



UTAH DEPARTMENT OF  
**HEALTH**  
**MEDICAID**

# **Utah Medicaid: Managed Care Perspectives**

Utah Department of Health  
Division of Medicaid and Health Financing  
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# Vision



## Our Vision For Utah:

A place where **all people**  
Can **enjoy** the best health possible,  
where all can **live**,  
**grow and prosper** in  
healthy and safe communities.

# History of Managed Care

- Utah Medicaid has been operating the Choice of Health Care Delivery waiver program since 1982
  - 1915(b) freedom of choice waiver request
- Originally voluntary enrollment in managed care plans
- Since 1995, all newly eligibles living in Utah's urban counties are enrolled in a managed care plan
  - Since 1996, 93-96% of all urban Medicaid clients have enrolled in managed care plans



# Health Plan Contracts

- Risk contracts
  - 1996-2002
- Non-risk contracts
  - 2002-2009
- Risk only contracts
  - Planning for 2012

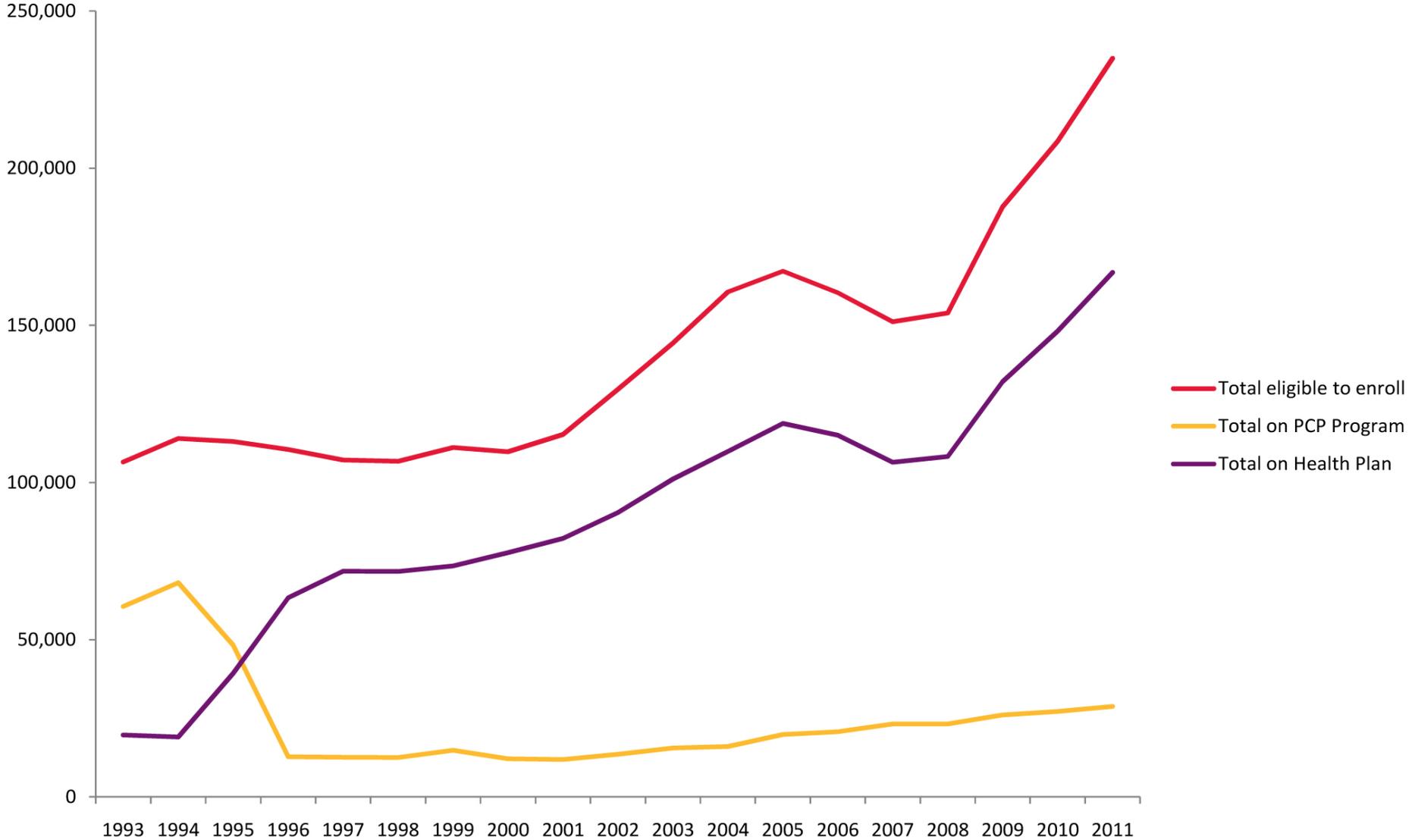
# Current Managed Care Plans



- Currently, Utah contracts with three health plans
  - Health U (University of Utah health network)
    - Operates as a non-risk Prepaid Ambulatory Health Plan
    - Medicaid pays inpatient claims as fee-for-service
  - Select Access (Intermountain Healthcare network)
    - Operates as a Primary Care Case Management system
    - Medicaid pays all claims on a fee-for-service basis
    - Select Access receives a per enrollee case management and network access fee
  - Molina Healthcare of Utah
    - Full-risk contractor under the federal definition of a Managed Care Organization

<b>Plan Name</b>	<b>Plan Type</b>	<b>Contract Type</b>	<b>Current Enrollment</b>
Select Access	Primary Care Case Management (PCCM)	- Fee-for-service - Network access fee - Case Management fee	72,448
Molina (urban)	Managed Care Organization (MCO)	Risk	50,121
Molina (rural)	Managed Care Organization (MCO)	Risk	7,219
Healthy U	Prepaid Ambulatory Health Plan (PAHP)	Non-risk plus administrative fee	37,445
H.O.M.E. (dual diagnosis)	Prepaid Inpatient Health Plan (PIHP)	Non-risk, prepaid	811
