MACPAC

Paying for Value in Medicaid

Overview of three state approaches

Medicaid and CHIP Payment and Access Commission
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Introduction

- All states seek value in their Medicaid programs to:
  - Contain costs
  - Improve access and outcomes
- Program framework allows for variation in state approaches to this common goal
- MACPAC is conducting an ongoing project to better understand approaches in specific states

Project approach

- Two day site visits to states to understand:
  - Factors that affected model choice and design
  - Policy issues and implementation
  - Ongoing operations and evaluation
- Semi-structured interviews with state officials and stakeholders
- Not a formal research study or evaluation

Site visit states and approaches

- Last year:
  - Minnesota: Integrated health partnerships
  - Oregon: Coordinated care organizations
  - Arkansas: Episode-based payments
  - Pennsylvania: Managed care payments
- This year:
  - Connecticut: Administrative services organizations
  - Oklahoma: Primary care case management
  - Maryland: Multi-payer medical home

Connecticut: HUSKY Health

Context

- From 1996-2011, medical services for children, parents, and pregnant women were provided through managed care contracts
  - Fee for service for older adults and individuals with disabilities
- In 2012, all populations transitioned to an administrative services organization (ASO) for medical services
  - Behavioral health and dental services already provided by ASOs

Connecticut: HUSKY Health

Rationale for ASO Transition

- Build upon successful model used for behavioral health and dental
- Improve access to and use of data
- Centralize and streamline administration, utilization management, and member and provider supports

Connecticut: HUSKY Health

Program Summary

- Community Health Network of Connecticut serves as medical ASO
- Functions include:
  - Prior authorization and utilization management
  - Predictive modeling to identify individuals needing care management and provision of care management
  - Assistance to enrollees and providers with referrals, service requirements, and coverage questions
- Quarterly payment with withhold contingent on performance targets

Connecticut: HUSKY Health

Ongoing Development

- Continuing effort to standardize claims data
- Plans to modernize provider payment methods
  - Patient-Centered Medical Home (PCMH) program was also implemented in 2012
- Integrating services and improving care coordination across ASOs

Oklahoma: SoonerCare Choice

Context

- Medicaid is administered by the Oklahoma Health Care Authority
  - Board members appointed by Governor and legislature
- Prior to 2004 – partially capitated Primary Care Case Management (PCCM) in rural areas, and managed care in urban areas
- In 2004 – expanded PCCM program statewide
- Recent initiatives intended to improve access, coordination, and care management

Oklahoma: SoonerCare Choice

Patient Centered Medical Home

- All SoonerCare Choice members enroll with a PCMH
- Provider payments include:
  - A monthly care coordination fee based on PCMH tier
  - Fee-for-service payments based on fee schedule
  - Performance-based SoonerExcel payments

Oklahoma: SoonerCare Choice

Care Management Functions

- Case Management Unit
  - Case management for enrollees based on specific programs, episodes, or events
- Chronic Care Unit
  - Care management for targeted chronic conditions
- Behavioral Health Unit
  - Conducts screenings, referrals, and care coordination
- Health Management Program
  - Embedded health coaches and practice facilitation within practices with high chronic disease burden

Oklahoma: SoonerCare Choice

Health Access Networks (HANs)

- Contracted networks that provide care coordination across member PCMHs and other providers and specialists
  - Oklahoma University Sooner HAN
  - Oklahoma State University HAN
  - Central Communities HAN
- HANs also provide practice facilitation to members
- Goals are to increase access to care, improve care coordination, and reduce costs

Maryland: Multi-Payer Medical Home Program

Context

- Pilot established by 2010 state legislation
  - Ends in 2015
- Administered by the Maryland Health Care Commission
- Participation required of all payers with premium revenues of $90 million and Medicaid
  - Federal and state employee plans, TRICARE, and some private employer plans also participate
- MHCC may also authorize “single carrier” programs

Maryland: Multi-Payer Medical Home Program

Program Summary

- 52 practices selected to participate
- Receive fixed transformation payments
  - PMPM paid semi-annually
  - Tiered based on practice size and NCQA PCMH certification level
- Eligible for shared savings based on total cost of care
  - Also, contingent upon performance metrics

Maryland: Multi-Payer Medical Home Program

Next Steps

- With end date of pilot approaching, state must decide on future of program
- Evaluation results based on first year showed:
  - About half of practices shared in savings totaling nearly $1 million
  - While some significant differences were observed, most of 48 measures did not differ from comparison
    - May be due to only having first year of data

Next Steps

Next Steps

- Continue monitoring states for program developments and evidence of effects on cost, access, and quality
- Roundtable with representatives from each state to focus on:
  - Changing provider behavior
  - Data and analytics
  - Integration of high-cost services
  - Monitoring and sustainability