

Medicaid Managed Care



Senate Health & Long-term Care Committee

January 13, 2020

MaryAnne Lindeblad, Medicaid Director

What is Medicaid Managed Care?

- ▶ **Definition:** a health care delivery system organized to manage cost, utilization, and clinical and service quality
- ▶ **How:** Medicaid managed care provides for the delivery of Medicaid health benefits through contracted arrangements
- ▶ **Why:** Improvement in health plan performance, health care quality, and outcomes are key objectives of Medicaid managed care

Fee-for-Service vs. Managed Care

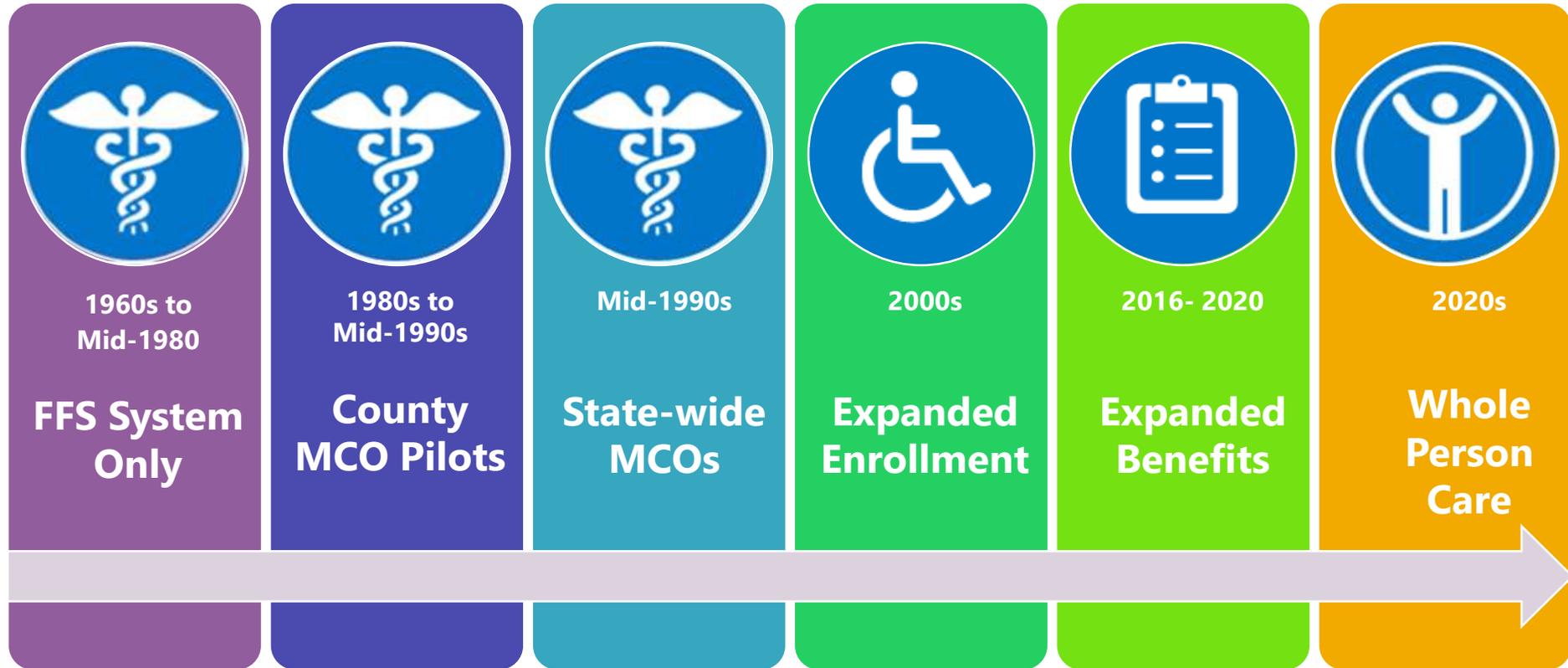
Historically, **Fee-for-Service (FFS)** has been the common approach taken by state Medicaid programs.

- ▶ In a Fee-for-Service model, health care services are paid for as individual units of service; every type of service has a pre-defined rate.
- ▶ This is an a la carte approach that emphasizes quantity of care over quality.

