

# Medicaid Managed Care: Partnering with the Commonwealth to Improve Medicaid Care and Outcomes

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VIRGINIA ASSOCIATION  
OF HEALTH PLANS

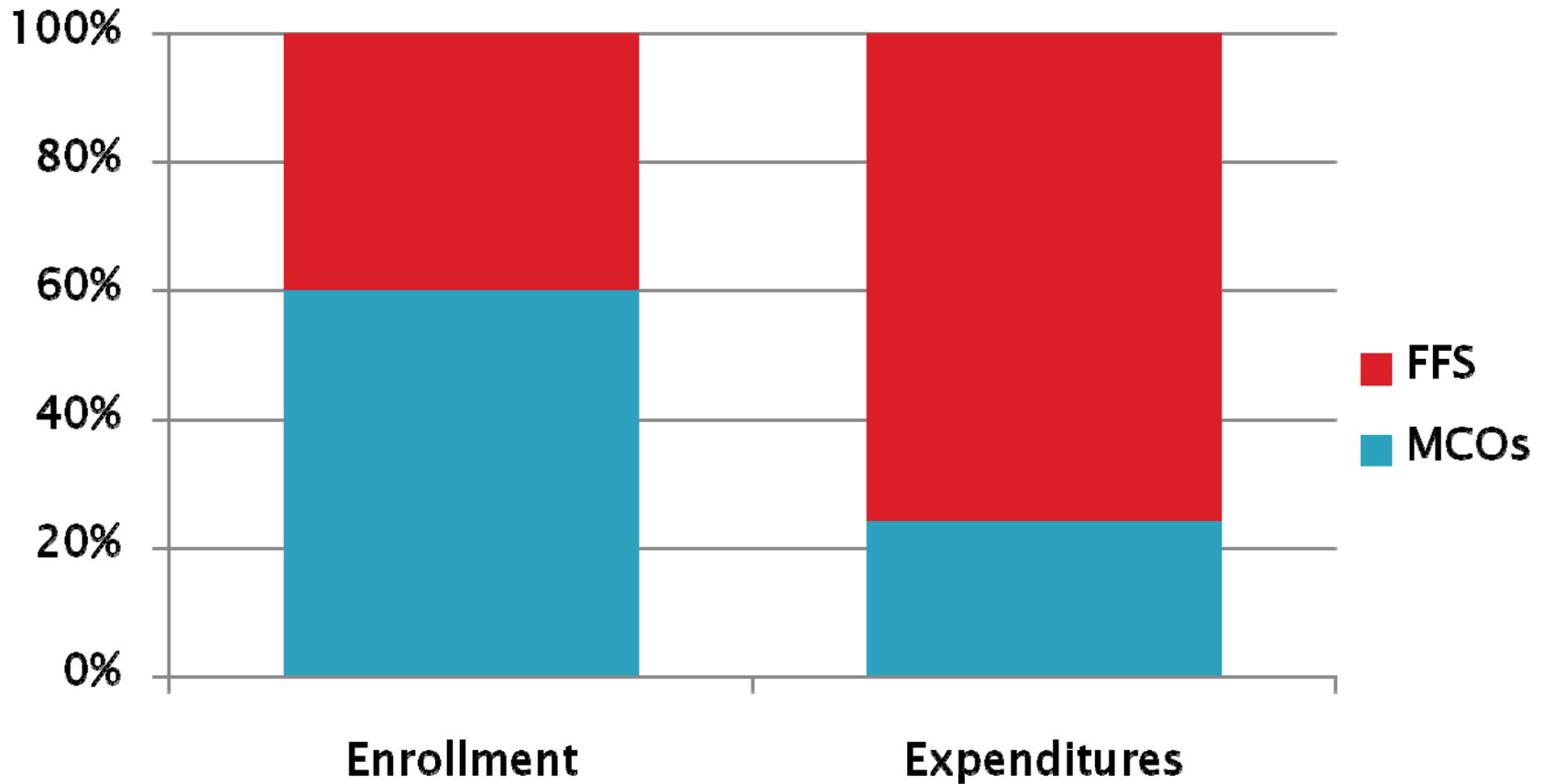
# Managed Care in Virginia: History

- ▶ 14+ year history in Virginia
- ▶ 5 plans
  - Anthem (204,454)\*
  - Optima Family Care (154,457)\*
  - VAPremier (147,265)\*
  - Amerigroup (37,040)\*
  - CareNet (Southern Health) (23,240)\*
- ▶ Most of the state served through managed care
  - Medallion II began January 1, 1996 and covered managed care recipients in seven Tidewater localities

