Statewide Medicaid Managed Care Fundamentals: Key Concepts of an Integrated Managed Care System

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Presented to:

House Health Innovation Subcommittee

October 12, 2017

Presentation Overview:

1. High level overview of the Florida Medicaid program
2. Understanding delivery systems: fee-for-service and managed care
3. Evolution of Florida Medicaid's delivery system
4. Overview of elements of Statewide Medicaid Managed Care

The Medicaid Program

- The Medicaid Program is a federal/state partnership jointly financed by state and federal funds.
- Within broad federal guidelines, each state designs its own program.
- Florida Medicaid program design:
  - Governed by federal regulation, and
  - Authorized by the Florida Legislature in Chapter 409.

Florida Medicaid – A Snapshot

Eligibles	• Fourth largest Medicaid population in the nation. • Approximately 4 million Floridians enrolled in the Medicaid program: o 1.7 million adults - parents, aged and disabled o 47% of children in Florida. o 63% of deliveries in Florida. o 61% nursing home days in Florida. • 85% of Florida's Medicaid population receives their services through a managed care delivery system.
Expenditures	• Fifth largest nationwide in Medicaid expenditures. • $26.8 billion estimated expenditures in Fiscal Year 2017-18 • Federal-state matching program – 61.62% federal, 38.38% state. • Average spending: $6,619 per eligible. • $17.5 billion estimated expenditure for managed care in 2017-2018

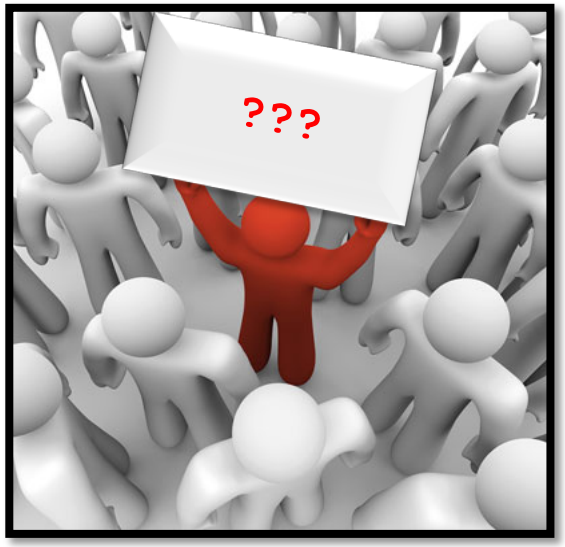
Medicaid Service Delivery Systems

- States may choose from a number of different systems through which to deliver Medicaid services.

- The two main “delivery systems” are:
  - Fee-for-Service
  - Managed Care

Delivery Systems: What is Fee-for-Service?

The Agency contracts directly with any provider who meets minimum qualifications. State cannot impose quality of care or performance standards.



Recipients locate and schedule appointments with Medicaid enrolled primary care and specialty providers without assistance from a case manager.

Providers are not required to accept new patients.

Delivery Systems: What is Managed Care?

Agency **contracts** with health plans and pays capitated payment

Recipients select the plan that will best fit their need

Case Managers

Providers furnish services to recipients

Plans **contract** with a network of qualified providers, negotiate varied payments and provide case managers

Delivery Systems: Fee-for-Service vs. Managed Care

Contracting	
Fee-For-Service (FFS)	Managed Care
No administrator empowered to ensure value. Any willing provider who meets minimum requirements gets a contract with the State. Providers paid a set rate statewide.	Health plan contracts are competitively procured and the number of contracts is limited to those that can provide the best value to the state. Select provider networks meet higher standards than FFS and are paid negotiated rates.
State has no authority to take compliance actions such as liquidated damages or sanctions for quality or performance problems.	Contracts include provisions for liquidated damages, sanctions or termination for failing to meet requirements, including quality and performance. Contracts include economic incentives –plans bear the risk for poor quality and performance and are rewarded for high quality.
State encourages providers to enroll in the program but cannot use leverage (either payment incentives or threat of compliance action) to make sure enough providers are available to meet the need.	Contracts require health plans to create and maintain a network of providers that will ensure access.
Contracts are for separate units of service, with no integration or coordination with other services.	Contracts are for comprehensive, integrated care (including preventive, acute, dental and behavioral health care, pharmacy and transportation), which incentivizes plans to coordinate care for best outcomes.

Delivery Systems: Fee-for-Service vs. Managed Care

Payment Methodology	
Fee-For-Service	**Managed Care**
Pay providers directly at a statewide set rate.	Pay health plans a fixed per member per month capitation rate. The health plans make payments to individual providers within their networks.
There is no payment flexibility:	Health plans have the flexibility to pay providers more or differently for service provided:
• Statewide rate set by the State, restricted by amount of funds appropriated for each service.	• Plans negotiate mutually agreed upon rates with providers.
• Each provider is paid the same rate – no volume-based pricing, no bundling, no geographic variations, no negotiations.	• Rates can be negotiated as FFS, bundled payments, sub-capitated payments.
• Separate fee paid for each individual service provided.	• Plans responsible for payment for all needed services for the enrollee, regardless of cost.
Methodology incentivizes quantity, not quality or efficiency.	Methodology incentivizes integrated care management, coordination, efficiency and high quality care.

