Financing & Payment

Making Medicaid Better Forum
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Definition of “Managing Care”

An approach to delivering and financing health care that is aimed at both

– improving the quality of care and
– saving costs.
Two Financial Models for Managing Care in Medicaid

Primary Care Case Management
- Blend of fee for service and traditional managed care
- Small case management fee with claims paid FFS
- PCP provides basic care & coordinates/authorizes other services
- Predominant in rural areas
- 30 states; 7.28 M Medicaid members enrolled nationwide

Risk Based Managed Care Organizations
- Fixed monthly fee per enrollee
- May provide comprehensive or limited services
- 36 states; 23.5 M Medicaid members enrolled nationwide
Medicaid Only & Medicaid Dominated MCOs

- Increasingly important factor in Medicaid managed care nationally
- Emerged following substantial exit of commercial MCOs in late 90s
- Account for over half of enrollment in Medicaid full risk plans nationally
- May be owned by safety net hospital/provider or be a multi-state, publicly traded company
Current Trends in Medicaid Managed Care

• Requests for Proposal (RFP) are more commonly used than Request for Application (RFA) process
• Expansion to additional geographic areas within state
• Historically, enrollment has primarily been families and children
• Increasing number of states are mandating enrollment of more complex populations
  – Children and adults with chronic illnesses
  – Enrollees eligible for both Medicare & Medicaid
Emergence of Enhanced Primary Care Case Management

- Building additional features to PCCM program to enhance ability of PCP to coordinate and manage care
  - People with chronic illness
  - High cost enrollees
- Enabling ePCCM programs to
  - Improve care for high-risk enrollees, and
  - Save costs by performing kinds of coordination traditionally associated with MCOs
Variation in State Implementation of Enhanced Primary Care Case Management

• Performance of necessary enhanced care coordination and management component
  – State staff
  – Community-based networks
  – Contractors
  – Physician practices

• Tools to support enhanced care coordination
  – Provider incentive payments
  – Provider profiling focusing on quality & access
  – Performance monitoring and reporting
Similarities in Louisiana’s Two 2010 Proposed Models for Managing Care

- Adequate Provider Network
  - ePCCM(Shared Savings) – primary care providers
  - Risk-Bearing – all provider types
- Linked to Network and to PCP within the Network
- NCQA patient-centered medical home (PCMH) recognition of practices
- Care Management
  - Primary Care Management
  - Case Management/Chronic Care Management
  - Quality Management
  - Utilization Management
- Member and Provider Services, Outreach & Education
- Grievance System
- Fraud and Abuse Monitoring and Reporting
Differences in Models as Designed by DHH

Enhanced Primary Care Case Management (Shared Savings)

- Provides primary care and coordinates other services
- CCN would receive monthly care management fee – **DHH will no longer directly pay PCP case management fee**
  - $14.81 Families & Children
  - $21.16 Disabled and Pregnant Women
- Limited risk
  - (return up to 50% of management fee if no savings)
- Shared Savings contingent on quality

Risk Bearing MCO (Prepaid Model)

- Provides all included health care services
- Monthly risk adjusted payment for each member
- Required to spend a minimum of 85% of PMPM on direct medical services and allowed to keep profit
- Full risk for covered services
- Responsible for claims adjudication with prompt pay requirements
- Withhold a portion of PMPM for not meeting quality expectations
## Requirements for Entities Managing Care of Medicaid and CHIP Enrollees

<table>
<thead>
<tr>
<th>Enhanced PCCM (s Model)</th>
<th>Risk Bearing MCO Model</th>
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<tbody>
<tr>
<td>• Meets the PCCM definition as defined in 42 CFR § 438.2</td>
<td>• Federally qualified as an HMO per 42 CFR Part 438.2</td>
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<td>• Be (or contract with) a Medical Necessity Review Organization</td>
<td>• Licensed or has a Certificate of Authority from the La DOI</td>
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<tr>
<td>• Provide financial reporting as requested by DHH</td>
<td>• Meet DOI solvency standards</td>
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<td>• Post surety bond for care management fee and maintain financial reserve</td>
<td>• Meet NCQA Health Plan Accreditation (or agrees to obtain when eligible to apply)</td>
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<tr>
<td>• Network capacity to enroll a minimum of 15,000 Medicaid members</td>
<td>• Provide financial reporting as requested by DHH</td>
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<td>• Network capacity to enroll a minimum of 25,000 Medicaid members</td>
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Rate Setting for MCO Model

- CMS requires “actuarially sound” rate
- Fixed monthly amount for each linked member which varies depending on
  - Age
  - Gender
  - Eligibility Category
  - Geographic Region
- Risk adjustment based on health status of members to deter “cherry picking”
- Can stipulate in contract policies for paying providers
- Length of contract and contract terms relative to future rate adjustments
Risk Adjustment

• Integrated into both the enhanced PCCM (shared savings) and MCO (prepaid) models
  – For ePCCM, in calculation of savings
  – For MCO, in determining monthly payment for each member

• Classifies persons based on likely use of health care resources

• Helps to level the playing field

• DHH has been working with Johns Hopkins Adjusted Clinical Groupings (ACG) model
Medical Loss Ratio (MLR)

• Medicaid Loss Ratio (MLR) is percentage of premium that is paid for health care

• Heightened focus as a result of MLR minimums in Health Reform Act for commercial plans

• States vary in Medicaid MLR requirements
  – Allowable cost in calculation of MLR
  – MLR percentage (88% in new Illinois program)
  – Requirements for timing of any refunds to state

• Texas Medicaid does not have minimum MLR but requires MCOs to return percentage of profits

• Stakeholder feedback is that DHH strengthen MLR requirements
Stringent Federal Requirements for Risk Bearing Medicaid Health Plans

- **Standards for Network Adequacy**
  - *Providers must be geographically accessible to all members*
  - *Must meet timeliness requirements*

- **Mandatory Reporting Requirements**
  - *Timeliness of appointments*
  - *Access*
  - *Utilization*
  - *Quality*

- **Standards for Quality of Care**
  - *Must demonstrate continuous quality improvement*

- **Capitation payments must be actuarially sound**
Measurement and Public Reporting in Medicaid Managed Care

- **HEDIS**—National set of quality, access, and effectiveness-of-care measures for managed care adapted to include measures applicable to the Medicaid population

- **CAHPS**—Set of surveys to capture consumers’ experience and satisfaction with MCOs, includes surveys designed for children and adults in Medicaid managed care

- **Public Reporting**—Published data on health plan performance on a website in a report, or in the form of a report card, to help Medicaid enrollees choose a health plan

- **Applicable to PCCM, Enhanced PCCM, and MCO models**
Additional Benefit of MCO Model

- Brings more predictable costs to Medicaid program
- Some financial risk is transferred from the State to the managed care organizations through capitation
- Less variability in State/Medicaid budget than is experienced with fee-for-service (FFS)
Identified “Issues” in Medicaid Managed Care (and Implications for Louisiana)

• Interruptions in Medicaid enrollment
  – Very low rate of churning in Louisiana
  – Not expected to be an issue because of our high retention rate

• Data needs for analysis and evaluation
  – expectation for submission of complete and correct encounter data
  – proposing stiff penalties for failure to submit accurate encounter data

• Appropriate payment
  – risk adjustment and stop-loss provisions to shield from excessive risk