

NORC Medicaid Managed Care Organization (MCO) Learning Hub

Funded by The Robert Wood
Johnson Foundation



Medicaid MCO Overview and Financing Presentation

NORC at the University of Chicago
Speire Healthcare Strategies, LLC

November 19, 2020



Medicaid MCO Learning Hub Partners

- **NORC is leading the project along with partner Speire Healthcare Strategies LLC**
- **Key Partners**
 - America's Health Insurance Plans
 - Association for Community Affiliated Plans
 - Community Catalyst
 - Families USA

Webinar Logistics

- All attendees will remain on listen-only mode
- Please send any questions for presenters using the chat box at the bottom – we'll have two Q&A break
- The slides can be accessed on our website here:
<https://www.norc.org/Research/Projects/Pages/medicaid-managed-care-organization-learning-hub.aspx>

Scott Leitz

- Senior Fellow at NORC at the University of Chicago and Project Director for the Medicaid MCO Learning Hub
- Former Minnesota Medicaid Director
- Former CEO for Mnsure, Minnesota's State Health Insurance Exchange and former State Health Economist in Minnesota



Medicaid Managed Care Four Part Series

- **Overview of Medicaid Managed Care**
- Medicaid Managed Care Financing
- Introduction to Medicaid Authorities
- Strategies for MCO Engagement

Overview of Medicaid

About Medicaid

- Established in 1965
- Shared federal and state program
 - States receive FMAP that varies based on per capita income
- States must cover mandatory populations
 - Low income kids and pregnant women (<138% FPG)
 - Seniors and people with disabilities who receive cash assistance through SSI
 - Certain very low income parents and caregivers
- States may also receive Medicaid funding for Optional populations
- The Affordable Care Act gave states the option to expand Medicaid to adult < 138% FPG
 - 37 states have expanded Medicaid
- State Medicaid programs must cover certain “mandatory” services, such as hospital and physician care, laboratory and X-ray services, home health services, and nursing facility services for adults.
 - States are also required to provide a more comprehensive set of services, known as the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, for children under age 21.
 - States may also cover optional services such as prescription drugs, dental care, vision services, hearing aids, and personal care services for frail seniors and people with disabilities

Medicaid by the numbers

- 74.6 million lives covered ¹
- 1 in 3 kids - 36 million kids in Medicaid and CHIP ¹
- 50% of all births ²
- 1 in 7 elderly - 6 million people ³
- 10 million people with disabilities ⁴
- 25% of total behavioral health spending ⁵
- Total cost of the program is \$597.4 billion ⁶

¹ <https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html>

² <https://www.macpac.gov/wp-content/uploads/2020/01/Medicaid's-Role-in-Financing-Maternity-Care.pdf>

³ <https://www.kff.org/report-section/medicaid-at-50-the-elderly/>

⁴ <https://www.macpac.gov/subtopic/people-with-disabilities/>

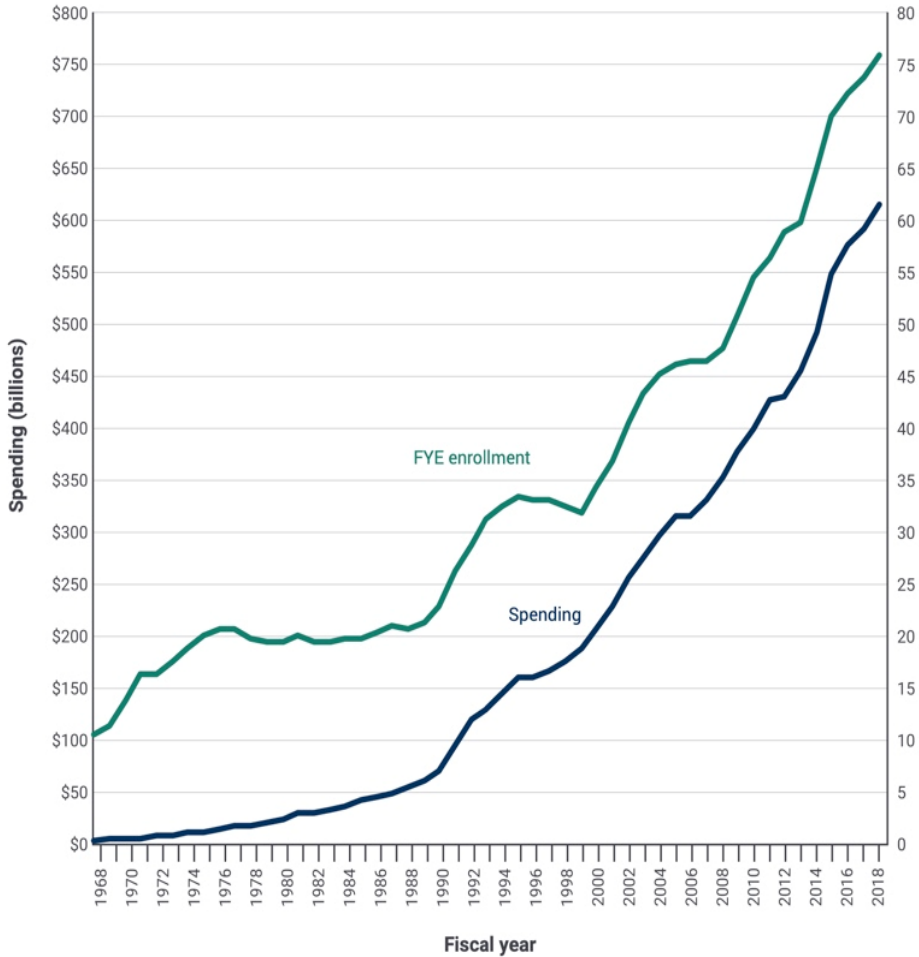
⁵ <https://www.kff.org/report-section/medicaids-role-in-financing-behavioral-health-services-for-low-income-individuals-issue-brief/>

