Medicaid Managed Care

Chelsey Matter, Executive Director, Government Programs
House Appropriations, Human Resources
3.23.2023

Blue Cross Blue Shield of North Dakota is an independent licensee of the Blue Cross & Blue Shield Association

Definition of Managed Care

- Managed Care is a health care delivery system organized **to manage cost, utilization, and improve quality**.
- Medicaid managed care provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that accept a **negotiated per member per month** (capitation) payment for these services.
- By contracting with MCOs to deliver Medicaid health care services to their members, states can better manage utilization of health services and take advantage of MCO's **experience in payment and care innovations**.

Key Terms and Definitions

- Alternative Payment Model (APM): A different way to pay for health care, aligning better outcomes with payment versus volume. Other common terms used: Accountable Care Organizations, Value-Based Care, Value-Based Payment
- Attribution: How a member is assigned to a primary care provider or group of providers.
- Capitation: Negotiated per member, per month amount for management of a population.
- Commercial insurance: Employer-sponsored coverage or Marketplace individual plans.
- Fee-for-Service (FFS): Traditional payment that involves payment for each service, regardless of outcome. More tests = more money.
- Medical Loss Ratio (MLR): Refers to the percentage of the premium dollars (or capitated amount in this case) that an insurance company spends to provide health care and improve the quality of care, versus how much the company spends on administrative and overhead costs.
- Network Adequacy: Ensuring members have access to health care services within a federally-defined distance and time.
- Profit Margin: Profit generated to the managed care organization after paying for medical expenses and accounting for administrative costs.

North Dakota Vision for Medicaid Managed Care

- Effectively and efficiently provide health care coverage to Medicaid Expansion (ME) members in a manner that **exceeds** State and federal requirements and standards;
- Improve health outcomes for the enrolled ME population, including through **high-touch care management**;
- Deliver high-quality, evidence-based care that is **cost-effective**;
- Utilize a **whole-person approach** to care that addresses physical, behavioral, and social risk factors to positively affect individuals' health; and,
- Employ innovative approaches to delivering and paying for services, including **value-added services**.

Source: Medicaid Expansion Request for Proposal (RFP)

