NCIOM ANNUAL MEETING SEPTEMBER 2019 - THE MOVE TO MEDICAID MANAGED CARE
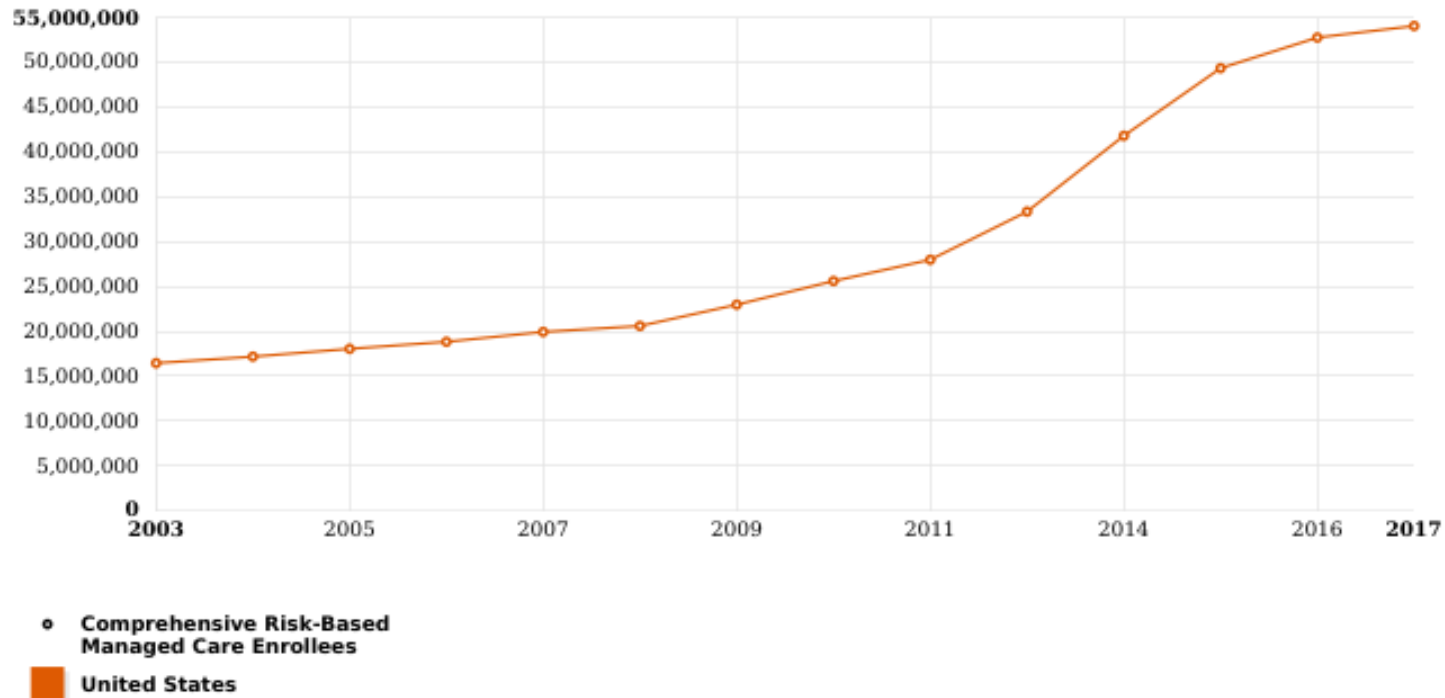
