Medicaid Managed Care and Persons with MR/DD

A Presentation to the Missouri Association of County Developmental Disabilities Services
July 2008

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Health Management Associates
State Objectives for Expansion of Medicaid Managed Care

- Reduce Cost
- Improve Access
- Improve Outcomes - Enhance Care Management
- Improve Quality
Types of Medicaid Managed Care

- PCCM (primary care case management)
- Risk-based capitated arrangements utilizing managed care organization (MCOs)
  - preventative and primary care, acute inpatient
  - long-term care, including HCBS waivers
  - integrated Medicaid managed care (primary and LTC)
  - integrated Medicaid and Medicare managed care
Medicaid Managed Care

- 39 states offer risk-based managed care to at least some of their Medicaid eligibility groups
  - Even states with mandatory or voluntary risk-based managed care enrollment for the ABD population often exempt:
    - Dual eligibles (Medicaid/Medicare)
    - Institutional residents (NFs, ICFs/MR)
    - Home and community-based services waiver (HCBS) enrollees
  - Most states enroll at least some SSI recipients into managed care
  - Some states limit enrollment by geographic area
Medicaid Risk-Based Managed Care Status: 50 States and DC

- 12 States No Risk-Based Managed Care
- 8 States Risk-Based Managed Care, Not Available to ABD Categories
- 8 States Risk-Based Managed Care, Voluntary for ABD Categories
- 16 States Risk-Based Managed Care, Mandatory for ABD Categories
- 7 States Mandatory/Voluntary Risk-Based Managed Care for ABD Categories
Medicaid Costs – A Major Driver of Expansion for AD Population

- Growth in enrollment of AD category continues - projected to continue at a faster rate than children and non-disabled adults
- Large proportion of Medicaid expenditures for recipients in the AD eligibility category
Aged and Disabled (AD) Enrollment/Costs

Enrollees
- Elderly = 9%
- Disabled = 17%
- Adults = 26%
- Children = 48%

2007 U.S. Total = 62.2 million

Expenditures
- Elderly = 22%
- Disabled = 46%
- Adults = 13%
- Children = 19%

U.S. Total = $305 billion in 2007*

*Expenditure distribution based on spending for medical services only and excludes DSH, supplemental provider payments, vaccines for children and administration.

Medicaid Enrollment Growth
Average Annual Growth Rates, 2000-2006

Aged/Disabled

Families

2.6% 2.9% 3.3% 2.0%

11.4% 5.7% 3.2% -0.4%


Growth in Medicaid Enrollees
Projected 2007 - 2017

Source: Calculations by Health Management Associates based on CMS historical data and Congressional Budget Office Projections through 2017, March 2007 Medicaid Baseline.
PCCM

- Remains in effect for persons exempted from MCO enrollment or in rural areas where MCOs have not been developed or do not operate
- 6,467,252 persons PCCM enrolled as of June 30, 2006 or 12% of total Medicaid population
Total Managed Care Enrollment
June 30, 2006

- Total Managed Care Population (comprehensive and limited): 29,830,406 (65%)
- Other (fee-for-service): 15,822,236 (35%)

Source: Data from CMS 2006 Medicaid Managed Care Enrollment Report
Arizona Health Care Cost Containment System (AHCCCS)

- Longest operating fully-capitated Medicaid program in nation
- Arizona Long Term Care System (ALTCS) capitation rates are blended rates - include nursing facility costs, HCBS, acute medical care services, behavioral health services, case management services and administrative costs
- ALTCS MCOs include counties, HMOs, tribes and state DD agency
  - ALTCS services for persons with DD - managed by the Arizona Department of Economic Security/Division of Developmental Disabilities (ADES/DDD)
    - Operates under a capitation arrangement with AHCCCS
    - DDD is expected to provide the same array of services as other ALTCS contracted managed care entities
    - July 2008 enrollment = 20,198 persons
Delaware, Maryland, Michigan

- Mandatory enrollment includes AD category
- Excluded groups:
  - Dual eligibles
  - Persons residing in NFs or ICFs/MR
  - Persons enrolled in HCBS waivers
Michigan

