The Value of Medicaid Managed Care

Briefing for the State of Idaho

Senate and House Health and Welfare Committees

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Medicaid Key Facts

- **Idaho's standard FMAP is 69.7%** – the federal government covers over 2/3 of Idaho's Medicaid program costs
- **Expansion FMAP is 90%**
- FMAP ranges from 50% in more affluent states to 83% in U.S. territories
- **Benefits of Medicaid**
  - Improves access to care; increased utilization of preventive, primary care, behavioral health services; improves medication adherence and birth outcomes
  - Improves financial performance of hospitals, clinics, and other providers
  - Improves enrollee health status, enabling kids to attend school and adults to work

Enrollment (October 2023)	**Idaho**	**United States**
Population	1,964,726	334,914,895
Medicaid & CHIP total	315,360 (16%)	87,289,666 (26%)
Medicaid	294,253	80,227,593
CHIP	21,377	7,062,073
Children (Medicaid & CHIP)	157,666 (50%)	39,443,087 (45%)

What is Medicaid Managed Care?

- **Medicaid managed care is a public-private partnership:** states contract with **managed care organizations (MCOs)** to carry out state Medicaid goals, administer day-to-day program operations
- **In 2024, 42 states use comprehensive managed care programs,** incl. Washington DC, Puerto Rico
- **State retains responsibility for determining Medicaid eligibility** and assigning enrollees to MCOs
- **Federal regulations give states significant flexibility** to design, customize, and implement managed Medicaid programs to meet their goals; include minimum benefits and reporting requirements
- **The state controls the managed care program** through oversight, network adequacy and contract requirements, financial measures to ensure MCOs perform (with federal support)
- **MCOs often work with ACOs,** support payment arrangements that deliver more cost-effective care
- Most states find that **MCOs are best positioned in the health care delivery system** to assume financial risk, contract with providers to promote quality care, communicate effectively with enrollees, provide additional services that reduce barriers to accessing care

Growth of Medicaid Managed Care

Payments to Medicaid MCOs have increased over time due to several factors

- **Medicaid expansion increased the number of people eligible for Medicaid**
- **The number of states using managed care** has grown, increasing from 36 in 2010 to 42 in 2023 (including Washington DC, and Puerto Rico)
- **States have included more people with complex care needs**/higher medical acuity in managed care arrangements – older adults, people with disabilities or using LTSS
- **Increases in the number/acuity of Medicaid MCO enrollees** have increased the average cost from $3,906 per person in 2010 to $6,364 per person in 2021[1]
- States with high Medicaid MCO enrollment[2]

TN	NE	KS	TX	IA	NJ	OR	NM
100%	99%	98%	97%	95%	98%	92%	92%

1. "Value of Medicaid Managed Care: Improving the Quality of Care in Medicaid", AHIP; https://www.ahip.org/resources/value-of-medicaid-managed-care-quality-in-medicaid
2. "Share of Medicaid Population Covered under Different Delivery Systems | KFF as of July 2022; Kaiser Family Foundation

Key Functions Medicaid MCOs Typically Perform

- **Provider Access and Availability**
  - Engagement and contracting, provider service and education, claims payments, value-based arrangements
- **Enrollee Engagement and Service**
  - Outreach and engagement, benefits information, provider selection, health education, appointment reminders, medication compliance, appeals and grievances, value-added benefits, social supports
- **Care Management**
  - Enrollee assessment and care planning, coordination of care across providers, care transitions planning, transportation to appointments, utilization management/medical review, drug formulary management
- **Quality Improvement and Reporting**
  - Quality metrics data collection and reporting, quality/performance improvement initiatives
- **Financial Management and Reporting**
  - Value-based payment arrangements, service utilization and cost, MLR reporting; fraud, waste, and abuse monitoring/ detection/ reporting

Why Do States Use Managed Medicaid Programs?

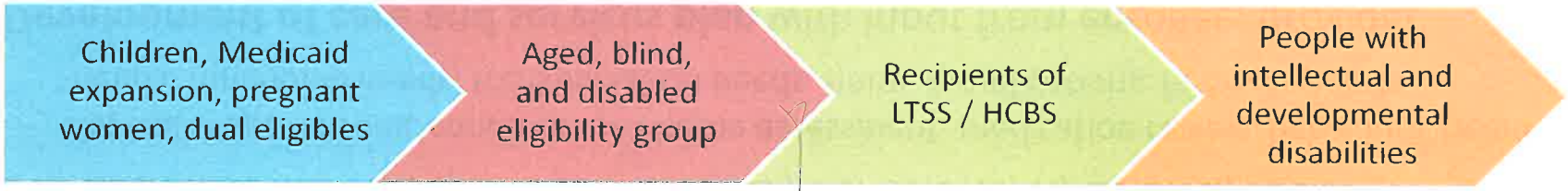
- **Better budget predictability** from moving from fee-for-service to capitated payments
- **Improved care coordination** closely tailored to needs of higher-risk enrollees
- **Leverage MCO capabilities**
  - Sophistication, innovation, experience from other state programs – what works and what doesn't
  - Business model and administrative infrastructure – IT systems, care management resources, provider services, member services functions, telehealth arrangements, enrollee engagement, quality improvement, fraud detection
- **Promote transitions to value-based arrangements**
- **Advance state Medicaid initiatives**
  - Integrating primary care and behavioral health care
  - Programs to reduce enrollee food insecurity, health-related social needs
  - Substance use disorder programs, medication assisted therapy

What is Care Coordination?