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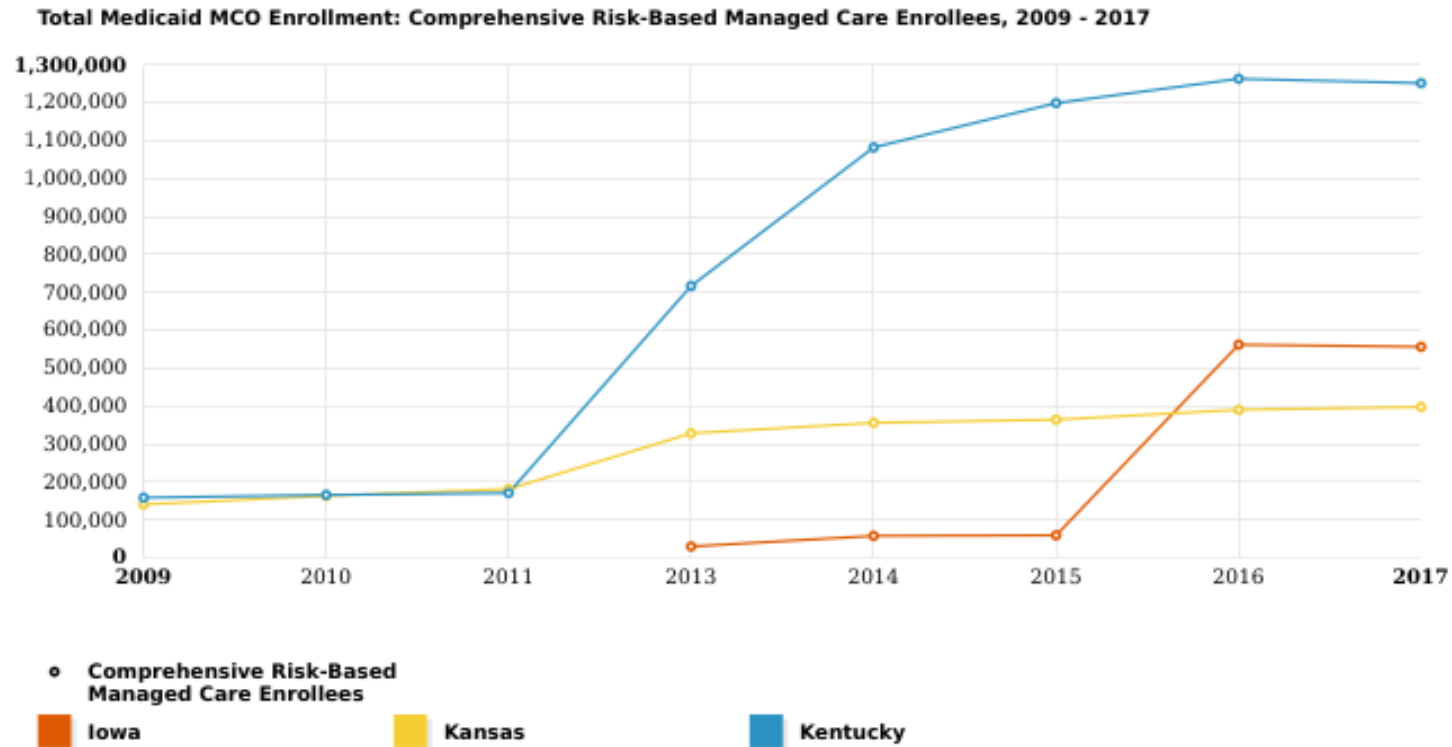# Move to Managed Care