⁶ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet>

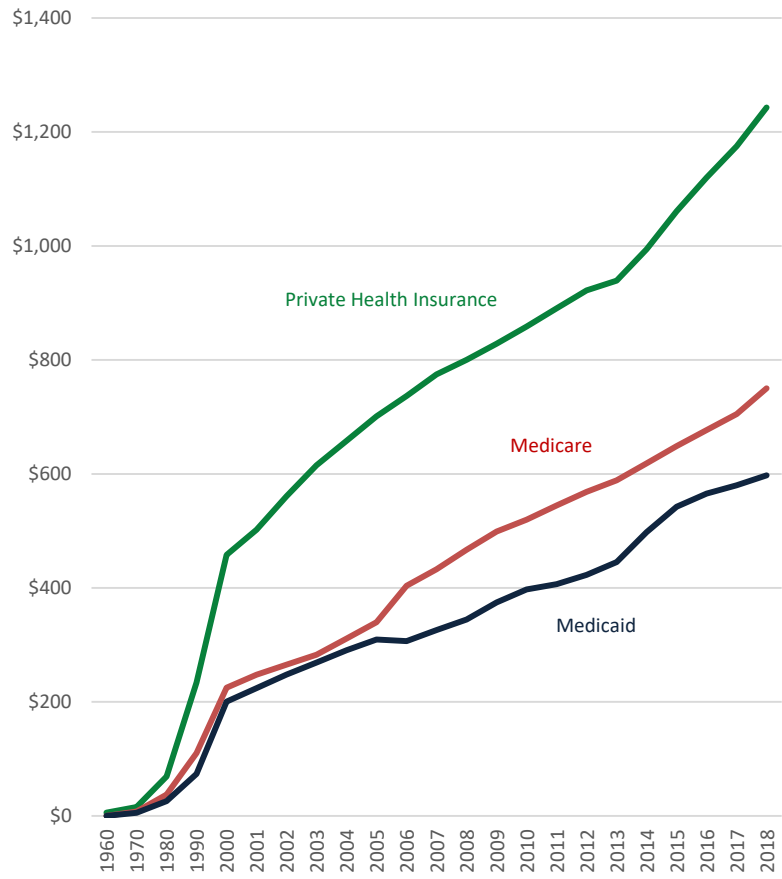
Medicaid Growth

Medicaid enrollment and costs continue to grow

Medicaid Enrollment & Spending 1968-2018



Medicaid, Medicare & Private Insurance Spending 1968-2018



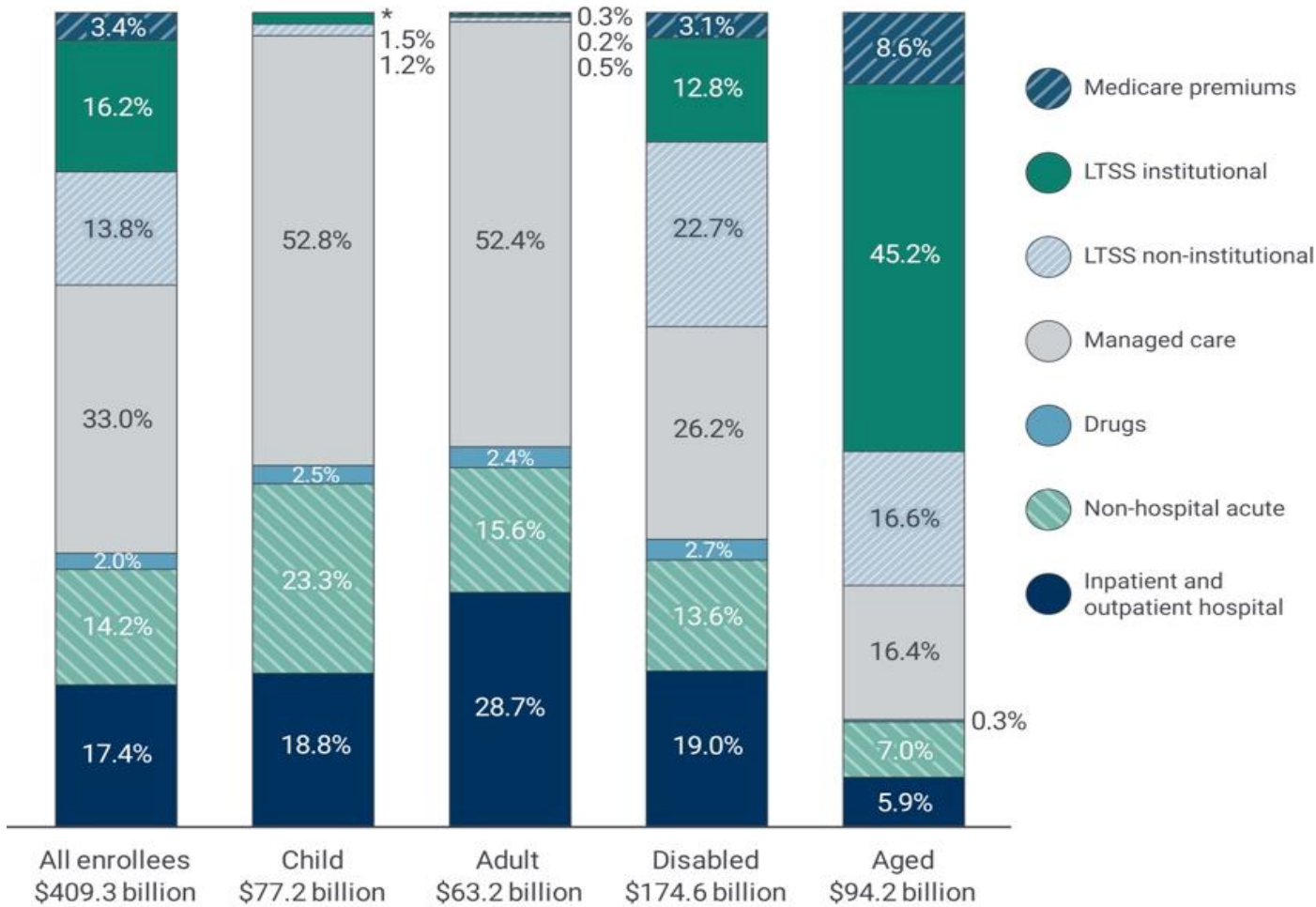
<https://www.macpac.gov/wp-content/uploads/2015/01/EXHIBIT-8.-Medicaid-Enrollment-and-Spending-FYs-1968-2018.pdf>

<https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet>

Medicaid Services

Medicaid is a comprehensive plan designed to meet the unique needs of those it serves

Distribution of Medicaid Benefit Spending by Eligibility Group and Service Category



See <https://www.macpac.gov/macstats/data-sources-and-methods/>

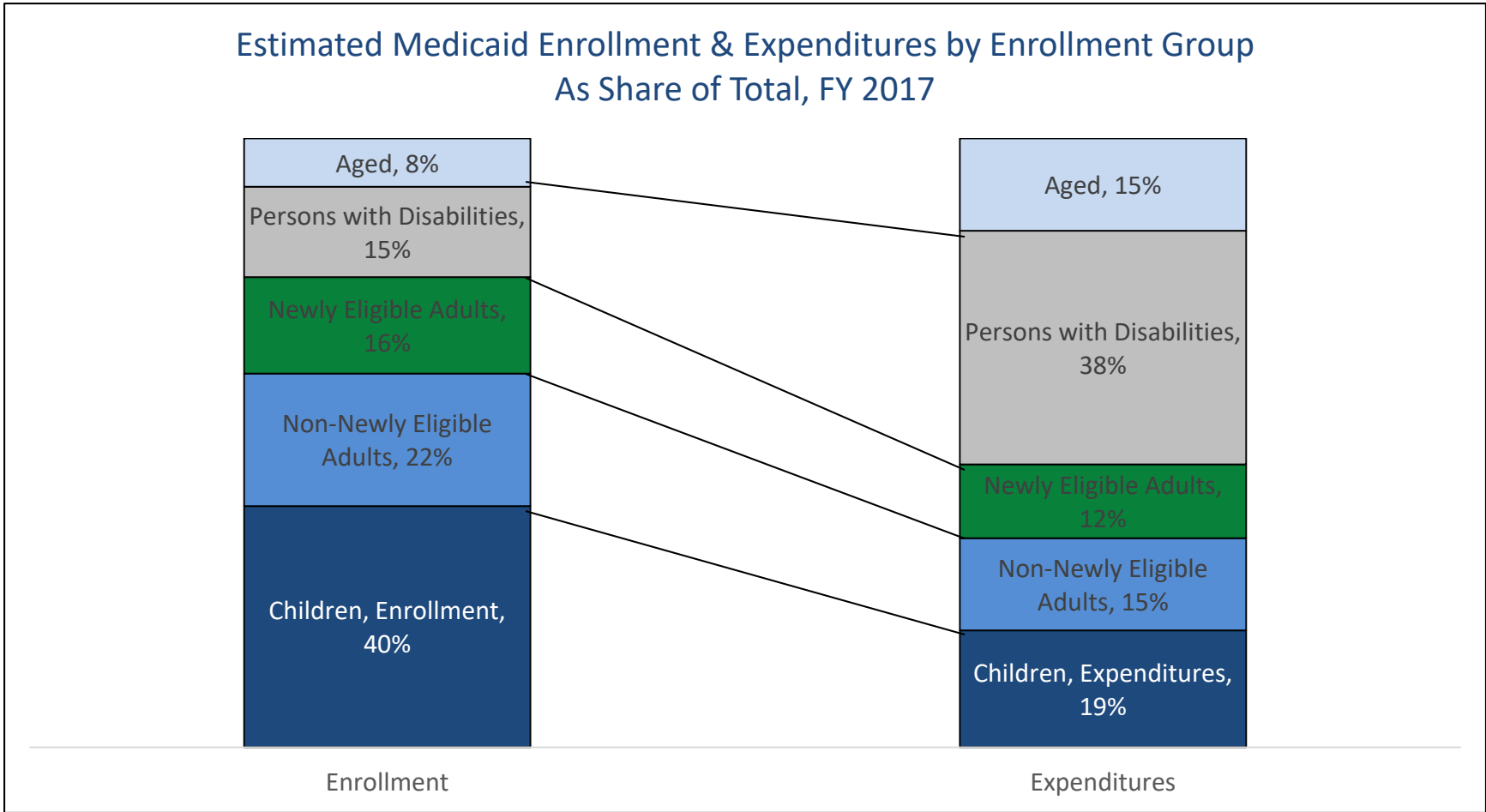
* Values less than 0.1 percent are not shown.