<b>Total Physical Health Managed Care Enrollment</b> (authorized under 1915(b) freedom of choice authority)			<b>168,044</b>
<b>Primary Care Provider Program</b> (voluntary rural program)	No federal approval required – voluntary state program	Medicaid provider agreement, Fee-for-service claims	<b>28,500</b>

# Utah Medicaid Managed Care Enrollment Primary Care Provider Program and Health Plans



# Primary Care Provider Program



- Voluntary state program
  - No federal approval required
- Medicaid provider agreement in rural areas
  - Providers are paid fee-for-service
- Current enrollment is 28,500 Medicaid clients
  - Enrollment dropped in 1996 when newly eligible Medicaid clients were required to enroll in a managed care plan

# Managed Care: Cost

- The PCCM (Select Access) and the PAHP (Healthy U) are the least expensive plans when comparing risk-adjusted experience
  - These plans are able to achieve savings because they have integrated networks which adds to efficiencies

# Managed Care: Quality

- Utah Health Plan Performance Report
  - Includes data from three commercial HMOs, two Medicaid HMOs and two CHIP HMOs
    - The two Medicaid health plans and two CHIP health plans represent all of the coverage options for these populations in Utah
  - Captures data from consumer surveys, reporting and evaluating their HMO experiences
  - About 35% of Utahns who currently have health insurance are covered by one of the health plans in this report
  - Data has been reported for more than 15 years

# Managed Care: Quality Con't.

- Health Plan Performance Report Key Findings:
  - Commercial HMOs had the most room for improvement, scoring above the national averages on only 27% of the measures reported
    - Areas for improvement: childhood immunizations, cancer screenings (colorectal, breast, cervical), and Chlamydia screenings
  - Medicaid HMOs did very well when compared with national averages, exceeding national averages on 77% of the measures reported
    - Areas for improvement: childhood immunizations and Chlamydia screenings

