

Medicaid Managed Care: A Primer

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Managed Care and Medicaid: Definitions, Concepts, and Big Questions

What is managed care?

- 1) Managed care refers, in general, to efforts to coordinate, rationalize, and channel the use of services to achieve desired access, service, and outcomes while controlling costs.
- 2) Risk-based managed care describes care from organizations that *provide or contract to provide* health care in *broad/specified areas* for a *defined population* for a *fixed, prepaid price* [where the managed care organizations (MCOs) are at *financial risk* to deliver the services for the fixed price]. Managed care organizations use various *strategies to control costs*.

– U.S. Department of Health and Human Services

What are the major models of managed care in Medicaid?

- ***Comprehensive risk-based managed care***: Through contracts with the state, MCOs assume full financial risk for a defined set of services in exchange for a fixed payment per Medicaid enrollee per month (i.e., a capitation payment, or premium).
- ***Primary care case management (PCCM)***: State-administered managed fee-for-service program under which a state pays a small per member per month (PMPM) fee, such as \$3, to contracted primary care case managers, who are not at financial risk, but who locate, coordinate, and monitor their enrollees' primary care and any other covered services that the contract may specify. PCCM is considered a form of comprehensive managed care.
- ***Limited benefit plans***: MCOs that contract with a state on capitation basis to provide limited types of outpatient or inpatient services, such as dental care or behavioral health care, to enrolled Medicaid beneficiaries.

Key Medicaid managed care authorities

- Section 1932(a): Provides state plan option to mandate enrollment in an MCO or with a PCCM
 - States cannot mandate managed care for children with special health care needs, dual eligibles, or American Indians
- Section 1915(b): Renewable 2-year waiver authority for mandatory enrollment (including dual eligibles) into MCOs or PCCM program
 - Beneficiaries must have choice of two or more plans or providers
 - Program must be cost-effective and efficient, and not substantially impair access to medically necessary services of adequate quality
 - Federal MCO requirements regarding networks/access, payment, quality, data reporting, beneficiary protection, etc.
- Section 1115: Provides HHS Secretary broad demonstration authority to approve waivers to test innovations to further the objectives of Medicaid program
 - Provides most flexibility of all Medicaid authorities to waive regular requirements
 - State must have a hypothesis to be evaluated using data from demo
 - Waiver must be budget-neutral

What has motivated states to adopt managed care in Medicaid?

- Capitated payment increases predictability in state Medicaid spending
- Potential budget savings
- Increased state bargaining power to obtain favorable rates from plans and limit Medicaid plan participation to MCOs of highest quality
- Potential to improve access to care
- Provides incentives for greater investment in preventive and primary care, management of chronic conditions, and care coordination (rather than volume)
- Contracting enables states to measure, monitor, and drive *performance*, through plan and provider standards, requirements, incentives, penalties, etc.

What are the major concerns about risk-based Medicaid managed care?

- Medicaid beneficiaries' care can be disrupted if their regular doctors or other providers do not participate in an MCO network
 - Concern is amplified for beneficiaries with chronic or complex conditions, who may have longstanding relationships with providers
- Potentially restricted access to specialist care if MCO requires referral by primary care physician, or if plan network is inadequate
- Inherent incentives for underservice by MCOs to maximize short-term profits
- Gaps in beneficiaries' understanding of managed care rules and systems
- Potentially difficult to navigate grievance and appeals processes because of multiple layers of accountability (i.e., provider, plan/insurer, state)