1 Values have not been updated from those published in the December 2017 data book due to the unavailability of more recent MSIS or Transformed MSIS data. This exhibit could not be updated to FY 2014 due to insufficient MSIS data for several states.

Source: MACPAC, 2017, analysis of MSIS data as of December 2016 and CMS-64 financial management report net expenditure data from CMS as of June 2016.

Enrollment vs. Expenditures

Distribution of Medicaid Enrollment versus Expenditures



Source: <https://www.cms.gov/files/document/2018-report.pdf>

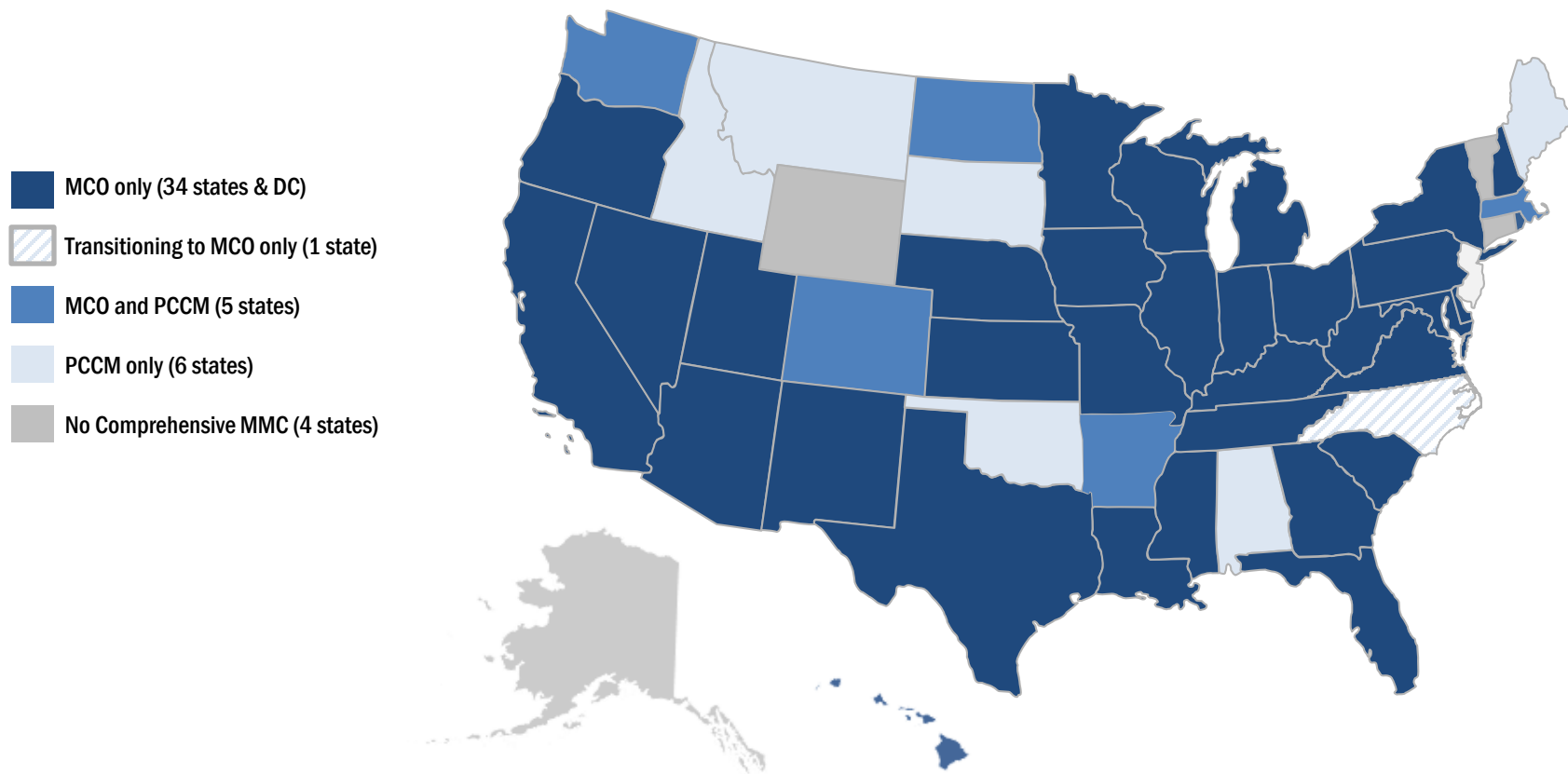
Overview of Medicaid Managed Care

Why do States Use Medicaid Managed Care?

- Most states have some form of managed care in place – comprehensive risk-based managed care and/or primary care case management (PCCM)
- Medicaid managed care organizations (MCOs) provide comprehensive acute care and in some cases long-term services and supports to Medicaid beneficiaries.
- MCOs are paid a set per member per month payment for these services and are at financial risk for the Medicaid services specified in their contracts.
- States have moved to Medicaid MCOs for a range of reasons, including:
 - Seeking to increase budget predictability;
 - Increase or improve access to care and providers;
 - Creating a more clear point of accountability.

Managed Care Penetration

40 States use capitated managed care models



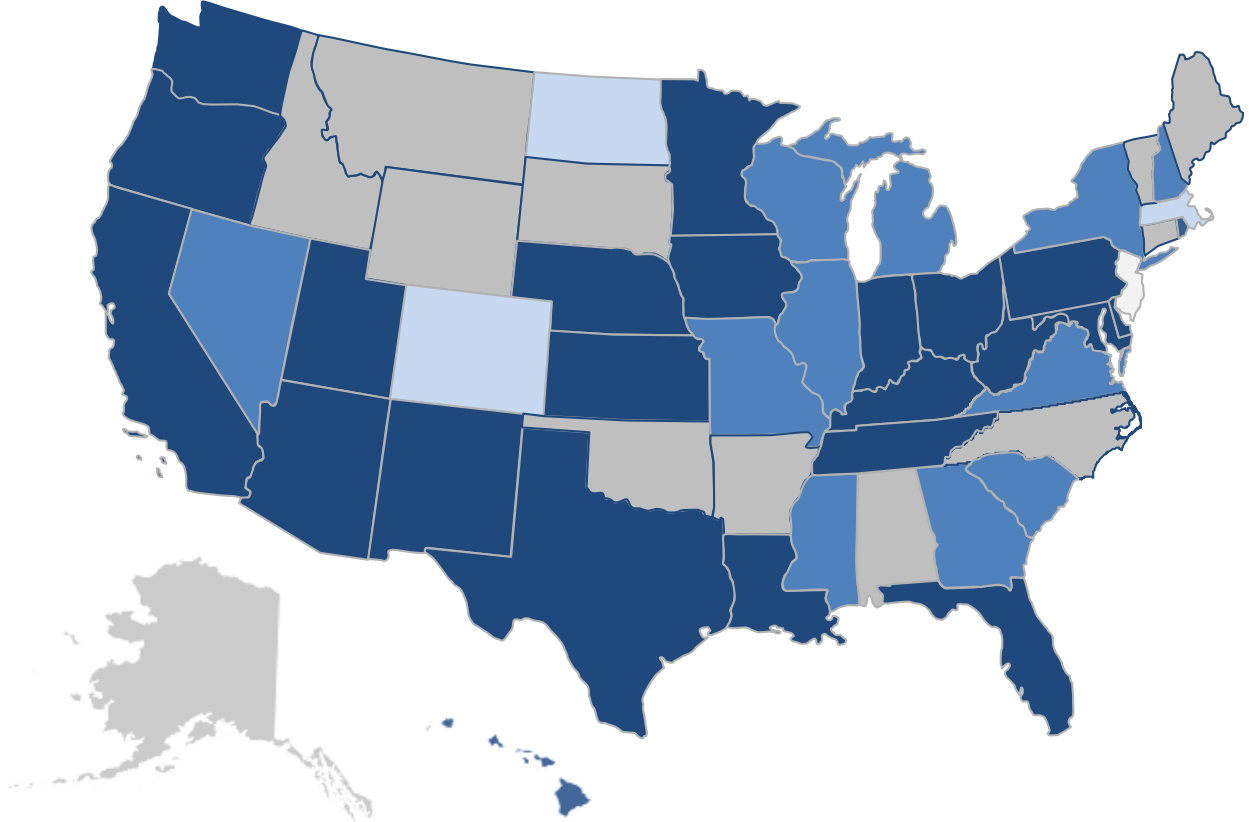
NOTES: CA has a small PCCM program operating in LA County for individuals with HIV. SC uses PCCM authority to operate a small, children's care management program and is not counted here as a PCCM.