Today, most states – including Washington – are embracing a **Managed Care** model of health care delivery.

- ▶ Under such models, a state Medicaid program contracts with private managed care plans (MCPs) to provide health care coverage to beneficiaries. The state then pays an MCP a per member per month/capitation payment.

Timeline to Integrated Managed Care



Medicaid Managed Care – Washington (cont.)

- ▶ 1.8 million Washingtonians enrolled in Apple Health (Medicaid) and approximately 86.6% are enrolled in managed care.
- ▶ Five Medicaid Managed Care Plans are contracted with the state to deliver physical and behavioral health
 - ▶ Molina Healthcare of Washington, Community Health Plan of Washington, UnitedHealthcare, Coordinated Care, Amerigroup
- ▶ Coordinated Care also manages care for children involved in the foster care system statewide

Integrated Managed Care is now statewide

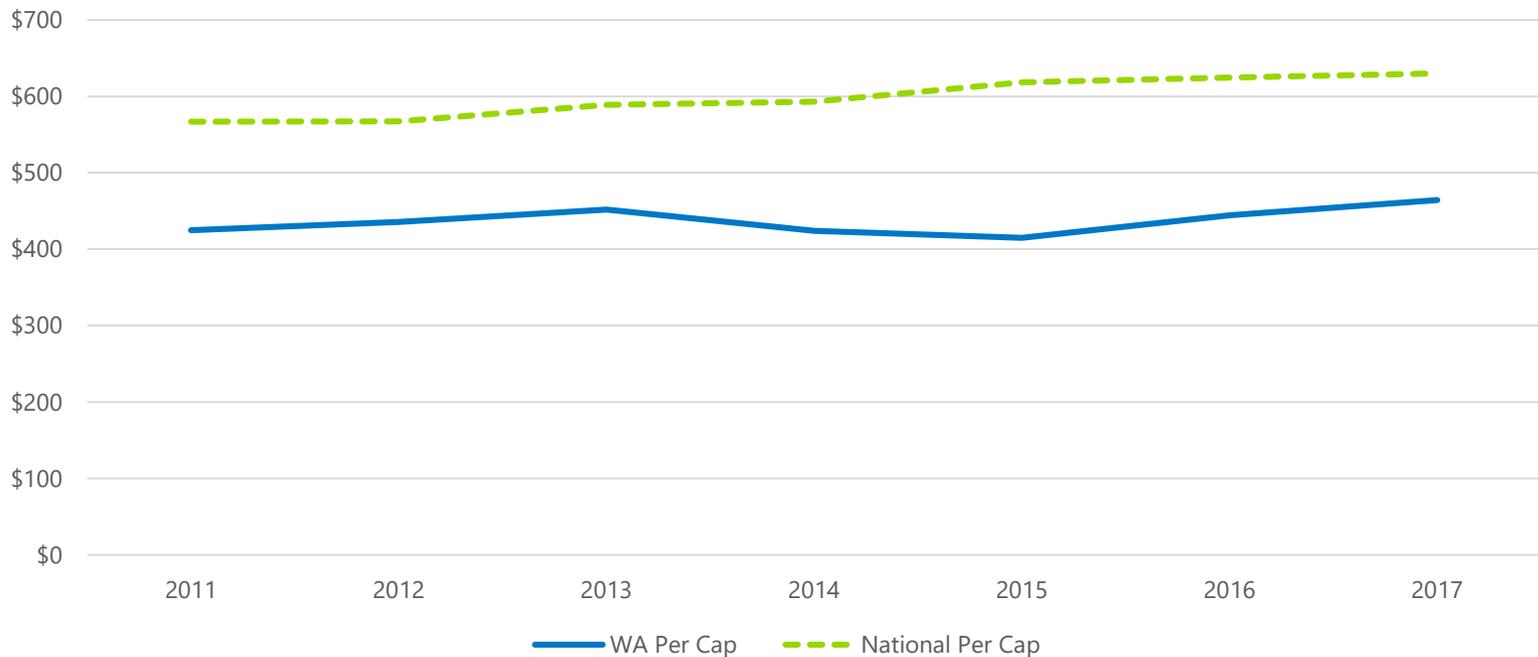
- ▶ Last three regions implemented IMC January 1, 2020
- ▶ Most Medicaid Clients are enrolled:
 - ▶ Medicaid only clients receive full medical and behavioral health benefits through managed care
 - ▶ Dual-eligible clients receive behavioral health benefits through managed care
 - ▶ American Indian/Alaska Native can opt out

