IMPLEMENTING THE MEDICAID MANAGED CARE PLAN

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Better Care Must Be the End Game

- For Consumers
- For Providers
- For Managed Care Organizations
- For Government Payers (County, State and Federal)
- Accrediting Organizations

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WHY MEDICAID MANAGED CARE?

Medicaid Managed Care: Understanding the Context

- Escalating costs
- Shrinking Revenue
- Calls for accountability
- Pressures from stakeholders (patients, providers, payers, etc.)
- Health Homes and Accountable Care Organizations are tools in Health Care Reform to manage care and improve outcomes.

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Purpose of Medicaid Managed Care Waivers

- Certain types of Medicaid Managed Care waivers are designed to manage the *growth* of Medicaid funding while, at the same time, maintaining high quality behavioral healthcare benefit plans.
- The objective is not to limit services for individuals, but to manage a system so that a person is guided to the *appropriate* level of care.
- A Medicaid Waiver is a mechanism giving the authority and resources to Manage a System of Care (all resources).

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Medicaid Managed Health Plans

- There are only three states without some Medicaid managed care --New Hampshire, Alaska and Wyoming.
- Behavioral Health Carve Out Model with Health Homes are being tested in several states (MO, RI, AZ, IA, OH, KS).
- Many states are moving 'disabled' populations (including populations with SMI) from fee-for-service financing model to a managed care financing model.

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HOW DOES MANAGING MEDICAID THROUGH A WAIVER LEAD TO BETTER CARE?

NORTH CAROLINA HAS SELECTED A REGIONAL APPROACH – 11 LOCAL MANAGED BEHAVIORAL HEALTH ORGANIZATIONS

Mergers of Local Management Entities and the Formation of Regional Managed Care Organizations for Medicaid

- Capitation and Risk are Model Components in the Medicaid Waiver
- Achieving the size to spread the risk – Session Law 2011-264 modified the minimum population requirements
- Five mergers either have been completed or will be completed by January 1, 2013, reducing the number of LMEs to

  11 LME/MCOs.

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New Waiver Management Tools

- Initial and Continued Stay Authorizations
- Provider Network Development and Monitoring – Managed Network creates opportunities for providers in network
- Provider Enrollment and Credentialing
- Quality Improvement Activities
- Payment of Medicaid Claims
- Partnership with CCNC Networks to care coordinate and improve outcomes
- Fraud, Waste and Abuse
- Managing for Outcomes

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Managed Behavioral Health Organizations MBHO's –Quality and Cost Outcomes

- Pennsylvania example: Behavioral Health Choices generated **$4 billion in savings** from 1997-2007.
- Massachusetts example: A **50% reduction** in ED visits and a **71% reduction** in psychiatric admissions for Medicaid enrollees over the 3-year period 2007-2010.
- Colorado example: MBHOs operating in CO for 14 years have **contained increases** in their capitation rate to 13.8%, far less than the inflation rate of 44% and the inflation rate of medical care of 82%.

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Medicaid Managed Care – MCO Responsibilities

- Controlling the selection of the professionals and provider organizations in a particular delivery system
- Setting service payment rates and methodologies
- Setting clinical best practice policies
- Establishing the framework for the measurement of clinical quality and performance

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Why A System Redesign?

- Improved Access
- Better Care
- Potential Cost Reduction

Why A System Redesign?

Improved Access

- With parity and national healthcare reform, more people than ever before will have access to treatment for mental health and addiction services through expanded public and private insurance coverage.
- Specialty behavioral healthcare organizations must expand capacity to meet increased demand and offer measurable, high-performing prevention, early intervention, recovery, and wellness services and supports.

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Why A System Redesign?

Better Care

- "Medical Homes" and "Health Homes" are becoming the primary focus of integration of care – connecting the head back to the body…

- Significant movement to "One Stop Shops" integrated healthcare service delivery models.

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Why A System Redesign?
Potential Cost Reduction

- We must also be ready to work with the expanded Medicaid systems and be able to bill through the new health insurance exchanges, Accountable Care Organizations (ACOs), Primary Care Medical Homes, Person-Centered Medical Homes and other funding sources.

