Mercer

welcome to brighter

The Value of Medicaid Managed Care

HSFO 2024

August 2024

Sam Espinosa — GHSC National Practice Leader, Mercer
Scott Katterman, FSA, MAAA, MPH - Principal, Mercer

A business of Marsh McLennan

This presentation is created on behalf of Mercer Health & Benefits, LLC (Mercer) for services in support of training offered by HSFO. This material is for educational purposes only and does not contain any consulting advice. The information contained herein is current as of the date of presentation and is provided by Mercer **“as is”**. Mercer expressly disclaims responsibility, liability, or both for any reliance on this presentation by any third parties or the consequences of any unauthorized use or disclosure other than as mutually contemplated when we were first retained by HSFO to provide this information.

1 | Overview of Managed Care

2 | What is value?

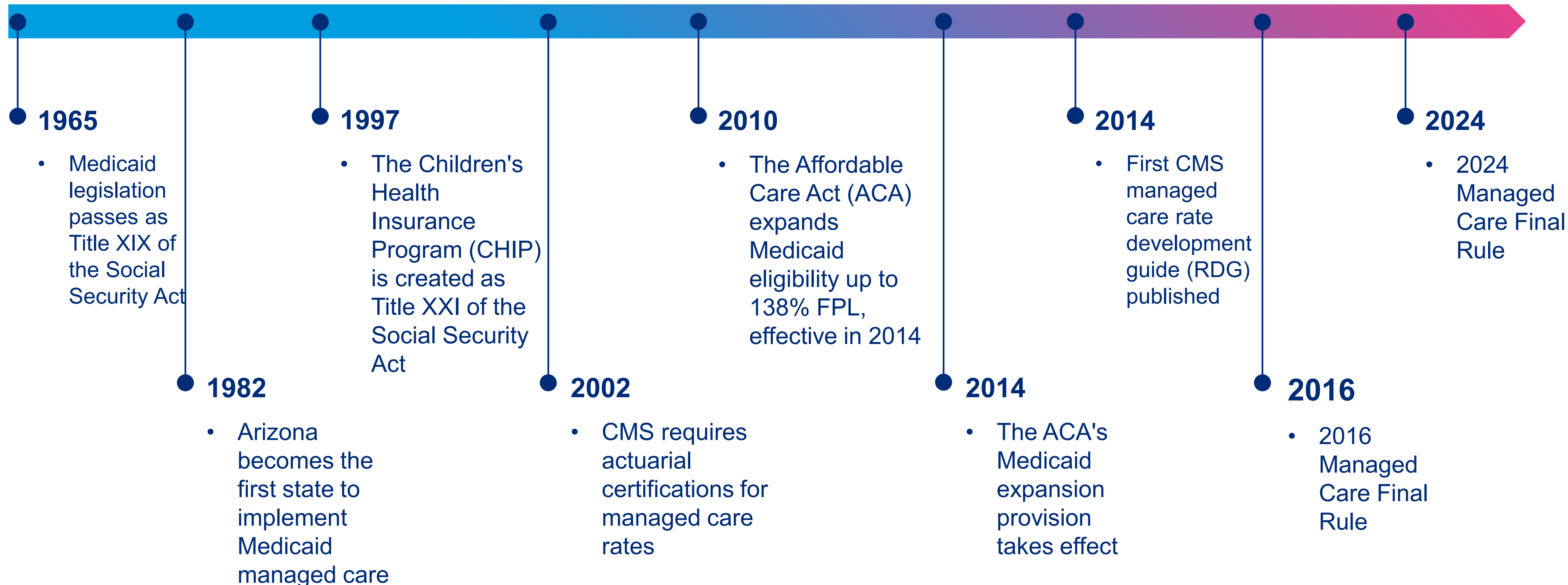
3 | Components of value

4 | Questions?

Overview of Medicaid Managed Care

Brief History of Managed Care

Timeline



Medicaid Managed Care

Managed Care vs. FFS

FFS		Managed Care
• Traditional Medicaid program • Beneficiaries generally have freedom of choice among providers • State contracts directly with healthcare providers to provide care to Medicaid beneficiaries and pay providers on a fee-for-service (FFS) basis • Limited or no care coordination and care management	vs.	• Typically allowed through 1115, 1915, or 1932 waivers • State contracts with managed care organizations (MCOs), who then contract with providers to deliver care • MCO manages the provider network and negotiates provider payment rates • Utilizes care coordination, utilization management, and quality improvement efforts • May include additional benefits beyond FFS • MCOs bear financial risk

Medicaid Managed Care

Types of Managed Care Programs

Types of Programs	- MCO: Managed care organization - PIHP: Prepaid inpatient health plan - PAHP: Prepaid ambulatory health plan - PCCM: Primary care case management
Types of Services	- Comprehensive Managed Care – Includes inpatient, outpatient, professional, behavioral health (BH), pharmacy - Pharmacy – Many states keep pharmacy in FFS even when using managed care elsewhere - Behavioral Health – Many states use separate managed care programs for BH compared to other services - Managed Long Term Services & Supports (MLTSS)

What is Value?

What is Value?

Value is More than Costs and Savings

- Value = benefits accrued to state vs. costs and savings
- Value answers the question: What are we getting for our spending?
- States aim to purchase healthcare efficiently and effectively

Components of Value

Cost and Savings

Impacts of Managed Care

Increased State Revenue

- Increased FMAP for administrative duties delegated to MCOs
- Premium tax/ managed care tax revenue
- DSHP funds
- Supplemental payments

Reduced Costs

- Managed care savings
- Provider contracting strategies
- Fraud, waste, and abuse reductions

Increased Costs

- State costs to administer managed care
- Duplicative administrative functions & costs
- MCO underwriting margin

Costs and Savings

Tools and Measures

Clinical Efficiencies

Are managed care plans avoiding costly and unnecessary healthcare events?