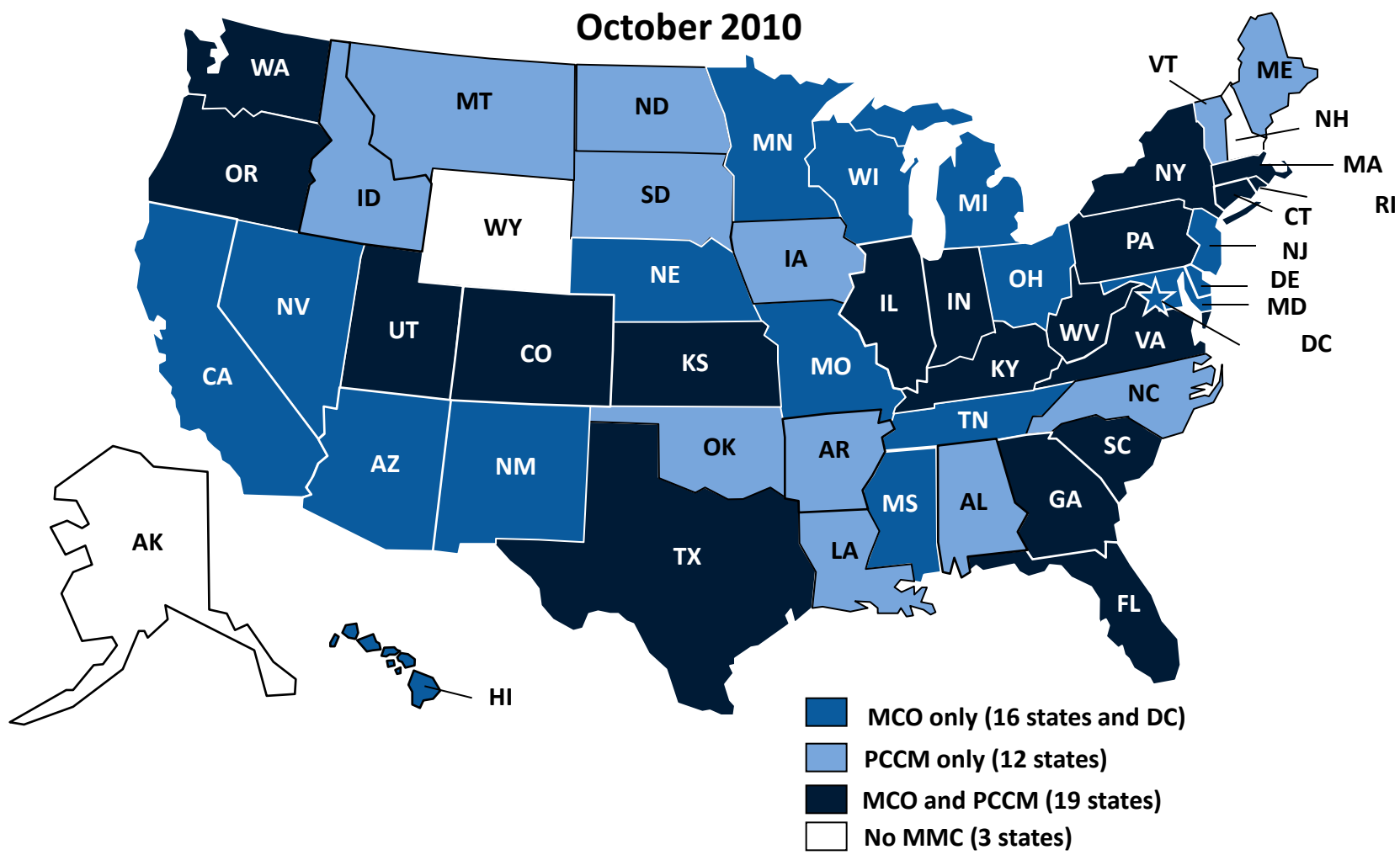
What is the evidence on the impact of Medicaid managed care?

- Research findings on *access* and *quality* in Medicaid managed care are mixed
 - Reflect important details of states' managed care programs, including oversight, as well as enrolled population studied
 - Lack of FFS measures of access and quality to serve as benchmarks
- Research findings on *savings* are also mixed, which may reflect, in part, differences in states' baseline Medicaid programs (i.e., savings compared to what?), details of their managed care programs, and study design
- The two potential sources of savings are *price* and *utilization*:
 - Savings on *price* are influenced by generosity of state's underlying FFS payment rates: states with high FFS rates may have “room” to negotiate lower capitation rates for MCOs, but states with low FFS rates will have trouble extracting savings in unit prices
 - Savings from improved *utilization* patterns are unlikely in short-term; budget-driven efforts to achieve savings could lead to in reduced access to care.