- Beneficiaries required to enroll with an MCO in 82 of 83 counties

- 15 counties in Michigan’s Upper Peninsula:
  - Served by a single health plan
  - Designated as “Rural Area Exception” counties
  - Required to enroll in the available MCO: may obtain certain services from providers outside the MCO’s network

- 10 counties included in the state’s Lower Peninsula
  - MCO is designated as “Preferred Option” (only one MCO is available)
  - Have the option to disenroll from the MCO at any time and receive care on a fee-for-service basis.
Michigan: Children's Special Health Care Services (CSHCS)

- Previously operated as a risk-based, capitated arrangement for Medicaid and CHIP
  - Ended capitation for Medicaid when CMS determined payment violated BBA requirements
    - Was no “real” risk – through use of risk corridors and cost settlement, risk was avoided

- Currently operating as:
  - A PCCM program for Medicaid
  - Capitated program for CHIP
Michigan: Washtenaw Community Health Organization

- Collaborative effort between Washtenaw County and the University of Michigan Health System
  - Formed in January 2000
  - Prepaid Inpatient Health Plan (PIHP) for the Southeastern Michigan Region
  - 4 counties: manages approximately $85 million in Medicaid services
  - Provides primary health care and specialty care services (including behavioral health services) to persons with mental illness, DD and substance abuse problems
  - Does not provide other acute care services such as inpatient hospitalization or outpatient hospital services

- Washtenaw County Board of Commissioners and Regents of the University of Michigan each appointed six members to the Board of Directors of WCHO

- WCHO provides a medical home for each person: depending on the needs of the person –
  - community mental health center
  - primary care clinic
Michigan: Washtenaw Community Health Organization

- WCHO contracts with Washtenaw County Community Support and Treatment Services for services for persons with serious mental illness and developmental disabilities
- Operates as a braided system of funding - Medicaid, Medicare, local tax dollars, mental health block grant funds, substance abuse block grant funds, private funds and state general funds.
- Evaluation - demonstrated a slight increase in physical health care and medical costs, with a marked decrease in mental health only diagnoses and treatment
New Mexico “Salud!”

- Mandatory for the majority of Medicaid beneficiaries, including disabled persons receiving federal Supplemental Security Income (SSI) benefits.
- Beneficiaries enrolled in a home and community-based waiver program (unless exempt based on other criteria) are also enrolled in Salud! for non-waiver services.
- Excluded groups:
  - Dual eligibles
  - Persons residing in NFs or ICFs/MR
Oregon Health Plan

- Managed care services provided by prepaid health plans that include fully capitated health plans (FCHPs), physician care organizations and primary care managers
  - Multiple benefit packages: AD beneficiaries receive the OHP Plus package
  - Mandatory unless in one of the “excluded” categories
  - 74% of OHP enrollees in a FCHP
Oregon has many types of capitated managed care plans

- Fully Capitated Health Plans (FCHPs) - 14 FCHPs 2007
- Dental Care Organizations (DCOs) – capitated for dental care
- Chemical Dependency Organization (CDO) – capitated for chemical dependency
- Mental Health Organizations (MHOs)
  - Fully Capitated Health Plans
  - County or regional governmental organizations
  - Private Mental Health Organizations
- Physician Care Organization (PCO) – 1 PCO 2007

Primary Care Managers (PCCM) – 3% of OHP enrollees 2007
Oregon Health Plan - Exclusions

- Beneficiaries residing in areas of the state where there is inadequate capacity within the prepaid health plan
- Beneficiaries covered by major medical insurance policies including Medicare supplemental policies or enrolled in certain Medicare Advantage plans
- Beneficiaries with specified medical conditions (ESRD, last 3 months of pregnancy, transplant scheduled)
- Tribal members wishing to receive services from a tribal clinic or similar facility
## OHP FCHP Rates