Total Medicaid MCO Enrollment: Comprehensive Risk-Based Managed Care Enrollees, 2003 - 2017

○ Comprehensive Risk-Based Managed Care Enrollees

■ United States

SOURCE: Kaiser Family Foundation's State Health Facts.

- States are relying on managed care for service delivery
- Three fourths of Medicaid enrollees nationwide are served through managed care
- Managed care enrollment continues to grow but it is flattening out
- Part of the reason for the growth was Medicaid expansion in the ACA

States with Recent Moves to Managed Care

Total Medicaid MCO Enrollment: Comprehensive Risk-Based Managed Care Enrollees, 2009 - 2017

- Comprehensive Risk-Based Managed Care Enrollees

Iowa   Kansas   Kentucky

SOURCE: Kaiser Family Foundation's State Health Facts.

- For both Kentucky and Iowa the growth in managed care is also tied to Medicaid expansion
- Kansas is just the move to managed care for all populations

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States with Long Histories of Managed Care

Total Medicaid MCO Enrollment: Comprehensive Risk-Based Managed Care Enrollees, 2009 - 2017
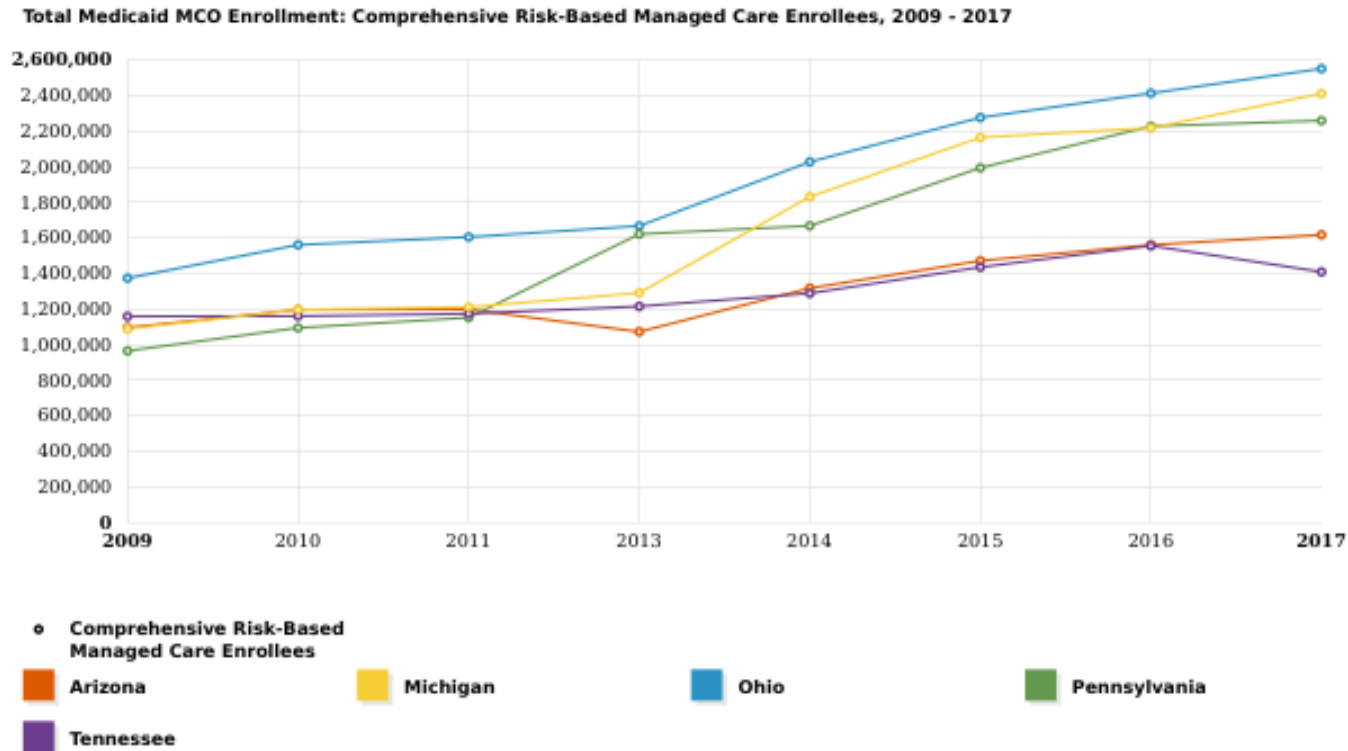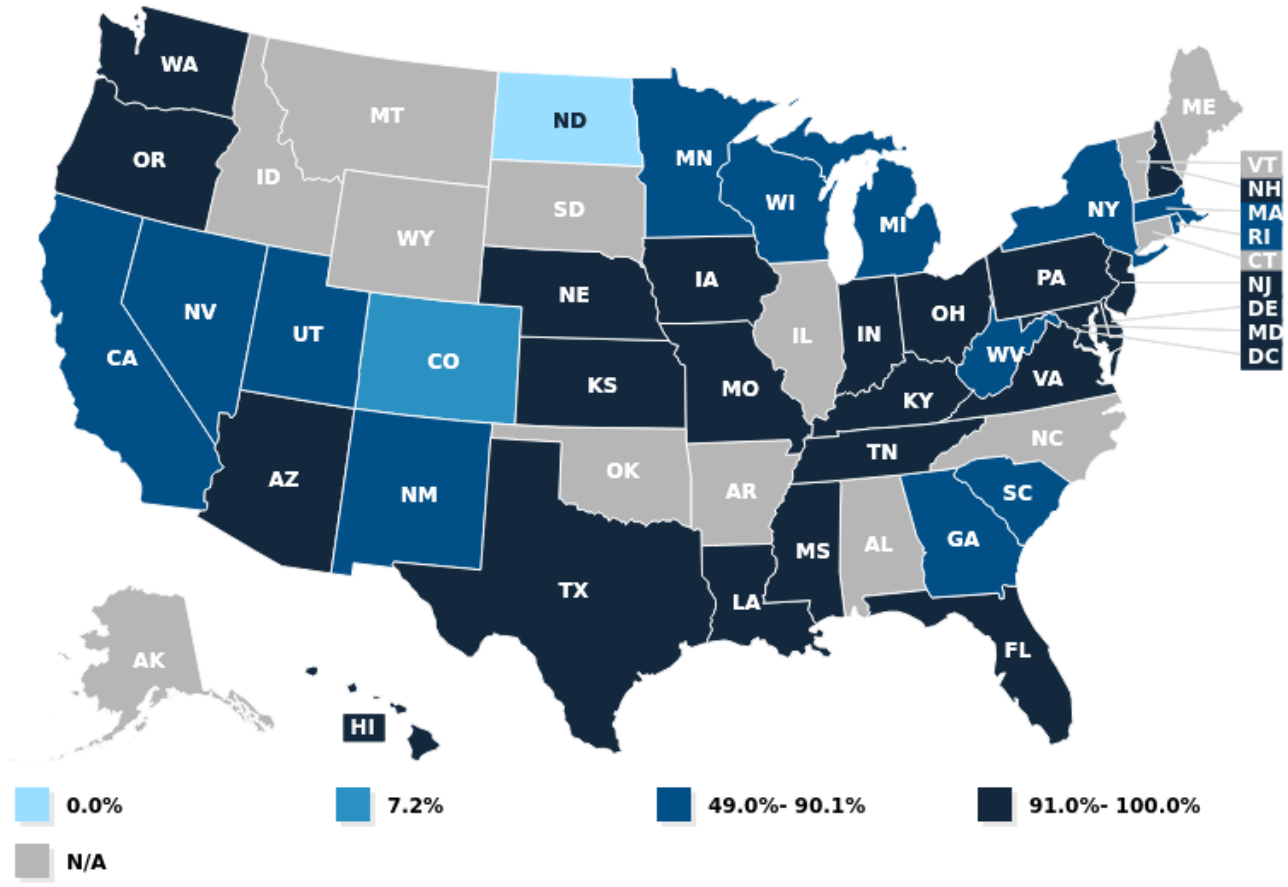

