

Medicaid Managed Care  
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# Overview of Presentation

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- Context for Managed Care in Maine
- What is Medicaid Managed Care?
- Why do States choose Managed Care?
- How does it work?
- How are major policy design decisions in developing a Managed Care Program?
- What are other states doing?
- What are outcomes from Managed Care?

# Maine Context

- Costs for elderly and disabled drive Medicaid costs (2008-2009)

Group	Population as % of Total	Costs as % of Total
Children	36%	18%
Adults	31%	9%
Elderly	16%	29%
Disabled	18%	45%
Total	100%	100%

- Enrollment 350,100
- Spending \$1,930 million

# What is Medicaid Managed Care?

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- Medicaid managed care is a general term that describes a number of different payment methods that states use to improve quality and control spending.
  - Primary Care Case Management
  - Administrative Service Arrangements
  - Capitated Managed Care

	<b>Primary Care Case Management (PCCM)</b>	<b>Administrative Services Organization (ASO)</b>	<b>Full Risk Contracting (Capitated)</b>
<b>With whom is the State contracting?</b>	Primary care providers (usually a doctors)	A third-party vendor. (Maine currently contracts with APS)	An entity that can legally assume full financial risk (usually an MCO)
<b>What does the contractor do?</b>	Coordinate care, make referrals, be available	Utilization review, enrollment, claims processing, reports	Coordinate care, manage network, assume full risk
<b>How is the contractor paid?</b>	Monthly fee for coordination, services are FFS	Fee for admin function provided; services are FFS	Full capitation for coordination and all services
<b>How is quality improved?</b>	State provides quality incentives to primary care providers	State may provide quality incentives to ASO, through ASO to providers, or directly to providers	State provides quality incentives to contractors, who in turn work with providers

# Why do states choose full risk managed care

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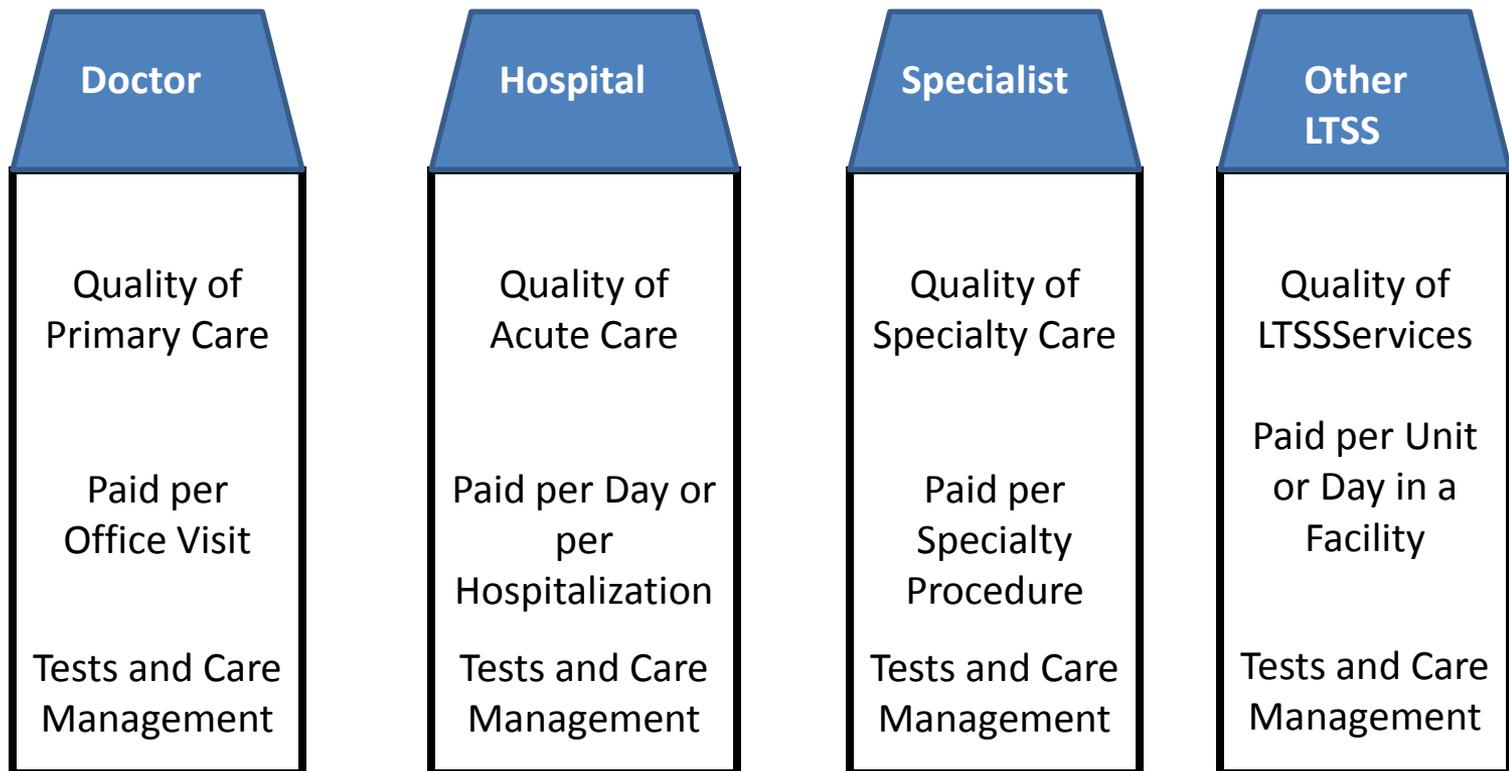
- Budget Certainty
  - Eliminates variability in utilization and cost
  - Only variable is enrollment
- Cost Savings
  - Rates paid usually assume budget savings
- Improve Care Coordination
  - Better “whole person management”
  - Opportunity to reduce or eliminate silos
- Increased accountability
  - Improved ability to measure system improvements
  - Hold plans accountable for quality improvements and outcomes