Delivery Systems: Fee-for-Service vs. Managed Care

Accessing Services	
Fee-For-Service	**Managed Care**
Recipient must navigate systems without assistance and independently locate needed providers and coordinate own care.	Plans are required to have case managers to help navigate the health care system, locate providers, and schedule appointments and transportation.
State cannot ensure enough providers and provider types (like specialists) participate. Providers are enrolled if they meet minimum qualifications. No quality, performance measures or geographic enrollment standards for providers.	Health plans must contract with enough providers to timely provide all covered services to all enrollees. • Standards for timely access of urgent care, sick care, and well care visits as well as availability within certain drive time and distance from recipients. • Plans can limit providers in their network to those who provide efficient services and meet high quality and performance to more effectively provide care and contain costs.
The State cannot require that providers accept Medicaid patient. Providers are not obligated to take a minimum number of Medicaid patients.	Plans are held accountable for ensuring the providers in their networks accept Medicaid patients.

Delivery Systems: Fee-For-Service vs. Managed Care

Integration and Incentives to Provide Appropriate Care	
Fee-For-Service	Managed Care
Different types of care are in “silos”. Individual providers are focused on the type of service they provide, not impacts to other “silos”.	The integrated care model holds plans accountable for preventive and acute care across all service types and forces care coordination between “silos”.
Providers are paid for each individual service provided, regardless of its effectiveness or outcome. There is no penalty to the provider for a failure to provide preventive or acute care that causes a need for more costly care later.	Risk based, capitated payments include costs for all service types, so plans will pay for more costly avoidable services if they do not provide appropriate preventive and acute care. This eliminates incentives to deny needed care. Profit Sharing (Achieved Savings Rebate) and Medical Loss Ratio mechanisms also eliminate incentives to deny needed care.
There is no measurement of quality or performance that results in an incentive or a disincentive for individual providers.	In a bifurcated system, even under managed care, if a managed care plan is not responsible for a certain segment of services, for example dental, you cannot get them to care about adverse impacts in that sector of services.

Evolution of Florida Medicaid Delivery System

1970 | 1980 | 1990 | 2000 | 2010 | 2020

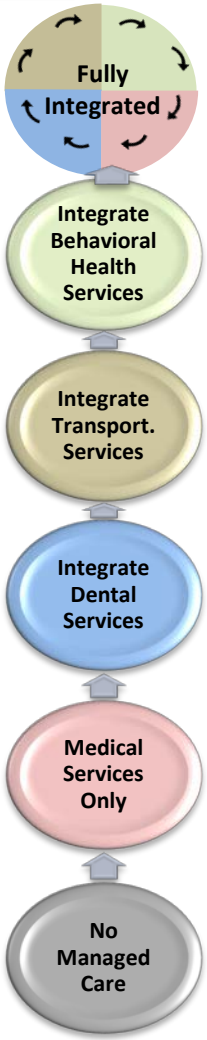
1970s
Fee-for-Service only/ No Managed Care

1980s
First Managed Care (Limited counties): Medical Services only

1990s
Managed Care Medical Services Only (limited counties)

2006
Medicaid Reform Pilot: Integrates Medical, Mental Health, Dental and Transportation into Managed Care (limited counties)

2014
Statewide Medicaid Managed Care: Fully Integrates Medical Care, Dental, Behavioral and Transportation into Managed Care (statewide)



Elements of Statewide Medicaid Managed Care (SMMC)

- Main elements of the SMMC program made possible by integrated care and limited networks:
  - Care Coordination
  - Expanded Benefits
  - Flexibility in Payment to Providers
  - Enhanced Provider Networks
  - Enhanced Quality and Performance

SMMC Elements: Setting the Stage

- Real life examples to help illustrate key concepts:

  - Deandrea is a 35 year old mother with depression. Deandrea has a three year old daughter named Tiffany. Deandrea and Tiffany are enrolled in the Managed Medical Assistance program. Deandrea does not have access to a car for transportation.

  - Victor is a 67 year old man who is currently residing in a nursing home. He is recovering from a fall that occurred at his home and hopes to return home when he is well enough. Victor is eligible for both the Long-term Care program and the Managed Medical Assistance program, as well as Medicare.

SMMC Elements: Care Coordination

Fee-for-Service	Managed Care
Recipients are responsible for navigating the health care system on their own.	**Integrated Model Enhances Effectiveness of Care Coordination** Health plan case manager helps enrollees navigate the health care system. Examples: • Scheduling appointments • Locating doctors and specialists • Help transitioning from one service setting to another (e.g., hospital to home) Helps connect the health care "dots" and promotes quality outcomes. Medicaid health plans must have an enrollee help line that can be accessed 24/7 to assist with inquiries from enrollees and caregivers.

