MONTANA LEGISLATIVE BRANCH

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Director
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DATE: November 3, 2010

TO: Legislative Finance Committee

FROM: Lois Steinbeck
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RE: Description Medicaid Managed and Programs Implemented by the Department of Public Health and Human Services

PURPOSE/GOAL

This memorandum describes managed care approaches to health care, discusses some aspects of more comprehensive managed care programs, and lists the various Montana Medicaid managed care initiatives that have been implemented by the Department of Public Health and Human Services (DPHHS), including one proposal that is nearing federal approval. The memorandum is intended to provide the Legislative Finance Committee (LFC) with background information to help it discuss the Medicaid managed care feasibility analysis or proposal that DPHHS may present at the November LFC meeting or during the legislative session.

WHAT IS MANAGED CARE?

The term managed care encompasses a wide variety of approaches to delivery and financing of health care services and is used by both publicly and privately funded health care plans. The stated goals of most managed care programs are to improve health outcomes and quality of care, and to control costs through oversight of certain services or populations of health care recipients. There are several basic elements to consider in a managed care program.

Type – There are many types of managed care programs. Primary care management models can link health plan participants with health care professionals for various levels of care coordination or management. Other programs can take a more intensive approach and can range from targeted, narrow focuses, such as intensive care management for persons with chronic health conditions such as asthma, to more comprehensive programs that enroll all health plan members and manage all health care services provided to those plan members.

Contract or Direct Administration - Usually a Medicaid state agency would contract with another entity (such as a private company) to implement and administer the managed care program. In some instances, the state agency could implement and directly administer a managed care program. However, that approach is used less frequently than the contracted services approach.

Provider Networks - In most cases, the managed care contractor has its own network of healthcare providers. Development of provider networks can be accomplished in a variety of

ways, but would involve establishing reimbursement rates and other plan components. Plan participants must use the managed care provider network. In some plans, participants can use out-of-network providers, but the co-payment is usually higher.[i]

Managed care networks are usually vertically integrated, meaning that all services are within the network and use of vendors outside the network is limited.

Reimbursement - Typically managed care contractors are reimbursed through a capitated or per member per month (PMPM) fixed rate that covers all necessary health plan services. Development of capitated rates can range from the payor establishing a certain fee based on a spreadsheet analysis of costs or developing rates through an actuarial analysis.

In some instances, the contract reimbursement might be a fixed amount for a fixed time period unrelated to the number of users.

Risk and Reward - Managed care contracts, especially those that are broad in scope, usually define the level of risk for which a contractor would be liable. In some instances, contactors assume the established rate and provide the necessary services and are at full financial risk if the cost of services is higher than the reimbursement rate. In other instances, contracts may include stop loss provisions that establish when a contractor is liable for loss and when and how much the Medicaid agency would participate in cost overruns.

Managed care contracts also may address the issue of cost savings. In some instances, the contractor may keep any savings or profit. In other instances, the contract may specify the allocation of savings between the contractor and Medicaid agency.

Some of the Policy Issues

There are a variety of policy issues related to managed care contracts identified by states implementing managed care services and in testimony before legislative committees. Some of the reasons that states opt to implement managed care contracts are:

- States may gain a higher degree of cost predictability
- States may test different types of service delivery and design to accomplish the best outcomes within existing resources
- Plan participants may gain access to services not allowed under Medicaid fee-for-service arrangements
- Plan benefits can be managed to emphasize preventive care and early intervention
- There can be more flexibility in service design and delivery compared to Medicaid fee-for-service
- Participating medical providers may be subject to less administrative burden compared to regular Medicaid fee-for-service
- Programs may provide a higher degree of efficiency in the use of limited resources

Some of the challenges of implementing managed care proposals:

- Oversight of service delivery, evaluation of outcomes, and determination of the amount of loss and profit incurred by the contractor can be difficult
- Legislative ability to influence program policy decisions may be significantly lessened

