MEDICAID DELIVERY MODEL OPTIONS FOR NEVADA

SEPTEMBER 2016

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BACKGROUND

- Nevada Legislature passed *SB514* in 2015
  - Requires an impact analysis of managed care program implementation for the waiver population
  - Provides DHCFP an opportunity to evaluate other Medicaid delivery model options
- DHCFP contracted with Navigant Consulting to assist in evaluating options

TODAY'S MEETING

- Navigant is presenting a range of options for consideration and comment
- These options consider:
  - Previous public comments and listening sessions
  - Interviews with DHCFP staff
  - Interviews with staff from other State Divisions and the Governor's Office
  - Reports and data regarding the Nevada Medicaid program, where available
  - Our experience with the evaluation criteria and options used by other states
- We have not made any recommendations to date, and DHCFP has made no decisions about these options

UPDATE REGARDING MCO CONTRACTING

- DHCFP is in the process of reprocuring MCOs, with new contracts effective July 2017
- Beginning July 2017, dental services will be carved out of MCOs and delivered through a dental prepaid ambulatory health plan (PAHP) on a statewide basis
  - DHCFP made this change to increase the focus on dental care and improve the State's performance on dental measures
  - MCOs will no longer be responsible for providing dental services, but must coordinate with the dental PAHP
  - DHCFP expects to release RFP in September 2016

MEDICAID DELIVERY AND FINANCING SYSTEM OPTIONS CAN BE PLACED ALONG A CONTINUUM

Traditional Fee-for-Service		
Free choice of Medicaid providers	Limited care coordination for select populations	Potentially more unnecessary service utilization

Full Risk-Based Managed Care		
Choice generally limited to in-network providers	Higher level of care coordination for all recipients	Potential for reduced inappropriate utilization

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HOW WILL WE EVALUATE DELIVERY MODEL OPTIONS?

Recipients

- Ensure appropriate use of all healthcare services
- Enhance access to care
- Improve healthcare outcomes
- Provide integrated service delivery and person-centered planning

Providers

- Increase the number of providers in shortage areas
- Maintain access to, and viability of, safety net providers
- Streamline responsibilities
- Increase use of evidence-based practices

State

- Improve quality measure monitoring
- Maintain or replace funding streams and generate savings
- Support operational feasibility
- Pay based on value

THREE PRIMARY POPULATIONS ARE CURRENTLY EXCLUDED FROM MANDATORY MCO ENROLLMENT

- Individuals who are aged, blind or have a disability
- Children in foster care (have option to enroll)
- Individuals in rural and frontier areas

We will consider characteristics specific to these populations when identifying delivery model recommendations.

INDIVIDUALS WHO ARE AGED, BLIND OR HAVE A DISABILITY OFTEN HAVE UNIQUE NEEDS

- Access to broad array of specialists and facilities
- Special outreach and accommodations to address communication and physical accessibility barriers
- Multiple chronic conditions and behavioral health needs
- Increased reliance on community and social support services
- Importance of involvement of families and caregivers
- Need for strong recipient protections
- Coordination with multiple state and local agencies

SIMILARLY, SPECIAL CONSIDERATIONS EXIST FOR CHILDREN IN FOSTER CARE

- Access to broad array of specialists and facilities
- Special healthcare needs, including behavioral health needs
- History of trauma
- Lack of stability in living arrangements and caregivers
- Importance of system of care principles
- Need for strong recipient protections
- Coordination with multiple state and local agencies

RURAL AND FRONTIER AREAS PRESENT DISTINCT CHALLENGES THAT OPTIONS WILL NEED TO ADDRESS

- Limited primary care providers, specialists and facilities
- Limited transportation options
- Time required to travel for healthcare services
- Privacy concerns
- Generally poorer performance on self-reported health status and health risk factors among residents (Medicaid and non-Medicaid) compared to residents of urban areas[1]

[1]University of Nevada School of Medicine. Nevada Rural and Frontier Health Data Book. 2015.

WHAT DELIVERY MODEL OPTIONS DID WE CONSIDER?

1. Expand the MCO program statewide
2. Carve in additional populations to MCOs
3. Add a managed long-term services and supports MCO
4. Add an administrative services organization
5. Develop accountable care organizations
6. Implement a patient-centered medical home program
7. Maintain current delivery systems

OPTION 1: EXPAND THE MCO PROGRAM STATEWIDE

- No changes to the populations or services covered by the MCOs
- Mandatory enrollment

Key Advantages	Key Disadvantages
• Increased budget predictability • Increased MCO accountability • Reduced disruption for recipients when moving • MCO incentives to increase providers • Increased access to care coordination services • Tools/incentives to reduce inappropriate service use • Option for more services not covered by FFS • More support to providers in frontier communities	• Potential insufficient budget during implementation • Provider and advocacy communities may not support • Limited FFS providers in frontier areas • Increased DHCFP oversight of MCOs needed

OPTION 2: CARVE IN ADDITIONAL POPULATIONS TO MCOS

- Add new populations to MCOs
- Mandatory enrollment
- Potential carve out of some services