### Statewide FCHP Rates

<table>
<thead>
<tr>
<th>Eligibility Category</th>
<th>Jan-08</th>
<th>July 2007</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>TANF Adults</td>
<td>$273.52</td>
<td>$250.97</td>
<td>9.00%</td>
</tr>
<tr>
<td>PLM Adults</td>
<td>$265.44</td>
<td>$215.75</td>
<td>23.00%</td>
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<tr>
<td>PLM, CHIP, or TANF Children Aged 0-1</td>
<td>$442.59</td>
<td>$400.40</td>
<td>10.50%</td>
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<tr>
<td>PLM, CHIP, or TANF Children Aged 1-5</td>
<td>$90.80</td>
<td>$82.10</td>
<td>10.60%</td>
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<tr>
<td>PLM, CHIP, or TANF Children Aged 6-18</td>
<td>$80.65</td>
<td>$71.46</td>
<td>12.90%</td>
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<tr>
<td>AB/AD with Medicare</td>
<td>$152.64</td>
<td>$150.73</td>
<td>1.30%</td>
</tr>
<tr>
<td>AB/AD without Medicare</td>
<td>$849.76</td>
<td>$661.48</td>
<td>28.50%</td>
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<tr>
<td>OAA with Medicare</td>
<td>$163.32</td>
<td>$161.78</td>
<td>1.00%</td>
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<tr>
<td>OAA without Medicare</td>
<td>$704.93</td>
<td>$501.35</td>
<td>40.60%</td>
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<tr>
<td>SCF Children</td>
<td>$147.62</td>
<td>$137.40</td>
<td>7.40%</td>
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<tr>
<td>OHP Families</td>
<td>$221.25</td>
<td>$204.23</td>
<td>8.30%</td>
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<tr>
<td>OHP Adults and Couples</td>
<td>$508.79</td>
<td>$458.80</td>
<td>10.90%</td>
</tr>
</tbody>
</table>
TennCare

- All beneficiaries including AD and dual eligibles enrolled in the MCOs
- The state contracts with full or partial risk health plans to provide all physical health services
- Carved out services:
  - NF or ICF/DD
  - HCBS waiver services
  - Targeted case management
  - Program of All-Inclusive Care for the Elderly (PACE)
  - Behavioral health (except in one region)
- One designated managed care region: the health plans provide behavioral health services in addition to physical health care services
California

- Multiple models of Medicaid risk-based managed care
- Not available statewide but available in a number of the state’s larger, urban areas
- One of the models of managed care, County Organized Health System (COHS), is mandatory for beneficiaries in the AD categories of coverage
  - Includes NF services
  - Carves out HCBS waiver services

- Examples of COHS
  - CalOPTIMA
  - Health Plan of San Mateo
New York

- Mandatory managed care enrollment in 14 counties
  - Includes AD beneficiaries
- Utilizes MCOs or Prepaid Health Services Plans
- Physical health benefits only
  - 136,130 SSI and SSI-related Medicaid managed care enrollees - 88,407 reside in New York City
  - NYC: required to select and enroll in 1 of 17 Medicaid managed care plans
Florida Children’s Medical Services

- Operated by the Department of Health
- Historic provider of Medicaid and Title V services to children with special healthcare needs and a provider for CHIP
  - Operated as a PCCM program until Medicaid Reform
  - Now operating as Provider Service Network in the two Reform areas (Jacksonville and Ft. Lauderdale areas)
  - Not yet using risk-based, capitation but must transition to this by end of third year of Reform contract
  - PCCM in remainder of state
  - Reform – enrollment is mandatory for most groups, persons with DD voluntary, in ICFs/MR excluded. CMS is one of many Reform plan choices.
Rhode Island RIte care

- RI’s Medicaid Managed Care Program
- Children with Special Healthcare Needs may enroll into the RIte Care MCO: Neighborhood Health Plan of Rhode Island
  - Children with Special Healthcare Needs are children “who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally”
  - Children who already have commercial health insurance (in addition to Medicaid) are not enrolled in RIte Care.