Goals of Medicaid Managed Care

- ▶ Improve access to care
- ▶ Test new ways of purchasing health care
- ▶ Achieve predictability for spending: “bend the trend”
- ▶ Improve quality
- ▶ Improve accountability

MC Controls Growth in Spending

WA Per Cap has remained lower than national average



Role of Managed Care Organizations in Washington

- ▶ Facilitate care management
- ▶ Assure clinical and service quality
- ▶ Build provider networks
- ▶ Engage & partner with communities
- ▶ Leverage data and technology
- ▶ Monitor & maintain compliance

Care management

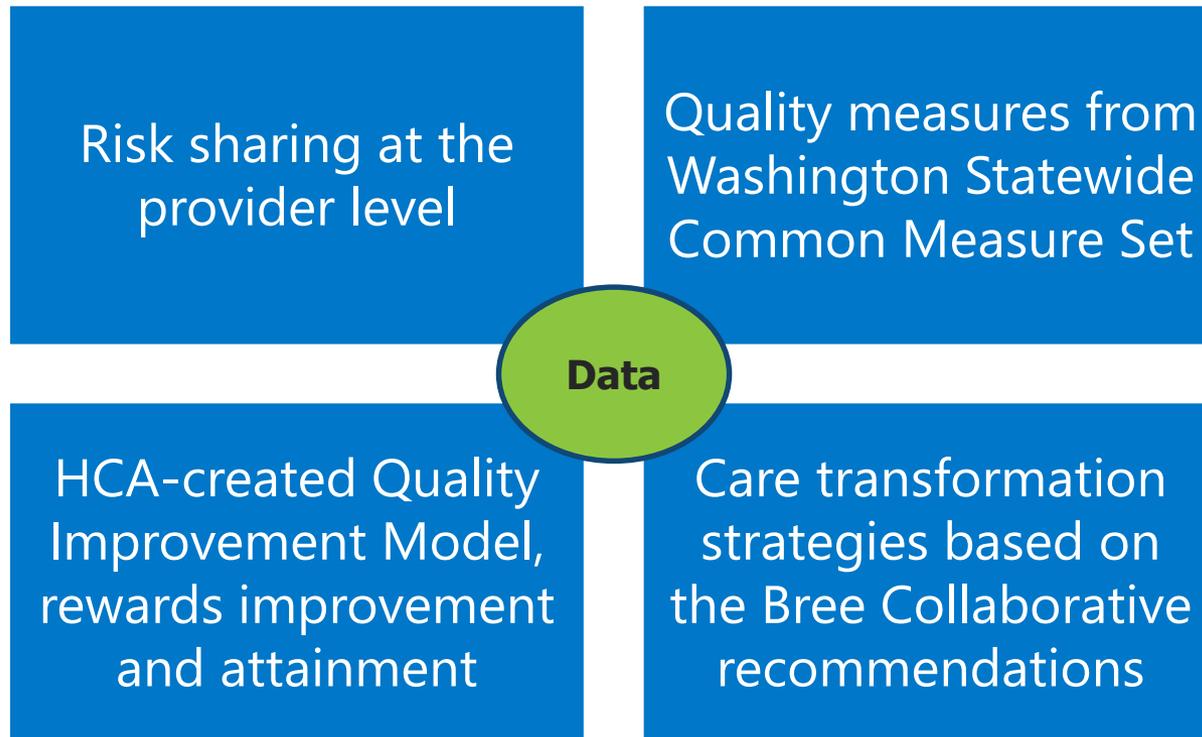
▶ Utilization Management

- ▶ Right Care: Medically Necessary
- ▶ Right Time: Pursue Appropriate lower level interventions first
- ▶ Right Provider/Right Care: Pay for quality/performance and Evidence Based Practices

