MONTANA LEGISLATIVE BRANCH

Legislative Fiscal Division

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DATE: December 3, 2003

TO: Legislative Finance Committee

FROM: Lois Steinbeck

RE: Medicaid Managed Care Programs – Legislative Finance Committee Review

INTRODUCTION

The Legislative Finance Committee (LFC) is required to review all proposed Medicaid managed care programs (53-6-116(5), MCA). This provision was approved in the November 1993 special session of the legislature in regard to the Department of Public Health and Human Services (DPHHS) initiation of a planning process to develop a mental health managed care program.

As a result of its interim study of public mental health services during the 1999-2000 interim, the LFC recommended a bill (SB 82), which was passed, to amend the statutes governing Medicaid managed care. Changes were made due to several interim study findings, including the issue that the definition of managed care was too broad and could initiate statutory provisions for LFC review and risk analysis for common methods of Medicaid reimbursement or small programs such as the ACT (Active Community Treatment) mental health programs in Helena or Billings.

DPHHS has submitted its proposed rules for a Medicaid disease management program to the LFC for review as a managed care program, even though it does not believe the program constitutes managed care. In response, this report:

- Explains the disease management program to fulfill the required LFC review
- Raises an issue with respect to the potential need to further refine statutes that define managed care programs
- Presents options for LFC consideration and action

BACKGROUND

The 2003 legislature adopted a cost reduction measure proposed by the executive branch to limit the number of physician visits that a Medicaid enrollee could receive without requiring special authorization. The measure was included in the appropriation as a Medicaid cost reduction ($5.3 million total funds, $1.5 million general fund over the biennium).

DPHHS is implementing a disease management program instead of limiting physician visits as an alternative to provide better health care and achieve a commensurate level of cost savings ($5

million total funds, $1.3 million general fund[1] over the biennium). To date, the department has received one comment on its draft rules (see Attachment 1) and the final rules will not be adopted until after December 5.[2]

The disease management program will target Medicaid enrollees[3] who have diagnoses of asthma, diabetes, heart failure, chronic pain or cancer. Other chronic disease diagnoses may be added to the program later. DPHHS will contract with disease management organizations that are clinically qualified and that use evidence based health practices. The organizations will provide care coordination and client education with the goal of helping clients improve self-care. DPHHS anticipates that cost savings will result due to increased efficiency in service delivery and cost effectiveness of services delivered. In addition, cost savings are anticipated because the targeted diseases are ones in which patient self-care efforts are significant.

Greg Petesch, Code Commissioner and Director of Legal Services for the Legislative Services Division recently advised DPHHS that its proposed rules for the Medicaid disease management program appeared to meet the statutory guidelines describing managed care and that as such the program was required to be reviewed by the LFC (53-6-116(5), MCA). Mr. Petesch's e-mail to the department is attached (Attachment 2) and the relevant statutory sections that he cited are also attached (Attachment 3).

The disease management program appears to meet the statutory definition of managed care because it is a system to provide services to a defined population based on high risk diseases and because eligible Medicaid participants are placed into the program without their consent (53-6-116(3) and 53-6-117(1), MCA). While persons may opt out of the disease management program, they are placed in the program without their permission or possibly even their overt knowledge. This involuntary assignment aspect of the program is central to Mr. Petesch's conclusion[4] that the disease management program meets the statutory tests for LFC review.

IMPORTANCE OF LFC REVIEW

Managed care programs can be comprehensive and complex. Legislative oversight and monitoring of development and implementation of these programs can provide the background and education to legislators to help them:

- Make informed decisions about statutory and fiscal requests made during the session
- Provide meaningful public forums regarding impacts of proposals
- Provide direction to the executive branch during formulation of the proposal
- Provide feedback on what the executive is doing well
- Potentially forestall problems or oversights

[1]General fund savings are slightly less due to total cost savings being less than estimated for a reduction in physician visits and also because of the temporary 3 percent increase in the federal Medicaid matching rate in fiscal 2004.
[2]Geralyn Driscoll, Attorney, DPHHS, Memo to Lois Steinbeck, November 21, 2003.
[3]Medicaid enrollees are not eligible for the disease management program if they are: in a nursing home for more than 30 days; eligible for Medicaid due to presumptive eligibility; or have certain types of dual eligibility for Medicare and Medicaid.
[4]Personal conversation with Greg Petesch, Code Commissioner and Director of Legal Services, Legislative Services Division, November 21, 2003.