SOURCE: KFF survey of Medicaid officials in 50 states and DC conducted by HMA, October 2019

Managed Care Penetration

69% of all Medicaid beneficiaries are in managed care

- >75% (24 States)
- 50-75% (11 States & DC)
- 1 - <50% (3 States)
- No MCOs (12 states)

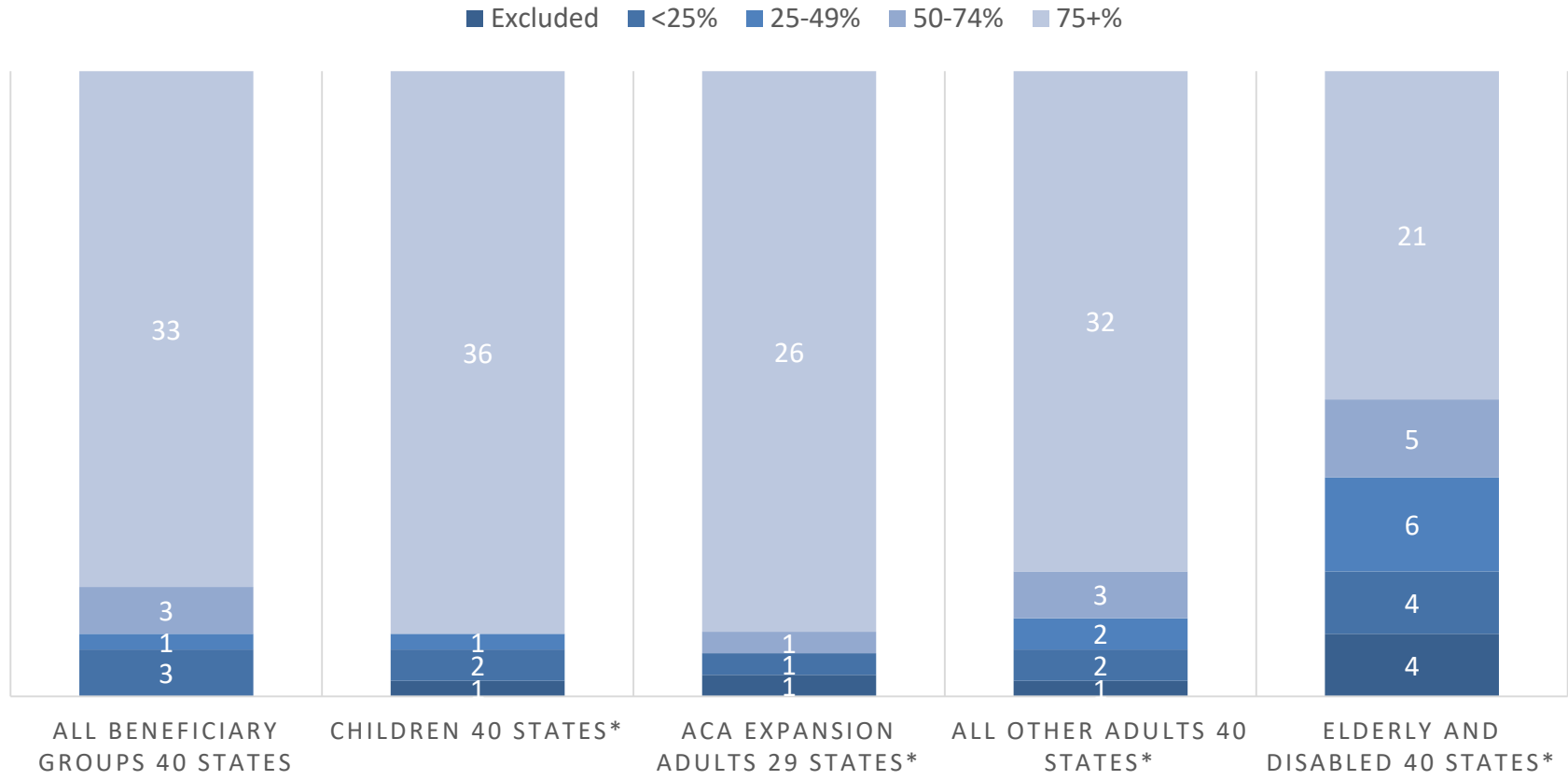


In most states with comprehensive MCOs, at least 75% of beneficiaries are enrolled in one.

SOURCE: KFF. Medicaid Managed Care Enrollment Reports. Centers for Medicare & Medicaid Services, US Department of Health & Human Services, 2019