# How Does it Work?

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- Medicaid agency sets quality standards, requirements, expectations for practice etc.
- A contractor agrees to provide all needed services and meet quality standards for a set price, called a **capitation**.
- Medicaid agency measures performance and pays incentives when meet goals
- Medicaid agency monitors quality closely

# Current System: Accountability and Payment in Service Silos



Member, family and individual case managers cope with multiple, separate services.

# Managed Care System: Global Accountability and Payment

Doctor

Hospital

Specialist

LTSS

Contractor is responsible for member outcomes  
across services.

Contractor receives a set monthly fee (capitation)  
regardless of the amount of services used.

Member experiences better coordination across  
services.

# What are design decisions?

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- Populations to enroll?
  - Parents and children
  - People with disabilities/long term care needs
  - Children with special needs
  - Other
- Services to include in capitation rate? (carve in/out)
  - Hospital and physician etc
  - Other (home care, mental health, nursing home, etc)
- Mandatory or Voluntary Enrollment
- Statewide or Regional

# What Changes for Members?

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- Change: members must choose a plan.
  - Mandatory enrollment – choice of a managed care plan
  - Voluntary enrollment – choice of a managed care plan or fee for service
- No change: member chooses a doctor. This happens now in Primary Care Case Management.
- No change: member must get a referral from the doctor for many specialty services.

# Managed Care Expansions

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- Managed Care expansions
  - West Virginia, California, Illinois, Kansas moving/considering moving Aged Blind Disabled into managed care
  - Mississippi and Louisiana are developing statewide models
- States with long term managed care
  - Arizona, California, Florida, Massachusetts, Minnesota, New Mexico, New York, Texas, Washington, Wisconsin, Tennessee, Hawaii and Penn.

# Outcomes from managed care

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- Increased likelihood of members having a usual source of care
- Reduces the use of emergency room use and hospitalizations
- Associated with smoking cessation among pregnant women
- Increases the likelihood that members will receive prenatal care, well-child care and childhood immunizations

# Success Factors

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- Cultivate long term collaborative relationships with contractors
- Measure performance
- Build effective administrative infrastructure
- Adapt to local conditions
- Engage stakeholders early and continuously

# Other Resources

- [http://www.maine.gov/dhhs/oms/mgd\\_care/mgd\\_care\\_index.html](http://www.maine.gov/dhhs/oms/mgd_care/mgd_care_index.html)

Katie Rosingana, Paul Saucier. Outcomes of Risk-based Managed Care Programs: A Review of the Literature; Muskie School of Public Service 2010.

Julie Fralich, Stuart Bratesman, et al. **Chartbook: Older Adults and Adults with Disabilities; Population and Service Use Trends**, Muskie School of Public Service. 2010.

Griffin, E., Fralich, J., McGuire, C., Olsen, L., Bratesman, S., Bubar, K., Ring, C., Yoe, J., & Turyn, R. (2009, March). **A cross-system profile of Maine's long term support system: A new view of Maine's long term services and supports and the people served**. Portland, ME: University of Southern Maine, Muskie School of Public Service and the Maine Department of Health and Human Services.