- NHP serves:
  - Low income families with children
  - Children with special health care needs
  - Children in foster care
## Medicaid Managed Acute and LTC:MR/DD

<table>
<thead>
<tr>
<th>Feature</th>
<th>AZ</th>
<th>MI</th>
<th>NC</th>
<th>PA</th>
<th>TX</th>
<th>WA</th>
<th>WI</th>
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</thead>
<tbody>
<tr>
<td>Name</td>
<td>ALTCS – DD/DES</td>
<td>PIHPs</td>
<td>Piedmont Cardinal Health Plan</td>
<td>Capitated Assistance Program</td>
<td>STAR+ PLUS</td>
<td>WMIP</td>
<td>Family Care</td>
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<td>Implemented?</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
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<td>Includes Persons with DD</td>
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<td>Serves <strong>Only Persons with DD</strong></td>
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<td>Includes Acute, primary and preventative health care services</td>
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<td>Includes behavioral health services</td>
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<tr>
<td><strong>Includes HCBS waiver services</strong></td>
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<tr>
<td>Includes ICF/MR services</td>
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<tr>
<td>Includes NF services</td>
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*Home health, DME, Personal care only*
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<thead>
<tr>
<th>Feature</th>
<th>State</th>
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<tbody>
<tr>
<td>Provider Type</td>
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<td>County/Tribe MCO</td>
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<td>State MR/DD Agency MCO</td>
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<td>Community-based Agency MCO</td>
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<td>HMO or other licensed managed care entity</td>
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<td>Funding Streams</td>
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<td>Medicaid funding</td>
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<td>State funding</td>
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<tr>
<td>Medicare funding</td>
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<td>County funding</td>
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<tr>
<th>Feature</th>
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<tr>
<td><strong>Medicaid Authority</strong></td>
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<td>1915(b) waiver</td>
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<td>1115 waiver</td>
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<td><strong>Geographic Implementation</strong></td>
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<td>Limited areas</td>
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<td><strong>Provider Selection</strong></td>
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<td>Any willing qualified provider MCO</td>
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<td>RFP for MCO</td>
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<td>Sole source for MCO</td>
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<td>x</td>
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<td>x</td>
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</tr>
</tbody>
</table>
Texas STAR and STAR+PLUS

- STAR: capitated acute care services
- STAR+PLUS: capitated acute and LTC services
  - AD beneficiaries must enroll into either STAR in counties without STAR+PLUS or into STAR+PLUS where implemented except:
    - Children with disabilities voluntarily enrolled
    - Does not specifically include persons with DD (and only offers CBA HCBS waiver services, a NF LOC waiver)
## 2008 STAR+PLUS Cap Rates

<table>
<thead>
<tr>
<th>Service Area / Risk Group</th>
<th>9/07 - 8/08 Estimated Member Months</th>
<th>9/07 - 8/08 Capitation Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bexar Medicaid Only OCC</td>
<td>287,582</td>
<td>$462.72</td>
</tr>
<tr>
<td>Bexar Medicaid Only CBA</td>
<td>5,458</td>
<td>$3,138.64</td>
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<tr>
<td>Bexar Dual Eligible OCC</td>
<td>266,464</td>
<td>$270.37</td>
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<tr>
<td>Bexar Dual Eligible CBA</td>
<td>20,977</td>
<td>$1,931.47</td>
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<tr>
<td>Nueces Medicaid Only OCC</td>
<td>118,034</td>
<td>$533.57</td>
</tr>
<tr>
<td>Nueces Medicaid Only CBA</td>
<td>2,353</td>
<td>$3,062.58</td>
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<tr>
<td>Nueces Dual Eligible OCC</td>
<td>118,633</td>
<td>$337.13</td>
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<tr>
<td>Nueces Dual Eligible CBA</td>
<td>12,858</td>
<td>$1,887.61</td>
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<tr>
<td>Travis Medicaid Only OCC</td>
<td>111,530</td>
<td>$419.60</td>
</tr>
<tr>
<td>Travis Medicaid Only CBA</td>
<td>1,943</td>
<td>$3,158.71</td>
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<tr>
<td>Travis Dual Eligible OCC</td>
<td>97,881</td>
<td>$238.63</td>
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<tr>
<td>Travis Dual Eligible CBA</td>
<td>10,710</td>
<td>$1,942.90</td>
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<tr>
<td>Harris County/Contiguous Medicaid Only OCC</td>
<td>463,464</td>
<td>$557.90</td>
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<tr>
<td>Harris County/Contiguous Medicaid Only CBA</td>
<td>13,893</td>
<td>$2,782.46</td>
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<td>Harris County/Contiguous Dual Eligible OCC</td>
<td>437,147</td>
<td>$206.31</td>
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<tr>
<td>Harris County/Contiguous Dual Eligible CBA</td>
<td>33,783</td>
<td>$1,639.80</td>
</tr>
</tbody>
</table>
MCOs