\*March 2010 Enrollment for Medicaid and FAMIS



# Where Do Medicaid Dollars Go?



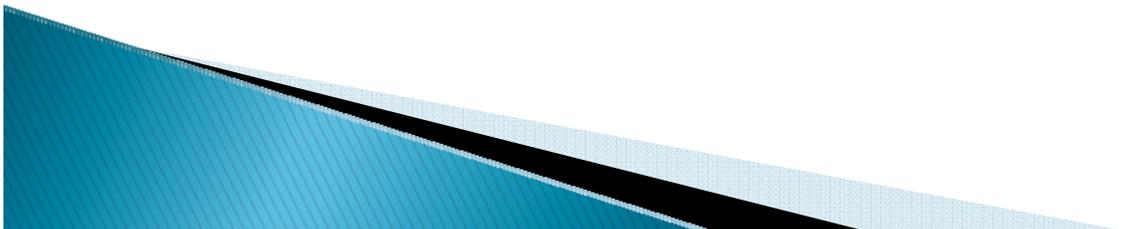
\*Virginia Medicaid Managed Care Performance Report 2007-2008

# Managed Care in Virginia: Populations Served

- ▶ Medicaid MCOs serve over 550,000 individuals
  - Over 60% of the Medicaid/FAMIS population is enrolled in managed care
- ▶ Populations covered primarily include (some exclusions may apply):
  - Pregnant women
  - Children
  - ABD
- ▶ Managed care has grown to cover certain adults with special health care needs.
  - ABD (income up to 80% FPL) added in 2006
  - HCBS waiver recipients who were enrolled in an MCO prior to becoming eligible for waiver services added in 2007

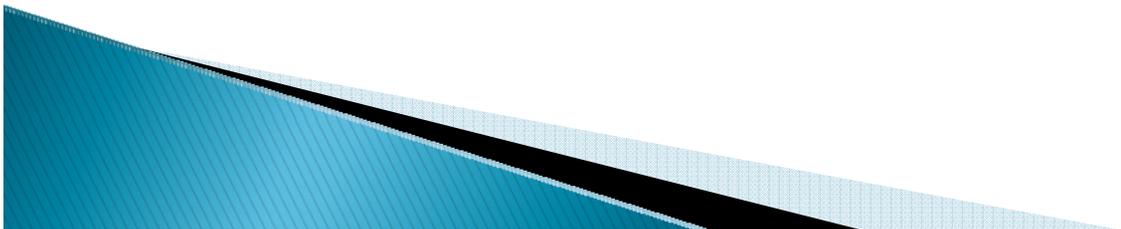
# Anthem HealthKeepers Plus Featured Programs and Services: Maternity Management

- ▶ Future Moms and Pregnancy Partners Maternity Management Programs
- ▶ Onsite Maternity Outreach Program at high volume hospital
- ▶ Promotion of national text4baby program
- ▶ Representation on the Commissioner of Health's State Infant Mortality Task Force
- ▶ Active participation on local coalitions for maternal and child health



# Anthem HealthKeepers Plus Featured Programs and Services: ABD Population

- ▶ Outreach to all new ABD members within the first 30 days of enrollment to link them to appropriate care management programs and community resources
- ▶ Underutilization monitoring program of ABD population
- ▶ Robust health risk assessment process

