Using Medicaid to Leverage Services

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Human Services Policy Committee

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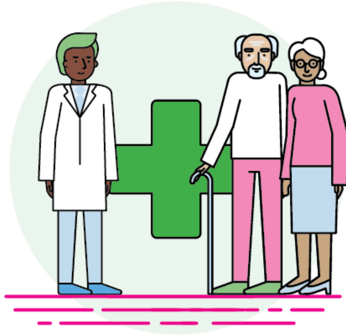
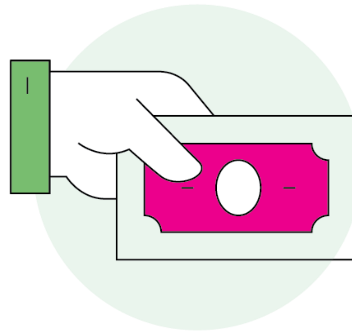
Who is AHIP?

America's Health Insurance Plans (AHIP) is the national association whose members provide coverage and health-related services that **improve and protect the health and financial security of consumers, families, businesses, communities and the nation.**

Medicaid Overview –



Health coverage for 74 million Americans



Federal/State partnership with shared funding

56 million managed care enrollees in 40 states and territories

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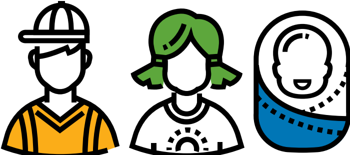
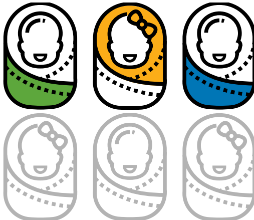
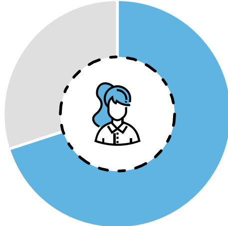
Who Does Medicaid Cover?



1/3 of all kids



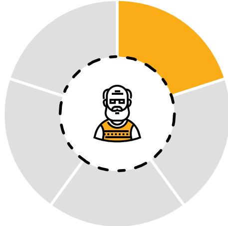
Half of all births



7 out of 10 kids at poverty level

2/3 of nursing home residents

45% of adults with disabilities



1 in 5 people with Medicare

State / Federal Partnership

- Medicaid is a state/federal partnership
- 56 Medicaid programs – 50 states, 5 territories, and D.C.
- Lead federal agency is CMS (Centers for Medicare and Medicaid Services)
- Designated state agencies provide state administration
- States design and operate programs within a federal framework
- Federal framework sets core benefits, eligibility standards, eligible populations
- State may cover additional services, populations, expand eligibility
- States decide on delivery system – fee-for-service (FFS), managed care, or a combination or the two; provider rates
- CMS reimburses states the federal share of Medicaid program expenses

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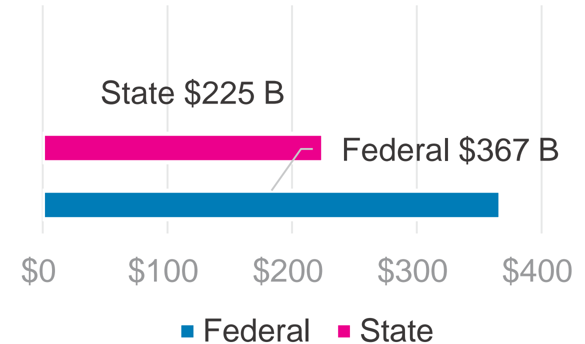
Financing of Medicaid

- Medicaid cost $592 billion in 2017
- Federal funds cover at least 50% of state costs
- FMAP – “federal medical assistance percentage”
- Current FMAP range from 50% (e.g., California) to 76.4% (e.g., Mississippi)
- Averages 62% across all 56 programs
- Calculated for each state based on its per capita income
- ACA provides enhanced FMAP to encourage Medicaid expansion; now at 90%
- With limited exceptions, federal funding is open-ended/uncapped