How Medicaid Managed Care Works

JENNIFER

AGE: 38

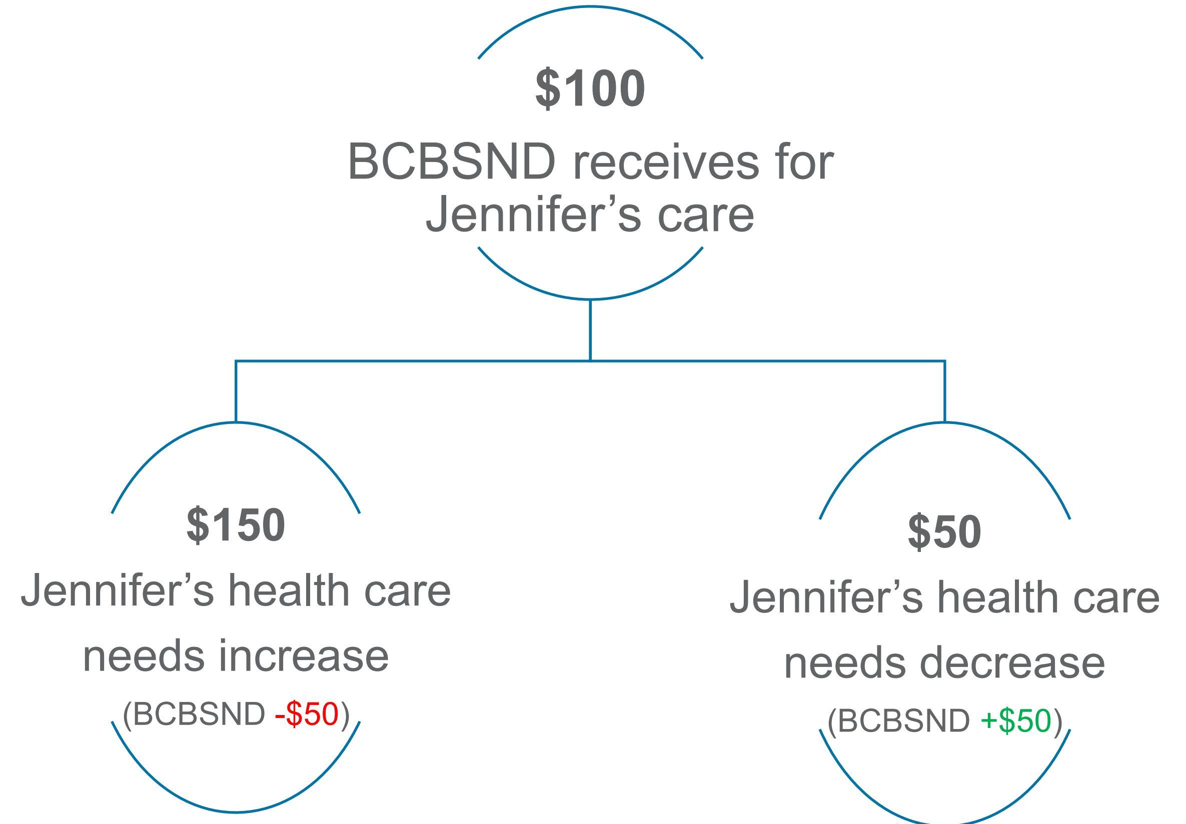
RESIDENCE: Streeter, ND

MEET JENNIFER

- Residing in Streeter, North Dakota, Jennifer has multiple health issues, including Hepatitis C, diabetes, hypertension, depression, multiple ER visits for pain, and back problems.
- She had two pregnancies complicated by hypertensive disease of pregnancy.
- There are no physical therapy services available in the member’s immediate area.
- Jennifer has been receiving pain management through her primary care physician for several years and her PCP is recommending surgery.

Example of How Medicaid Managed Care is Funded

- Legislature appropriates funds for Medicaid Expansion
- State's contracted actuaries review claims history and set per member, per month capitation rate *annually* ($100)
- State monitors BCBSND's performance against set standards
- BCBSND's profit margin is capped