Kaiser/HMA Survey of Medicaid Managed Care (MMC): Selected Highlights

FIGURE 9

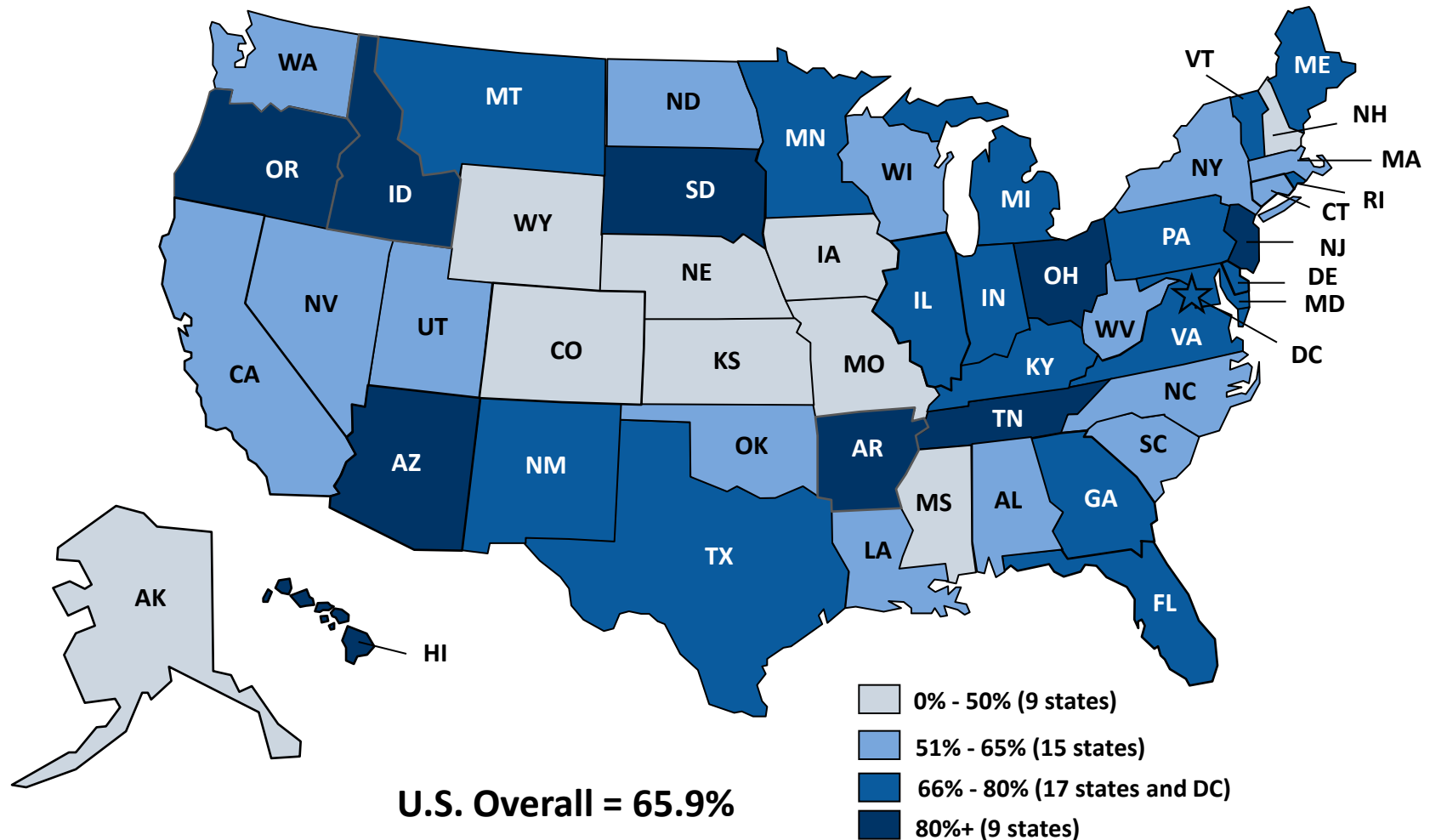
Almost all states operate comprehensive MMC programs



Note: MCO is managed care organization and PCCM is Primary Care Case Management.
SOURCE: KCMU/HMA Survey of Medicaid Managed Care, September 2011.

