

Medicaid Monitoring

An Overview of Managed Care

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Background

States have increasingly turned to the use of managed care for their Medicaid programs in the past two decades, as they seek ways to control costs of the program. This briefing paper provides an overview of the types of managed care programs available to states, the benefits and concerns associated with the programs, and some factors that may influence future development of managed care programs in Montana.

How Managed Care Works

Most state Medicaid programs started out using what's known as a "fee-for-service" model. This model pays a doctor, hospital, or other health care provider a fixed amount of money for each type of medical service a Medicaid enrollee receives. The person may obtain care from any provider who has agreed to take part in the Medicaid program.

In contrast, managed care programs limit the ways in which enrollees obtain services. Generally, managed care efforts can be divided into two categories:

- "capitated" systems, in which a state contracts with a private company that oversees health care services for enrollees and assumes the financial risk of providing coverage; or
- "primary care case management" systems, in which a state retains the risk of providing coverage but pays certain health care providers a monthly fee for coordinating the care of certain enrollees.

Both systems try to control costs by managing the ways in which Medicaid enrollees receive care and use services.

Under a capitated system, a managed care organization (MCO) sets up its own network of health care providers. Medicaid enrollees using that MCO typically must see the providers in that network. The state pays the MCO a fixed amount of money for each enrollee. The company then must try to ensure that the total costs of providing care to all the Medicaid enrollees in the program doesn't exceed the total amount paid by the state.

Under a primary care case management system, Medicaid providers are still reimbursed by the state on a fee-for-service basis. However, enrollees are assigned to a specific primary care provider. They may not see specialists or obtain care from anyone other than the designated primary care provider unless the provider authorizes that care. Providers who serve as care managers receive an additional monthly fee for providing that service.

As of October 2010, most states used one or both types of managed care systems. Thirty-six

states contracted with MCOs for capitated managed care programs that covered all or portions of their Medicaid populations. Thirty-one states used primary care case management systems. Only three states — Alaska, New Hampshire, and Wyoming — did not have managed care systems as of October 2010.¹ Many of the states without a capitated system were primarily rural in nature.²

Managed care programs may be either voluntary or mandatory. However, a state that wants to require Medicaid enrollees to participate in a managed care program must seek a waiver from the Centers for Medicare and Medicaid Services (CMS) to do so.

Pros and Cons of Managed Care Programs

Managed care systems use a variety of means to coordinate care and control costs. Typically, the systems require enrollees to use certain providers, obtain prior authorization for some services, and use of lower cost or outpatient services when possible.

These tools are seen by managed care advocates as a way to make sure that the health care services that are provided are both necessary and coordinated. They say that the coordination prevents unneeded or duplicated medical tests or services and results in better health outcomes. And if an enrollee needs services from more than one health care provider, the oversight provided by the MCO ensures that each provider is giving the appropriate type and amount of care.

In addition, states pay a fixed dollar amount for each person served by the MCO. As a result, they are better able to predict their Medicaid budgets if their caseloads remain relatively stable.

However, MCOs and individual providers participating in case management programs receive fees from the state to cover their administrative costs. The fees may reduce some of the savings from the use of managed care. And critics of managed care systems maintain that some MCOs focus more on keeping their costs low than on ensuring quality of care.

States also must walk a careful line in setting the capitation rates so that they are high enough to allow MCOs to recruit a provider network but not so high that the capitated system costs a state more than a non-managed care program would. Ensuring that enough providers are taking part in the capitated program is also critical to success, studies say.

¹Kathleen Gifford, Vernon K. Smith, Dyke Snipes, and Julia Paradise, "A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey," *Kaiser Commission on Medicaid and the Uninsured*, September 2011, P. 2

²"Report to the Congress: The Evolution of Managed Care in Medicaid," *Medicaid and CHIP Payment and Access Commission*, June 2011, P. 3.

A Lewin Group review of 24 studies of capitated managed care programs noted that nearly all the studies showed managed care programs saved money. The savings ranged from one-half of 1 percent to 20 percent.³ However, the report also noted that rural settings "pose daunting challenges to the managed care model in Medicaid (as well as for other payers.) The limited number of providers can make development of a network problematic, and the market may be unable to provide the economies of scale that are achievable in more metropolitan areas."⁴

Meanwhile, a report by the Kaiser Commission on Medicaid and the Uninsured noted both the benefits of managed care and the issues that states should consider: "At the same time that managed care offers significant potential to improve access and care for Medicaid beneficiaries, it can fail as a strategy if capitation payment rates are not adequate, transitions from fee-for-service are not well-conceived, provider networks are not sufficient to meet the care needs of the enrolled population, or state oversight of managed care programs is lacking."⁵

Managed Care in Montana

Montana's Medicaid program operates three managed care programs: Passport to Health, the Health Improvement Program, and Team Care. All three programs use the case management system, in which participating providers receive a monthly fee for overseeing care for certain enrollees. Following is a brief description of each program:

- The Passport to Health program operates across the state using providers who have agreed to take part. Medicaid enrollees choose a primary care provider and must either obtain medical care from that provider or receive approval from the provider to obtain certain services or care from other providers. Medicaid may decline to pay for medical care obtained from a non-Passport provider or for care that was not authorized by the Passport provider. Health care providers receive \$3 per month for each Medicaid enrollee in their care. Seventy percent of Montana's Medicaid enrollees are covered by the Passport program; groups that are excluded from the program include people who qualify for both Medicare and Medicaid, foster children, and people who are in nursing facilities.⁶
- The Health Improvement Program operates through 13 federally qualified Community

³ "Medicaid Managed Care Costs Savings -- A Synthesis of 24 Studies," *The Lewin Group* as prepared for America's Health Insurance Plans, July 2004 and updated March 2009, P. 1.