▶ Case Management for High Needs Members

- ▶ Complex case management, care coordination, disease management, and health education
- ▶ Health Homes as example of strong community based care management

Common elements in HCA's new models of care



Whole-person care

▶ Patient experience

- ▶ “No wrong door” to care, seamless experience, higher satisfaction, stigma reduced, greater likelihood of needs being identified and met

▶ Clinical outcomes

- ▶ Improved outcomes for both physical and behavioral conditions when care is integrated

▶ Costs

- ▶ Clinical integration reduces overall costs of care

▶ Provider experience

- ▶ Higher clinician satisfaction in integrated settings

Better health, better value

▶ **Practice transformation:**

- ▶ Population health (focus on health outcomes)
- ▶ Whole-person care (body, mind, teeth, etc.)

▶ **Financial oversight and new models of purchasing:**

- ▶ Rigorous and regulated managed care rate development
- ▶ Value-based payment

▶ **Medicaid Transformation:**

- ▶ MCOs partner with the community to address the most challenging patients
- ▶ MCOs shift from traditional medical model to whole person care and social determinants of health

Questions?

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A photograph of a woman with long brown hair, wearing a red top and pink pants, sitting on the floor and reading a colorful book to a young child with brown hair, wearing a pink polo shirt and blue shoes. The child is looking at the book with interest. The background is a bright, blurred indoor setting, possibly a living room or playroom, with a television and some furniture visible.

Children's Mental Health Work Group

Senate Behavioral Health Subcommittee

January 17, 2020

MaryAnne Lindeblad – Medicaid Director

Children's Mental Health Work Group (CMHWG)

Established in 2016 legislation, the CMHWG's work is focused on:

- Identifying barriers to and opportunities for behavioral health services and strategies for children, youth and young adults (prenatal to age 25 years old) and their families that are:
 - Accessible
 - Effective
 - Timely
 - Culturally and linguistically relevant
 - Supported by evidence
- Advising the Legislature on statewide behavioral health services and recommended improvements.
- Monitoring enacted legislation, programs, and policies.

- Work group established
E2SHB 2439
- Report and recommendations
December 2016

2016

- Provider reimbursement for depression screens
- Care coordination and network adequacy requirements
- Child psychiatry residency
- Pilot behavioral health leads at ESDs
- Behavioral health consultation for child care providers
E2SHB 1713
- Paperwork reduction requirements
E2SHB 1819

2017

- Maternal depression - Same-day consultation line and support to health care providers
SSB 6452
- Strategy for Medicaid funding for infant home visiting
Additional child psychiatry residency
- Pilot mental health literacy curriculum for students
E2SHB 2779

2018

- First episode psychosis New Journeys programs statewide
- Social-emotional learning in schools
Additional coaching for early achievers child care providers
- Additional child psychiatry residencies
2SSB 5903
- Family-initiated treatment
E2SHB 1874
- Pilot PAL for Schools, including behavioral health education
ESHB 1109

2019

CBHWG and subgroups

The work group met four times during the interim.

In addition, five subgroups, that included CMHWG members and others, met and developed recommendations in these areas:

- ▶ Partnership Access Line (PAL)– development of funding model
- ▶ Prenatal to age five relational health
- ▶ Family Initiated Treatment (E2SHB 1874, 2019)– follow up recommendations
- ▶ Workforce (serving prenatal to age 25)
- ▶ Student well-being and school-based supports, including connections to behavioral health and intellectual developmental disabilities [IDD] services and supports

2020 recommendations

Partnership Access Line Funding Model

- ▶ A CMHWG sub-committee convened during the 2019 interim per 2SSSB 5903.
- ▶ The sub-committee developed a funding model recommendation for the behavioral health consultation and referral services (PAL lines).
- ▶ The model includes:
 - ▶ Partnership Access Line, started in 2008
 - ▶ PAL for Moms (2 year pilot – January 2019 through June 2021)
 - ▶ Referral Assistance Line (2 year pilot – January 2019 through June 2021)
 - ▶ Tele-behavioral Health Call Center/Psychiatry Consultation Line (PCL) which started 7-1-19
- ▶ PAL for Moms and the Referral Assist Line will be added to the funding model if and when they become permanent programs.

