Managed Care Medicaid vs Fee-for-Service Medicaid

Chris Cochran, Ph.D.
Department of Health Care Administration and Policy
University of Nevada Las Vegas

Background

- FFS has been used by state Medicaid programs for decades.
  - Paid participating physicians, clinics, hospitals, and other providers a fee for each service they furnish
  - FFS can lead to rewarding volume, regardless of health outcomes or quality of care
  - Can also lead to fragmented care, redundancies in care and gaps in care
- States have increasingly expanded Medicaid managed care
  - To improve quality
  - Increase Medicaid budgeting predictability
  - To help control Medicaid spending
- With substantial expansion of Medicaid through the ACA and potential increase in state allocations expansion of Medicaid Managed Care alternatives may be essential

Medicaid Fee for Service

- A method in which doctors and other health care providers are paid for each service performed.
- States create their payment methodologies
- FFS are typically used to address high needs survey populations
  - e.g. Individuals with mental illness or other severe chronic illnesses
  - Individuals in remote areas where access to a health care network is limited
### What is Managed Care?

- An organized effort by health insurance plan and providers using financial incentives and organizational arrangements to alter provider and patient behavior so that health care services are delivered and utilized in a more efficient and lower-cost manner.
  - Focus on efficient management of services
  - Negotiation of prices with providers
  - Core features of managed care:
    - Integration of financing, insurance, delivery, and payment
    - Formal control over utilization

### Objectives of Managed Care

- Enhanced cost containment
- Some forms of rationing
- Administrative an clinical efficiency
- Reduce duplication of services
- Enhance appropriateness of care
- Comprehensive contracting mechanisms
- Manage provider and consumer behavior

### Critical Components for MC

- Preparing and educating covered members
- Information systems and insistence on quality outcome measures
- Plan/Provider Control of Utilization – controlling provider and patient behavior
- Use of gatekeeper (primary care physicians and "hospitalists")
- Capitation
- Risk sharing reduces needed services to patients
- Contracting (negotiated fee for service)
Medicaid Managed Care

- State contracts with Managed Care Provider
- State still handles "eligibility"
- Insurance company accepts a fixed "rate" to manage patient
- This is called a "Risk Contract"
- Patient is "managed" through insurance company
- State oversees compliance

Managed Care Advantages and Disadvantages

- Advantages
  - Controlled cost
  - Controlled provider behavior
- Disadvantages
  - Restricted access to providers
  - Lower reimbursement compounded by lower Medicaid reimbursement rates
  - Controlling patient behavior (e.g., Medicaid may pay the provider at the FFS rate even if the patient goes "out of network").

Expansion of Medicaid on Nevada

- Most of Nevada’s Medicaid population is covered through managed care organizations (risk based)
- Expansion of the ACA has resulted in a substantial increase in the Medicaid population
- In Nevada, the Medicaid population is 630,000 or about 23% of the state population
  - Represents an 87% increase in Medicaid since 2013
  - Medicaid managed care covers more than
- In 2014 – first year of ACA expansion – 464,000 Nevadans were covered the Medicaid Managed Care
- This expansion addresses the potential need for Nevada to expand its MCO market
Challenges of Medicaid Expansion

- Explosion of newly covered individuals creates chaos in access
- Heavy reliance on emergency room primary care
- Many providers not willing to accept Medicaid patients
- Current MCOs will need time in educating expanded population about best use of health plans
- Not enough providers to address patient needs
  - New MCOs may help, but they will face the same challenges as existing MCOs
- Many of NV’s surrounding western states use a variety of MC options to address growth in Medicaid population

Option: Value Based Payment and Medicaid

- Several states looking to change from volume-driven fee-for-service payments and toward value-based payment (VBP) arrangements.
- States can leverage MCO contracts to accelerate wide-scale adoption.

Changing FFS to FFS Managed Care through Value Based Payments

- Require MCOs to adopt a standardized VBP model
- Require MCOs to make a specific percentage of provider payments through approved VBP arrangements.
  - performance incentives or penalties, shared savings and/or risk based on quality and cost targets, episode or bundled payments, or global payment programs.
- Require MCOs to launch VBP pilot projects subject to state approval
  - Could help the state phase in workable phase in of FFS Managed Care for specific populations
- Require the MCOs to move toward implementation of more sophisticated VBP approaches over the life of the contract.
  - Gives providers time to adjust to improve their accountability over time
Uses of Value Based Payments

- Medicare currently uses value based reimbursement
- But expansion is targeted to home health and skilled nursing facilities
- This may present opportunities for Medicaid patients who currently make up a sizeable portion of these programs.

Value Base Purchasing Options

- Primary Care Case Management (PCCM)
- Pre-Paid health plans (PHP)
  - non-comprehensive health plan that provides only certain services (e.g., dental, non-emergency medical transport)
  - Other options can include behavioral health specific (non-comprehensive)
- Managed Long-Term Services and Supports (MLTSS)
- Health Homes
- Accountable Care Organizations (related to value base payment)
- Patient Centered Medical Homes
- Nevada is one of the few states that has not implemented at least one other option of delivery system health reform models such as these

Other Challenges

- Can state effectively move high needs users into managed care plans and still achieve quality
- Getting more providers into the MCO plans to help manage the patient care
  - Does expansion of MCOs increase providers or do the same providers contract with multiple MCOs
- Getting patients the medical literacy about using their plans
- Addressing the role of providers to enhance proper utilization of services
- Eliminating barriers to patient compliance