Key Advantages	Key Disadvantages
• Increased budget predictability • Increased MCO accountability • Reduced disruption for recipients as service needs change • MCO incentives to increase providers • Increased access to care coordination services • Tools/incentives to address inappropriate service use • Option for more services not covered by FFS	• Potential insufficient budget during implementation • Provider and advocacy communities may not support • Limited FFS institutional and HCBS providers • Some MCOs may not have intensive care management expertise • Some MCOs may not have experience with HCBS • Increased DHCFP oversight of MCOs needed

OPTION 3: ADD A MANAGED LONG-TERM SERVICES AND SUPPORTS MCO

- Provide institutional and HCBS; could also provide medical services
- Statewide
- Mandatory enrollment

Key Advantages

- Increased budget predictability
- Increased MCO accountability
- MCOs with specific LTSS expertise
- MCO incentives to increase providers
- Increased access to care coordination services
- Tools/incentives to address inappropriate service use
- Option for more services not covered by FFS
- More support to providers
- Simplification of HCBS waiver administration

Key Disadvantages

- Likely insufficient number of recipients to support separate managed LTSS MCOs
- Potential insufficient budget during implementation
- Provider and advocacy communities may not support
- Limited FFS institutional and HCBS providers
- Difficulty coordinating if services provided separately
- Increased DHCFP oversight of MCOs needed
- Limited evidence regarding outcomes

OPTION 4: ADD AN ADMINISTRATIVE SERVICES ORGANIZATION (ASO)

- Administrative and care management services for FFS recipients
- Per member per month (PMPM) payment to ASO, with agreements for quality improvements and savings
- Dedicated primary care provider for recipients
- DHCFP pays providers for current FFS services
- MCOs continue to serve current populations in Clark and Washoe counties

Key Advantages

- Improved care coordination and care transitions
- Increased access to recipient support services
- Improved quality measure monitoring
- Tools to address inappropriate service use
- More support to providers
- Easier transition to future MCO expansion, if desired

Key Disadvantages

- Limited additional budget predictability
- Limited ability to incentivize providers
- Extensive DHCFP oversight of ASO needed

OPTION 5: DEVELOP ACCOUNTABLE CARE ORGANIZATIONS (ACOS)

- Network of physicians and hospitals with shared patient responsibility
- ACOs in regions outside of Clark and Washoe counties
- Shared savings arrangements between DHCFP and ACOs
- DHCFP pays providers for FFS services
- MCOs continue to serve populations in Clark and Washoe counties

Key Advantages	Key Disadvantages
• Providers may retain more control • Providers may be most familiar with recipient needs • No formal prior authorization processes or rate negotiations with MCOs	• Limited additional budget predictability • May lack provider capacity to develop ACOs • Significant provider start-up costs • May have limited ability to serve populations requiring LTSS • Increased DHCFP administrative responsibilities • Mixed evidence regarding outcomes

OPTION 6: IMPLEMENT A PATIENT CENTERED MEDICAL HOME (PCMH) PROGRAM

- Provider groups certified and enrolled as Medicaid PCMHs
- Dedicated PCMH for recipients
- PMPM, lump sum payments and/or incentive PCMH payments
- *Option*: Regional support networks to support PCMHs

Key Advantages

- Broader scope of recipients' needs addressed
- Potential to reduce inappropriate service use
- Improved provider readiness for alternative delivery models
- Benefits to broader population

Regional Support Networks Option

- Targets regional needs
- More care management services
- More support to providers

Key Disadvantages

- Limited additional budget predictability
- Limited PCMHs in Nevada
- Many providers may not have necessary resources or infrastructure
- Adds administrative responsibilities for DHCFP

OPTION 7: MAINTAIN CURRENT DELIVERY SYSTEMS

- Current FFS system for current FFS service areas and populations
- Current MCO program for current MCO service areas and populations

Key Advantages	Key Disadvantages
• Budget predictability for enrolled population • Opportunity for cost containment and quality improvement • General level of comfort with model • Recognition of challenges in care delivery and access in frontier regions and for complex populations	• Limited budget predictability for highest cost populations and services • Limited care coordination and support for some recipients • Current MCO program has below average HEDIS rates and recipient satisfaction levels, overall • Some providers view MCO program as administratively difficult • Requires DHCFP to support multiple Medicaid delivery systems

DELIVERY MODELS SHARE COMMON APPROACHES TO SUPPORT PEOPLE WITH SPECIAL NEEDS

Benefits	MCO	ASO	ACO	PCMH
Coordinate and link individuals with primary, behavioral health and long-term services and providers to meet complex needs	X	X	X	X
Develop formal agreements and referral relationships among critical providers			X	X
Ensure individuals have a person-centered plan, updated regularly	X	X	X	X
Use interdisciplinary teams in care planning and/or service provision	X	X	X	X
Meet face-to-face with recipients to assess ongoing needs and gaps in care	X	X	X	
Connect individuals with community and social supports	X	X	X	X
Identify resources to assist individuals with independent living	X	X	X	X
Incorporate evidence-based practices into service delivery				X

All delivery model options will require careful planning and monitoring, with input from stakeholders, to ensure benefits can be realized.