	D.C.	MD	VA
Federal match rate (FMAP)	70%	50%	50%

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Medicaid Enrollment

- Person applies to state, county or *enrollment facilitator*
- Agency verifies person meets criteria: residence, income, eligibility category
- Person is enrolled in FFS Medicaid or is asked to choose a managed care plan
- If no choice, may be auto-assigned to managed care plan
- Managed care enrollment may be mandatory or voluntary; determined by state, may vary with eligibility group
  - Mandatory for most enrollees in D.C., MD and VA
- Some groups often excluded from managed care; e.g. dual eligibles, I/DD

Medicaid Managed Care

- 38 states, Washington D.C., and Puerto Rico use managed care to serve some or all of their Medicaid enrollees
- Managed care plans serve over 56 million enrollees, approximately 75% of total
- States contract with several Medicaid MCOs through competitive procurements; typically for three years
- State pays MCOs a fixed per-person monthly amount *(capitation payment)* to provide benefits to each Medicaid enrollee
- MCOs use those funds to pay for all of their enrollees' covered Medicaid services and supports; MCO at risk for any costs exceeding the capitation payment
- States set terms: contracts include comprehensive requirements for MCO payment, provider network access/adequacy, performance, reporting and administration
- Managed care provides states with budget predictability, improved care management, ensures services are appropriate and necessary

Washington D.C. Metro Medicaid Plans

District of Columbia	Maryland	Virginia
AmeriHealth Caritas	Aetna	Aetna/Coventry
Amerigroup	Anthem/Amerigroup	Anthem/HealthKeepers
Health Services for Children with Special Needs	Kaiser Health Plan	Magellan Complete Care
Trusted Health Plan	Maryland Physicians Care	Sentara/Optima Health Plan
	MedStar Family Choice	Virginia Premier Health Plan
	United Health Care	United HealthCare
	Priority Partners	
	Riverside/Univ. MD Health Partners	

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Washington D.C. Metro Medicaid Programs

Which Medicaid benefits are covered in managed care?

Benefit/Group	District of Columbia	Maryland	Virginia
Behavioral health	Managed care except SUD	Primary BH in managed care Specialty BH in BHO	Managed care
Pharmacy	Managed care	Managed care	Managed care
MLTSS	FFS	FFS	Managed care
Hospital	Managed care	Managed care	Managed care
Physician	Managed care	Managed care	Managed care
Outpatient	Managed care	Managed care	Managed care
Diagnostic	Managed care	Managed care	Managed care
Emergency	Managed care	Managed care	Managed care

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Washington D.C. Metro Medicaid Groups

Which Medicaid eligibility groups are in managed care?

Benefit/Group	District of Columbia	Maryland	Virginia
Moms and kids	Yes	Yes	Yes
Single adults	Yes	Yes	Yes
Aged/blind/disabled	Yes	Yes	Yes
People with I/DD	No	Yes	Yes
People with physical disabilities	Yes	No	Yes
Dual eligibles	Yes (voluntary)	No	Yes
Foster kids	Yes – special plan	Yes	Yes

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Significant Obstacles

- **Reciprocity:** no blueprint for inter-state reciprocity in Medicaid
- Different eligibility groups in managed care; state would have to take initiative on FFS enrollees
- Providers willing to enroll in Medicaid in adjacent states, accept rates
- FMAP differences – D.C. 70% vs. MD and VA 50%
- MCOs contract with in-state providers, with limited exceptions
- State capitation rates based on in-state claims experience
- Accounting for increased out-of-state services in reporting, quality metrics, rates
- Continuity of care – coordination, communication to/from primary providers

Questions to Consider

- What is the magnitude or frequency of the problem?
- Is problem generalized or focused on certain specialties?
- Would enrollees access adjacent state care occasionally or continuously?
- Would routine care providers enroll in Medicaid in adjacent states?
- Would providers accept MCO rates from adjacent states?
- Would providers educate office staff?
- What could be accomplished using limited referrals with case rates?
- Would state Medicaid agencies make reciprocity a priority? Would CMS approve?

Questions?

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