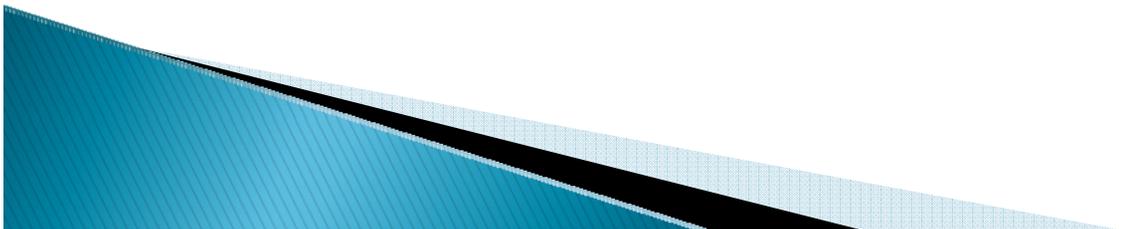


# Why Medicaid Managed Care?

- ▶ MCOs take the risk
  - Known capped expense for the state
- ▶ Economies of scale
- ▶ Stringent accreditation requirements = Higher quality
  - All plans NCQA accredited (one of the first states to require)
  - Several top 50 Medicaid plans by US News & World Reports
- ▶ Quality management and improvement
  - Disease management and nurse triage phone lines
  - Participation in DMAS Quality Collaborative
- ▶ More and better choices for enrollees
  - Credentialed provider networks

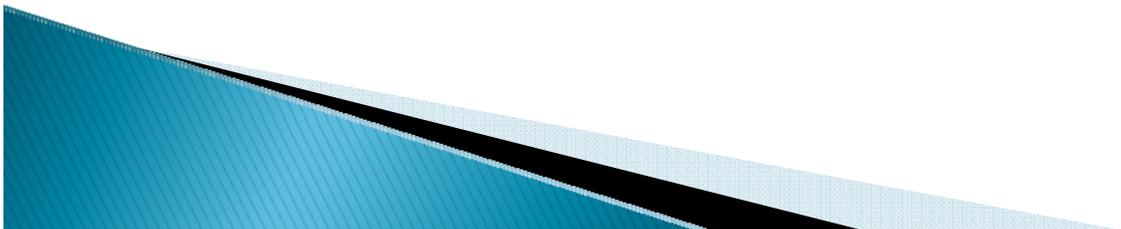
# Budget Impacts (FY10–FY12)

- ▶ In FY 2010, Medicaid MCOs sustained a three pronged reduction
  - Artificial ceiling on capitation payments (\$42 million GF/NGF)
  - Delayed payment (\$119.5 million GF/NGF)
  - Provider flow-through reductions
- ▶ Further provider flow-through reductions are taking place now through FY 12 due to the loss of FMAP
- ▶ The 3 largest plans together lost over \$20 million in 2009



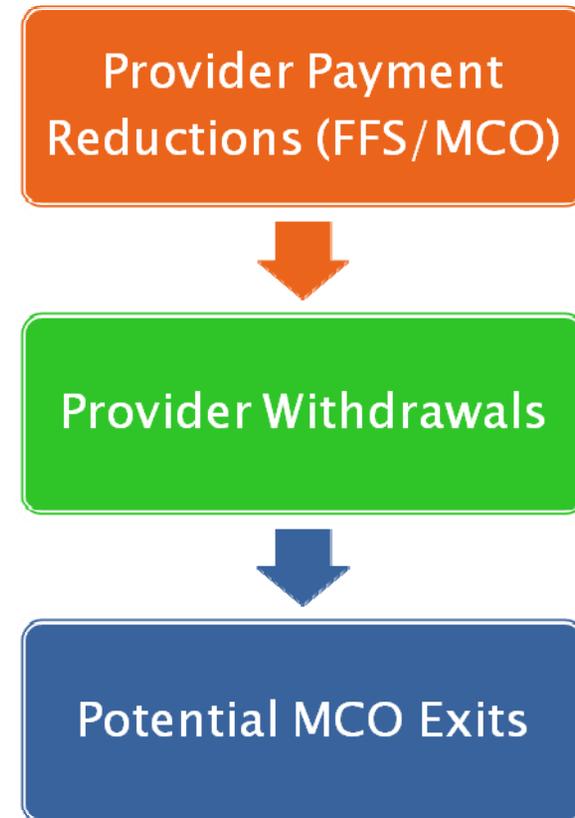
# Bad Economy = Cost Challenges

- ▶ Significant growth in membership
  - More enrollees leads to increased expense
  - Increased demand for providers
  - Additional member churn with growth
- ▶ Increased medical cost trends
  - Growth in chronic and disabling conditions
  - Complexity of care



# Bad Economy = Cost Challenges

- ▶ Access compromised with provider cuts
  - Budget reductions for providers flow through to the MCOs
    - Higher ER utilization
    - Increased hospital/physician pressure for revenue replacement
  - MCO exits mean greater cost and uncertainty for the Commonwealth
    - Potential to see additional service area reductions