Since most managed care programs involve shifting financial risk to providers and require state administrators to find new and innovative ways to monitor quality of services and outcomes, the paradigm shift in moving from fee for service systems can be significant. Financial consequences can be considerable – in both positive and negative ways. However, the negative consequences, such as financial failure of a provider or potentially an entire service network, could be grave. The state may still be financially responsible to assume the cost of privately provided services and be without a way to deliver services to persons who may be at high risk of physical harm without continued services. In some circumstances costs could also shift to local governments.

APPLICABILITY OF MANAGED CARE REVIEW TO DISEASE MANAGEMENT PROGRAM

The statutory tests designed to trigger LFC review of managed care may need to be fine-tuned. The disease management program does not meet several tests that are commonly held traits of managed care programs. It does not:

- Restrict freedom of choice of providers
- Require Medicaid enrollee participation
- Require participating providers to manage or provide all medical treatment for an assigned Medicaid enrollee
  - For instance, if a person with diabetes also has a mental illness, the disease management organization is not required to provide treatment for the mental illness
- Require providers to assume most or all financial risk related to treatment of the disease

OPTIONS

The LFC has several options.

It can take no action.

This option would potentially trigger LFC review of programs that are not the type of actions that meet typical managed care criteria.

It can revise or request advice to revise the managed care statutes that trigger LFC review.

This option would allow a review and potential legislation to change statutes to ensure continued LFC review of managed care programs. The LFC can direct staff from the Legislative Fiscal Division (LFD) to prepare options or the LFC can direct LFD staff to work with Legislative Services Division staff, the Children, Families, Public Health and Human Services Interim Committee, and DPHHS staff to recommend changes for potential legislation.

Attachments (3)

ATTACHMENT 2

-----Original Message-----
From: Petesch, Greg
Sent: Tuesday, October 28, 2003 1:26 PM
To: Sliva, Dawn
Subject: Medicaid disease management program

This program appears to be a managed care program. Sections 53-6-116 and 53-6-117, MCA, appear to be implemented. In addition, 53-6-116(5), MCA, requires the program to be submitted to the Legislative Finance Committee for comment.

ATTACHMENT 3

RELEVANT MCA SECTIONS

53-6-116. Medicaid managed care -- capitated health care**.** (1) The department of public health and human services, in its discretion, may develop managed care and capitated health care systems for medicaid recipients.

(2) The department may contract with one or more persons for the management of comprehensive physical health services and the management of comprehensive mental health services for medicaid recipients. The department may contract for the provision of these services by means of a fixed monetary or capitated amount for each recipient.

(3) A managed care system is a program organized to serve the medical needs of medicaid recipients in an efficient and cost-effective manner by managing the receipt of medical services for a geographical or otherwise defined population of recipients through appropriate health care professionals.

(4) The provision of medicaid services through managed care and capitated health care systems is not subject to the limitations provided in 53-6-104. The managed care or capitated health care system that is provided to a defined population of recipients may be based on one or more of the medical assistance services provided for in 53-6-101.

(5) The proposed systems, referred to in subsection (1), must be submitted to the legislative finance committee. The legislative finance committee shall review the proposed systems at its next regularly scheduled meeting and shall provide any comments concerning the proposed systems to the department.

History: En. Sec. 1, Ch. 460, L. 1991; amd. Sec. 2, Ch. 31, Sp. L. November 1993; amd. Sec. 449, Ch. 546, L. 1995; amd. Sec. 2, Ch. 466, L. 2001.

53-6-117. Participation requirements. (1) The department of public health and human services may require medicaid recipients to participate in a managed care system.

(2) Recipients who are required by the department to participate in a managed care system shall participate as required in order to remain eligible for medicaid.

(3) The department may require the participation of medicaid recipients in managed care systems based upon geographical, financial, social, medical, and other factors as the department may determine are relevant to the development and efficient management of managed care systems. **History:** En. Sec. 2, Ch. 460, L. 1991; amd. Sec. 450, Ch. 546, L. 1995.