- **Ongoing care coordination targeted to people with greater needs**
  - Older adults, people with multiple chronic conditions, disabilities, mental/cognitive impairments, predisposing conditions
- **Evaluation of individual needs** – medical, behavioral, functional, social
  - Typical scope: chronic conditions, in-home assessment, medication review, behavioral health needs, functional needs, transportation needs, home modifications, family supports
- **Development of care and services plan** with input from enrollee, provider
- ***Work the plan*** – follow-up to confirm services were received, identify/correct gaps
- **Care managers/coordinators** – nurses, health workers with special training – coordinate care working with the enrollee's providers, community organizations
- **MCO care coordination staff reduce burden on primary/specialty physicians**

How Do States Design Managed Care Programs?

- **Many Medicaid programs start with lower acuity enrollees,** then add higher acuity enrollees to managed care over time



- **State decides populations in managed care, scope of benefits**
  - Programs with integrated benefits (physical health, behavioral health, prescription drugs) improve overall quality by giving MCOs full insight into enrollees' care needs
- **Competitive procurements** – state sets qualifications, scope of services, contract terms
- **State can set provider contracting standards, provider payment levels/rate floors**
- **Have tools to ensure MCO quality and performance,** such as bonuses and penalties, other risk mitigation strategies

How Do States Set Medicaid Capitation Rates?

- **Capitation rates must be actuarially sound**
  - "…projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the MCO for the time period and the populations covered under the terms of the contract."[1]
- **Actuarial rate development process**
  - Analyze historical utilization and costs by type of service and population group
  - Project future costs based on cost and utilization trends
  - Include allowance for costs of administration, taxes and fees, modest margin
  - Calculate capitation rate for each population groups
- **Rates must include a medical loss ratio (MLR) requirement**
  - MCOs must spend at least 85% of capitation on costs of health services, quality improvement, fraud waste and abuse. State can set a higher MLR, provided rates remain actuarially sound.

1. 42 CFR 438.4

How Do Medicaid MCOs Work with Providers?

MCOs contract with providers to meet network adequacy standards

- MCOs must meet state and federal government standards – scope of specialties and contracted services, provider-to-enrollee ratios, time and distance
- May include telehealth; out-of-state providers for services unavailable in state (e.g., transplants)

Contract payment examples

- Negotiated rates – MCO and provider agree on rates
- State minimum rate floors, fee schedule – state determines rate basis
- Sub-capitation – provider receives capitated payment for scope of services, attributed enrollees
- Value-based contracting – provider paid based on performance on quality metrics
- MCOs may administer directed payments as determined by state

Contracting with ACOs/VCOs

- Often through sub-capitation – capitated payments for enrollees attributed to ACO/VCO
- Based on scope of services, performance on quality and enrollee experience metrics
- Requires administrative capabilities at ACO/VCO level

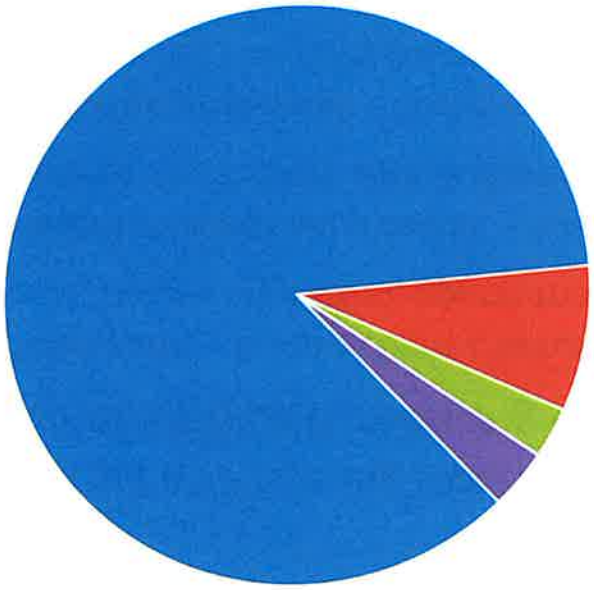
Medicaid Managed Care Brings Innovation

Medicaid MCOs bring experience with innovations that increase the effectiveness and reach of Medicaid, reducing the long-term need for health services. Examples:

- **Telehealth** – telepsychiatry/behavioral health therapy, remote monitoring, virtual urgent/primary care, health education, appointment/medication reminders
- **Health related social needs** – food vouchers, cooking classes/nutritional counseling, connections to community service organizations, "in lieu of services"/ILOS, transportation, OTC drugs
- **Home environment** – home modifications, mold/allergen eradication, in lieu of services/ ILOS – services not normally covered that address a particular need, are cost effective, and reduce need for covered services, respite care for caregivers
- **Provider supports –** provider grants for disability accessible equipment, EPSDT clinic days, integrated dashboard for pharmacies, SUD facility bed tracking tool, physical/behavioral health integration initiatives, interim support payments during pandemic

Medicaid MCO Profit Margins

Medicaid MCO Financial Results 2022[1]



On average, Medicaid MCOs spent 85.8% of capitation revenues on health care services/quality, 8.1% on administration, 2.8% on taxes and fees; achieved modest net margins of 3.3% (N=185)

- Healthcare services, quality improvement 85.8%
- Administration net of taxes, fees 8.1%[2]
- Taxes and fees 2.8%
- Net margin 3.3%

Comparison with average net margins of other healthcare entities[3]:

- Drug companies 15.2% (n=245)
- Healthcare products 8.2% (n=230)
- Hospitals 5.1% (n=32)
- Healthcare support services 2.5% (n=119)

1. Source: "Medicaid Managed Care Financial Results for 2022", Milliman; June 2023. Accessed at https://www.milliman.com/-/media/milliman/pdfs/2023-articles/6-29-23 medicaid-managed-care-financial-results-2022-final.ashx
2. "Administration" includes e.g., staffing, IT systems, call centers, claims processing, accounting, member/provider services, care management. See slides 4-5.
3. Source: "Margins by Sector (US)", NYU Stern School of Business. Accessed at https://pages.stern.nyu.edu/~adamodar/New_Home_Page/datafile/margin.html

Medicaid MCOs Improve Quality of Care

- As of January 2024, **80% of Medicaid MCOs (236 of 292) are accredited by NCQA** (National Committee for Quality Assurance)[1]
- **Medicaid MCOs routinely monitor and report performance on quality measures** in standardized measure sets such as HEDIS® and CAHPS®[2]
- Over a five-year period, **Medicaid MCOs improved their performance on 26 out of 30 (87%) key HEDIS® and CAHPS® quality measures**[3]
- **States employ a variety of financial incentives to ensure quality care in MCOs**[3]
  - 24 states offer **bonus payments** for achieving specified quality metrics
  - 25 states use **capitation withholds** of 1 to 2%
  - 8 states make **preferential auto-assignment of enrollees** based on quality metrics

1. Source: "Health Plan Report Cards", National Committee for Quality Assurance; https://reportcards.ncqa.org/health-plans?order=asc&pg=1&order-filter=filter-plan&filter-plan=Medicaid
2. "2023 Health Plan Ratings Required CAHPS and HEDIS Measures", National Committee for Quality Assurance; https://www.ncqa.org/wp-content/uploads/2023-HPR-List-of-Required-Performance-Measures_Updated_7.26.2023.pdf
3. "Value of Medicaid Managed Care: Improving the Quality of Care in Medicaid", AHIP; https://www.ahip.org/resources/the-value-of-medicaid-managed-care-quality-in-medicaid

Medicaid Managed Care Will Benefit Enrollees

- **One-stop source of information** for all aspects of Medicaid coverage through MCO
- **Personalized, tailored care coordination**
- **Assistance choosing and connecting with providers**
- **Appointment and medication reminders, telehealth access**
- **Health education and engagement**
- **Health related social needs benefits and supports**
- **In lieu of services/ ILOS** – services not normally covered that address a particular need, are cost effective, and reduce need for covered services
- **Coordination with other programs and community organizations,** assistance with applying for federal government programs

Medicaid Managed Care Will Benefit Idaho

- **Improve budget predictability**
  - Capitation-based payments transfer full risk to MCOs for contracted services and populations
  - For capitated enrollees, payments will vary with *number of enrollees,* not with utilization
- **Reallocate staff resources** – state can shift focus from operations to planning and oversight roles
- **Improve effectiveness of Medicaid expenditures**
  - **Increase Medicaid enrollees' use of primary and preventive care,** medication adherence
  - **Ensure medically necessary care** while reducing duplicative or unnecessary services
  - **Leverage MCO administrative infrastructure and capabilities**
  - **MCOs assume full financial risk** for contracted services, consistent with actuarial certification
- **Improved access, quality of care and services**

In Conclusion

- **Medicaid managed care will improve effectiveness and quality** of Idaho's Medicaid program, budget predictability, use of state staff resources; offer experience, innovations, and infrastructure
- **Idaho would have broad flexibility in planning, design, and implementation** of its managed Medicaid program
- **Allow plenty of time** for planning and design, stakeholder engagement, implementation, refinement
- **Include long-term plan** for integration of comprehensive benefits
- **Seek assistance from state Medicaid leaders** with managed care experience and success; e.g., Arizona, New Mexico, Ohio, Oregon, Tennessee, Texas
- **Engage with Medicaid MCOs and providers** as partners to identify issues, develop solutions, solve problems

Questions?

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