SMMC Elements: Care Coordination In Action

Deandrea needs to be seen by a mental health provider and needs transportation.

Deandrea contacts her plan case manager who schedules a three way call with her mental health provider and helps with setting up an appointment.

The case manager also schedules transportation to the appointment.

Victor no longer needs the intense physical therapy he is getting in the nursing facility but is still quite frail.

During a face to face meeting with his health plan case manager he requests to move back home.

The case manager schedules home health services, homemaker, bed rails, and a shower chair so he can move home.

SMMC Elements: Expanded Benefits

Fee-for-Service	Managed Care
Recipients can only access benefits covered by Medicaid.	**Integrated Care Model Incentivizes Expanded Benefits: Providing additional preventive care can result in reduction in need for more expensive emergency or acute treatment.** • Recipients can access benefits not covered by Medicaid. The plans are responsible for all payment for these benefits with no additional cost to the state. • Examples: o Preventive adult dental (e.g., cleanings) o Over the counter medication and supplies o Flu vaccines for adults o Lodging and food when traveling to receive medical services o Support for transition out of a nursing facility (e.g., rent deposit) o Transportation to services other than medical appointments

SMMC Elements: Expanded Benefits in Action

Victor has a sore throat and a cough.

Victor thinks about going to an urgent care clinic, but remembers that his plan offers over-the-counter benefits. Victor visits his local drugstore and obtains pain reliever, cough medicine, and cough drops that help him to feel better. No further treatment is needed.

SMMC Elements: Flexible Provider Payments

Fee-for-Service	Managed Care
Providers receive the same reimbursement amount when providing the same service. The reimbursement amounts are set by the Agency and posted in the Agency fee schedules. The Agency cannot pay a provider more than the amount of reimbursement funded by the Legislature and listed in the fee schedule.	**A fully integrated model provides plans with additional flexibility for provider payment arrangements.** Providers and the managed care plans negotiate mutually agreed-upon rates. Plans and providers can use this to their advantage: • Providers can negotiate a higher rate over the fee-for-service level • Plans can use higher payments to entice providers into their network who otherwise would not serve Medicaid recipients.

SMMC Elements: Flexibility in Payment to Providers In Action

Deandrea needs to see an orthopedist who specializes in a specific procedure.

Only a few providers offer the procedure in the state, and the closest provider isn't accepting any new Medicaid patients.

The plan negotiates an agreement with the provider at a higher rate than offered by traditional Medicaid to treat Deandrea.

SMMC Elements: Enhanced Provider Networks

Fee-for-Service	Managed Care
There are no provider network access standards in the fee-for-service program. Any willing provider who meets minimum requirements enters into a provider agreement with the State.	**Ability to limit provider network based on quality, performance and access results in enhanced provider networks.** There are strong standards to ensure enrollees can get access to services: • Providers must be available within a certain drive time and distance for each enrollee. • There are provider to recipient ratios. • Time and distance standards and/or provider ratios are established for more than 40 provider types in the SMMC contract. Plans select network providers and develop provider contracts to ensure these standards are met.

SMCC Elements: Enhanced Provider Networks In Action

Tiffany's pediatrician recently retired, so she needs a new pediatrician.

Plans are required to have pediatricians within 35 miles of recipients.

Deandrea selected a new pediatrician for Tiffany who is located close to her home and is also close to a bus route.

The plan pays for Deandrea and Tiffany to take the bus to see the new pediatrician.

SMMC Elements: Enhanced Quality and Performance

Fee-for-Service	Managed Care
There is not a process for measuring quality in the fee-for-service program.	**Ability to limit their networks to providers with high performance allows plans to meet national quality standards.** The Agency measures the quality of health care the plans provide using standard measures (HEDIS) used by the majority of health plans in the United States. Examples: • Timely prenatal care • Children receiving immunizations & check-ups • Management of diabetes & hypertension The Agency compares plans' scores to Medicaid plans nationally. • Plans earn bonuses for exceeding standards and are assessed liquidated damages for failing to meet standards.

SMMC Elements: Enhanced Quality and Performance in Action

There are performance measures associated with well-child check-ups and antidepressant medication management

Deandrea is currently prescribed antidepressant medication, but doesn't like the side effects. Tiffany is due for her 4-year old well-child check-up and immunizations.

The plan sends Deandrea a reminder that it is time for Tiffany's check-up. The plan case manager calls Deandrea and schedules an appointment with her psychiatrist about her antidepressant medication.

Deandrea takes Tiffany to her well-child visit and works with her psychiatrist to adjust her medication. The side effects get better, and she continues taking the medication.

Plan scores well on these two performance measures

Wrap Up

Integrated managed care allows all medical services to be provided through one comprehensive health plan.

Managed care provides flexibility while adding enhanced accountability.

Managed care allows for enhancements around provider network requirements, quality, and performance.

The structure of the SMMC program allows integration across medical and long-term care services.

Questions?