# Managed Care: Quality Con't.

- Consumer satisfaction results concluded commercial HMOs are:
  - Above national averages for the ratings of health plan, physicians, overall health care, getting care quickly, and physician communication
  - Below national averages for the rating of specialists and getting needed care
- Consumer satisfaction results concluded Medicaid HMOs are:
  - Above national averages for the ratings of health plan, physicians, overall health care, specialists, getting care quickly, physician communication, and getting needed care
  - Below national averages for customer service

# Mental Health Waiver

- In 1991, Utah received approval from CMS to implement a prepaid mental health plan
  - Freedom of Choice 1915(b) waiver
- Utah's Prepaid Mental Health Plan (PMHP) now operates in 27 of Utah's 29 counties
  - Current enrollment is 229,433 (approximately 92% of Utah Medicaid clients are enrolled)
  - The remaining two counties provide mental health services on a fee-for-service basis

# Mental Health Waiver Con't.

- Overall objectives:
  - Maximize PMHP contractors' flexibility to effectively and responsibly use Medicaid funds to ensure clients have access to mental health services
  - Improve mental health outcomes for Medicaid clients in their communities
- All Medicaid clients are automatically enrolled in the PMHP that serves their area and are required to obtain covered mental health services from that contractor

- Healthy Outcomes Medical Excellence (H.O.M.E.)
  - H.O.M.E. is a coordinated health care model and center of excellence for meeting the medical and mental health needs of people with developmental disabilities
  - The program was developed through a grant funded by the Robert Wood Johnson Foundation
  - H.O.M.E. is operated by the University of Utah Neurobehavior Clinic under 1915(a) authority

# H.O.M.E. Con't.

- H.O.M.E. provides services to children and adults including primary care, psychiatric evaluations, medication management, counseling services, behavior support, and case management
- Many H.O.M.E. patients have impairments in their intellectual and/or social functioning which are a result of other developmental problems such as genetic disorders, birth trauma, Autism spectrum disorders, and brain injuries

# H.O.M.E. Con't.

- Currently, there are 840 patients enrolled
- Individuals enrolled in H.O.M.E. are initially enrolled in a physical health plan and a PMHP when they become Medicaid eligible
  - As slots become available in the H.O.M.E. program, an individual may be enrolled in H.O.M.E. at that time the individual is disenrolled from their physical health and behavioral health plan
  - H.O.M.E. is then paid the same PMPM that was previously paid to the physical and behavioral health plans for each month the individual is enrolled in and receiving services from H.O.M.E.
    - Therefore, the cost to enroll an individual in H.O.M.E. is cost neutral

# H.O.M.E. Con't.

- H.O.M.E. has been operated as a non-risk contract
- Due to difficulty complying with CMS requirements for conducting upper payment limit tests the contract is moving to a risk basis
- H.O.M.E. complies with 42 CFR 438 regulations regarding Prepaid Inpatient Health Plans

# Care Coordination

- All Medicaid clients are encouraged to find a primary care provider/medical home
  - Clients with disabilities receive assistance with accessing services, such as home health care and specialty care
  - Individuals with chronic diseases receive educational materials and reminders to seek regular care for their condition
    - Patients with Hemophilia are managed through a contract with the University of Utah
    - Health plans also promote preventive service programs

# Care Coordination Con't.

- Women with high risk pregnancies receive additional care coordination
- Restriction Program
  - Provides extra structure (lock-in to one pharmacy/physician) for clients that exceed two non-emergent Emergency Department (ED) visits, or exhibit other behaviors such as doctor shopping or pharmacy hopping that warrant additional controls on their claims
- Emergency Department Grant (Safe to Wait)
  - Two Medicaid staff members outreach to Medicaid clients that receive care in an ED for non-emergent reasons
    - Influenced client's decision making by a 55 percent reduction in repeat non-emergent ED visits for participants