FIGURE 10

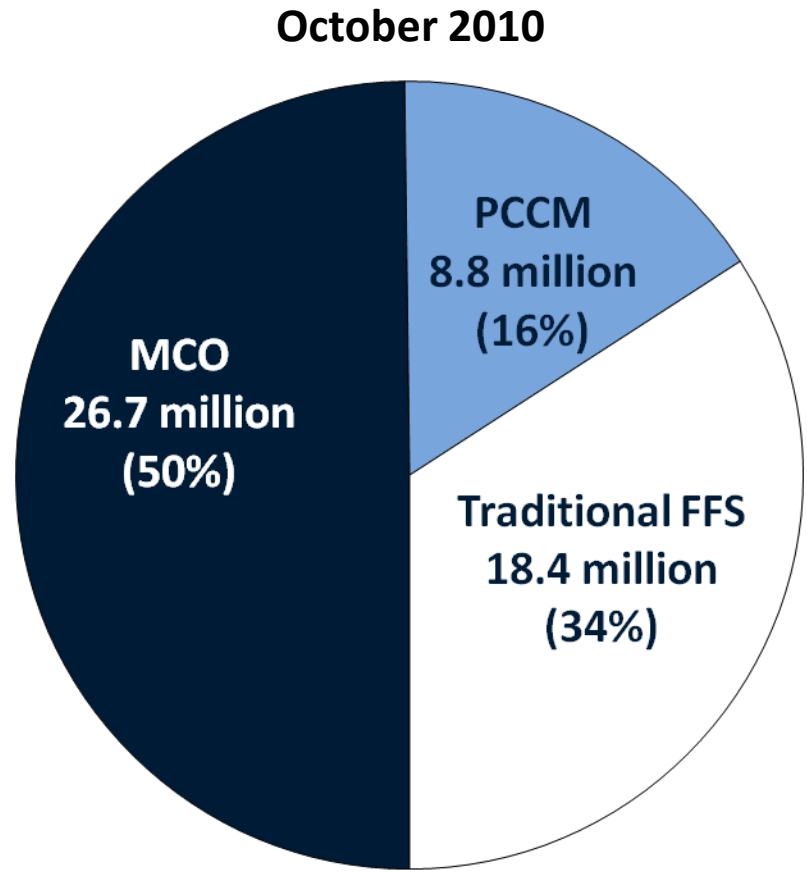
Managed care penetration rates vary considerably by state



Note: Reflects enrollment in MCOs and PCCMs. Most data as of October 2010.
SOURCE: KCMU/HMA Survey of Medicaid Managed Care, September 2011.

FIGURE 11

Nearly 2/3 of Medicaid beneficiaries are enrolled in comprehensive managed care



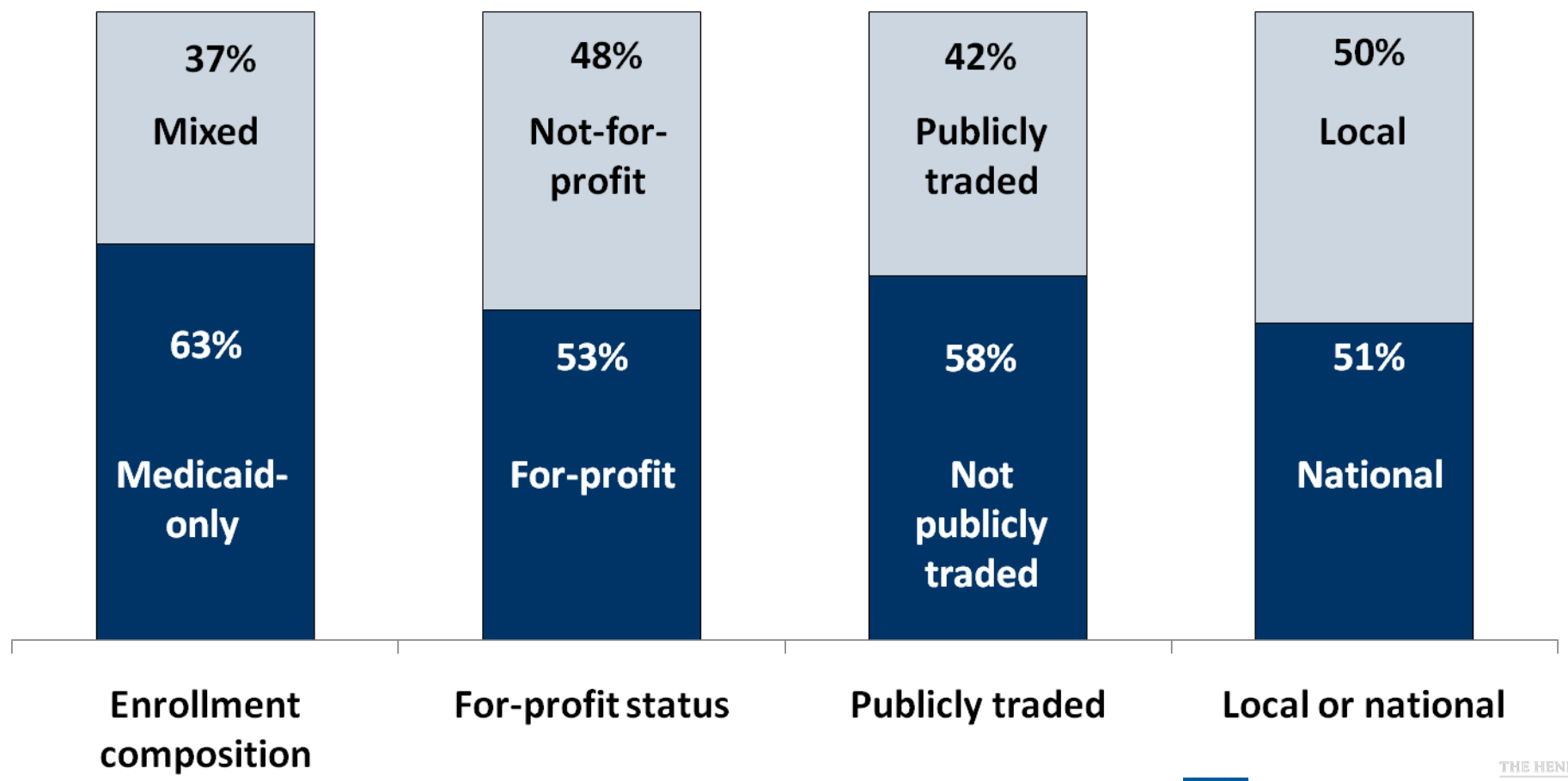
Total = 53.9 million Medicaid beneficiaries

