Medicaid Managed Care 101

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Agenda:

Section 1: Fee-for-Service vs. Managed Care
Section 2: Managed Care Overview
Section 3: Managed Care Plan Types
Section 4: Managed Care Authorities
Section 5: Managed Care Implementation

Learning Objectives

- Understand key features, terminology, and concepts underlying Medicaid managed care.
- Describe the difference between fee-for-service and managed care.
- Explain the goals of managed care.
- Identify the Medicaid authorities and state considerations for implementing managed care.
- Describe the requirements of states and managed care plans.

Key Terminology

- CMS: Centers for Medicare & Medicaid Services
- CHIP: Children's Health Insurance Program
- FFS: Fee-for-service
- HCBS: Home and community-based services
- LTSS: Long term services and supports
- MCO: Managed care organization
- MMC: Medicaid managed care
- PAHP: Prepaid ambulatory health plan
  PCCM: Primary care case management
- PIHP: Prepaid inpatient health plan
- SPA: State plan amendment
- SSA: Social Security Act

Section 1: Fee-for-Service vs. Managed Care

Overview – FFS vs. MMC

Fee-for-service (FFS)

- *Relationship:* State contracts directly with health care providers.
- *Payment:* Providers receive payment for each health care service provided to consumers.
- *Accountability:* Providers do not bear financial risk for the provision of services.
- Note: FFS has historically been the predominant delivery system.

Overview – FFS vs. MMC (Cont.)

Medicaid Managed Care (MMC)

- *Relationship:* State contracts with a Managed Care Organization (MCO), not a direct service provider.
- *Service Delivery:* Consumers receive part or all of Medicaid services from health care providers that are paid by a MCO that is under contract with the state.
- *Payment:* MCOs receive capitated payment from the state for a specified benefit package on a per member per month basis.
- *Accountability:* The MCO is responsible for the provision and coverage of Medicaid services.

Managed Care Payment

- Capitation
  - State pays a fixed per member per month amount to the MCO for providing Medicaid services to enrollees. The amount is pre-set, so the MCO bears financial risk for services actually provided.
    - 37% of all Medicaid expenditures were capitated in 2014.

- Nonrisk Contracts
  - State reimburses the MCO for the incurred costs for providing Medicaid services to enrollees. Therefore, MCOs are not at financial risk for changes in the utilization of services or for the actual costs incurred.

Section 2: Managed Care Overview

Overview

- Historically, MMC was largely limited to children, parents, and pregnant women.
- Many states initially began by offering only primary and acute care for some older adults and individuals with disabilities.
- More recently, states have been expanding MMC programs to include additional populations and services.
- Managed care has become the predominant Medicaid delivery system.
  - 39 states deliver some or all Medicaid benefits through managed care.
  - 67% of all Medicaid consumers are enrolled in managed care (for some or all services).

Managed Care Goals

- Accountability for enrollees' outcomes rests with a single entity in an effort to achieve the following:
  - Improve *care coordination* among health care providers;
  - Increase capacity to measure enrollees' *health and quality of life;*
  - Improve the potential to *lower overall costs.*
- Payments allow for more budget predictability for states.
- Delivery of the right care at the right time and in the right place.
  - Example: Calling a nurse advice line to address health concerns rather than visiting the emergency room.

Managed Care Flexibility

"In Lieu of" Services

- Medically appropriate, cost-effective alternative to a service that is included in the state's Medicaid plan.
- These alternatives must be authorized in the state's contract with the MCO.
- Voluntary alternative offered to the enrollee.
- Example: A home modification that allows a member rehabilitating from an injury to safely return home rather than extending a stay in a rehab facility.

Managed Care Flexibility (Cont.)

- **Value-Added Services**
- Service that an MCO provides to improve the quality of care and/or reduce costs but that is not included in the state plan or MCO contract.
- MCO is not paid for these services; services are provided at the MCO's discretion.
- Example: limited adult dental benefits when the MCO is not required to provide dental benefits.

CMS Managed Care Final Rule

- In April 2016, CMS issued regulations (CMS-2390-F) aimed at modernizing and strengthening MMC rules.
- Goals of the final rule include:
  - Supporting delivery system reforms;
  - Aligning MMC requirements with other health coverage programs;
  - Improving the enrollee's experience;
  - Improving accountability and transparency;
  - Advancing the quality of care.

CMS Managed Care Final Rule (Cont.)

- For the first time, the CMS Final Rule included provisions for Managed Long Term Services and Supports (MLTSS).
- Key MLTSS provisions include:
  - Identifying enrollees with long term services and support (LTSS) needs;
  - Compliance with person-centered planning and home and community-based settings regulations;
  - Required stakeholder advisory groups to oversee MLTSS programs;
  - Creating an enrollee support system.

Section 3: Managed Care Plan Types

Managed Care Plan Types

- **Comprehensive Managed Care Organization (MCO)**
  - Health plan that delivers inpatient services and *at least* three Medicaid mandatory benefits.
  - All MCOs use a capitated payment method.