SOURCE: Kaiser Family Foundation's State Health Facts.

- Traditional states saw increases in managed care enrollments
- Most of the increases were due to Medicaid expansion in this graph except for Tennessee
- Ohio added other populations to managed care: children with special needs, foster care, and duals

Managed Care Penetration

- 38 states use some amount of managed care for service delivery

- 23 states have over 90% of the Medicaid population served through managed care

Medicaid Managed Care Penetration Rates by Eligibility Group: Children, as of July 1, 2018

0.0%   7.2%   49.0%- 90.1%   91.0%- 100.0%

N/A

SOURCE: Kaiser Family Foundation's State Health Facts.

Managed Care Penetration

- While use of managed care as a delivery system is high it is not equal among all populations

Distribution of Managed Care Enrollees by Eligibility Group, FY 2013

Basis of eligibility	Any managed care	Comprehensive managed care[1]	Limited-benefit plans	Primary care case management
Total	**77.5%**	**53.9%**	**49.5%**	**12.7%**
Children	92.8	67.8	58.8	17.4
Adults	66.9	50.9	35.9	9.3
Disabled	70.4	40.2	53.1	11.3
Aged	47.9	18.1	40.7	2.5

Source: MACPAC - - https://www.macpac.gov/subtopic/enrollment-and-spending-on-medicaid-managed-care/

National Trends in Managed Care

- Continued focus on pay for performance (P4P)
  - This is often paid through bonus payments or withholds tied to quality measures usually HEDIS
- Many states are mandating that a certain percent of payments to providers be in a value-based (VBP) payment model
  - There are a subset of states that mandate certain models of VBP
- More states are adding social determinants of health (SDoH) to their managed care contracts
  - This is the newest area and states are still trying to figure out what they expect of plans

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Headlines from Other States

Specific State Problems with the move to managed care or plan oversite

- Iowa – Des Moines Register - *UnitedHealthcare is pulling out of Iowa's private Medicaid management program* - March 29, 2019

- Iowa – Sioux City Journal - *Federal officials investigating Medicaid managed-care denials, including in Iowa* - April 18, 2019

- Kansas – Dodge City Daily Globe - *Aetna apologizes for failure to abide by $1 billion Medicaid contract in Kansas* - Aug 27, 2019

- Kentucky – Becker's Hospital Review - *Kentucky health plan may be insolvent by mid-2019, CEO says* - January 24, 2019

- Ohio – Columbus Dispatch - *Drug middlemen charging Ohioans triple the going rate or more* – June 27, 2018

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The Main Issues with the Problems

- State took the money from the Medicaid budget based on managed care savings estimates
  - Savings accrue overtime due to reductions in trends not immediate savings
- State went from no managed care to everyone in managed care including long-term services and supports overnight
  - States who have done this move successfully used a phased in approach
- The move to managed care was not accompanied by a change in the state agency oversight
  - States must continue vigilant oversight of the managed care program
- The state did not act quickly when a problem was discovered
  - Action needs to be taken in days or weeks not months or years

Agency's Move to Managed Care

- The state Medicaid agency must change how it operates the Medicaid program

- Active oversite of the plans is critical

- The Medicaid agency cannot simply apply its fee-for-service principles of program management to a managed care environment

- The entire organization must oversee the MCOs

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Staffing

- Some states have taken the approach that the move to managed care means less state staff is needed and cut the number of FTE in the Medicaid agency
  - This often led to poor plan oversight and many problems
- Most state Medicaid agencies are under resourced to run a fee-for-service program
  - The number of staff under FFS may be the number needed to oversee the managed care program
- Biggest issue in the transition is that the staff's roles change from doing the work to contract management and enforcement
- Giving the agency flexibility on staffing is helpful

Lessons Learned

- The best laid plans of mice and men often go awry
- Holding on and hoping it will change is not a strategy
- There are always opportunities
- A journey without data can get you lost
- If you stare into the rearview mirror you will end up in a ditch
- Have the tough conversations
- Culture eats strategy for lunch

On Effective Contracting and Implementation

- Contracts with MCOs must be detailed enough to make expectations clear, with each requirement carefully defined, and with appropriate reporting and monitoring processes to ensure compliance.

- Marketing guidelines should be structured to prevent potential problems.