Note: MCO is managed care organization, PCCM is Primary Care Case Management, and FFS is fee-for-service.

SOURCE: KCMU/HMA Survey of Medicaid Managed Care, September 2011.

FIGURE 12

Medicaid-only MCOs dominate and over half of MCO enrollees are in for-profit plans



SOURCE: KCMU/HMA Survey of Medicaid Managed Care, September 2011.

States use quality data to assess and drive plan performance and assist beneficiary choice

- All MCO states and over half of PCCM states require HEDIS®, CAHPS®, or similar state-developed measures of access, clinical quality of care, and patient satisfaction
 - Top measures reflect Medicaid priorities, e.g., prenatal and postpartum care, childhood immunization status, appropriate asthma medication, comprehensive diabetes care, care following hospitalization for mental illness
- Three-quarters of MCO states publicly report on the quality of their health plans, and half of PCCM states publish quality reports on those programs
- 15 states with MCOs and one PCCM-only state prepare quality “report cards” for beneficiaries to use when choosing a plan or a provider

Many states are invested in initiatives to improve care coordination, linkages, and integration

- 39 states have a medical home initiative in place or under development, and the same number report disease management or care management programs, which are often integrated into MCOs or PCCM programs.
- 22 states plan to elect the new “health home” option for Medicaid beneficiaries with chronic conditions.
 - 6 states now have approved programs (MI, RI, NY, OR, NC, IA)
- Nine states reported having an ACO initiative in some stage of development, and three states indicated proposed legislation in 2011 to require Medicaid payment to ACOs or begin a pilot.