BlueAlliance CARE+

BCBSND Implementation Efforts

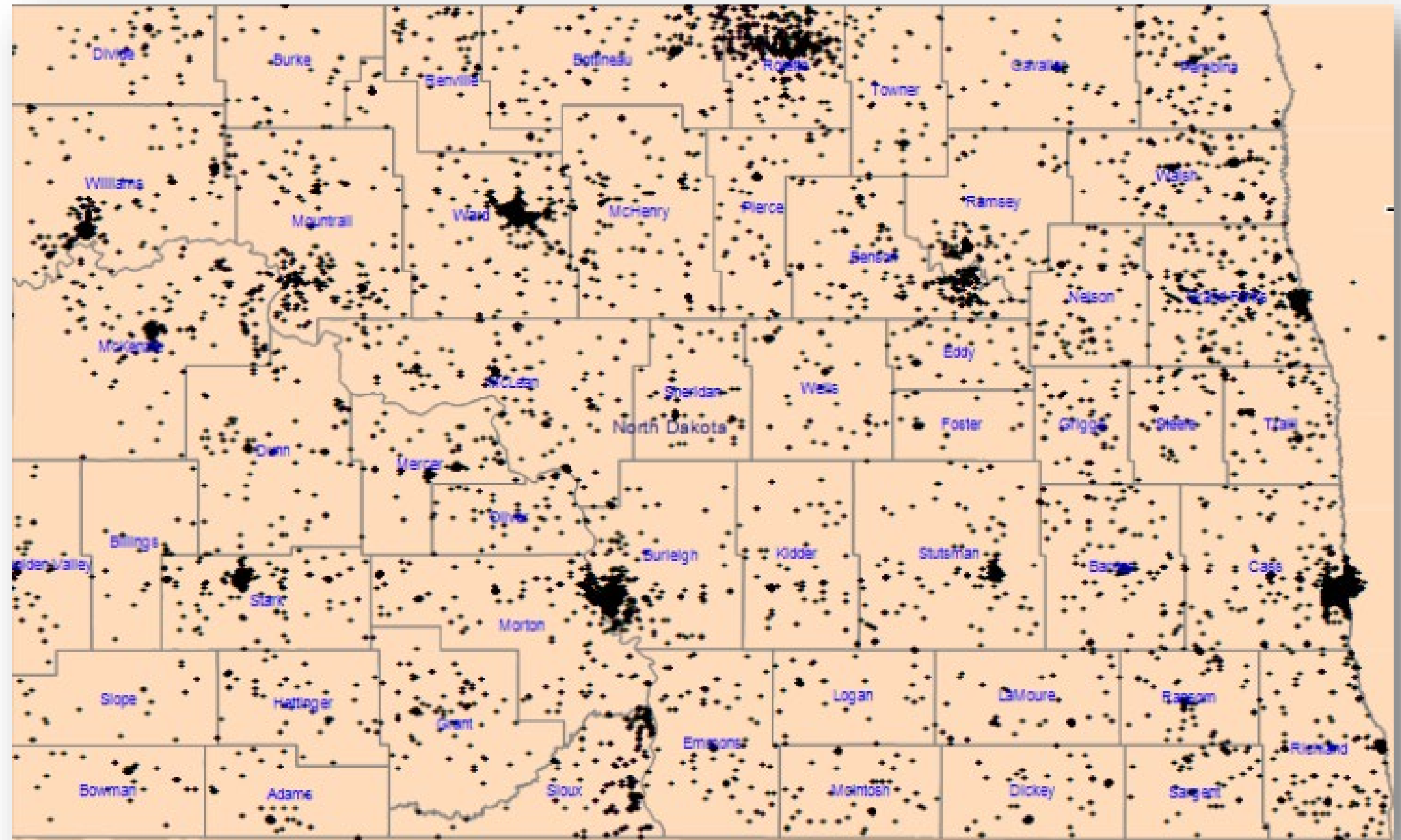
- January 1, 2022 go-live
- 28,000+ members at go-live, just under 35,000 members
- New programs/benefits:
  - Nurse line
  - Crisis line
  - Department of Corrections collaboration
  - Several crisis benefits
  - Members have access to all of our satellite offices for support if needed
  - Partnership with Arkos Health for in-home services
  - Virtual platforms added for behavioral health and wellness