- **Prepaid Ambulatory Health Plan (PAHP)**
  - Health plan that does *not* cover inpatient services and provides *less* than three mandatory benefits or any optional benefits.
  - PAHPs can use capitated payments or have a nonrisk contract.

- **Prepaid Inpatient Health Plan (PIHP)**
  - Health plan that delivers inpatient services and *less* than three mandatory benefits or any optional benefits.
  - PIHPs can use capitated payments or have a nonrisk contract.

PCCM vs. Managed Care Plans

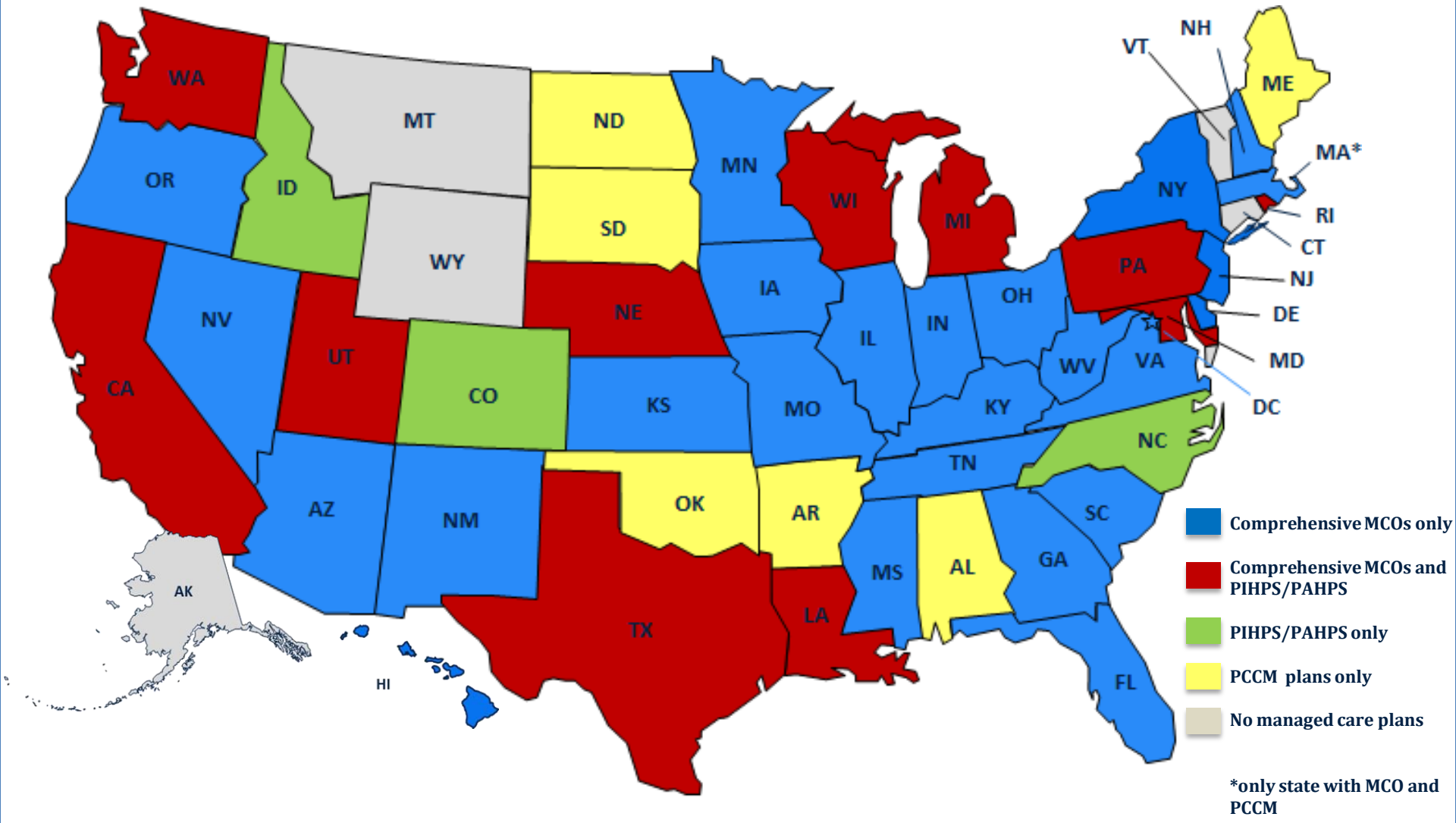
Primary Care Case Management (PCCM)

- *Relationship:* States contract with primary care providers or care management entities for case management (location, coordination, and monitoring) services.
- *Payment:* States make a monthly payment for the coordination of the enrollee's care.
  - There are no capitated payments. States continue to pay for covered benefits on a FFS basis.

Plan Examples

MCO	PIHP	PAHP	PCCM
Hospital	Hospital	Dental	Case Management
Physician	Physician		
Lab/Radiology/ Home Health	Laboratory		
Prescriptions	Mental Health/ Substance Abuse		
Mental Health/ Substance Abuse			

Medicaid Managed Care Penetration, 2016



Section 4: Managed Care Authorities

State Implementation

- States decide how to structure their managed care program by determining:
  - Who will enroll (eligibility groups);
  - What services will be provided by the MCO;
  - Where the MCO will operate (geographic reach).