States are extending MMC to beneficiaries with more complex needs

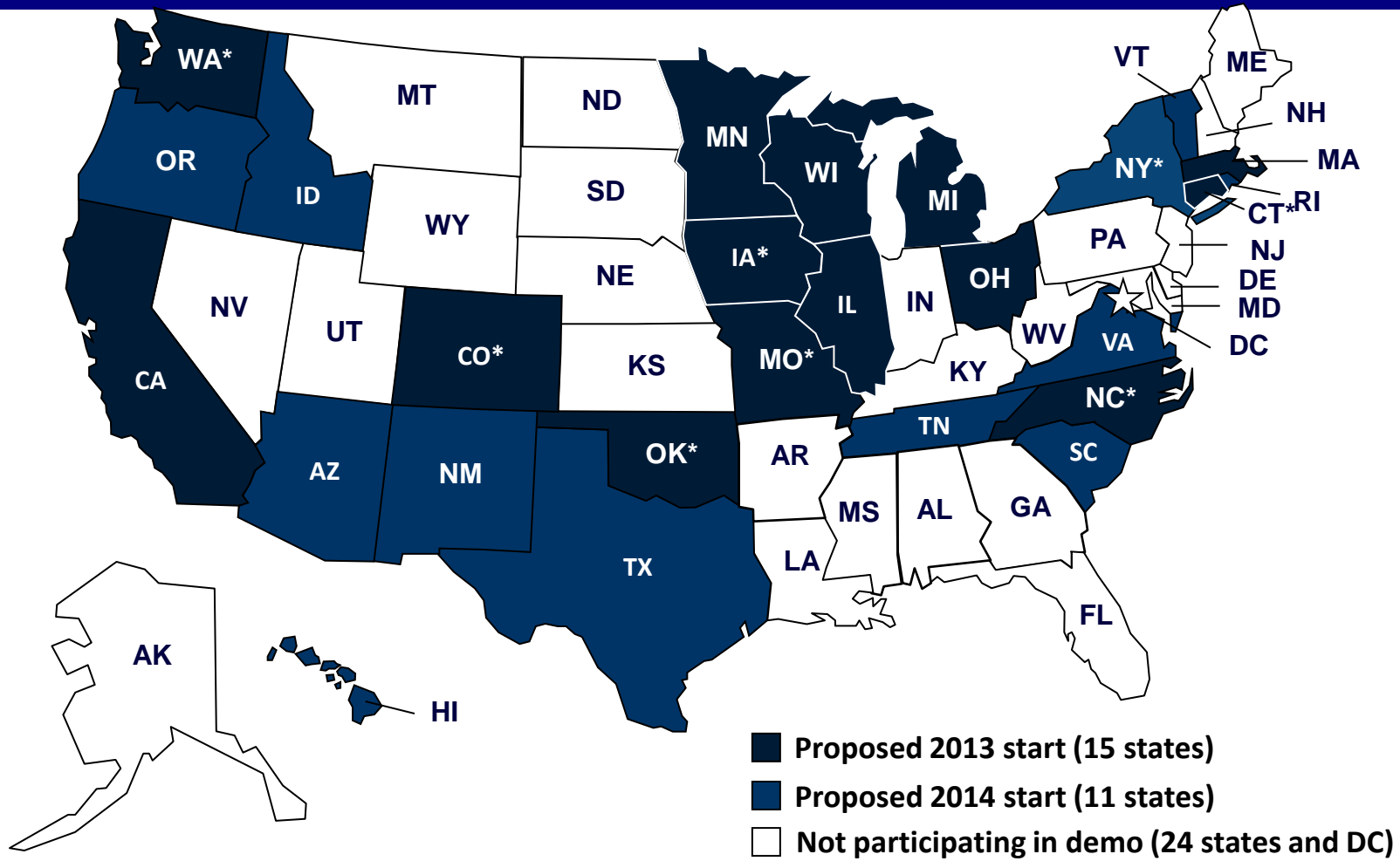
- Vast majority of states mandate MMC for most children (46) and pregnant women, parents, and other caretaker adults (44)
- Majority of states report at least some mandatory MMC enrollment for children with disabilities receiving SSI (26), children with special health care needs (32), and non-dually eligible seniors (29) and people with disabilities (33)
- 18 states report some mandatory MMC for people receiving HCBS, and 15 report some voluntary MMC, but 22 states always exclude these individuals
- 25 states report some managed care enrollment of dual Medicare-Medicaid eligibles, on a voluntary or mandatory basis, for at least some services

Managed care experience serving disabled Medicaid beneficiaries is still limited and research is scant

- Studies investigating impact of MMC on access to care and costs for *nondisabled* beneficiaries have produced mixed results
- Evidence from one study of MMC and disabled adults shows those in counties with mandatory MMC were more likely to have usual source of care, but faced longer waiting times, had more problems obtaining specialist care, and were less likely to get flu shot in last 12 months, compared to those in FFS-only counties.(Burns, 2009)
- Standard measures of access, quality, and outcomes may not be appropriate/adequate for people with chronic disabling conditions
- Few standard measures of access and quality exist for LTSS exist; evidence on impact of managed LTSS on costs or outcomes is limited and inconclusive

FIGURE 17

26 states are moving forward with proposals to participate in dual eligible demos



* CO, CT, IA, MO, NC propose managed FFS models. NY, OK, WA propose both capitated and managed FFS models. All others propose capitated models only.