- Types vary by state
- Commonly HMOs, networks (physician or provider service networks)
- May also include traditional community based organizations/entities willing to assume risk and meet specific financial, network and performance requirements
  - Might include counties, health centers, certain types of medical providers (home health agencies, hospice providers, etc.)
  - “Alternative” MCOs more common when AD groups and/or LTC services are part of managed care plan
  - Steep learning curve for the inexperienced…
Risk-Based Managed LTC or Integrated Acute/LTC

- **Groups**
  - Predominantly elders
  - Sometimes adults with physical disabilities
  - Less commonly persons with MR/DD

- **Services**
  - Predominantly includes HCBS waiver and other HCBS (primarily personal care, DME and home health)
  - Often NF – full or partial risk
  - Less commonly ICF/MR
Groups Commonly Excluded from Risk-Based Managed Care

- Beneficiaries residing in a NF or ICF/MR
- Children in foster care
- Beneficiaries enrolled in hospice
- Beneficiaries enrolled in HCBS waivers
Enrollment/Disenrollment Policies

- Governed both by federal and state requirements
- Vary depending on the type of managed care arrangement, the goals of the state when designing the program, and financial issues.
  - Include mandatory and voluntary enrollment, passive enrollment, “opt-out”, lock-in and disenrollment for cause
MCO Procurement/Contracting

- State may use application, procurement or sole source contracting
- Choice of 2 MCOs or 1 MCO and other option (PCCM/FFS) required
- May include CBOs and other qualified entities as defined by the state (and approved by CMS)
MCO Financial Requirements

Because there will be a risk-based arrangement, there are generally specific financial requirements, including:

- Cash on hand
- Surplus accounts
- Insolvency protection
MCO Financial Requirements Example - Florida

• Provider Service Network (PSN) must meet capital requirements of Medicare Advantage organizations (42 CFR 422.382-390)
  ◦ At time of application have a minimum net worth = $1.5 million
    • At time of contract implementation = greater of $1 million or 2% of annual premium revenues up to and including the first $150 million of annual premium
    • Of that, the greater of $750,000 or 40% of minimum net worth must be in cash or cash equivalents.
  ◦ Cash-on-Hand Requirements: working capital in the form of cash or cash equivalents, excluding revenues from Medicaid premiums, equal to at least the first three months of operating expenses or $200,000, whichever is greater
MCO Florida PSN Financial Requirements (continued)

- Medicaid Surplus Requirements: equal to one and a half times the entity’s monthly prepaid revenues.
- Medicaid Insolvency Requirements: Must deposit into a restricted insolvency protection account 5 percent of the capitation payments made by the agency each month until a maximum total of 2 percent of the total current contract amount is reached.

- States may give non-HMO MCOs transition time, gradual assumption of risk etc. to support viability
  - Florida: PSNs have three years FFS before required capitation
MCO – Network and Access

- Network must be established before enrollment begins
  - Contracts (sub-contracts) must be executed – generally a sample contract must be approved by state prior to execution
  - Credentialing of sub-contracted providers required
  - MCO must demonstrate all contracted service provider types under contract
  - MCO must demonstrate sufficient access to all required provider types/services
MCO – Other Requirements

• Care management system
  ◦ Possible a 24/7 call center or nurse help line
  ◦ Disease management programs a common requirement
  ◦ More about this later…..

• Member services
  ◦ Member outreach and enrolment
  ◦ Member handbook
  ◦ Cultural competency
MCO Rates

- Developed by state – often by a contracted actuary
  - Must be reviewed and approved by CMS
- Developed on a PMPM basis
  - Generally based on a state’s past experience providing the covered services to the target population under a fee-for-service arrangement
  - Often discounted – for example, 92% FFS
  - Generally segregated by, at a minimum age, sex and eligibility groupings
  - Might also include case-mix adjustment, geographic and other adjustments
- Level of risk may vary by program, group and/or service
  - MCO can be 100% at-risk or risk might be shared with state
What is a viable membership?