# Medicaid Client Accountability



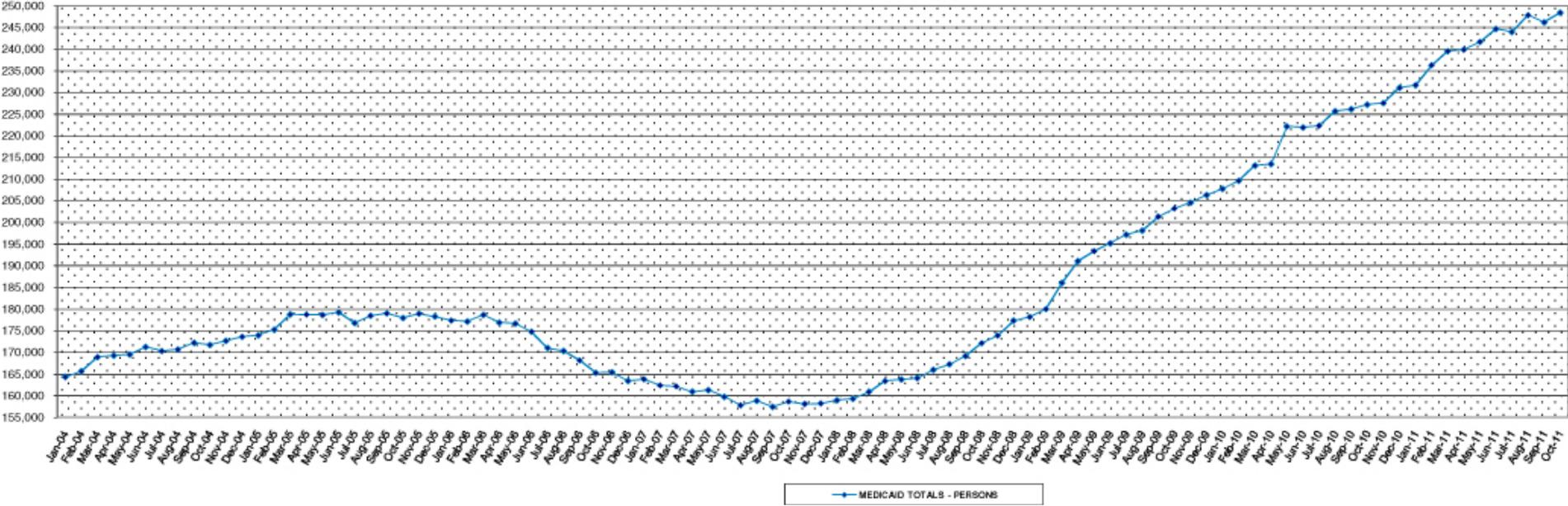
- Federally required to provide Medicaid clients with information about medical benefits and health plan choices available
  - Health Program Representatives (HPRs) educate Medicaid clients about wise use of medical cards, rights and responsibilities, co-pays and selecting health plan or primary care physician
    - Education is available in person, by phone and on the internet (<http://health.utah.gov/umb>)
  - HPRs are state employees located in eligibility determination offices and local health departments
    - 24 full-time employees

# Additional Support Program



- Tobacco Cessation Program
  - HPRs provide:
    - Assessment and referral services available for Medicaid pregnant women
    - Help Medicaid clients enroll in a cessation program through the local health department or offer information about the Tobacco Quit Line
    - Provide follow-up support to clients

MEDICAID TOTALS - NUMBER OF PERSONS



# Transforming Medicaid

- On June 30, 2011 the Department submitted an 1115 Waiver Request to CMS to transform the way Utah operates its Medicaid program in order to attempt to slow the growth of its costs

# Transforming Medicaid Con't.



- Three major goals:
  - Restructure payments to reward health care providers for delivering the most appropriate services at the lowest cost and in ways that maintain or improve recipient health status
  - Pay for episodes of care rather than for each service
  - Restructure cost sharing provisions and other incentives to reward recipients for personal efforts to maintain or improve their health and use providers who deliver appropriate services at the lowest cost

# Accountable Care Organization

- The current Utah Medicaid fee-for-service/ managed care model will be replaced with the Utah Medicaid Accountable Care Organization (ACO) model
  - The ACOs will create an environment in which they deliver necessary and appropriate care, while demonstrating that quality of care and access to care are maintained or improved
  - The ACO contracts will be paid on a full-risk capitation basis
  - Capitation rates will be risk-adjusted

