State Medicaid programs are increasingly relying on Managed Care delivery models to serve existing and new populations enrolled in Medicaid. There are numerous examples of state challenges resulting from incomplete strategic design, lack of data analysis, and planning that does not incorporate the myriad of interrelated complexities involved in the funding, contracting, and program oversight of Medicaid Managed Care expansions. This paper outlines some of those challenges and offers potential solutions.

Overview

Medicaid managed care (MMC) is certainly not a new delivery model. Historically MMC has included risk based health plan contracting and Primary Care Case Management (PCCM) models primarily focused on the relatively healthy Aid to Families with Dependent Children (AFDC) and related populations.

Over the past decade Medicaid programs have greatly expanded the use of MMC and this trend has accelerated in recent years, due in part to state financial constraints because of the economic recession and its relatively slow recovery. Over the past 9 years managed care enrollment has increased from 58% to 74%, and the Medicaid population has grown from 40 million to 57 million from 2002 to 2011. The number of fee-for-service enrollees actually saw a slight decline during the same period.

With continued state financial constraints, state Medicaid programs are increasingly pursuing at-risk contracting to promote budget savings and predictability in forecasting for both the remaining fee-for-service participants as well as new populations. Recent examples of this trend include Kentucky’s 2011 expansion to statewide managed care, Kansas’ current plans to do the same, and New Hampshire’s plans to move virtually their entire fee-for-service population to managed care in two phases. The second phase will include waiver and nursing home participants. New York is also an example of a state moving new populations into MMC with the inclusion of behavioral health patients and previously carved out pharmacy participants. New York expanded MMC to behavioral health patients through new contracts with behavioral health plans while they ended the fee-for-service carve out for pharmacy benefits for those beneficiaries enrolled in their Medicaid managed care organizations (MCOs), approximately 75% of Medicaid enrollment.

Many states will also experience expansions in MMC enrollment associated with the new populations being added in states that have or will choose to expand Medicaid in response to the Affordable Care Act.

Some recent examples include Kentucky’s rapid deployment in 2011, signing three risk-based contracts in July, receiving Centers for Medicare and Medicaid Services (CMS) approval in September and moving 550,000 KenPAC members in November of the same year. Kentucky’s program was implemented using the traditional approach to managed care contracting and use of the Medicaid Management Infomation System (MMIS).

As already mentioned Kansas is planning to move to managed care using their Medicaid Management Information System (MMIS) infrastructure to receive and route encounter claims to health plans. New Hampshire is also planning to move its Medicaid population, including waiver and nursing home patients, to health plans.

Opportunities for Improvement

The following examples based upon publically available information are intended to illustrate the types of opportunities for improvement for Medicaid agencies when expanding MMC, extending MMC to new populations, and in some cases managing the programs over time. References to specific state Medicaid programs are being provided to help illustrate the challenges and opportunities for readers and do not imply criticism of those referenced.

Moving too rapidly can overly burden state staff and exacerbate existing program issues. For a recent example, in November 2011 Kentucky greatly expanded the use of MMC within the State. The Urban Institute and the University of Kentucky prepared a report, “Evaluation of Statewide Risk-Based Managed Care in Kentucky: A First Year Implementation Report” which detailed a number of findings to illustrate this point. The following were included among their observations:

- “…there has been a shortage of personnel with managed care experience, particularly at the state and plan levels.”

- “While a large number of reports are required from plans, placing a large burden on stressed staff, at this point it is unclear whether and how the reports are being used for plan monitoring and associated quality oversight.”
The ‘carve in’ approach can be beneficial if there is adequate access to behavioral health services, and if there is a close linkage between primary care and behavioral health care. However, currently this does not appear to be the case in Kentucky.

New Jersey Medicaid has also had issues with monitoring MMC organizations. The Comptroller of New Jersey found evidence that two of the State’s MMC health plans failed to meet contractual requirements to support fraud and abuse detection. One firm was identified in an audit released in 2009 and the second in July 2013. Audit results indicate an issue with contract monitoring from the responsible agency which indicates an opportunity for improvement regarding contract oversight. It is also apparent that the contract structure addressed fraud and abuse through specific staffing levels rather than through an alignment of financial objectives. While not excusing the audited HMO’s non-compliance, this situation could have been avoided through a more thoughtfully aligned contract structure to incent detection of fraud and abuse. Fraud and abuse is a large problem for most Medicaid programs and states need to ensure their MMC vendor contracts are aligned to eliminate these costs, to the extent possible, rather than enabling a profit margin on this wasteful spending.