NOTE: MO and MN have a proposed 2012 start.

SOURCE: CMS Financial Alignment Initiative, State Financial Alignment Proposals, <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsInCareCoordination.html>.

Key managed care issues

- Payment
 - Setting adequate and appropriate capitation rates
 - Uncertain savings
- Provider networks and care delivery
 - Adequate provider networks
 - Coordination of behavioral and physical health care
 - Standard utilization management tools may reduce access for people with disabilities
 - Coordination of acute and long-term services and supports
- Beneficiary protection and oversight
 - Beneficiary engagement, outreach, and assistance
 - Managing transitions
 - Monitoring and oversight

Community Care of North Carolina (CCNC): The Enhanced Medical Home

Fundamentals of CCNC

- Builds on Carolina Access with goal of improving quality while containing costs
 - Premise: costs of medical homes (more use of primary care and Rx; infrastructure/medical management costs) will be more than offset by reduced inpatient hospital and ER use, as access to primary care, Rx, chronic care management increases
- Comprised of 14 regional non-profit, physician-directed networks; networks link over 1 million Medicaid enrollees with PCPs, and link PCPs with local hospitals, case managers, social service agencies, and health depts, to function as *enhanced medical homes*
 - Networks pool technology and administrative resources, and provide support to physician practices and assist them in implementing CCNC initiatives
 - Individual networks pilot care approaches, share best practices with other networks
- Nearly all PCPs participate in CCNC; state pays PCPs \$2.50 PMPM (in addition to FFS payments), and pays networks \$3.72 PMPM
 - Higher payment for ABD enrollees: \$5 PMPM and \$13.72 PMPM, respectively
- Informatics support continuous quality improvement
 - Doctors, networks receive regular data reports comparing their performance with others'
 - Program-wide data monitoring and analysis, evaluation of cost savings/effectiveness

CCNC mechanisms for managing care and continuous quality improvement

- Each network develops its own care management department based on knowledge of local resources and stakeholders, but core elements – practice guidelines and standards for care management activities and reporting – are uniform across networks
- All care management activities documented in patient-centric, electronic case management information system (CMIS), a web-based system the state uses to assess impact of care management
- Transitional care program is targeted to patients in hospital to reduce preventable readmissions
- Medication management for individuals with chronic diseases
- Customized practice and patient tools, educational materials

Evidence on CCNC's clinical performance: improved utilization patterns and high quality