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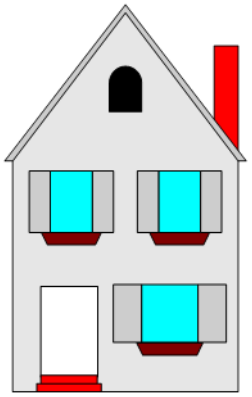
Global Managed Care Policies and Strategies to Improve Behavioral Healthcare



Person Centered Medical Homes

- Access
  - ✓ Services earlier on
  - ✓ No show management
  - ✓ Same day access
  - ✓ Reduced time from first call to treatment
- Outcomes
  - ✓ Same day access
  - ✓ Engagement strategies
  - ✓ New models of care (integration, coordinated care, ACOs, Specialty care, health homes)
- Costs
  - ✓ Value based purchasing (pay for performance, episodes of care)
  - ✓ Rates
  - ✓ Collaborative documentation
  - ✓ Maximizing capacity

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Key Policy Drivers of a "Reformed" Healthcare System To Address Outcomes, Access and Costs

- Prevention and Wellness Focused
- Managed Care (2012 Version)
- Integrated "Horizontal" Care Delivery System

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Key Policy Drivers of a "Reformed" Healthcare System To Address Outcomes, Access and Costs

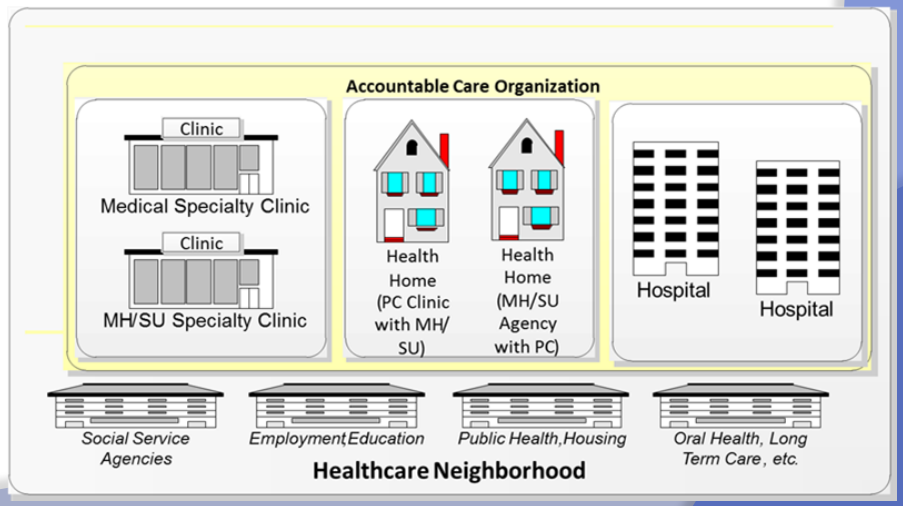
- New Integrated Management Entities for Medicaid and Medicare Funding:
  - Accountable Care Organizations - Medical Center and Primary Care Practice Partners with specialty providers under contract for service delivery
  - Health Homes, Health Home Neighbors - Population-based integrated care model targeting consumers with chronic conditions, which coordinate medical and behavioral health care, and community and social supports
  - Primary Care Medical

Homes - Coordinated care

model focused on acute care

for all populations

  - Care Coordination to improve care



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MANAGING MEDICAID FOR PERSONS NEEDING LONG-TERM CARE IS A CHALLENGE

Managed Medicaid 1915(i) Option

- Serving people in their communities reduces Medicaid costs and leads to better outcomes for those served.
- North Carolina's State Plan Amendment for the "i" Option HCBS was submitted on April 30, 2012.
- Effective date January 1, 2013.
- 1915(i) allows NC to provide some Medicaid services currently available only through the CAP or Innovations Waiver to an additional, specifically defined population. These additional people must be determined to be Medicaid eligible.

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QUESTIONS ?

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