Medicaid Managed Care Penetration Rates

Managed Care Penetration Rates Across Medicaid Eligibility Groups

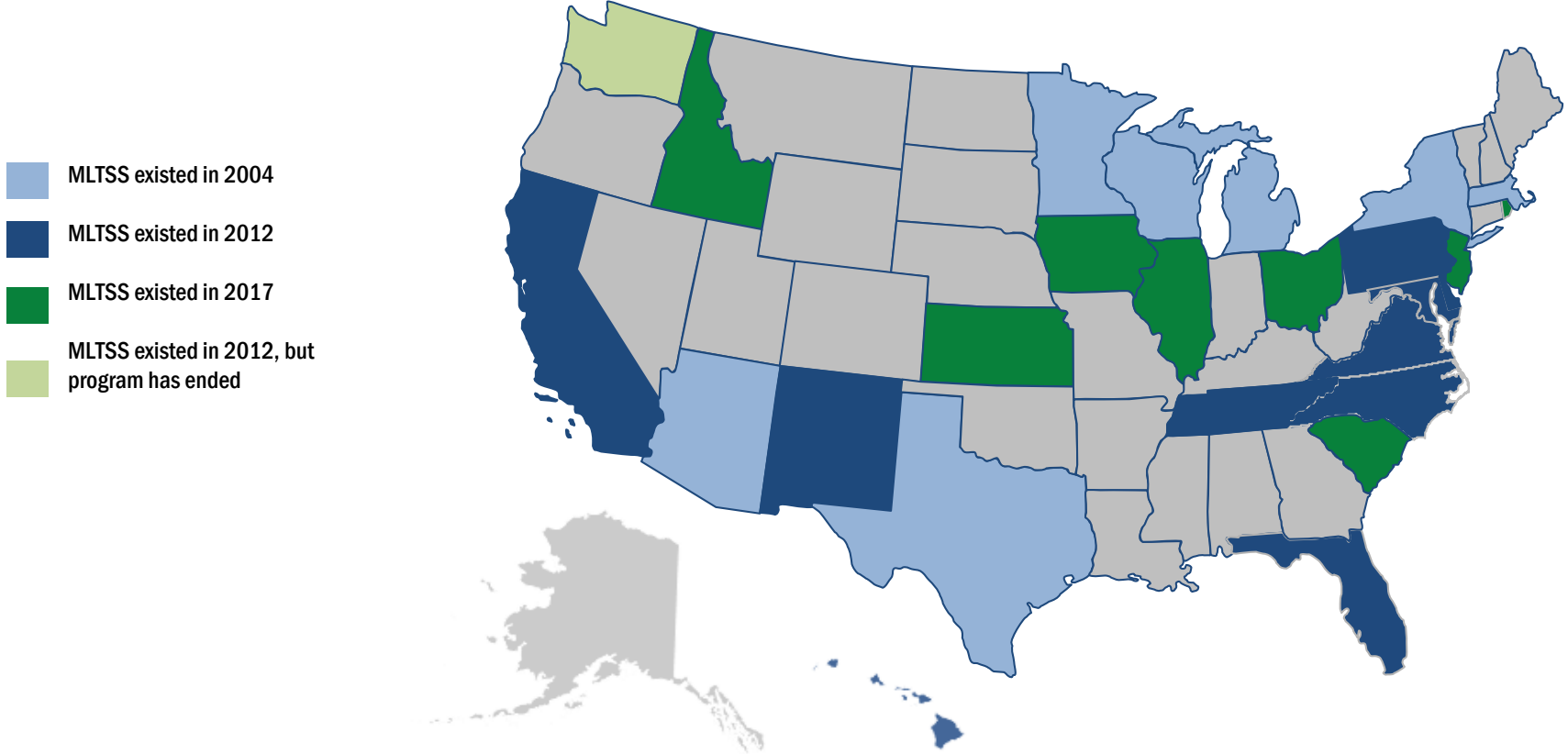


NOTES: Limited to 40 states with MCOs in place on July 1, 2019. Of the 34 states that had implemented the ACA Medicaid expansion as of July 1, 2019, 29 had MCOs in operation. *Maryland reported the MCO penetration rate for “All Beneficiary Groups” but did not report penetration rates for the individual eligibility categories and Georgia reported the MCO penetration rate for all categories except “All Other Adults”; therefore, the rates reported in the 2018 survey were used for the missing penetration rates.

SOURCE: KFF Survey of Medicaid Officials in 50 states and DC conducted by HMA, October 2019

Managed Care LTSS Penetration

24 States Covered LTSS Under Medicaid MCO Contracts*

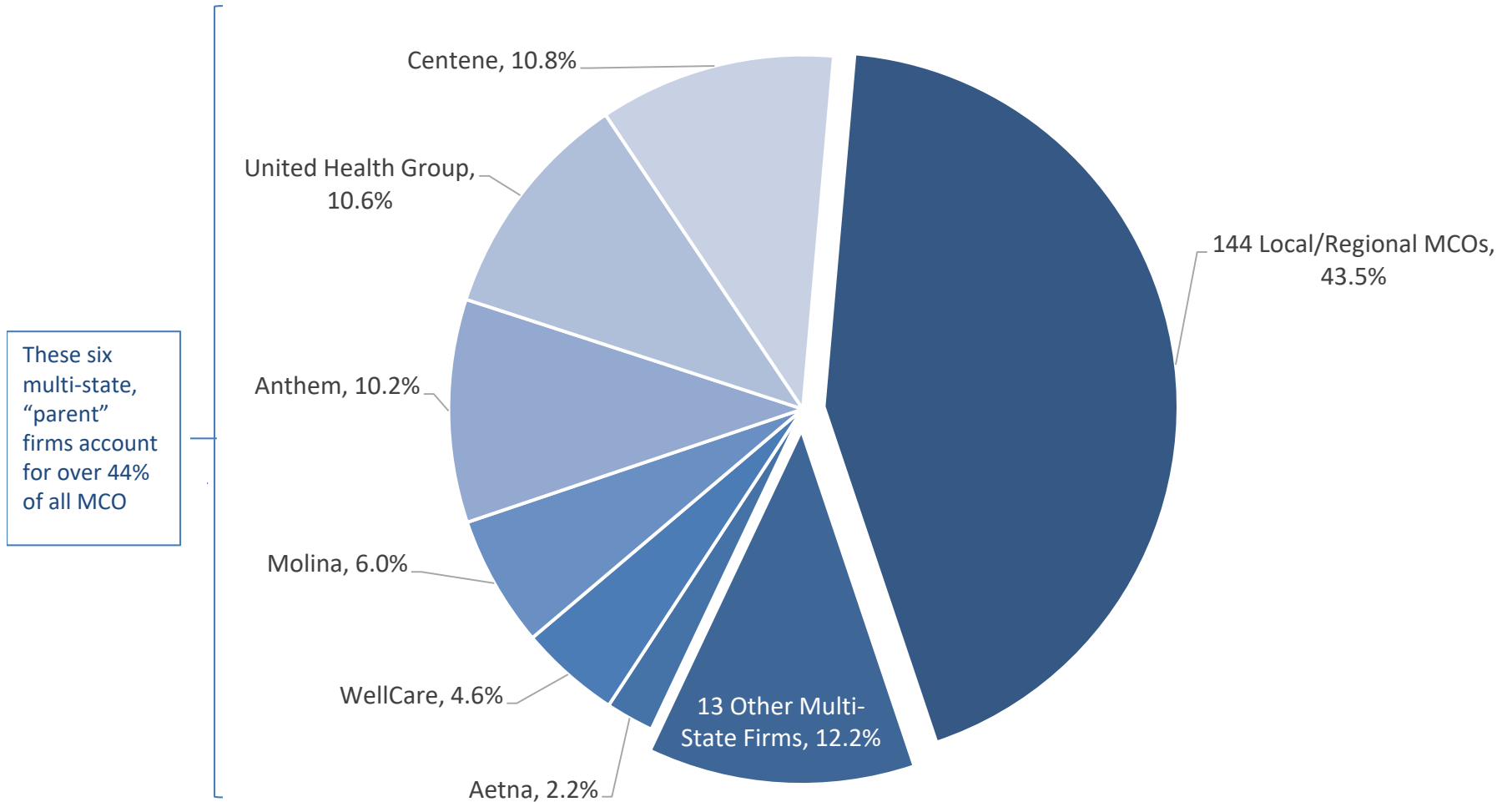


SOURCE: [The Growth of Managed Long-Term Services and Supports \(MLTSS\) Programs: A 2017 Update](#), prepared by Truven Health Analytics for CMS, January 2018.