OPPORTUNITIES EXIST TO PROTECT INDIVIDUALS WITH SPECIAL NEEDS UNDER DELIVERY MODEL OPTIONS

- Strong State monitoring and enforcement:
  - Grievances and appeals
  - Service utilization
  - Performance on expanded set of measures, covering healthcare and quality of life outcomes
  - Recipient satisfaction
- Public reporting and accountability
- Ombudsman program
- Standard assessment tools, developed with stakeholder input
- Cultural competency training
- MCO requirements or incentives to:
  - Pay minimum FFS rates to network providers
  - Develop agreements with community organizations with relevant expertise
  - Maintain continuity of care and recipient access to traditional providers
  - Maximize service provision in home and community based settings

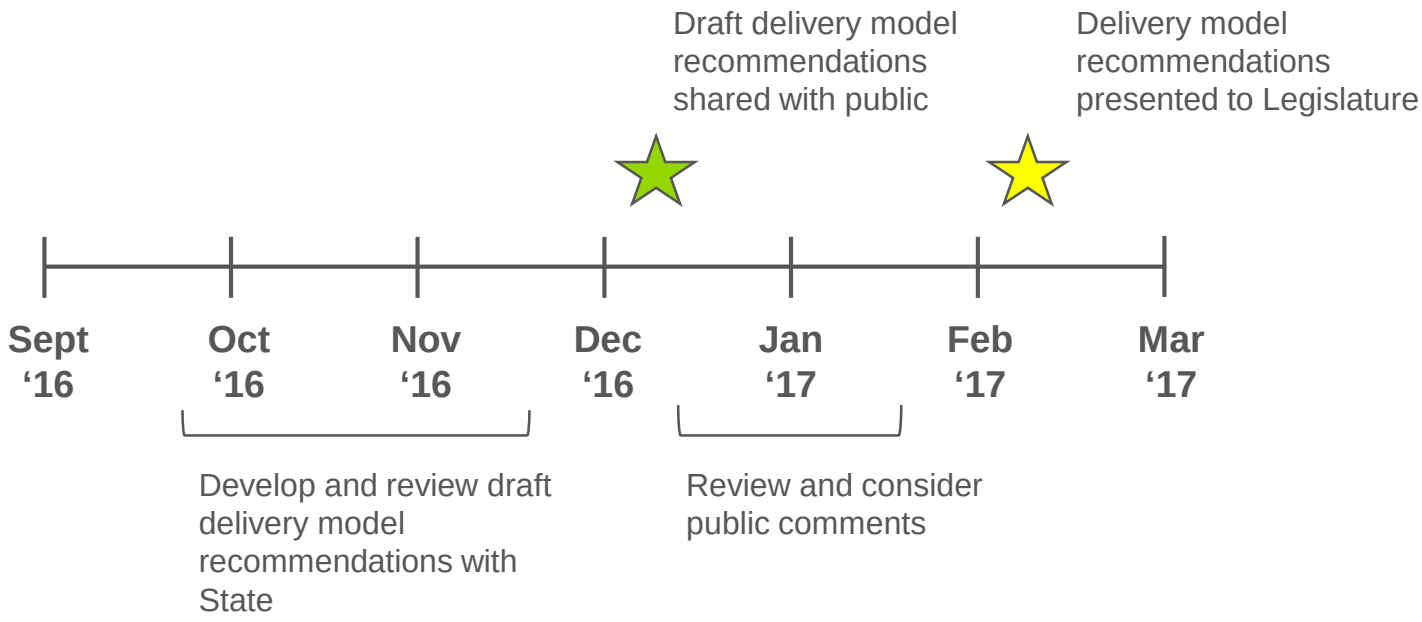
OPTIONS WILL ADDRESS HOW REVENUE UNDER SUPPLEMENTAL PAYMENT PROGRAMS WILL BE AFFECTED

- DHCFP makes supplemental payments to some providers, in addition to regular claims-based payments
- These supplemental payment programs are an important source of revenue for providers

CMS WILL NOT ALLOW THESE PAYMENTS UNDER FULL-RISK MANAGED CARE, BUT OPTIONS EXIST TO MAINTAIN FUNDING

- Make Graduate Medical Education payments to qualifying hospitals for managed care services, in addition to FFS services
- Combine supplemental payments into rates for select providers, and require MCOs to pay network providers minimum FFS rates
- Create funding pools and/or incentive programs through an 1115 demonstration to make additional provider payments based on:
  - Uncompensated care costs
  - Specific criteria or quality improvements

NEXT STEPS



Note: Timeline is approximate and subject to change

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COMMUNITY INPUT

- Which delivery models do you think would work best in Nevada and why?
- What other changes do you recommend to improve the delivery of Medicaid services in Nevada?
- Are there other Medicaid delivery models or innovations that Nevada should consider?

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