# Accountable Care Organization Con't.

- The ACOs will have more flexibility to distribute payments to their network of providers
- Rather than reimbursing providers based on the units of service delivered, the ACO could make payments for delivering the necessary care to a group of Medicaid enrollees for a specified period of time
- The ACO could also choose to distribute incentive payments through its network of providers when various cost-containment, quality or other goals are met

# Accountable Care Organization Con't.

- A centerpiece of the ACO care delivery model is a “Medical Home”
- Each Medicaid client will have access to a primary care provider or a group of primary care providers who will deliver care, as well as coordinate the client’s use of medical services throughout the ACO network of providers

# 1115 Waiver Request

- Scope of benefits
  - Current Medicaid managed care contracts include inpatient hospital, outpatient hospital, physician services, home health and other ancillary services
  - Those services plus non-behavioral health pharmacy benefits will be included in the ACO benefit package
  - Including pharmacy benefits in the ACO scope of services will better align the incentives of prescribers with the goal of providing the most appropriate service at the lowest cost

# 1115 Waiver Request Con't.

- Quality of care
  - Utah intends to monitor the ACOs' quality of care by using HEDIS data
    - The agency will utilize existing processes and procedures which have been established and guided by federal regulation for managed care organizations
  - In order to renew a contract authorized under this 1115 Waiver, the ACOs will be required:
    - To participate in quality improvement activities
    - To adhere to metrics specific to an ACO that the Department will develop with input from providers and client advocates

# 1115 Waiver Request Con't.

- Individual accountability and responsibility
  - This proposal seeks to engender an enhanced sense of responsibility and accountability on the part of Medicaid clients
  - Medicaid clients would participate more in the cost of their health care
    - The Department seeks to update archaic limits on Medicaid co-payment amounts

# 1115 Waiver Request Con't.

- Patient compliance
  - Increasing patient compliance results in better outcomes, lower costs and long term stabilization of chronic conditions
  - This proposal will allow an ACO to offer incentives that will help increase patient compliance for victims of chronic disease states
    - Two of the proposed incentives
      - (1) limiting or waiving co-payments
      - (2) granting limited cash awards for compliant behavior, which reduces the need for additional service