BlueAlliance CARE+

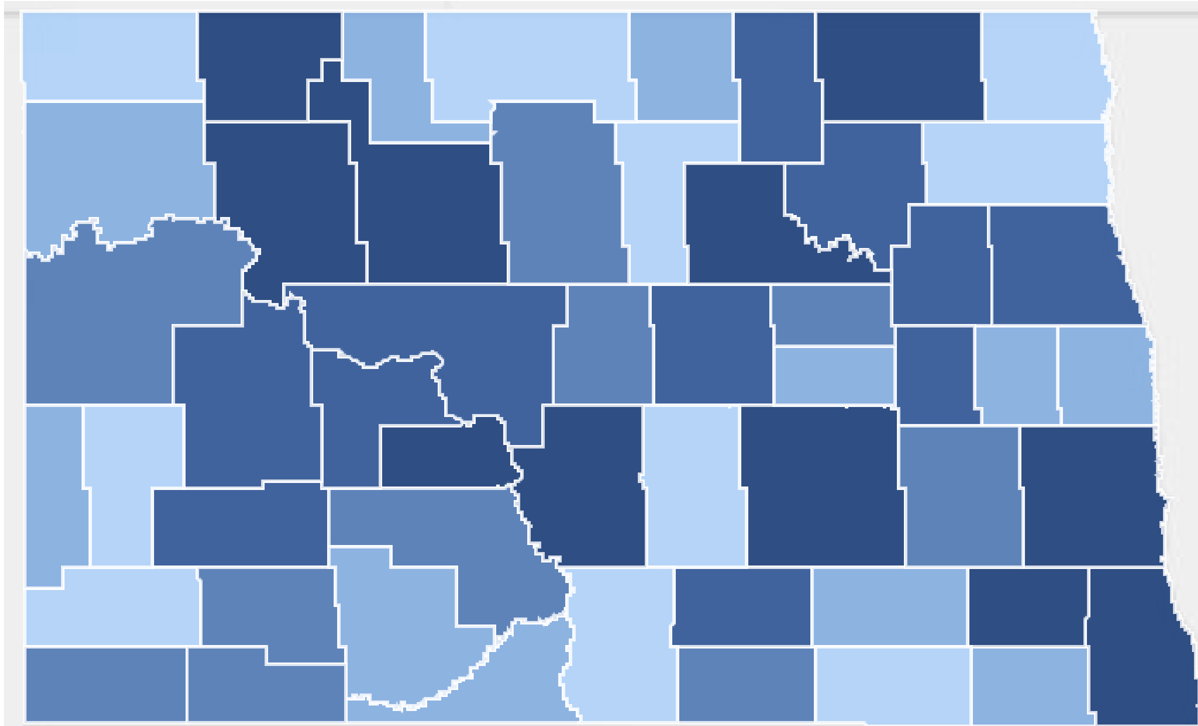
Medicaid Expansion Operations

Member Demographics

- 76% of members between the ages of 21 and 39
- Male: 50%, Female: 50%
- 300+ total homeless members
  - Primarily in Fargo, Bismarck, Fort Yates, Minot and Williston



Medicaid Expansion Operations
Member Demographics


February 2022 – January 2023 – Darker colors represent high risk populations

Health Segment	Percentage
Healthy	13.52%
Non-User	31.99%
Significant Acute	6.78%
At Risk	4.70%
Minor Chronic	6.34%
Multiple Minor Chronic	2.26%
Moderate Chronic	8.18%
Complex Chronic	14.52%
Multiple Complex Chronic	11.16%
Critical	0.55%

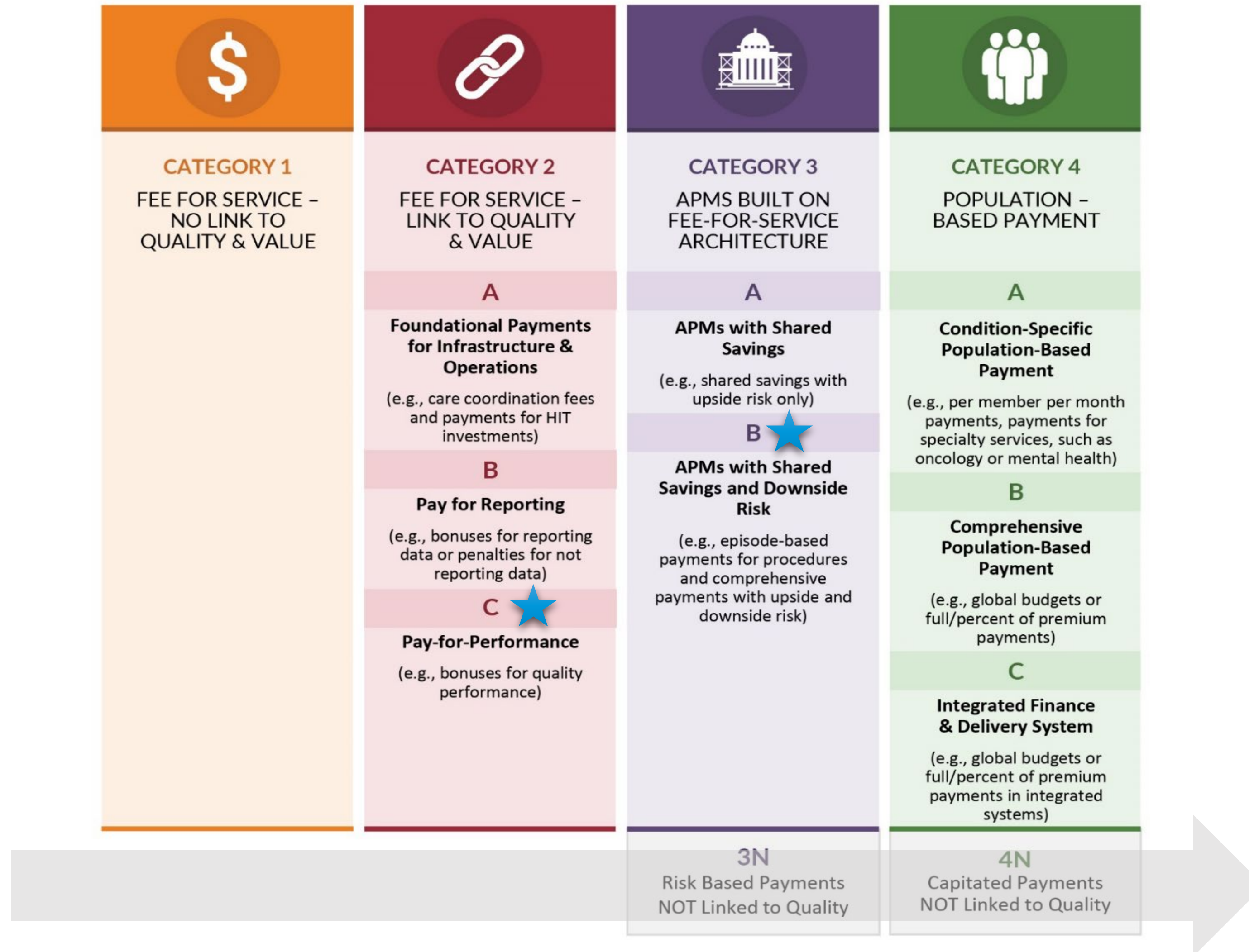
Roadmap to Adopt Value-Based Payment (VBP)