* As of August 2017

MCO Market Share

Medicaid Managed Care Enrollment Market Share by Firm as of 7/2017

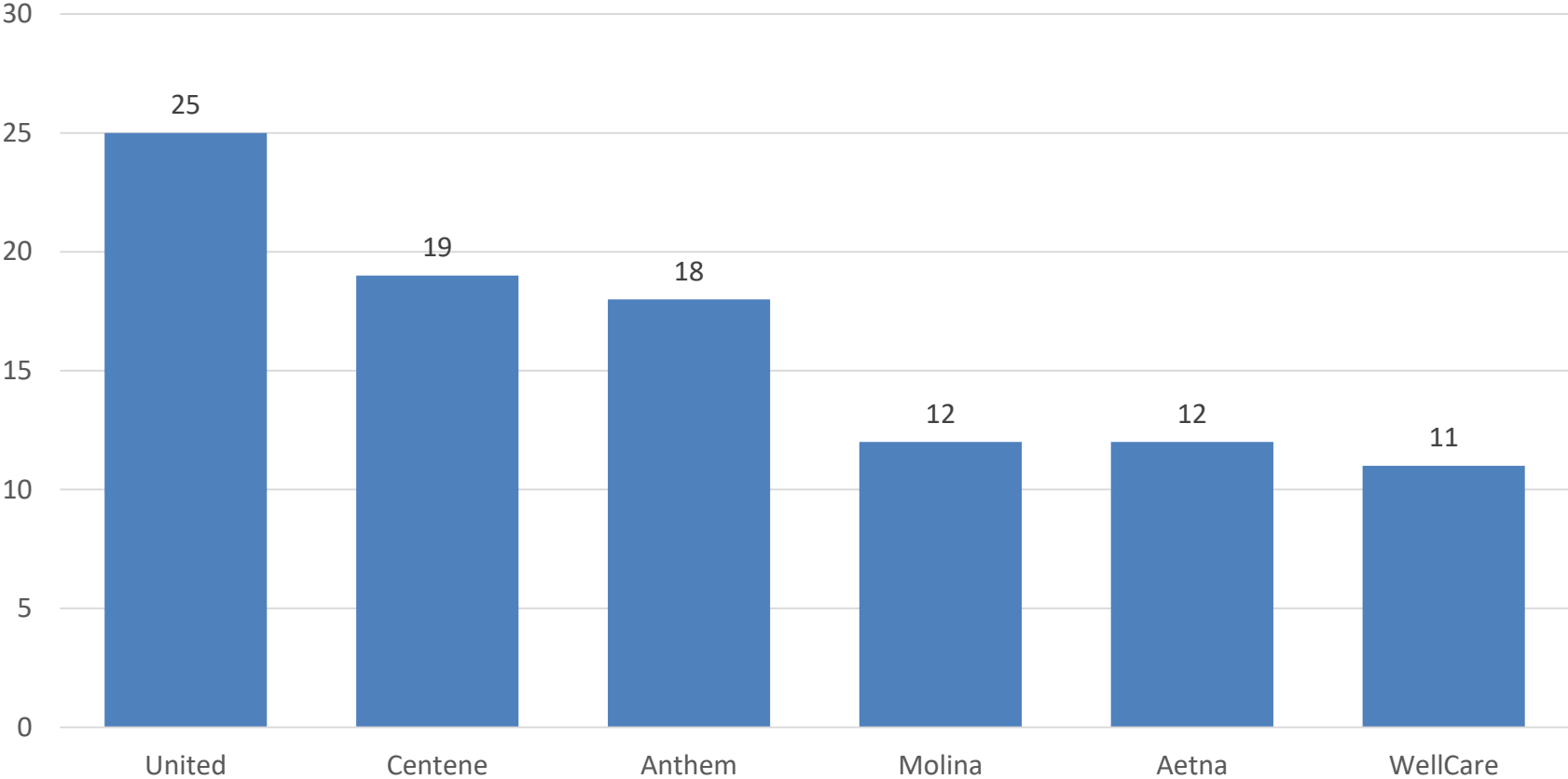


SOURCE: KFF, Medicaid Managed Care Enrollment Reports, Centers for Medicare and Medicaid Services, 2019

Medicaid Managed Care Geographic Reach

Six firms have broad geographic reach in Medicaid, each with MCOs in 10 or more states

Number of states where plans offer Medicaid MCOs as of July 2017:



SOURCE: KFF. Medicaid Managed Care Enrollment Reports, Centers for Medicare and Medicaid Services, 2019

Importance of Overall System Design & Program Structure

State Contracting Strategies

States use different approaches for managed care contracting

Financial Arrangements

- Full risk
- Partial risk (e.g., including risk corridors)

Authority Granted

- Limited health plan flexibility
- Range of flexibility to provide “room” to innovate

Populations Included

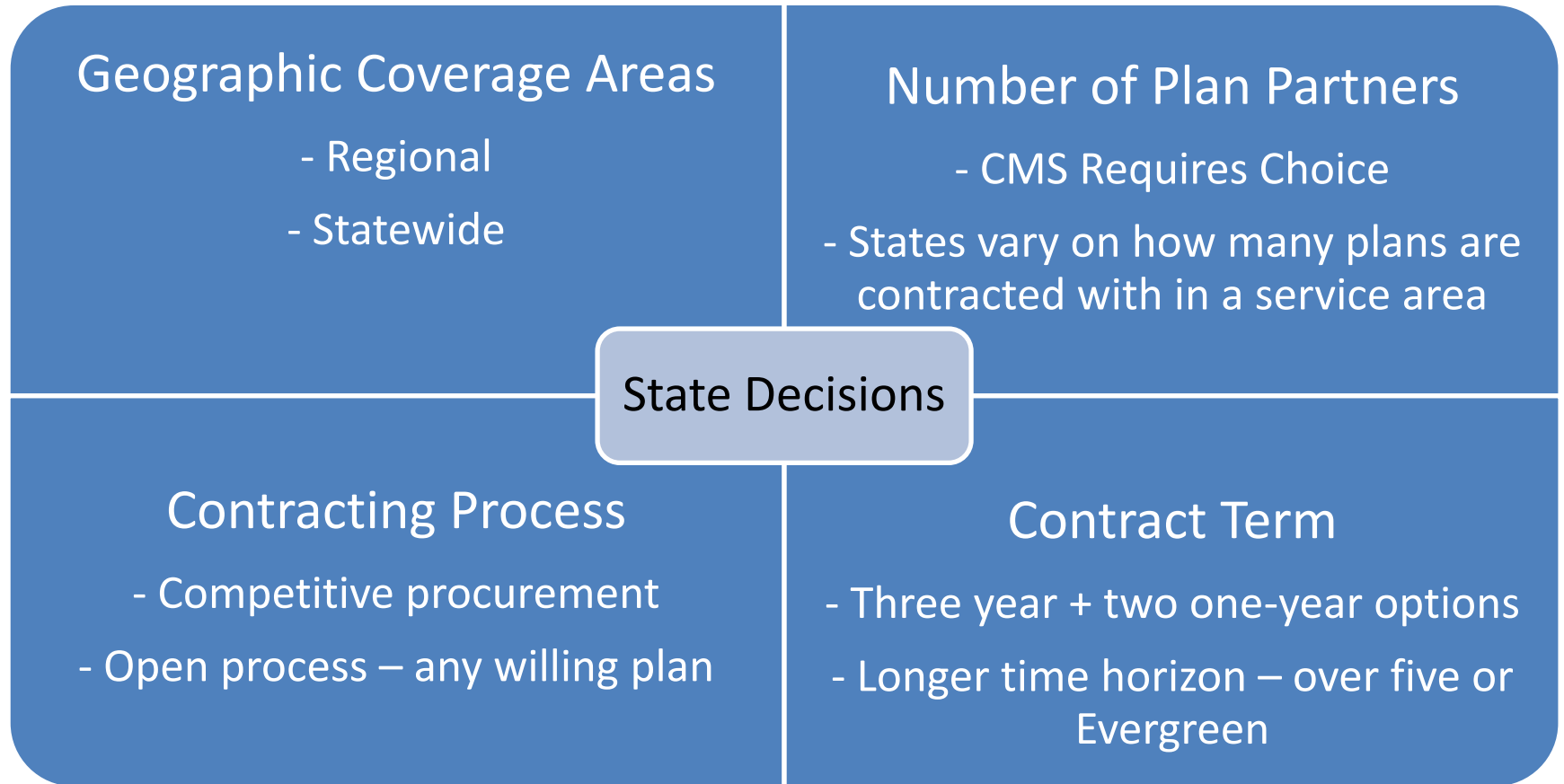
- Children
- Pregnant Women
- Aged and/or Physically Disabled
- Individuals with Intellectual and/or Developmental Disabilities
- Expansion
- Duals

Services Included

- Acute Care Services
- Pharmacy
- Behavioral Health
- Dental
- LTSS

State Contracting Strategies

States use different approaches for managed care contracting



Medicaid Managed Care...more to come

- States continuing to explore transitioning to managed care
 - North Carolina
 - Oklahoma
- Discussions continue in other states
 - Arkansas
 - Alabama
- Managed Care's role with integrating care for Dual eligibles will continue to grow
- Managed Care will play a key role in the integration/coordination of the social determinants of health

QUESTIONS?