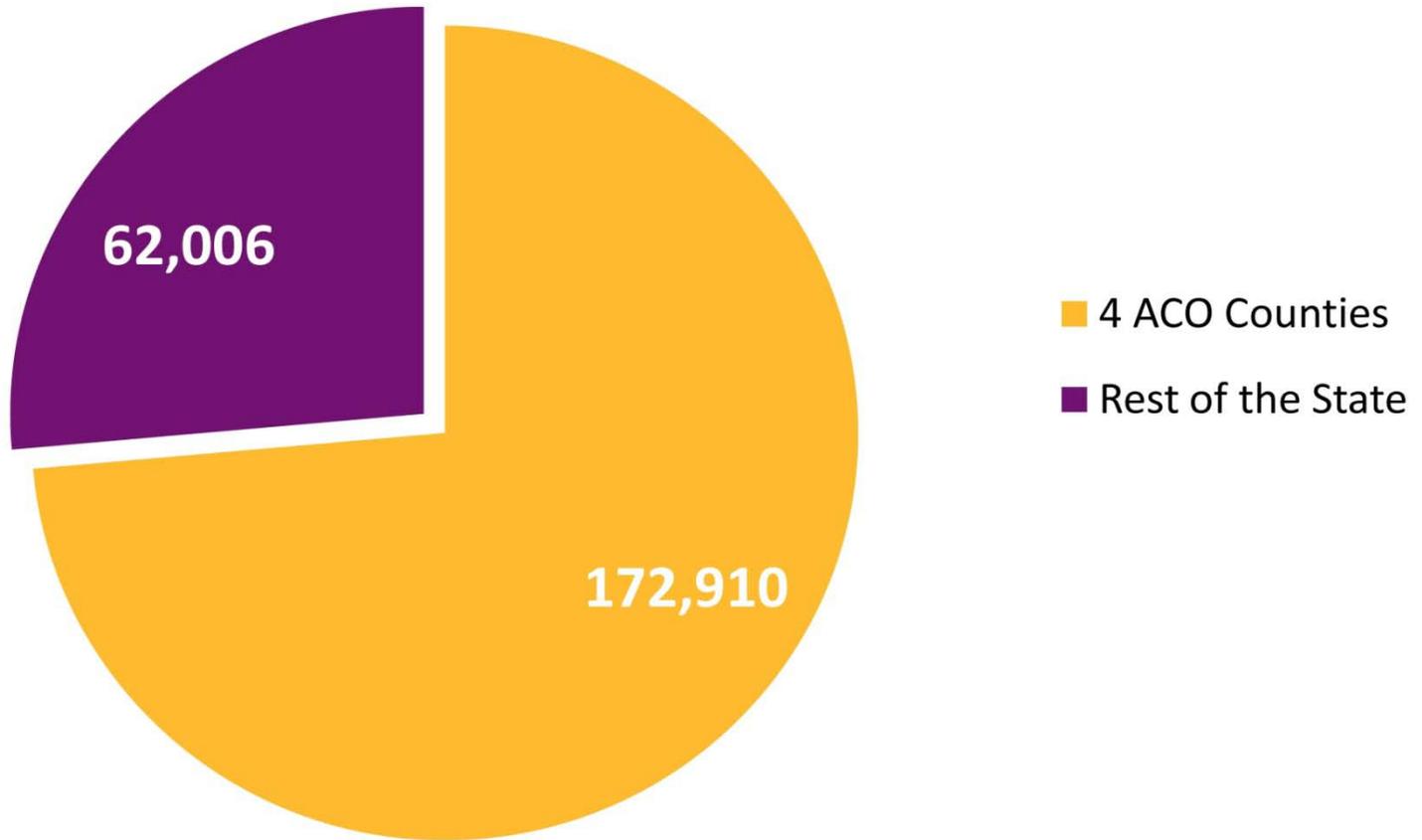
# 1115 Waiver Request Con't.

- Premium subsidy option
  - Under an existing 1115 waiver, Utah currently offers a health insurance premium subsidy to low-income individuals who are not eligible for Medicaid coverage
  - This reform proposal seeks to also allow a Medicaid client the option to receive a premium subsidy and purchase a health insurance product through the State's Health Insurance Exchange as an alternative to enrolling in the Medicaid ACO product

# 1115 Waiver Request Con't.

- Geographic implementation
  - Medicaid currently has three managed care organizations providing services to clients in the state's four most populous counties: Salt Lake, Davis, Utah and Weber
  - The reform proposal looks to implement the ACO contracting model in these same four counties

## Medicaid Clients Potentially Covered Under Proposed Waiver



# 1115 Waiver Request Con't.

- Implementation timeframe
  - The State needs federal approval before it can implement these modifications
  - The Department is currently in discussions with the Centers for Medicare and Medicaid Services to see which portions of the proposal will be approved
  - Depending on the timeliness of approval, implementation may begin as soon as July 1, 2012

# Lessons Learned

- What would Utah have done differently?
  - The Division spent five years completing the upper payment limit test as mandated by CMS for the non-risk contracts
    - Conducting a non-risk contract upper payment limit test as defined by CMS means taking all claims adjudicated by a health plan and re-adjudicating them through the state medical claims system
      - Since June, 2006, the efforts of a very talented staff person have been devoted to this thankless task (the individual has an MBA and spent years as a software developer in the private sector)
      - The task is not yet complete

- What does a state need to have in place before implementing different types of managed care?
  - Actuarial services – contracts
  - External Quality Review Organization (EQRO) contract to assess and monitor health plan compliance
  - State staff to develop and monitor contracts, handle quality oversight
  - Constituent services – hearings
  - Staff or contract to enroll Medicaid clients into health plans – HPRs

# Contract Requirements

- What critical contract requirements are needed to ensure desired outcomes?
  - Quality measures - HEDIS, CAPHS or similar
  - Reporting requirements
  - Access to care
  - 42 CFR 438 - Managed Care Regulations

# Questions?

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