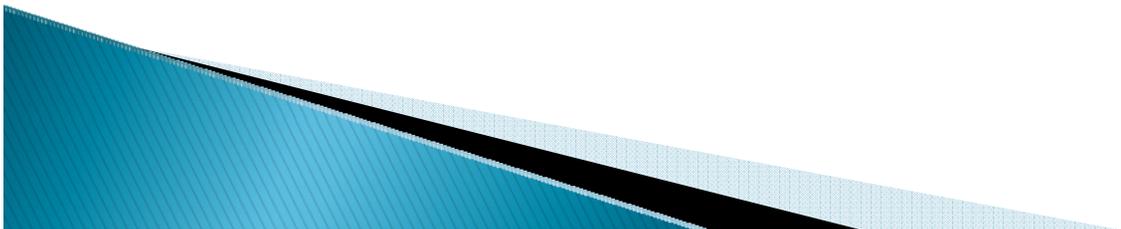


Down Stream Effect of  
Provider Cuts = Reduced Access

# Federal Health Reform: Challenges & Opportunities

## ▶ Enrollment

- Increased membership = Future state costs
  - 270,000 – 425,000 estimated new enrollees
- Increased state expense with potential “woodwork” effect as previously eligible but unenrolled individuals discover they qualify
- Potential MCO expansion (geographic and eligibility group)



# Federal Health Reform: Challenges & Opportunities

## ▶ Access to providers

- Need to retain current as well as recruit new Medicaid providers in populated areas
- Encourage the location of providers in rural areas
  - *Providing care to rural areas of Appalachia can be difficult. The remoteness and poverty of the region force people to rely on yearly clinics. Programs like the Health Wagon take the clinic to the patient by converting an RV to a “mobile health unit” that makes rounds in the hills of Appalachia. But this only serves a portion of the people who need care (Statehouse News article on the 11<sup>th</sup> annual Remote Medical Care Clinic in Wise)*
- Creation of alternative delivery models
  - Telemedicine
  - Nurse run clinics
  - Upgrading the safety net
  - Supporting FQHCs

# Federal Health Reform: Challenges & Opportunities

- ▶ Realignment of payment incentives to focus on quality outcomes – Must share risk
  - ACOs
  - Medical homes
  - Improve quality and clinical outcomes
    - Self-insured employers are taking innovative steps to improve quality as reported in Kaiser Health News.
    - *Lowe's negotiated flat-rate fees with the Cleveland Clinic for complex cardiac procedures. Lowe's is not charged extra if a patient is re-admitted to the clinic for care resulting from the surgery.*
    - Recognizing quality orthopedic outcomes at a hospital, John McNaly's employer, Alpha Coal West, *offered to pay his travel expenses if he would have the surgery in Fort Collins, Colorado, a five hour drive from his home near Gillette, Wyoming.*

# Federal Health Reform: Challenges and Opportunities

## ▶ Serving new enrollees

- High initial medical costs as new enrollees may not have had access to care
- High emergency room usage
  - ER visits in Massachusetts have risen by 9% from 2004 to 2008 despite the nearly universal health insurance mandate (Boston Globe)
  - 1 in 8 ER visits by adults in 2007 involved individuals with a mental disorder or substance abuse disorder
    - 21% were uninsured (AHRQ)
  - *Several national and statewide studies have shown that expanding insurance coverage does not reduce ER visits. This is because the uninsured “are not really responsible for significant ER use” as explained by David Morales, Massachusetts Commissioner of the Division of Health Care Finance and Policy. (The Boston Globe)*

# Federal Health Reform: Challenges and Opportunities

- ▶ Benefit package
  - It is unknown what the benefit package for the 138% FPL group will look like
  - Potential for increased complexity and differentiation among Medicaid enrollees
- ▶ IT
  - Movement towards a more paperless system
  - Creating eligibility determination systems
  - Improve the accuracy of collected information
  - Simplify and streamline eligibility procedures
  - Coordinate seamless transition of Medicaid enrollees to connector
- ▶ Fraud and abuse
  - Provider and enrollee
    - Unconventional billing patterns
    - Appropriate standards of care
    - Drug diversion

# Questions?

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