- Structuring managed care contracts to anticipate and minimize the impact of adverse events is difficult, including cost shift to other state funded programs
- State and federal funding that formerly supported services to individuals may be diverted to administrative cost and profit and there may be duplication of administrative costs between the Medicaid agency and the contractor
- Establishing provider networks, especially in rural and frontier areas can be difficult
- Provider rates may be lowered or reimbursements delayed to the point that providers' financial viability is threatened
- State agencies may not have the requisite experience to administer managed care contracts

MONTANA MEDICAID MANAGED CARE PROGRAMS

DPHHS has implemented several Medicaid managed care programs and is nearing federal approval for a HIFA (Health Insurance Flexibility and Accountability) Medicaid waiver to expand Medicaid eligibility to a limited number of adults with a severe and disabling mental illness.

Passport to Health - One of the first Medicaid managed care programs implemented by DPHHS is the Passport to Health Program (PASSPORT) and it is still operational. It is a primary care case management model that provides a medical home for Medicaid eligible persons. Under PASSPORT, Medicaid clients choose one primary care provider. With some exceptions, all services to PASSPORT clients must be provided or approved by the PASSPORT provider.

DPHHS estimates that about 68% of the Medicaid population is enrolled in the PASSPORT program and that the program reduces costs by about $20.0 million each year. Primary care providers are paid a fee of $3.75 PMPM.

Mental Health Access Plan - In 1997, DPHHS instituted a comprehensive mental health managed care program for all Medicaid eligible persons and for persons served in the state funded mental health plan. The contract was statewide and managed by a single entity. The contract was ended in 1999.

Nurse First - In 2004 DPHHS initiated the Nurse First program. It is a contract for 24/7 telephone access to nurse with goal of directing persons to the best care option (self care, physician visit, emergency room). The Nurse First call line is still operational.

Disease Management - In 2008, DPHHS implemented a contracted disease management program for Medicaid eligible persons with certain chronic health conditions (asthma, diabetes, heart failure, cancer or chronic pain) to receive one-on-one education, counseling and follow-up about their condition from a registered nurse. The contract was not considered to be cost effective and was discontinued.

Health Improvement Program - In January 2009, DPHHS initiated the Health Improvement Program (HIP) and the first persons were enrolled in February 2010. DPHHS purchased a modeling application that uses Medicaid paid claims to predict potential future high cost and utilization for individual Medicaid clients. DPHHS has 14 contracts with Community Health

Centers including 1 Tribal health center to provide care management for Medicaid eligible persons identified at high risk of an inpatient hospital admission. HIP is reimbursed at the same rate as the Passport program - $3.75 PMPM.

HIFA (Health Insurance Flexibility and Accountability Medicaid Waiver) - DPHHS is in final negotiations with the federal Centers for Medicare and Medicaid for approval to implement a waiver to expand Medicaid eligibility to certain low-income adults with a severe and disabling mental illness who are currently eligible for the state funded Mental Health Services Plan (MHSP). Initially the waiver would allow 400 individuals to receive Medicaid funded mental health services and a basic package of physical health services.

This waiver was discussed with the 2005 Legislature. The waiver application was submitted in June 2006.

Inadequate Information to Describe Current Proposals

DPHHS is considering the feasibility of two proposals for federal approval to waive one or more required elements for state Medicaid programs. One is a managed care proposal reported to combine all Medicaid services in a five county area[ii] and the other deals with prescription drugs. However, there is insufficient information available to describe either proposal beyond these general terms or to know when the proposals may be discussed with the LFC, other legislative bodies, or the public.

[i] In Medicaid managed care plans, use of out-of-network providers may not be feasible since persons who are Medicaid eligible are low-income and without a waiver of federal regulations, co-payment amounts must be established at minimal levels.

[ii] Mike Dennison, "Governor Mulls Medicaid Managed Care," Helena Independent Record, October 14, 2010, p. 1.