2020 recommendations

Partnership Access Line Funding Model (cont.)

- ▶ Commercial carriers will be assessed the non-Medicaid costs.
- ▶ HCA will pay administrative costs associated with assessment
- ▶ The Joint Legislative Audit and Review Committee will conduct an evaluation of the PAL for Moms and Referral Assist Line.
 - ▶ Performance measures will be developed for each of these programs, with requirements for quarterly reporting.

2020 recommendations

Renew the workgroup

- ▶ Change name officially to include “behavioral” health
- ▶ Include transition age youth in scope
- ▶ Add youth voice to the workgroup
- ▶ Add standing subgroups:
 - ▶ School-based Services and Suicide Prevention
 - ▶ Add standing Family, Youth, and System Partner Roundtable Resolution

2020 budget recommendations

- ▶ Fund behavioral health navigators in all nine Educational Service Districts.
- ▶ Provide flexible funds for clinician training and mentoring.
- ▶ Increase behavioral health counseling and psychotherapy and care coordination rates by eight percent, or the Medicare rate, whichever is higher, for all settings.
- ▶ Analyze the impact of changing Medicaid policy to match best practices for mental health assessment for infants and children to age five.
- ▶ Extend PAL funding for Mom and the PAL Referral Assistance Line for Kids pilots (January 2020 - June 2021) to avoid early termination.

Themes of the CBHWG

- ▶ Overarching theme of ensuring equity, diversity, inclusion and trauma informed approaches in all services, training, and system design
- ▶ Developmentally appropriate services in the “0 – 25” age group
- ▶ Cross system coordination
- ▶ Network adequacy
- ▶ Workforce
- ▶ Provider rates

More information

- ▶ CMHWG Co-Chair: MaryAnne Lindeblad
- ▶ CMHWG Co-Chair: Representative Frame
- ▶ Website:
<https://www.hca.wa.gov/about-hca/behavioral-health-recovery/childrens-mental-health-workgroup-cmhwg>
- ▶ E-mail: cmhwg@hca.wa.gov



Children's Mental Health Work Group

The **Children's Mental Health Work Group (CMHWG)** was established in 2016 to identify barriers to children, youth and families face accessing mental health services, and advise the Legislature on statewide mental health services for this population.

Areas of focus and successes

Rates

- Increases in Behavioral Rehabilitation Service rates [ESB 1109 (2019)]
- Increases in bi-directional behavioral health rates [SSB 5779 (2017)]
- Reimbursement for primary care depression screens for mothers of infants to 6 months and youth, ages 12-18 annually [E2SHB 1713 (2017)]

Workforce development and training

- Funding for two psychiatric residencies at UW and two at WSU [E2SHB 1713 (2017), E2SHB 2779 (2018), and 2SSB 5903 (2019)]

Service delivery and care coordination

- HCA to ensure adequate care coordination and network capacity in managed care contracts [E2SHB 1713 (2017)]
- HCA to report annually on network adequacy for eating disorder treatment [E2SHB 2779 (2018)]
- OIC to require carriers to post behavioral health provider directories and complaints filed [ESHB 1099 (2019)]
- Family Initiated Treatment, addressing parental participation in their children's behavioral health treatment (E2SHB 1874 (2019))
- Development of a statewide plan to implement New Journeys, a coordinated specialty care program for early intervention treatment of psychosis [2SSB 5903 (2019)]
- Paperwork reduction – DSHS/HCA to streamline documentation requirements [E2SHB 1819 (2017)], and ensure that initial documentation requirements are no more burdensome than for primary care (E2SSB 5432 (2019))
- Partnership Access Line – Same day consultation and support for physicians in assessment/treatment of maternal depression [SSB 6452 (2018)] and behavioral health referral service for youth and families

School-based services

- Office of the Superintendent of Public Instruction (OSPI) to pilot behavioral health leads at two educational service districts (ESDs) (E2SHB 1713 (2017))
- Beginning in 2020-21, school districts to use one professional education learning day for social-emotional learning, trauma-informed practices, mental health, anti-bullying, or cultural sensitivity [2SSB 5903 (2019)]
- Point of contact in each school for students experiencing homelessness; state-funded grants for schools serving students experiencing homelessness [SSB 5324 (2019)]