- Experience
  - Arizona leadership:
    - Acute care MCO at least 25,000 beneficiaries
    - LTC MCO at least 1,500 members.
  - Florida managed care agency: 3,000 to 5,000 members
  - Centers for Medicare and Medicaid Services (CMS) - requires Medicare Advantage (MA) applicants to have at least 5,000 enrollees in urban areas or 1,500 in non-urban areas (may grant a waiver to this requirement)
Capitation Rate Problems

Payments might be insufficient if:

- There are too many high-cost enrollees and rates were not adequately risk-adjusted
- There are unexpected expenses (like a community-wide outbreak of influenza that results in hospitalization and even admission to a nursing home)
- The health plan fails to monitor high-cost episodes and misses opportunities to reduce costs (like monitoring ER use, hospitalization, increasing prescribed drug usage, incidents, etc.)
- The rates were not calculated appropriately
Quality Requirements and Incentives

- EQRO
  - Performance Measures
  - Acute Care
    - HEDIS
      - Immunizations
      - Access to preventative care
      - Access to specialty care
      - Well-child visits
      - Dental care
    - Long-Term Care
      - Diabetes monitoring
      - Time to initiation of HCBS from date of enrollment
  - PIPs – by MCO and group PIPs
- Pay for performance
Biggest Challenges for CBOs in Managed Care

- Securing adequate PMPM from state
- Development of infrastructure including IT
- Reaching financial viability (membership numbers)
- Actively managing care – including care not directly controlled by MCO (not included in capitation)
- Encounter data collection and submission
Care Coordination/Care Management

- Some states have implemented special care coordination and care management requirements
  - Primary desire is to reduce duplication, coordinate services from multiple payor sources, improve consumer health/functional outcomes, and (hopefully) achieve some long-term cost savings.
  - In LTC programs – incentivize community-based residency, provide a single point of accountability across acute and LTC programs
  - Top 4% beneficiaries = 50% of spending*

Care Coordination/Care Management

- Initial models were often “disease management” models
- Emphasis now is on more comprehensive “care management”
- MO Reform proposal – proposed a “health care home”.
  - Four national physician organizations have developed a consensus definition of medical home as “a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient’s family.”

*Purchasing Strategies to Improve Care Management for Complex Populations: A National Scan of State Purchasers. Melanie Bella, Chad Shearer, Karen LLanos, and Stephen A. Somers. March 2008.CHCS.*
What’s Happening in Care Management?

**States are experimenting**

<table>
<thead>
<tr>
<th>Stratifying beneficiaries and using tiered care management approaches</th>
<th>Strengthening the relationship between PCP and patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrating medical, behavioral and psychosocial services</td>
<td></td>
</tr>
<tr>
<td>Trying P4P, shared savings, and shared risk arrangements with providers</td>
<td>Designing consumer-driven or consumer directed health care options</td>
</tr>
</tbody>
</table>

Recent Findings in Care Management

- Some states are identifying the high-cost beneficiaries and targeting these beneficiaries for intervention
  - Recent data identifies most frequent diagnostic pairs among costliest 5% of Medicaid beneficiaries

- States are mining Medicaid claims data and performing assessments to gather additional information to identify and stratify beneficiaries
Most frequent diagnostic pairs among costliest 5% of Medicaid beneficiaries

<table>
<thead>
<tr>
<th>Diagnostic Pair</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular–Pulmonary</td>
<td>30.50%</td>
</tr>
<tr>
<td>Cardiovascular–Gastrointestinal</td>
<td>24.80%</td>
</tr>
<tr>
<td>Cardiovascular–Central Nervous System</td>
<td>24.80%</td>
</tr>
<tr>
<td>Central Nervous System–Pulmonary</td>
<td>23.80%</td>
</tr>
<tr>
<td>Pulmonary–Gastrointestinal</td>
<td>23.80%</td>
</tr>
<tr>
<td>Cardiovascular–Psychiatric</td>
<td>22.00%</td>
</tr>
<tr>
<td>Cardiovascular–Renal</td>
<td>20.80%</td>
</tr>
<tr>
<td>Central Nervous System–Gastrointestinal</td>
<td>20.70%</td>
</tr>
<tr>
<td>Psychiatric–Central Nervous System</td>
<td>20.70%</td>
</tr>
<tr>
<td>Cardiovascular–Diabetes</td>
<td>19.20%</td>
</tr>
</tbody>
</table>