Medicaid Managed Care Financing

Tom Betlach

- Medicaid Director - AZ 2009-2019
- Medicaid Deputy Director 2002-2009
- AZ State Budget Director 1997-2002
- Former NAMD President & Vice President
- CBO Panel of Health Advisors



Darin Gordon

- Medicaid Director - Tennessee 2006-2016
- Medicaid Deputy Director/CFO 2004-2006
- Former NAMD President & Vice President
- MACPAC Commissioner

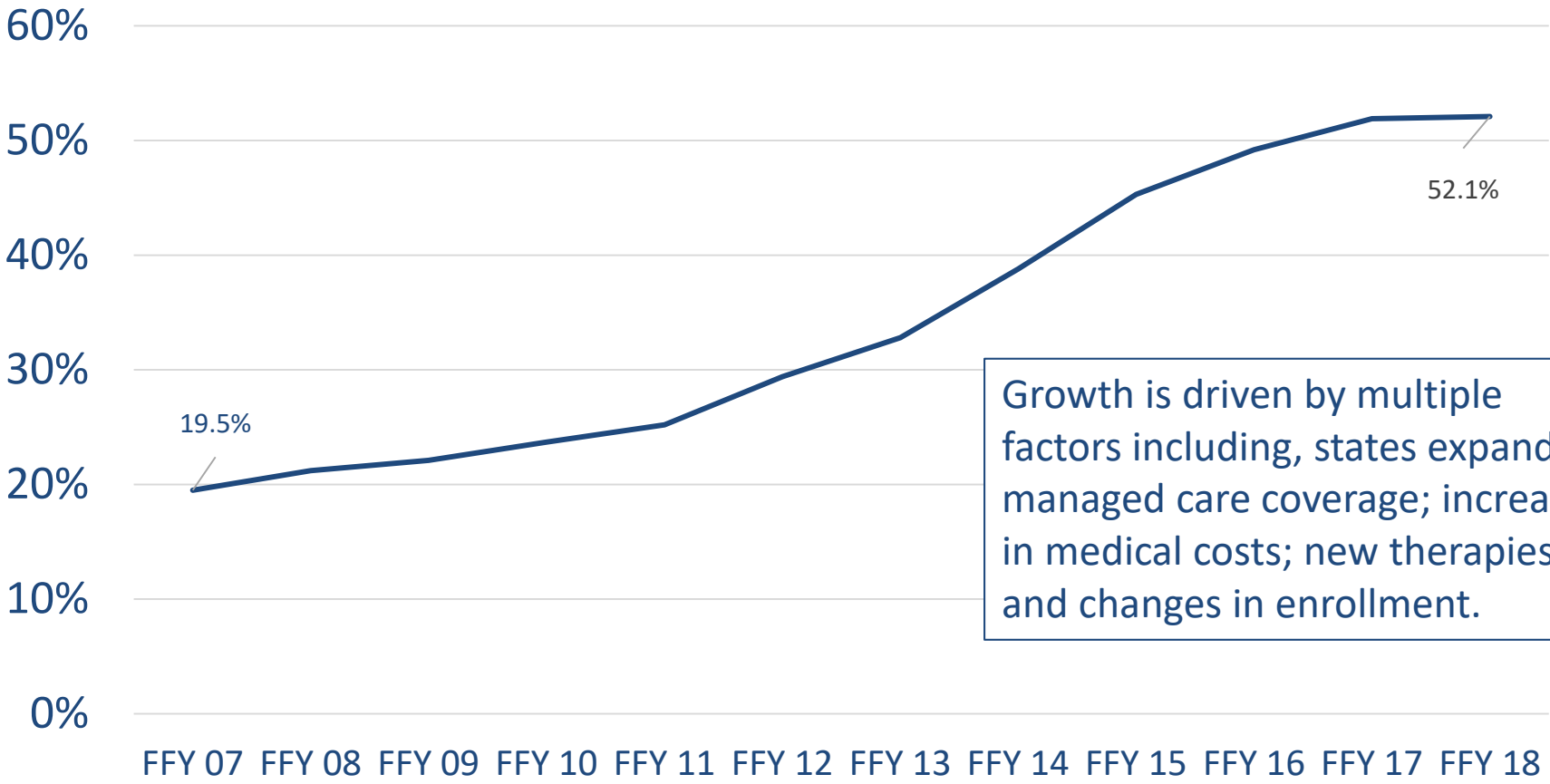


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Growth of Managed Care

Medicaid Managed Care Expenditures as a Percentage of Total Medicaid Expenditures FFY2007-2018



Growth is driven by multiple factors including, states expanding managed care coverage; increases in medical costs; new therapies; and changes in enrollment.

Source: CMS-64

Financial Glossary

Capitation – An actuarially determined fixed Per member per month (PMPM) payment to a MCO in advance, for which the Contractor/MCO provides a full range of covered services

Reinsurance - A risk-sharing program provided to MCOs for the reimbursement of certain Contract service costs incurred for a member beyond a predetermined monetary threshold.

Risk Contract - A Contract between the State and MCO, under which the Contractor receives fixed payment to:

- Assume risk for the cost of the services covered under the Contract; and
- Incur loss if the cost of furnishing the services exceeds the payments under the Contract. [42 CFR 438.2]

Rate Code - Eligibility classification for capitation payment purposes.

Risk Group - Grouping of rate codes that are paid at the same capitation rate.

Risk Corridor – Contractual Arrangement that limits overall losses or gains by MCOs

Medical Loss Ratio (MLR) – MLR measures the portion of capitation that is paid out to support health care claims and certain quality improvement activities. Medicaid managed care regulation from 2016 establish requirements for MLR at 85% and provide an option for states to recoup. CMS issued additional guidance in June 2020.

Program Design Drives Rate Setting

The state makes program design decisions on what services are included in the capitation rate

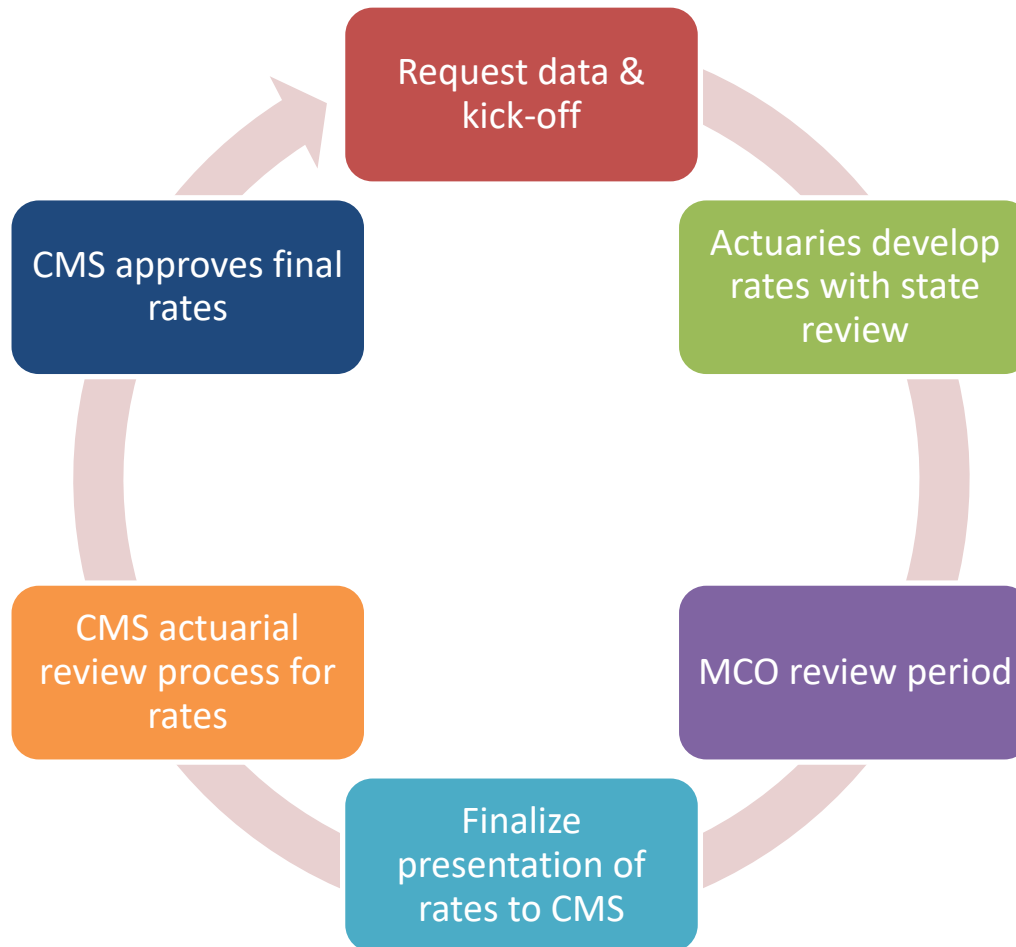
Integrated Plan	Carve Out Models	Carve Out FFS	Combination FFS/MCO
<ul style="list-style-type: none">• Physical Health• Behavioral Health• Long Term Care• Dental• Prescription Drugs	<ul style="list-style-type: none">• Physical Health• Behavioral Health• Dental• Non-Emergency Medical Transport. (NEMT)	<ul style="list-style-type: none">• Pharmacy• Behavioral Health• NEMT• Dental	<ul style="list-style-type: none">• Physical health

