Understanding Medicaid Managed Care

-- For Agency Staff --

Learning Objectives

- **To Understand:**
  - Basic principles of Managed Care as a payment vehicle for health care services
  - The structure of the current NYS Medicaid Managed Care program
  - Anticipated changes as the State rolls out a new Medicaid Managed Care Model to support those with Behavioral Health needs.
  - What to do to prepare myself for the “Managed Care World”

Setting The Stage For Understanding Managed Care

Vision for Medicaid Reform

"It is of compelling public importance that the State conduct a fundamental restructuring of its Medicaid program to achieve measurable improvement in health outcomes, sustainable cost control and a more efficient administrative structure."

- *Governor Andrew Cuomo, January 5, 2011*

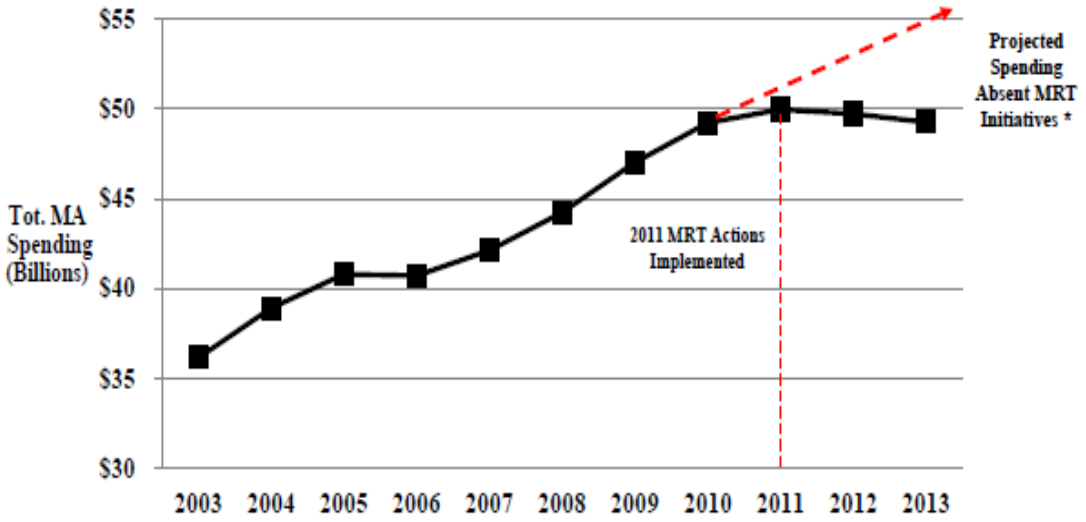
EXPECTED OUTCOMES:

- Improved Health Status
- Improved Quality of Care
- Reduced Costs

Care Management For All

Medicaid Expenditures: 2013

NYS STATEWIDE TOTAL MEDICAID SPENDING (CY 2003-2013)



Calendar Year	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
# of Recipients	4,267,573	4,594,667	4,733,617	4,730,167	4,622,782	4,657,242	4,911,408	5,212,444	5,398,722	5,598,237	5,792,568
Cost per Recipient	$8,469	$8,472	$8,620	$8,607	$9,113	$9,499	$9,574	$9,443	$9,257	$8,884	$8,504

https://www.chcs.org/media/CHCS-DSRIP-Presentation-Slides.pdf

Managed Care: Definition

- An integrated system that **manages health services** for an enrolled population rather than simply providing or paying for the services
- Services are usually delivered by providers who are contracted under a capitated payment structure or employed by the health insurance plan
- Value of services vs. volume of services

Managed Care: Goals

- **Control Costs**
  - Health care costs growing faster than GDP
  - Reduce inappropriate use of services
  - Focus on value
- **Improve Service Quality**
- **Improve Population Health**
- **Increase Preventive Services: <u>Promote Health</u>** (not just treat illness)

Managed Care: Key Ingredients

- Care “management”
  - Utilization management
  - Health management
- Vertical service integration and coordination
- Financial risk sharing with providers

Managed Care: Key Components

- Network of providers created via contracting
- Prior approval required for inpatient admissions, specialty visits, elective procedures, etc.
- Benefits package with a defined set of covered services
- Contained list of covered pharmaceuticals (Formulary)
- Utilization review practices to manage inpatient admissions and length of stay
- Credentialing
- Outcomes & data driven decision making

How Managed Care Is Paid

Capitation

- Managed Care Organization receives a **fixed** payment each month for each member: Per Member Per Month (PMPM) from New York State
  - Fixed fee is for a specific time period (typically a month)
  - Covers defined set of services (these are the benefits)

- Provider accepts risk for delivering services:
  - Agrees to comply with prior authorization and utilization management practices
  - May enter into pay for performance arrangement

How Providers Are Paid

- Negotiated fee for service: some MDs, ancillary services, labs, etc.
- Capitation Rate: MD groups, hospitals, Accountable Care Organizations (ACOs) or Independent Practice Associations (IPAs)may enter into such agreements.
  - May include shared risk/savings arrangement
- Per diem/ fixed daily payment: hospitals, SNF
- Payment based upon the episode of care:
  - Diagnostically Related Groups (DRGs)- Today
  - Acute /post acute bundled payments- Future

Determining Service Provision and Payment

YES

- Member?
- Service Included?
- Medically Necessary?
- Authorization?
- MCO Network?

The answers to all of the above questions must be "YES" if the service is to be paid by the MCO.