Stratification Example

**Oklahoma Health Management Program**

- Predictive modeling software identifies high-cost beneficiaries
  - First excludes dual-eligible, institutionalized, and home and community-based waiver beneficiaries
  - Identifies the top 5,000 beneficiaries with chronic conditions with the highest predicted future costs
- Using same software, ID Tier 1 (highest cost) and Tier 2
  - Tier 1: Receives in-person nurse care management services and self management education
  - Tier 2: Call center based nurse care managers

*Purchasing Strategies to Improve Care Management for Complex Populations: A National Scan of State Purchasers. Melanie Bella, Chad Shearer, Karen LLanos, and Stephen A. Somers. March 2008.CHCS.*
Predictive Modeling and Persons with DD - Example

- Kansas
  - 2-year DHHS Medicaid Transformation Grant
  - Partners: Ingenix Public Sector Solutions, Inc. and University of Kansas Medical Center Schools of Medicine and Pharmacy
  - 8-site pilot project - began in 2007
    - Development disability organizations and independent living centers
      - Case managers provided with training and a computerized, claims-based querying system to obtain history and need for preventive health care services

Source: KS Health Authority Press Release. Sites chosen to participate in pilot program with aims to improve health services for disabled Kansan. February 19, 2007.
Medical Home Example: Rhode Island Connect Care Choice

- Targeted to AD/SSI
- ID all SSI, SPMI and DD
  - Exclude institutionalized and dual-eligibles
- Use claims data to generate moderate- or high-risk scores to identify the target population
- PCCM-enrolled high-risk AD population—use “Advanced Medical Home Model”.

Medical Home Example: Rhode Island Connect Care Choice

- PCP required to:
  - Partner with patients
  - Incorporate the Chronic Care Model (DM)
  - Use a chronic care coordination team that includes a nurse manager
  - Link to behavioral health providers
  - Adopt e-prescribing, e-billing, and computerized evidenced-based clinical decision guidelines at the point of care

Washington State – Multiple Pilots

- Chronic Care Model for clinical practices - private sector patients with chronic diseases
- Intensive Chronic Case Management - Medicaid only clients receiving LTC services at home
- Chronic Care Management – Medicaid-only not in LTC but with high-cost conditions
- Integrated Programs (WMIP and MMIP)
What We Know About the Effectiveness of Various Types of DM and Care Management

- Some states report + outcomes – cost savings and/or other outcomes

- But…. There is little knowledge about what works – what is the right combination of standard features and person-centered or individual tailoring?¹

Federal Case Management Issues

- H.R. 2642, Supplemental Appropriations Act
- Moratorium on several rules including TCM until April 2009
- Stopped
  - Prohibition of Medicaid payment for case management services deemed “integral” to the administration of another program
  - Reduction in the number of days Medicaid would cover transitional case management prior to a person’s discharge into the community
  - Requirement that case management services be billed in 15 minute (or less) increments
CMS Q and As 4/18/08

- **Does this rule apply to Primary Care Case Management (PCCM) services?**
  - No. PCCM remains unchanged and is defined in section 42 CFR 440.168 of the Medicaid regulation.

CMS Q and As 4/18/08

If an individual is enrolled in a Managed Care Organization (MCO) which is paid a capitated rate that includes primary care coordination, can the individual receive targeted case management services outside of the MCO plan?

Yes. A beneficiary enrolled in a MCO may receive services to coordinate his or her primary health care under the plan and also receive targeted case management services, as described in the regulation, outside of the managed care plan.

• Receipt of targeted case management outside of the managed care plan may require adjustment of the managed care rate if it affects the actuarial value of services furnished by the managed care plan.
Do these regulations also apply to case management provided as a service under 1915(c) Home and Community Based Services waiver programs?

- Yes. CMS has determined that the policies set forth in CMS-2237-IFC will apply to the definition of case management services as provided under section 1915(c) Home and Community Based Services waiver programs.