Rate Setting

The Capitation Rate setting process establishes a range that then ultimately requires the state to select a specific rate in that range. It is a multi-step process:

- Review Multi-year Base data – based on encounters and financials
 - Multi-year analysis for base rates
 - Used to determine underlying trends and costs
- Trend
 - Apply trend analysis to various risk groups by MCO covered services provider types (IP, OP, Physician, Dental) – Based on actual experience
- Apply adjustments based on policy and programmatic changes
 - Benefit changes
 - Provider payment changes
 - New benefits or coverage changes
- Actuarial Soundness –
 - Capitation rates are projected to provide for all reasonable, appropriate and attainable costs that are required under the contract

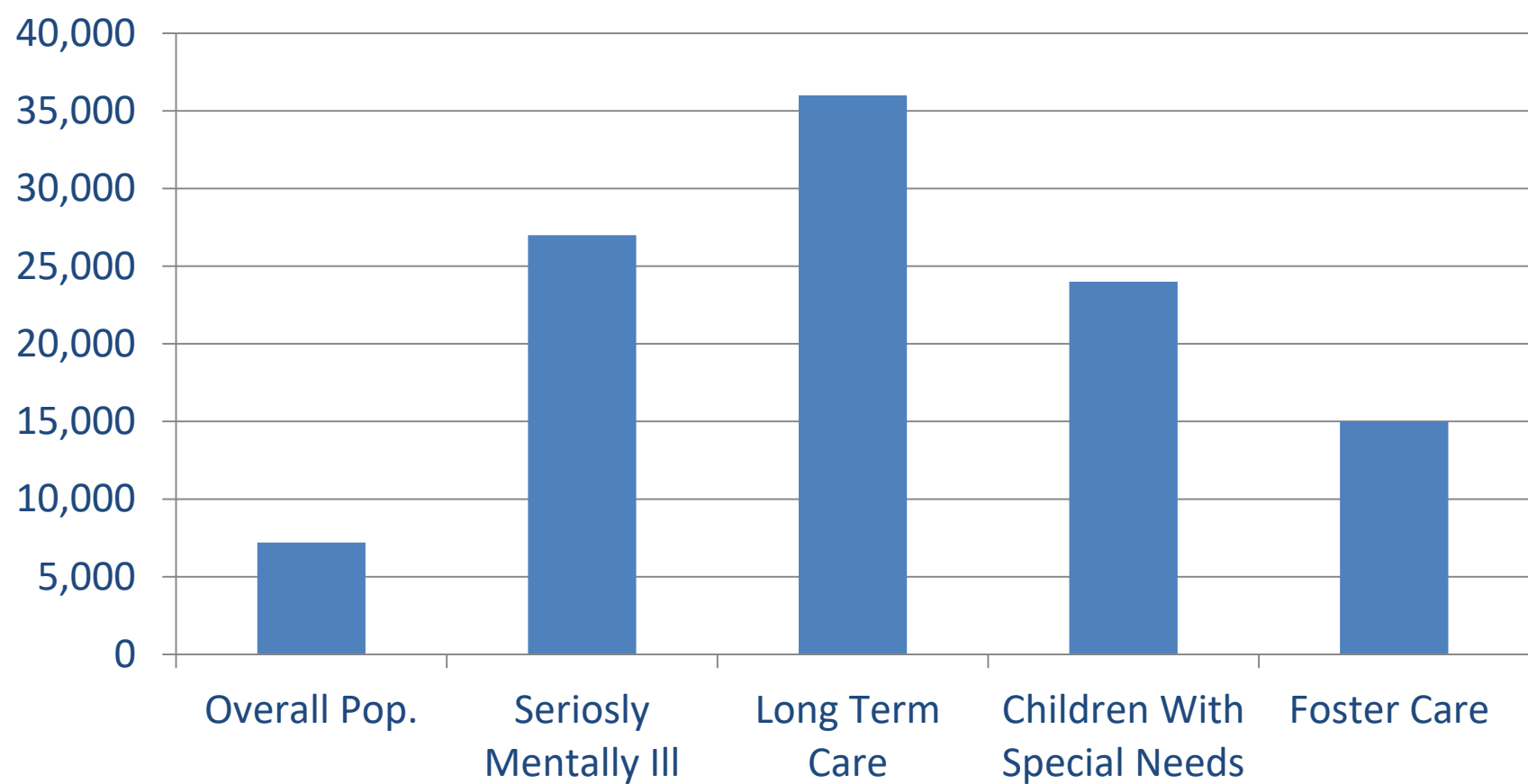
Actuarial Process



The capitation rate development process is only as good as the data, info, and assumptions that are used in the process.

Risk Groups Allow States to Address Unique

Arizona Per Member Per Year Costs



Capitation Rate Setting Tools and Flexibilities

- Directed Payments – 42 CFR part 438.6c provides states with flexibility to establish value-based payments to providers based on quality measures
 - Additional information can be found here
<https://www.medicare.gov/medicare/managed-care/guidance/state-directed-payments/index.html>
- Risk Corridors – NAMD data shows that majority of states are imposing Risk Corridors to limit MCO potential profits and losses associated with uncertainty
 - Risk Corridors can be based on MLR or profit calculations
 - Risk Corridors can be Symmetrical – Asymmetrical or Tiered
- Risk Adjustment – Many states use a variety of methodologies to impose budget neutral adjustments on capitation rates to address variance in member risks between MCOs

State Best Practices On Capitation and Oversight

- Ensure strong encounter data that drives capitation rate development
- Evaluate MCO financial performance on regular basis and compare to capitation trends
- Ensure strong internal consistency between policy initiatives and capitation development
- Conduct third-party financial audits documenting plan performance
- Track and Trend overall capitation trends
- Leverage use of creative capitation rate setting to drive policy objective – example long term care HCBS utilization
- Leverage encounters and capitation process to ensure appropriate Third-Party Liability coordination of benefits
- Utilize capitation rates as part of a competitive MCO contracting process
 - Rates can be bid for program and/or administration

Arizona Capitation Rate Trends



Understanding Reserves

- States set reserve requirements for MCOs in case of both unanticipated increases in costs and/or to protect if a plan leaves the market
- Reserves are used first to keep the MCO in business, then to address unanticipated risk and to ensure payments to providers if the MCO leaves the market
- Reserves are NOT profit
- These solvency requirements are typically set by a state department of insurance or by the Medicaid agency
- MCOs are becoming more innovative in approaches around leveraging reserves to address important issues like Social Determinants of Health.

QUESTIONS?

Upcoming Webinar & Website

We invite you to attend the 3rd and 4th presentations of this MCO 101 series:

Introduction to Medicaid MCO Authorities and Strategies for MCO Partnerships

- Date and Time: **Thursday, 12/3 @ 3pm EST**
- [Register here](#)

For more information about the Medicaid MCO Learning Hub, including accessing slides and presentation recordings, please visit our website:

<https://www.norc.org/Research/Projects/Pages/medicaid-managed-care-organization-learning-hub.aspx>