Health Care System Challenges

- 20% of people discharged from general hospital psychiatric units are readmitted within 30 days.
  - A majority of these admissions are to a different hospital.
- Discharge planning often lacks strong connectivity to outpatient aftercare.
  - Lack of assertive engagement and accountability in ambulatory care.
  - Contributes to: readmissions, overuse of ER, poor outcomes and public safety concerns.
- Lack of Substance Use Disorder (SUD) care coordination for people with serious SUD problems leading to poor linkage to care following a crisis or inpatient treatment.
- People with serious mental illness die about 25 years sooner than the general population, mainly from preventable chronic health conditions.

Other Health Care System Challenges

- **Criminal Justice**
  - People with mental illness and/or substance use disorders are over represented in jails.
- **Employment**
  - Unemployment rate for people with serious mental illness is 85%.
  - 33% of people entering detox were homeless and 66% were unemployed in 2011.
- **Homelessness**
  - A significant percentage of homeless singles populations has serious mental illness and/or substance use disorder.

DIA: Drowning in Acronyms!

Services Covered by MMCO:

- Partial hospitalization
- Continuing Day Treatment
- PROS
- ACT
- Substance Use Disorder outpatient services… Including OTP
- Residential rehabilitation(SUD residential services to be redesigned and clinical services to become billable)
- Inpatient Psychiatric services (currently FFS for all SSI Medicaid recipients)

Managed Care Organizations and Health and Recovery Plans (HARPs)

What is a HARP?

Health and Recovery Plans (HARPs)

Via New York State DOH:

"Distinctly qualified, specialized and integrated managed care product for individuals with significant behavioral health needs"

Enrollees can receive current services as well as Adult Home and Community Based Services

Eligibility based on utilization pattern or functional impairment.

Managed Care & HARP

- **What Changed?**
  - All Medicaid recipients will be members of a Managed Care Plan (except those dually-eligible for Medicare)
  - Individuals w/significant needs can become a part of a Health and Recovery Plan (HARP) - receive services not available through the standard BH plan
  - HARP members will be eligible for Adult Home and Community Based Services (HCBS)
  - The HARP model:
    - Is person centered, recovery-focused
    - Relies on care management for high need individuals
    - Emphasizes community services rather than inpatient services
    - Integrates Services
    - Creates greater system accountability and supports for achieving outcomes

Health and Recovery Plans (HARPs)

Who is eligible?

- Must meet the target risk criteria and risk factors

Target Criteria:

- Eligible for Mainstream enrollment and Medicaid enrolled
- 21 and older
- Serious Mental Illness/Substance Use Disorder diagnoses
- Not dually eligible for Medicare
- Not participating in OPWDD program

All HARP enrollees will be expected to have a Health Home Care Manager

Services To Be Covered by HARPs

Referred to as Home and Community Based Services (HCBS) for Adults Meeting Targeted and Functional Needs.

- Rehabilitation (Psychosocial Rehab, Community Psychiatric Support and Treatment (CPST), crisis intervention)
- Peer Supports
- Habilitation/Residential Supports in Community Settings
- Respite (Short Term Crisis Respite, Intensive Crisis Respite)
- Non-medical transportation
- Family Support and Training
- Employment Supports (Pre-voc, transitional Employment, Intensive Supported Employment, Ongoing Supported Employment)
- Educational Support Services
- Supports for Self-Directed Care (To be phased in as a pilot)(Information and Assistance in Support of Participation Direction)

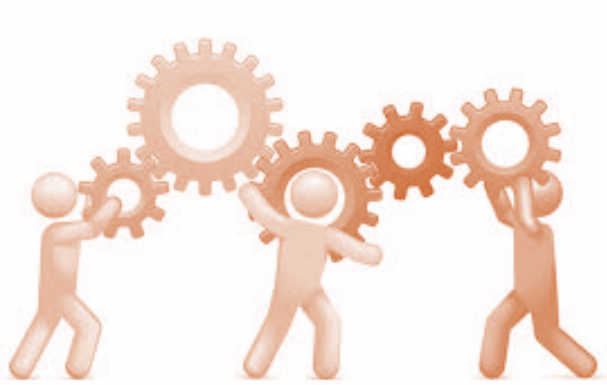
MCO & HARP: Expected System Outcomes

- Improved individual health and behavioral health life outcomes
- Improved social/recovery outcomes including employment
- Improved member‘s experience of care
- Reduced rates of unnecessary or inappropriate emergency room use
- Reduced need for repeated hospitalization and re-hospitalization
- Reduction or elimination of duplicative health care services and associated costs
- Transformation to a more community-based, recovery-oriented, person-centered service system.

What Should Staff Do to Prepare?

Getting Ready!

- **Innovate/Adapt:** Consider how your work might need to change in order to support the outcomes required in the transformed system
- **Training:** Think about the training you will need in order to be successful in this new model – and share your thoughts with your supervisor
- **Stay Informed:** Read articles and other materials given you to better understand how these changes will impact your work
- **Get Involved:** Participate in relevant trainings / agency planning sessions



Areas to Think About

- **Evidence Based Practices:** Everything under managed care is going to link back to evidence based practices and the ability to measure progress

- **Value over Volume:** Under Managed Care, payment will be more dependent on outcomes and goals reached with individual clients as opposed to the number of clients seen.

- **Understanding Managed Care lingo:** In order to get the best care for clients, learning the vocabulary necessary to advocate on their behalf when speaking with Managed Care companies will be vital.

Steps to Take

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* Visit www.mctac.org to view past trainings

* **Develop** relationships with Managed Care Companies and learn how to speak their language

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@CTACNY

THANK YOU

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