- Authorities are necessary because managed care often "waives" several core Medicaid policies: Comparability, statewideness, and freedom of choice.

Managed Care Authorities

- Social Security Act (SSA) provides four ways that states may operate their programs (numbers refer to SSA sections):
  - §1915(a) - Voluntary Program;
  - §1932(a) - State Plan Amendment (SPA);
  - §1915(b) - Managed Care Waiver;
  - §1115(a) - Research & Demonstration Project.

- States may use multiple authorities depending on the program's design and the populations receiving benefits.
- CMS will provide technical assistance to direct states to the proper authority for their program's design. CMS must also approve state plans for managed care.

Authority Comparison

	§1915(a)	§1932(a)	§1915(b)	§1115(a)
Ability to Mandate Enrollment	No	Yes; except special needs children, AI/AN, dual eligibles	Yes	Yes
Service Area	Statewide or limited to certain areas	Statewide or limited to certain areas; Can also offer different benefits to enrollees	Statewide or limited to certain areas	Statewide or limited to certain areas
Selective Contracting	Not allowed	Allowed	Allowed	Allowed
Cost-test	Not required	Not required	Required	Required
Approval Timeframe	No timeline	90 days	90 days	No timeline
Approval Period	Indefinite	Indefinite	2 years	5 years

§1915(a) State Implementation

- Approximately 14 §1915(a) programs in country;
- Over half enroll older adults and/or individuals with disabilities and include HCBS.

California	Colorado
DC	Wisconsin
Massachusetts (Senior Care Options)	Minnesota (MN Senior Health Options)

§1932(a) State Implementation

20 states operate one or more programs through this authority.

- They are split between small, regional programs and large, statewide programs.
- States with large statewide programs include:

District of Columbia	Georgia
Louisiana	Mississippi
Nevada	North Carolina
Ohio	South Carolina
Washington	Wisconsin

§1915(b) State Implementation

- About 14 states operate programs through this authority.
- A few provide limited benefits (primarily mental health) and others are large statewide and comprehensive programs.
- States with large statewide programs include:

Florida	Iowa
Kentucky	Michigan
Missouri	Nebraska
Pennsylvania	Utah
Virginia	West Virginia

§1115(a) State Implementation

- A number of states operate managed care through this authority.
- All are large statewide programs, and all but Indiana, Maryland, and Oregon also include HCBS.
- States using this authority include:

Arizona	California	Delaware
Hawaii	Indiana	Kansas
Maryland	Massachusetts	Minnesota
New Mexico	New York	Oregon
Rhode Island	Tennessee	Texas

Section 5: Managed Care Implementation

State Contract & Rate Approval

States select the MCOs that they will contract with;

- Typically done through competitive procurement, although some states take 'any qualified plan.'

States have to write the MCO contract;

- State administrative code/legislation, etc.
- CMS has extensive Federal requirements for MCO contracts.

States also have to set the payment rates, following CMS guidelines.

CMS must review and approve both the MCO contract and rates;

- Federal funds are not available to the state without both being approved .

State Preparations

- States have to educate and inform Medicaid consumers about changes that will occur with the transition to managed care;
  - Includes public meetings, website updates, mailings, and provider communication.

- States are required to ensure that MCOs are operationally ready to serve Medicaid consumers;
  - Readiness reviews (required per CMS Final Rule, effective 7/1/17) of all systems and processes - claims, enrollment, encounter data, medical management, and quality.

- States have to ensure that their staff have the necessary skills and knowledge to provide appropriate ove

Managed Care Plan Requirements

Key requirements

- Sufficient providers to ensure access to services (network approved and monitored by state);
- Coordinate care for members who have special needs or use long term services and supports (LTSS);
- Measure and report to the state on quality of care;
- Provide access to member services by phone, web, and email;
- Authorize (when appropriate) and pay providers timely for services;
- Have an appeal process for disagreements on service access;
- Spend at least 85% of payments from the state on services and quality activities (effective 7/1/17);
- Implement activities to minimize fraud, wast[illegible]

Implications for Ombudsmen

Managed Care and LTSS Ombudsmen

- The expansion of managed care for LTSS means that many LTCOs will interface with plans, either today or in the near future
- States must have beneficiary supports in their managed care systems
  - Choice counseling to all individuals, and additional assistance to people who require LTSS
    - Must be an independent, conflict-free entity
  - Plans have appeals and grievances: Ombudsmen may need to assist Medicaid beneficiaries with this process
  - Language interpretation supports
  - Rights of individuals to switch plans if there is a disruption due to a change in the network status of their current provider of employment, residential, or institutional supports
- Many states have a managed care ombudsman
  - Should not be the same as the State Ombudsman*
  - Opportunities for collaboration: stay tuned for a future webinar on this topic

*Discussion to be continued in a future webinar.

Additional Resources

Additional Resources

- CMS Final Rule (CMS-2390-F)
- Medicaid.gov
- Kaiser Family Foundation
- NASUAD