Medicaid Managed Care: States Moving to Go All-In

By Debra Miller [1]
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WASHINGTON, D.C.—State Medicaid programs increasingly are depending on managed care arrangements, Julia Paradise, associate director of the Kaiser Commission on Medicaid and the Uninsured, told state legislators attending the CSG Medicaid Leadership Policy Academy in Washington, D.C., Sept. 15-17.

“States see managed care as a strategy to extract savings,” she said.

The easiest way to define managed care, Paradise said, is that it isn't fee-for-service.

Essentially, Medicaid managed care is one of three kinds of programs.

Comprehensive risk-based managed care provides a per-member, per-month fee to an entity to cover the costs of all services for enrollees. The risks involve the possibility that the fee may not cover all necessary expenses the company is obligated to pay. Managed care organizations may be either for-profit or not-for-profit.

Primary care case management is a strategy to provide more coordinated services through a primary health care provider, but the provider assumes no financial risk. Patient-centered medical or health homes can be one strategy for primary care case management.

The third type of managed care arrangement is a limited benefit plan involving, for instance, for pharmaceutical benefits or behavioral health care benefits. In the Medicaid world, these are usually called carve outs, where the comprehensive risk-based managed care entity is not responsible for these particular services. Certain populations also can be carved out.

Disabled and older enrollees who often require facility-based long-term care services are frequently excluded from the risk-based plans.

According to her latest national data from July 2011, one-third of Medicaid enrollees were still in fee-for-service programs; 51 percent are in risk-based plans. Paradise said the trend is increasingly away from fee-for-service toward risk-based plans.

The research on managed care is mixed, she said. Comparison of quality measures in managed care to fee-for-service systems is hampered because of the lack of quality measures of fee-for-service systems.

“The findings on savings are mixed. It is not too satisfying. On the national level, there do not seem to be savings, but there may be savings in some states,” she said.

Savings in states can come from two areas, according to Paradise. One is price, but that really depends on where the state is in setting its fees for various providers and services. Managed care organizations may not be able to lower prices and recruit providers. Managed care organizations also may curb the numbers and types of services utilized through eliminating duplication and unnecessary procedures and tests, but here, too, it depends on the states’ actions before moving to managed care.
Many states have already used a number of the available tools to remove unnecessary service utilization, and other states are learning from their actions.

For instance, Florida Medicaid Director Justin Senior told legislators his state is moving all Medicaid enrollees into a statewide managed care system. In 2011, the legislature passed a measure to roll out managed care to the 3 million Florida Medicaid enrollees throughout the state. The federal government approved the state’s Medicaid waiver in June 2013.

Senior said there is almost no carve out for certain populations.

“No cherry picking and no lemon dropping,” Senior called the Florida all-in approach to managed care.

Senior said the state is seeking to “put competition into the market place in virtuous ways … to insert competition to drive better outcomes.”

The state did not have a preference for either not-for-profit or for-profit groups. Both provider-owned networks and more traditional for-profit insurance companies are participating in Florida.

The bidding process is complete and Senior said state officials are pleased with the results.

“Plans were racing to the top in terms of what they offer as benefit packages,” said Senior.

Benefits packages were expanded beyond the required Medicaid services. For instance, Senior said, adult dental services were routinely covered in the bids.

The plans had broad, unprecedented service networks. Physician payments rates were slated to be enhanced within two years. All plans will pay Medicare physician reimbursement rates, traditionally higher than Medicaid. All plans proposed to waive co-payments from the enrollees.

Overall, Florida expects a 5 percent savings. The state also is looking to improve outcome and quality scores, Senior said.

In response to questions, Senior said the Florida waiver application included an evaluation plan; he expects periodic reports to look at quality and outcome information, as well as cost-savings before the final five-year waiver period ended.

In New Jersey, at-risk managed care has been a tool for the state’s Medicaid program since 1996. John Koehn, president of Amerigroup New Jersey, a division of Wellpoint, said the key to lower health care costs is to deliver the “right care at the right time in the right place.”

The examples he provided included using patient-centered medical homes to reduce avoidable hospital readmissions. In New Jersey, 30-day readmissions were reduced 10 percent for Medicaid enrollees with diabetes and 77 percent for those with asthma. Using predictive models to identify high-risk patients early on and deliver appropriate preventive services saved more than $134 per member per month, according to Koehn. Changing the locale in which services are delivered from the hospital to independent labs, outpatient surgery and imaging centers saved more than $500,000 in lab, ambulatory surgical and radiology services.
Koehn reviewed some challenges to Medicaid and managed care organizations. He said as higher-cost, higher-need populations enter managed care, companies are required to develop new care strategies.

For instance, he asked, “when does it make sense to go to their homes?” Sometimes, he said, “it isn’t medical advice they need; it’s getting them to medical attention. Using community members may be the best way to get them to care.”

As the population ages, service demand will increase. But Koehn said managed long-term care isn’t about nursing homes, “it is about community services to postpone nursing home care.”

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