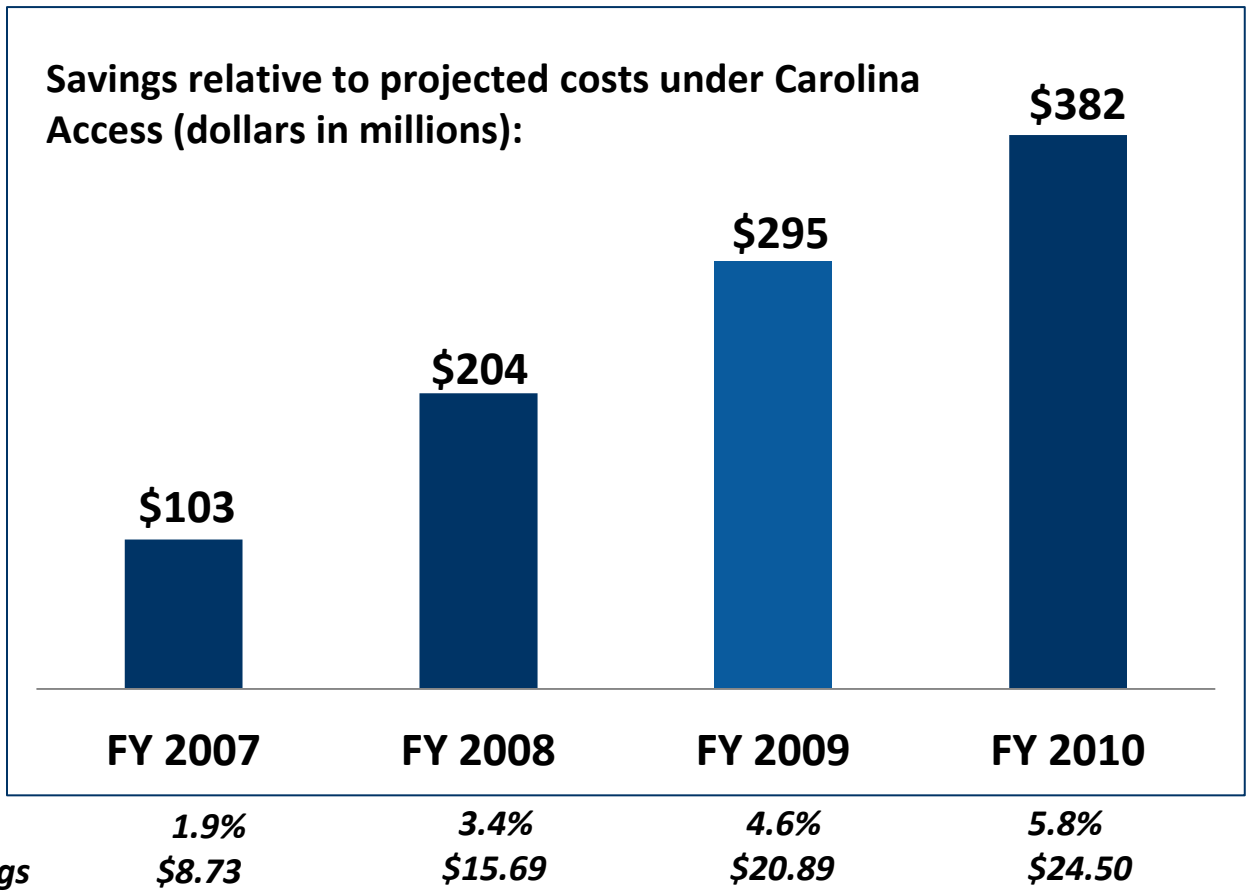
- CNCC enrolls more complex, higher-risk adult and senior population than Carolina Access;
 - Almost 50% have a chronic condition, compared to 28% in FFS
 - Almost twice the rates of asthma, diabetes, Alzheimer's and mental illness
 - Illness burden in CCNC population rose 7% during 2007-2010
- More favorable utilization patterns are seen in CCNC population overall, within each CCNC population group, and among specific clinical risk groups
 - Lower rates of inpatient and ER use among non-ABD CCNC children, including those with asthma, compared to non-CCNC children
 - ER visit rate for non-ABD CCNC population is 40% lower for adults and 19% lower for children, compared to non-CCNC
 - Among adults (both ABD and non-ABD) with schizophrenia and other moderate chronic conditions, inpatient admissions and ER visits are consistently lower among CCNC-enrolled, and PCP visits and Rx use are consistently higher
- High quality of care: benchmarking to commercial health plans, CCNC is in top 10% in HEDIS scores for diabetes, asthma, heart disease

SOURCES: *Enhanced Primary Care Case Management System*, NNCCN Quarterly Legislative Report, as of January 1, 2011; *Performance Analysis: Healthcare Utilization of CCNC-Enrolled Population 2007-2010*, prepared by Treo Solutions for CCNC, June 2012.

FIGURE 23

Evidence on savings: Medicaid savings of nearly \$1 billion over 4 years (FY 2007-2010)

In FY 2010, CCNC risk-adjusted PMPM costs were about 15% lower than non-CCNC PMPM costs, for both children and adults. They were 3.3% lower for the ABD Medicaid-only population, and 1.8% higher for ABD dual eligible group.



SOURCE: *Analysis of Community Care of North Carolina Cost Savings*, Milliman Client Report prepared for NC Division of Medical Assistance, December 2011.

New initiatives underway to enhance CCNC

- Transitional support and care management for ABD population
- Behavioral health integration/coordination
- Palliative care
- Enhanced management of pharmacy
- Enhancements to informatics center

Additional KCMU resources on Medicaid managed care

- *A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey*, September 2011. <http://www.kff.org/medicaid/8220.cfm>
- *Medicaid Managed Care: Key Data, Trends, and Issues*, February 2012. <http://www.kff.org/medicaid/upload/8046-02.pdf>
- *People with Disabilities and Medicaid Managed Care: Issues to Consider*, February 2012. <http://www.kff.org/medicaid/8278.cfm>
- *Health Homes for Medicaid Beneficiaries with Chronic Conditions*, August 2012. <http://www.kff.org/medicaid/8340.cfm>