Infant and early childhood mental health

- Implementation of infant and early childhood mental health consultations in 2 regions [2SSB 5903 (2019)]

Promote culturally/linguistically appropriate services, hiring and support throughout system

2020 CMHWG Recommendations to the Legislature

Rates

- Increase children’s counseling and psychotherapy, and care coordination rates (budget proviso)

Workforce development and training

- Provide flexible funds for clinician training and mentoring (budget proviso)

Service delivery and care coordination

- Extend PAL for Moms and Referral Assist Line funding through end of pilot period (Jan. through June 2021) [budget proviso]
- Implement recommended sustainable funding model for original PAL, PAL for Moms and Referral Assist Line – commercial carriers pay proportional share of non-Medicaid costs

School-based services

- Fund behavioral health navigators in all 9 ESDs [OSPI agency request]

Infant and early childhood mental health

- Analyze the impact of changing Medicaid policy to match best practices for mental health assessment for infants and children to age 5

Overall

- Re-authorize the CMHWG to continue its work and expand focus to include:
 - Change name to “behavioral health”
 - Add member roles for transition age youth (to age 25) and individuals with lived experience receiving services as youth
 - Equity, diversity and inclusion, and trauma-informed approach as core components
 - Standing subgroups: School-based Behavioral Health and Suicide Prevention and Family, Youth, and System Partner Resolution subgroup
 - Review and revise membership categories to ensure cross-system coordination and create a more diverse work group, including youth and young adults

Ongoing themes and issues

Services for young adults
Cross-system coordination
Network adequacy
Workforce

Provider rates
Racial diversity and inclusion
Trauma informed approach

About the Children’s Mental Health Work Group

The CMHWG includes representatives from the Legislature, state agencies, health care providers, tribal governments, community health services and other organizations, as well as parents of children and youth who have received services.

Its work is focused on identifying barriers to and opportunities for behavioral health services and strategies for children, youth, and young adults (prenatal to age 25 years old) and their families that are: accessible, effective, timely, culturally and linguistically relevant, and supported by evidence.

The CMHWG also advises the Legislature on statewide behavioral health services and recommend improvements, and monitors enacted legislation, programs, and policies.

CMHWG Co-chairs

Representative Noel Frame
Washington State Legislature

MaryAnne Lindeblad
State Medicaid Director

Medicaid background

Primarily managed care

The Health Care Authority (HCA) purchases health care services for Medicaid populations in a state/federal partnership program. HCA purchases care through FFS and managed care programs.

HCA covers 1.8 million lives – 87% are enrolled in managed care, and the remainder in our fee-for-service (FFS) program (dually eligible and Tribal).

HCA contracts with five managed care plans, which in turn, contract with independent providers and coordinate and manage care of Medicaid enrollees.

Rates Methods

Fee-For-Service (FFS) or Managed Care

There are two approaches to rate setting:

- (i) Traditional FFS, which establishes a rate associated with a specific procedure code that the provider bills HCA after seeing a patient; or
- (ii) Managed care, which is a capitation based on a developed rate that incorporates a prepaid per-member per-month (PMPM) for each individual enrolled in the managed care plan.

In addition, there is separate methodology for federally qualified health centers and rural health clinics, based on certain cost-basis federal requirements.

Managed care rates vary by eligibility group (Apple Health Family and Adult; State Children's Health Insurance Program or SCHIP; and Aged, Blind, and Disabled or ABD).

The rates are set annually and includes all major covered services provided through the Medicaid program, now including behavioral health (services for mental health and substance use disorders).

The managed care plans negotiate rates with providers under a state capitated budget arrangement. The plans are at risk for over-utilization in managed care, whereas the state is at risk under FFS.

FFS rates are updated annually in a budget neutral manner using Resource Based Relative Values Units (RBRVUs), which are weights set by the U.S. Centers for Medicare and Medicaid Services (CMS).