- Identify costly and clinically inappropriate events that would otherwise inflate cost estimates
- Examples: low-acuity emergency room visits, avoidable inpatient admissions, unnecessary c-sections

Unit Costs

Are managed care plans contracting wisely and appropriately with providers?

- Provider rate benchmarking
- Maximum Allowable Cost (MAC) pharmacy pricing
- State directed payments
- Value-based payments (VBP) and alternative payment models (APMs)

Fraud, Waste, and Abuse

Are managed care plans actively identifying and avoiding fraudulent and abusive spending?

- Program integrity requirements and initiatives
- Fraud prevention activities spending
- Fraud recoveries
- Identification of historical fraud, waste, and abuse that would otherwise inflate cost estimates

Managed Care vs. FFS

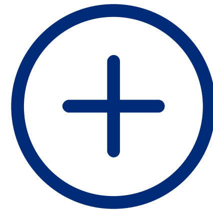
How do costs under managed care compare to FFS?

- Risk adjusted total cost of care (TCOC) comparisons
- Unit cost vs. utilization savings
- Administrative cost comparisons

Flexibilities Allowed Through Managed Care

Waiver Authority

- Flexibility to tailor program to achieve state-specific policy objectives
- Managed care often implemented through 1115 waivers



Value-Added Services

- MCOs have flexibility to cover additional services beyond state plan covered Medicaid benefits, which is typically not allowable through FFS
- This spending is excluded from managed care rate setting
- Examples: dental, vision, hotel stays, food boxes

Community Benefit Expenditures

- Spending for activities that improve access to health services, enhance public health, and relieve government burden
- Can include health education, community testing/screenings, addressing social determinants of health, and reducing health disparities

Flexibilities Allowed Through Managed Care

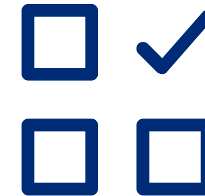
(continued)

Value-Based Purchasing (VBP)

MCOs can engage in VBP arrangements with providers more easily than states can

State Directed Payments (SPDs)

States can direct MCOs to pay downstream providers in ways that help further state objectives



In-Lieu of Services (ILOS)

- MCOs can offer alternative benefits or providers that replace state plan covered services
- Cost are allowable in managed care rate setting

2024 Medicaid and CHIP Managed Care Final Rule affects these flexibilities

Quality

MCO Tools and Activities

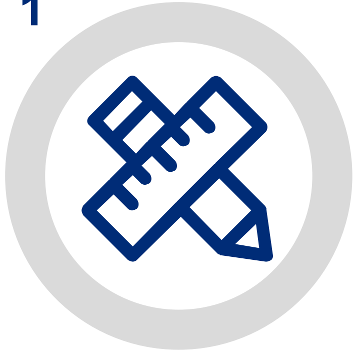
MCOs use numerous approaches to improve quality of care, including:

- Care Coordination
- Provider Education and Support
- Screening/Testing Efforts
- Medication Management Processes
- Require Clinical Best Practices
- Provide Quality Incentives
- Population Health Initiatives
- Preventative Care
- Health Information Technology Investments
- Health Equity Initiatives

Quality

Measurement Approaches

1

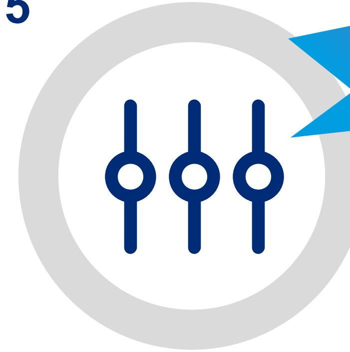


2

3

4

5



CMS Measures

- CMS Core Measures (Child, Adult)
- LTSS Quality Measures
- CMS HCBS Quality Measure Set

HEDIS

- Developed and maintained by NCQA

Financial Measures

- HCQI spend
- Clinical efficiency analyses

External Quality Review (EQR)

- In-depth, independent evaluation of MCO quality and performance
- Periodic reviews required by CMS

Quality Rating System (QRS)

- Public website for beneficiaries to easily access quality and other information
- Website required by late 2030
- Must include mandatory components established by CMS, plus optional state components

Access

Considerations, Evaluation Tools, and Enforcement

Access considerations

- MCOs can be more flexible and nimble at addressing specific access challenges, but require state support to help address global statewide provider shortages
- Any willing provider exceptions
- Evaluate access by region, service type, and sub-population when determining overall access across the state

State Tools to Evaluate and Enforce Access

- Managed care network adequacy standards (42 CFR 438.68, 438.206, and 438.207) and associated managed care contract requirements
- EQR — includes review of member access
- Directed payments when payment is a driver of access challenges
- State annual network certification to be posted online
- Appointment wait time standards; 90% compliance required
- Secret shopper surveys
- Enrollee experience surveys

New requirements from 2024 Final Rule

Final Considerations

Member Experience

Provider Experience

Partnership

- Managed care introduces multiple additional organizations with which members and providers must interact
- MCOs can be valuable experienced partners for the state in the delivery of healthcare, but can also introduce powerful new political dynamics into the Medicaid system

Questions?

Services provided by Mercer Health & Benefits LLC.

A business of Marsh McLennan

Copyright © 2024 Mercer Health & Benefits LLC. All rights reserved.