Washington State Health Care Authority

Medicaid managed care and fee-for-service

An overview of two Medicaid delivery models

Background

Washington began moving toward managed care in the late 1980s for Apple Health (Medicaid), when it was recognized that:

- A fee-for-service model does not lend itself to care coordination and disease management, and
- Managed care can control costs while ensuring quality of care and access to care.

More populations have moved to managed care over time, with the last large shift occurring in 2012 when the Medicaid blind and disabled population moved to managed care. Washington has continued to move Apple Health (Medicaid) enrollees to managed care, including foster children, the homeless and newly enrolled clients.

Today, nearly 85 percent of the full-benefit Medicaid population is served by managed care.

Per RCW 74.09.522, "The Legislature finds that competition in the managed health care marketplace is enhanced, in the long term, by the existence of a large number of managed health care system options for Medicaid clients. In a managed care delivery system, whose goal is to focus on prevention, primary care, and improved enrollee health status, continuity in care relationships is of substantial importance, and disruption to clients and health care providers should be minimized."

As directed by the Legislature and to increase access and improve quality of services provided, Washington's Apple Health (Medicaid) program has largely shifted to managed care, with key exceptions:

- Federal law makes American Indian/Alaska Natives voluntary and they are exempted from managed care.
- Clients eligible for both Medicare and Medicaid services are not enrolled in managed care.

As directed in 2014 by House Bill 2572 and Senate Bill 6312, the Health Care Authority and the Department of Social and Health Services implemented a phased approach to integrating physical and behavioral health services in managed care.

As of April 1, 2016, all Apple Health (Medicaid) clients residing in Southwest Washington are accessing all physical and behavioral health services in an integrated, coordinated way.

Definitions

Managed care is a health care delivery system organized to manage cost, utilization, and quality. Medicaid managed care provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that accept a set per member per month (capitation) payment for these services.

By contracting with various types of MCOs to deliver Medicaid program health care services to their beneficiaries, states can reduce Medicaid program costs and better manage utilization of health services. Improvement in health plan performance, health care quality, and outcomes are key objectives of Medicaid managed care.

Fee-for-service (FFS): Clients who are not served in managed care receive services through the Medicaid fee-for-service program, where HCA pays providers directly for each service they provide.

Managed care improves quality and manages costs

- Medicaid managed care models typically yield cost savings.[1]
- Medicaid managed care improves health plan performance, health care quality, and outcomes for people and families.

Managed care and fee-for-service comparison

Service	Managed care	Fee-for-service	Description
Care coordination	Yes	No	MCOs provide care management to complex patients such as the blind/disabled population in order to assure patients connect to needed services, including community-based resources such as housing and medical services (e.g. specialty care). MCOs also provide access to 24/7 nurse advice lines. Establishing similar services within a FFS context would be prohibitively expensive, given the necessary infrastructure and training. Such care coordination is a feature of integrated managed care in Southwest Washington, which includes the blind/disabled population.
Outreach and communication to providers and clients	Yes	No	MCOs engage in significant outreach with their clients, including health risk assessments at time of enrollment and extensive coordination of complex conditions and co-morbidities. This does not occur for FFS populations. Through provider outreach and contracting, MCOs establish extensive primary care and specialty physician networks that include providers that have not historically participated in the Medicaid FFS program. In addition, MCOs provide feedback reports to providers on quality and utilization metrics.
Premium tax	Yes	No	Washington assesses a premium tax and WSHIP assessment on all fully insured health plans, including Medicaid MCOs. In combination, these assessments total 3% of premiums. Because there is federal match (as high as 100% for newly eligible adults), the premium tax results in net revenue to the state. For the blind/disabled

[1] http://blogs.chicagotribune.com/files/lewinmedicaid.pdf

Service	Managed care	Fee-for-service	Description
			population, the premium tax results in a net general fund-state benefit of $21.5M annually.
Primary care access	Yes	No	MCOs are contractually required to maintain adequate primary care networks, and help patients establish care with a primary care provider at time of enrollment. This ensures patients have access to a primary care home and "whole person" care. Such care has been shown to improve clinical outcomes and reduce costs. FFS patients are not assigned to a primary care provider and must find their own providers.
Population health management	Yes	No	MCOs use data to define the needs of distinct populations and reach out to these populations to proactively assure they receive appropriate health care services, such as preventive care. They also monitor trends with higher risk populations such as unnecessary emergency room use to assure appropriate intervention is made.
Performance standards	Yes	No	MCOs are required to monitor and report customer satisfaction scores, performance measure data (HEDIS), and must meet network distance, customer service and appointment timeliness standards to assure access and quality of services. If thresholds of performance are not met for key indicators, MCOs must establish corrective action plans.
Quality improvement	Yes	No	MCOs are required to follow national standards to develop performance improvement plans MCOs are subject to annual external quality review: quality oversight of access, quality of care and timeliness.
Complex case management	Yes	No	MCOs must meet national standards for how they help clients with complex needs, such as referrals to other services and medication management.
Utilization management	Yes	Limited	MCOs use data and prior authorization processes to assure appropriate, cost-effective health care at the right time, right place with the right service. HCA provides clinical oversight to ensure clinical standards of promptness and

Service	Managed care	Fee-for-service	Description
			quality are met. Utilization management for FFS is limited to certain services and provider types (e.g., dental, durable medical equipment, rehab services) and is labor-intensive.
Appeal process	Yes	No	If the MCO denies a service, enrollees have access to the MCO appeal process and the independent review process managed by the Office of Insurance Commissioner. FFS enrollees do not have this access to appeal and their first option is an administrative hearing. The MCO appeal process contains special enrollee protections (e.g., mandates a different reviewer decides on the appeal than made the original denial decision) and is regulated by CFR and monitored by the National Committee for Quality Assurance (NCQA) and HCA.
National standards	Yes	No	All MCOs are required to have NCQA accreditation, an extensive process that provides ongoing quality assurance monitoring. Included in this accreditation is a robust enrollee grievance resolution process, monitored by both NCQA and HCA. In some cases, MCOs are required to provide written resolution. MCOs are required to report grievances, actions and appeals to HCA each quarter.
Health screenings and assessments	Yes	No	MCOs are required to provide initial health screens and initial health assessments. For clients who do not choose a plan, managed care assignments are partially based on health screening completion rates.
Identification of special health care needs	Yes	No	MCO contracts contain provisions for identifying enrollees with special health care needs and providing care coordination activities.
Transitional health care services	Yes	No	Assistance for enrollees upon hospital discharge or other health care transitions.
Access to other state services	Yes	Limited	MCOs provide support accessing services such as transportation, interpreter services, housing and food assistance. Similar direct assistance is available on a limited and more ad hoc basis to FFS clients.