- New skill sets are required of staff as you shift from FFS to managed care – more of a regulator function.

- Contracts should be routinely reviewed and amended as appropriate – continuous improvement.

- There must be different types and levels of incentives and sanctions which are used when necessary to ensure compliance. Automated systems for tracking deliverables is essential.

- Seek Innovative Ideas from the plans. Leverage the broad experience of the plans when looking to develop innovative solutions to the challenges the program is facing.

- This is a partnership so be willing to take a look at issues when circumstances arise that could not have been foreseen or when concerns are raised.

On Quality

- Access to reliable encounter data as quickly as possible is extremely important. Hard data is needed to dispel misinformation and anecdotes and focus on the best opportunities.

- Quality requirements should be spelled out for health plans – e.g. accreditation requirements and timelines, performance measure reporting requirements. Accreditation takes time so clear milestones should be established to assess progress toward the goal. Consider P4P arrangement to reward plans for accreditation level received.

- Independent, external review (EQRO, accrediting body like NCQA, etc.) goes a long way to quelling stakeholder concerns.

- MCO required reporting of standardized, evidenced-based performance measures allows for tracking trends over time and for comparison to national norms (e.g. HEDIS).
  - If other information that the state receives can be used for monitoring performance, the state can use that data, but it can lead to disputes.

On Quality *(continued)*

- Consider developing a state level survey that will allow tracking of issues of interest to the state over time. This would be in addition to MCO level surveys like CAHPS.

- Pay for Performance incentives and or assignment preference tied to specific performance measures can be used effectively to target attention to highest state priorities. Alignment of strategies across Medicare and Medicaid should be a consideration.

- Network monitoring should include 5 components:
    - Establishment of network standards for various provider types (e.g. geographic, appointment time)
    - Tracking compliance with standards based on network information self-reported by MCOs
    - An audit process to validate MCO self-reported information
    - Monitoring appeals
    - Encounter data (some providers will not become a participating provider but are willing to see our members)

- Tracking and analysis of enrollee appeals can be an important quality monitoring tool

On Transition *(continued)*

- The move from FFS to managed care is hard

- There will be issues because these are complex programs with thousands of providers and millions of beneficiaries

- State needs to closely monitor the transition and have a team ready to address issues

- Flexibility is needed from all parties

- Expectations need to be realistic

Duals in Managed Care

- Duals are one of the last eligibility groups to be moved to managed care
- One reason for this is that the federal government had not made it easy to do in the past
- The Medicare-Medicaid Coordination Office was created in 2010 by the ACA
- The Financial Alignment Initiative was launched in July 2011
  - It allowed for two models – Fee-for-service and managed care
  - Only a limited number of states would be approved

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CMS Financial Alignment Initiative

- Two states are using the FFS model
  - Colorado
  - Washington
- Ten states are using the capitated managed care model
  - California
  - Illinois
  - Massachusetts
  - Michigan
  - New York
  - Ohio
  - Rhode Island
  - South Carolina
  - Texas
  - Virginia

FAI Capitated Model

- Requires a 3-way contract between the plan, CMS, and the State
- There are 2 separate capitation payments
  - One from Medicare
  - One from the State
- The plans must be Medicare Advantage plans
- The state shares in the Medicare savings
- Both CMS and the state provide oversite
- People can be passively enrolled into the managed care plans
  - However, mandatory enrollment is not allowed

D-SNP Models

- Dually Eligible Special Needs Plans (D-SNPS) are a type of Medicare Advantage plan.
- In order to operate in a state they must have a contract with the state to facilitate coordination of Medicare and Medicaid services for enrollees, although states are not required to enter into such contracts
  - These are called MIPPA agreements
- New laws and regulations:
  - Allow for seamless enrollment, which is when a person becomes dually eligible, they are passively enrolled into a managed care plan
  - Mandate more coordination of services and data in MIPPA agreements
- The one outstanding question is how do states see savings from this model

QUESTIONS