- Centers for Medicare and Medicaid Services (CMS) believes there is opportunity in Medicaid
- Medicare reports 90% of payments were part of VBP arrangements vs. 32% in Medicaid
- CMS advises states can facilitate shifts to value by:
  - Participating in multi-payer efforts (alignment)
  - Seeking extensive stakeholder engagement
  - Focusing on sustainability and continued aligned incentives

Source: HMA Weekly Roundup, September 23, 2020

Value-Based Payment Categories

Pressure from CMS and state budgets has led states to explore use of VBP models



https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf

BCBSND's Value-Based Payment Journey

- 2009 – MediQHome
- 2011 – Total Cost of Care
- 2016 – BlueAlliance
- 2018 – Comprehensive Primary Care Plus
- 2022 – Care+ for Medicaid Expansion

Over **90%** of primary care providers participate

BlueAlliance CARE+

Quality Improvement Success

- Lower trend in avoidable hospitalizations
- Decreases in potentially preventable emergency room visits
- Increases in well child visits in infants and young kids
- Lower overall total cost of care trends

Key Components of Medicaid Expansion VBP

		BlueAlliance 2022 (Commercial Members)	BlueAlliance Care + (Medicaid Expansion Members)
Quality Measures	Attestation process	✓	✓
	Breast Cancer Screening	✓	
	Child & Adolescent Well Care Visit	*Shadow Measure*	
	Colorectal Cancer Screening	*Shadow Measure*	
	Potentially Preventable Admissions	✓	✓
	Potentially Preventable ER Visits	✓	✓
	Post-Discharge Follow-up Visits	✓	✓
	Primary Care Visits	✓	✓
	Well Child Visits 0-15 & 15-30 Months	✓	
Attribution		Retrospective monthly attribution	Retrospective monthly attribution + assignment for non-users
Member Months		12 minimum member months for quality	10 minimum member months for quality
Claims Runout		3 months	2 months
Contract Term		2020 - 2022	2022 only

BlueAlliance CARE+

BlueAlliance Care+ Strategy

Transforming health, community by community, through innovative programs.

BCBSND's goal is to design and implement value-based programs that support the provider community in our collective efforts to deliver a sustainable, meaningful, and reliable healthcare experience for our members.

Questions

Thank you!