⁴ *Ibid*, Pages 6-7.

⁵ Kathleen Gifford, Vernon K. Smith, Dyke Snipes, and Julia Paradise, "A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey," *Kaiser Commission on Medicaid and the Uninsured*, September 2011, P. 1.

⁶ Interview with Mary Dalton, Manager, Medicaid and Health Services Branch, Department of Public Health and Human Services, Oct. 13, 2011.

Health Centers and one tribal health center. The program targets about 3,000 Medicaid enrollees who have the most acute conditions and who are expected to have the most expensive claims. The program matches enrollees with a care management team, with a goal of improving their health and reducing the need for high-cost services such as hospitalization. Nurses review medication use, remind patients of upcoming appointments, arrange transportation, and teach enrollees the skills they need to take care of themselves. The health centers receive \$3.75 per month for each Passport enrollee in the county or counties they serve.

- Team Care requires certain Medicaid enrollees to receive their primary care from one designated provider and their prescription drugs from one designated pharmacy. Enrollees also have 24-hour access to an advice line staffed by a nurse. People are enrolled in this program if they have used more medical services than the average enrollee. They are identified through a review of claims data showing that they've exceeded a threshold of use; a review of pharmacy claims; or referrals by providers. A provider receives \$6 per month for each Team Care enrollee in the provider's care.

Montana currently does not have a capitated Medicaid managed care program. However, it did contract with a private company in the 1990s for a capitated program for mental health services. Problems with that contract prompted the 1999 Legislature to eliminate funding for managed care, leading to termination of the contract. (See related briefing paper, *Montana's History with Managed Mental Health Care*, October 2008.)

Considerations for Future Managed Care Options in Montana

As Montana policymakers consider ways to rein in Medicaid costs, they will need to keep in mind how federal and state laws may affect the approach the state must take to a capitated managed care program. They also may want to consider the efforts related to a recently proposed pilot project.

In 2010, the Schweitzer administration proposed creating a capitated managed care program in Cascade, Lewis and Clark, Choteau, Judith Basin, and Teton counties. A draft concept paper developed by the Department of Public Health and Human Services (DPHHS) said the state would contract with one MCO to provide all health care services for all Medicaid enrollees in those counties. The state also said the pilot would reduce Medicaid costs in the target area by 10%.

The department noted in its concept paper to CMS that limiting the contract to one MCO "is crucial given the limited number of enrollees in the target counties. Having more than one managed care plan would not provide a population large enough to attract qualified managed care plans if the number of enrollees must be split between more than one plan."⁷

⁷ "Montana Regional (Five County) Demonstration Project DRAFT Concept Document for Discussion with CMS," *Department of Public Health and Human Services* [on-line]; available at

State officials said earlier this year that CMS gave the state strong indications that it may not approve the proposal because it would limit consumer choice to one MCO.⁸

The department also hired Mercer, a national consulting firm, to perform an actuarial analysis of the proposal. Mercer concluded that the state may achieve some savings with the pilot project, particularly in mental health and substance abuse treatment.⁹ However, its report noted that "a major challenge will be identifying a MCO partner and negotiating administrative costs to a reasonable level so as not to consume all of the potential utilization management savings."

The analysis also said that the existence of the Passport to Health program reduced the potential for savings, because a form of managed care is already in place. In addition, it said Montana's rural nature "will also reduce the savings potential to a certain degree."

Mercer's analysis concluded that the state might be able to save \$4.5 to \$8.5 million in the five counties, where Medicaid expenditures in fiscal year 2010 totaled almost \$137 million.¹⁰ That represented less than the 10% savings target set by the Schweitzer administration.

Meanwhile, federal law requires that states provide competition even within a managed care program by allowing enrollees to choose between at least two MCOs. That requirement may be waived in a rural area. But under federal regulations approved in 2002, a state that limits choice to a single MCO must also allow Medicaid enrollees to choose from at least two physicians or case managers and to obtain services from any other provider if necessary care cannot be obtained otherwise.¹¹ That requirement could limit the state's ability to predict or manage costs even if it uses a capitated managed care program.

Finally, lawmakers in 2011 put additional requirements in place for any Medicaid managed care program.

<http://www.dphhs.mt.gov/boardscouncils/healthcoalition/5countyconcepthandout12012010.pdf>; accessed Nov. 2, 2011.

⁸ Anna Whiting Sorrell, comments to the Children, Families, Health, and Human Services Interim Committee, June 20, 2011.

⁹ "Medicaid Managed Care Savings Assessment," prepared by Jonathan Marsden of Mercer for DPHHS, June 6, 2011, P. 13.

¹⁰ Ibid, P. 14.

¹¹ 42 CFR 438.52 - Choice of MCOs, PIHPs, PAHPs, and PCCMs.

Among other things, Senate Bill 351:

- establishes public notice and public comment requirements that DPHHS must meet before issuing a request for proposal (RFP) or awarding a contract;
- requires that the Legislative Auditor's Office and the State Auditor's Office analyze any RFP for actuarial soundness, network adequacy, and consumer choice;
- requires DPHHS to seek an independent analysis before awarding a contract, to verify that the potential contractor is able to comply with the goals of the proposed program;
- creates an advisory council to review RFPs for managed care systems;
- requires that an MCO have a network of health care providers that ensures that health care services are provided without unreasonable delay; and
- requires that any MCO be regulated under the state's insurance laws if the company's contract with the state:
 - ▶ is valued at \$1 million or more in state and federal Medicaid funds;
 - ▶ is in effect statewide; or
 - ▶ covers 20% or more of the Medicaid population.

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