, and test different payment methodologies.
- Medicaid and Behavioral Health Divisions are using existing resources to obtain a Medicaid Mental Health Managed Care Organization to administer Medicaid mental health benefits.
- The Medicaid Division is exploring an opportunity to pursue technical assistance from the Centers for Medicare and Medicaid to develop a different financing model to better coordinate benefits for the dual eligibles (individuals who are covered by both Medicare and Medicaid).

# Strategies to achieve goals

#### Medicaid programs need to focus on the following goals:

- Improve care management & care coordination,
- Secure provider networks for enrollees,
- Lower spending or make it more predictable, and
- Improve program accountability

#### The strategies to achieve these goals will vary, based on:

- Population characteristics
- Population density
- Provider availability
- Plan participation, and
- Existing managed care arrangements

# Future of Managed Care?

- Most states are anticipating some expansion or reform efforts in their managed care approaches
- Historically, mandatory use of Medicaid managed care has focused on low-income children & parents
- More states are considering mandating enrollment of special needs populations
- Most states are pursuing ways to better coordinate care for dual eligibles
- Some states are moving to different models of managed care called Accountable Care Organizations

### Next steps for Idaho

- Public discussions: What do citizens want and what can businesses provide?
- Analysis of the data: Where are the opportunities to achieve our goals and what strategies should be used?
- Foundation building: What pilots can be implemented to test new models of payment and care delivery?
- **Limited-benefits plan expansion**: What requirements should be included for a Medicaid mental health carve-out that will lay the foundation for an improved statewide mental health system?
- A Plan and proposal for funding: What development needs to occur that will help us meet current needs, prepare for future enrollment expansion, and be sustainable over time?

#### Questions?

Send questions to: Leslie Clement, Deputy Director

clementl@dhw.idaho.gov

Much of the material included in this presentation was based on the *Report to the Congress: The Evolution of Managed Care in Medicaid,* June 2011. A Medicaid & CHIP Payment and Access Commission report.