Managed care plans are not held to a strict fee schedule, but have the flexibility to pay providers based on network, access, quality achievement, reduction of ER and hospital utilization, including value based purchasing approaches such as capitation and bundled payments.

Managed care is the mode of service delivery, not just in Washington but in 38 other states.

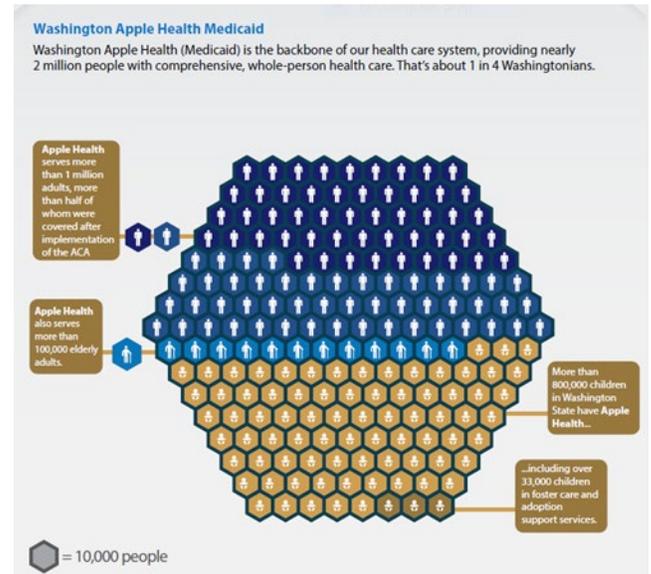


Figure 1. Washington Apple Health provides care for nearly 1 in 4 Washingtonians from all walks of life.

Increases in rates were regular, but now more targeted

Rates for both FFS and managed care are based on legislative appropriations. The last across-the-board increases were in the mid-2000s.

Before that, the legislature would budget increases of 1-2% annually to keep up with inflation.

Given budgetary challenges, recessions, and a move to managed care, those almost automatic across-the-board rate increases have stopped.

As a part of the Affordable Care Act, CMS increased primary care rates to match Medicare rates for a two year period during 2013-2014. The results were mixed due to the short term nature of this increase.

In 2018, a small pediatric rate increase that included a much needed increase for vaccine service rates, but the other impacts have been difficult to assess. Increases often prevent current providers from leaving the program rather than increasing the overall number of providers.

Managed care in Washington

In response to serious access issues, the state moved the first major population groups (pregnant women and children) into managed care starting in 1993. This improved access to care, especially for primary and specialty care.

In 2012, the second major expansion occurred to add the non-dually eligible Aged, Blind and Disabled (ABD) population. The state expanded to the five managed care plans we have today.

Finally, in 2014 the state expanded Medicaid under the Affordable Care Act, covering nearly 600,000 new people (who earn under 138% of the Federal Poverty Limit, roughly \$17,000/year for individuals).

Managed care regulations and actuarial rate setting offer considerable oversight

The managed care program is heavily regulated by CMS, in partnership with HCA, in terms of rate setting, network adequacy, solvency and quality.

For managed care populations, CMS requires the state to use an actuary to certify 'actuarial sound' rates, which means rates that are "projected to provide for all reasonable, appropriate, and attainable costs that are required, [and] developed in such a way that would reasonably achieve a medical loss ratio standard [as] long as the capitation rates are adequate for reasonable, appropriate, and attainable non-benefit costs."

"Actuaries must develop and apply trend factors, including cost and utilization, to base data that are developed from actual experience of the Medicaid population in accordance with generally accepted actuarial practices and principles." CMS then must ensure the strict set of requirements are met before approving the rates. (42 CFR 438.1-5; Sec. 1102 of the Social Security Act, 42 U.S.C. 1302).

MC Controls Growth in Spending

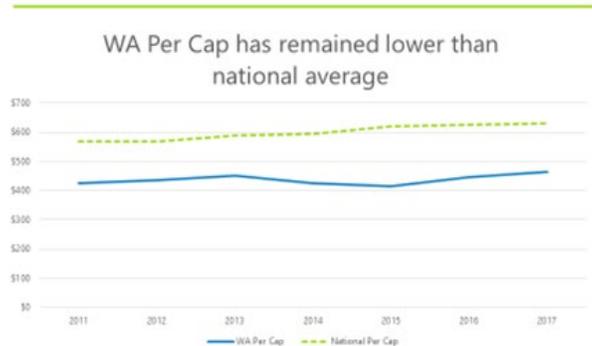


Figure 2. Per capita Medicaid spending in Washington State has stayed significantly under the national average.