Coordination with non-MMC Providers

In moving existing populations to a MMC delivery model, states also need to coordinate with existing or planned new contracts for other related services, such as their MMIS vendor or any carved out vendors such as Pharmacy Benefit Managers (PBM) or behavioral health organizations. New Hampshire is a strong example of the coordination required with existing vendors. New Hampshire was in the process of implementing a replacement MMIS when legislation was passed to move to a Statewide MMC delivery system, known as “Care Management” in New Hampshire, in a three phased approach. New Hampshire Medicaid had to work through deployment delays associated with a replacement MMIS before initiating the changes necessary to support their MMC model. New Hampshire had originally planned on implementing their MMC model in January 2013. In order to do so, the State had to address the new MMIS vendor contract, the legacy vendor contract and a Medicaid PBM vendor contract in addition to working through MMC provider network issues associated with hospital litigation, while also planning their oversight of the three new MCO contracts.

New Hampshire is currently building out the encounter processing capability with their vendor, while also addressing provider network issues with the MCOs and refining their oversight approach to MMC before deploying the 1st phase of Care Management. One of the ongoing challenges with MMC oversight is receiving the proper and high quality data to effectively manage the health plans serving the Medicaid population. With a greater emphasis on quality and outcome measurement along with contract structures to reward reducing the rate of cost increases, this is critical to the long term success of the program.

After Governor Cuomo took office in New York, he empaneled a Medicaid reform committee to make substantial changes to the Medicaid program in New York, including expanding managed care to pharmacy and behavioral health beneficiaries. Prior to his election, New York had begun a replacement MMIS procurement in 2010. The procurement reached the stage of proposal evaluation before it was cancelled, at least in part due to the structural changes in the Medicaid program being implemented by the new administration. The replacement MMIS procurement was recently released in 2013. New York has had to address multiple vendors with additional contract extensions resulting from the delayed procurement timeline.

It is vital that states work with their existing and potential contractors and vendors when expanding or creating a MMC based delivery capability. While some of these partners will experience declines or elimination of business they typically have the data and information to enable careful analysis and planning for your MMC expansion. Working with them in a transparent manner also helps to avoid the risk of legal or protracted contract disputes that can interfere or reduce focus on your primary objectives.

Accountability, Quality, and Value-Based Purchasing

Traditionally many Medicaid MCOs also leveraged the fee-for-service foundation in developing their provider networks. As one of, if not, the dominant healthcare purchasers in many states, Medicaid programs should work to create alignment among value based purchasing initiatives and their managed Medicaid delivery models to ensure that payment and delivery systems do not result in overly burdened providers or create conflicting financial incentives. Viewing Medicaid in the context of a multi-payer system and aligning incentives is critical to controlling future costs and in constructing managed care contracts with the most appropriate incentives and financial levers.

Many Medicaid programs have already instituted quality and value-based purchasing design features. These are almost all designed to link patient care to health outcomes. This includes pay-for-performance programs or MMC auto-assignment algorithms based on quality scores to reward higher performing plans. Many agree that more fundamental reforms are necessary and CMS is instituting a number of programs and demonstrations in Medicare and supporting grants and waivers in Medicaid. In terms of leveraging the MMC delivery systems to foster value based innovations, there are multiple things to consider when states design their MMC contracts. States can incent preferred delivery system improvements through thoughtful development of MMC contracting requirements. This includes such things as:
Exchanges, all payer claims data, and additional transparency such as Health Information Exchanges, Health Insurance entirely new data sources are increasingly becoming available. The health care industry is undergoing dramatic changes and requirements and metrics are required for the future. To support delivery model changes and to plan what data to utilize the existing and new data sources to complete analysis making fully informed decisions. It is key for states to fully leverage less comparative data available from other states to assist in populations such as long term care or waiver, there is much new data sources need to be evaluated and a process determined to continually evaluate and plan the use of such data, while ensuring proper data security is in place will be an ongoing need for Medicaid programs nationwide.

Conclusions

As states move forward with expanding or refining MMC delivery models, it is critically important for states to effectively monitor and review the performance of health care delivery. This oversight ensures that MCOs are meeting their contractual obligations, providing quality care, and appropriately access to care, while continuing to deliver cost-effective management. In a MMC environment, states can and should play a centralized role in measuring and reporting performance, administering pay-for-performance programs, identifying opportunities for improvement, and monitoring utilization to identify potential fraud and abuse across managed care networks.

About Sellers Dorsey

Sellers Dorsey can help you. Our experts can assist in managed care strategy, contracting, plan monitoring, or review your managed care expansion plans. Sellers Dorsey can also assist states with population analysis and review for planned new populations, assist in defining the proper metrics, and financial alignment to support your program objectives.

Sellers Dorsey is a national consulting firm specializing in Medicaid financing, policy, operations, and information technology. Many of our staff are former state Medicaid officials. We have significant experience serving Medicaid agencies, Medicaid MCOs, and provider organizations. Medicaid MLTSS is a core competency. More information is available online at www.sellersdorsey.com.