Actuarial soundness

FFS rates may have limited utility to help set managed care rates; actuaries must review many factors and assess utilization

When moving a population to managed care, the state's contracted independent actuary may initially use the FFS rates as a benchmark, but FFS comparisons become less reliable overtime.

Although FFS rates are often portrayed as having a flat trend, it is important to consider that even if unit costs are flat, utilization can increase. Thus, contracted rates as a percent of FFS should be analyzed in light of the volume of the underlying claims.

In addition, lower claim volume may result in more volatile estimates.

When the actuary considers transitions from FFS to managed care, there usually is a unit cost increase factored in to reduce utilization. Managed care plans require more from providers to reduce utilization, but plans may need to increase rates as a result. In the 2012 change, the actuary included a 1.5% increase more than FFS in order to achieve significant targeted reductions in utilization of 25-30% for hospital days relative to estimated FFS days over time.

Actuaries also adjust the rates based on experience, both up and down. For example, in 2012 the legislature had interest to reduce ER utilization, and based on evidence based policy change, the actuary was able to determine a reduction in utilization was appropriate. On the other hand, actuaries may increase utilization in areas such as primary care visits for well child and immunizations based on clinical experience or other legislative policy change.

HCA contract terms also protect the state from any plan making excess profits. If the plan experiences a profit (gain) exceeding 3%, HCA will share equally in the gain between 3 percent and 5 percent. HCA will recover all gains exceeding 5%.

Managed care rates have remained steady over time, while improving access to care for the vast majority of the population

Managed care plans have to contract for an adequate provider network, so with a vastly greater caseload since 2014 Medicaid expansion, the pressures on the system have been extraordinary.

Provider reimbursement rates only represent a single dimension of managed care and should not be considered in isolation. Provider reimbursement rates are correlated with provider network adequacy, utilization, and other factors, and provider reimbursement may impact these factors.

The chief success for moving to managed care has been improvements in access to care. Prior to expansion of managed care, the state experienced serious access to care deficiencies in many communities. Contractual arrangements that hold plans accountable for access, and requirements that every member has an assigned primary care provider, have all improved results.

Adding the ABD population in 2012, resulted in significant improvement in access for that population. Likewise, Medicaid expansion likely would not have been as successful without the managed care plans and their networks.

Enrollees are satisfied

The 2019 Social & Health Services Client survey conducted by Research and Data Analysis program, has reflected an increasing trend over the last 12 years in client satisfaction, specific to access to care. Specifically:

- 86% of clients said it was easy to get services through Apple Health
- 90% of clients said they were able to get Apple Health services as quickly as they needed
- 93% of clients felt that the providers' offices were open at times that were good for them

Recent implementation of behavioral health integration provides a whole person care approach

Managed care plans are now responsible for both physical and behavioral health (integrated managed care). This is a nationally leading effort, but serious challenges remain.

Challenges with changes in federal regulation from 2017 make it more difficult for directed payment arrangements – that is targeting rates to certain providers – it is not impossible but there are significant requirements in the process.

Specific legislative appropriations often requires HCA to ensure strong contract terms are in place and tighter communications with the managed care plans and providers to ensure funds like the recent legislative appropriated behavioral health enhancement funding gets to providers as intended. We are seeing success here, but it has been challenging.

Given all the population and programmatic changes that have occurred in Washington over the past 15 years, it is very difficult to prepare a longitudinal evaluation of trend. A recent high-level and simplified analysis in the managed population that was previously Healthy Options (Family and SCHIP) and comparing with the current Apple Health Family and SCHIP populations shows that in 2008, the PMPM for that population was projected to be \$180.79. Taking into account a number of factors, the rate for 2020 is \$190.33. That is an average annual trend over 12 years of 0.4%.