

How managed care can help save Medicaid

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The Right Care, Right Now, Right Near You



Neighborhood Health Plan of Rhode Island

- **Mission-driven HMO**, created by health centers in 1994, committed to access for all
- **Leading insurer for RItE Care** (RI's Medicaid Managed Care Program) with 58% market share, serving more than 75,000 members
- The first community health center based health plan in the country to be **rated “Excellent”** by the National Committee for Quality Assurance (NCQA) (in 2001)
- **“The #3 Medicaid health care plan in America,”** according to a joint ranking by U.S. News & World Report and NCQA (March 2006)
- **Hablamos Juntos grant award winner** - Selected by The Robert Wood Johnson Foundation to address racial and ethnic health disparities through medical interpreter reimbursements, standards and training

Why Managed Care for Special Populations?

- **Access**
 - ✓ Support services that eliminate barriers to care (emergency BH, transportation, BH step-down, interpreters)
 - ✓ Create access standards in network provider contracts
 - ✓ Work with community partners to establish continuum of care
- **Quality**
 - ✓ Provide standardized measurement and expectations for care
 - ✓ Analyze data & work with providers to address issues
 - ✓ Incentives motivate behavior change
 - ✓ National benchmarking (NCQA, HEDIS, CAHPS)
- **Cost**
 - ✓ Elderly & disabled are minority of caseload but majority of costs
 - ✓ Purchaser of services rather than a payer (sets standards)
 - ✓ Reduce IP medical and BH hospitalizations
 - ✓ Plans front load \$ in primary care (“well care, not sick care”)
 - ✓ Reduce pharmacy spending

Children with Special Healthcare Needs

- **Population** - Children who are SSI eligible, children with Katie Beckett provisions and children in subsidized adoption placements; Most are eligible up to age 21 (4,200 kids)
- **Challenges** – Multiple medical chronic conditions & developmental delays, poor provider & social service access; member difficulty navigating the system efficiently; inaccurate member information prohibits timely medical/behavioral health screening & assessment
- **Solutions** – Individual member health screening & assessment, care coordination & case management among medical, behavioral and social services; specific individual disease management & education
- **Results** – 21% reduction in hospital medical days; 25% reduction in behavioral health IP days; 25% increase in access to professional medical services; 80% increase in access to outpatient behavioral health services; and 94% member satisfaction with care coordination/case management

Children in Substitute Care

- **Population** - Children who are in in-state foster or group home placements (2,200 kids)
- **Challenges** - Poor access to primary care and specialty providers; high ER use; fragmented behavioral health services leads to high-end psychiatric placements; DCYF caseworkers focused on protection, not health care; state system placement capacity
- **Solutions** – Individual member health screening and assessment, care coordination and case management among medical, behavioral and social services; case management coordination (state system and health plan); creation of community based services for diversion of hospital admissions
- **Results** – Increased service capacity for diversion of hospital admissions; 16% increase outpatient community based behavioral health visits; 25% increase in access for professional medical services; individual child case mgmt coordination between state & health plan; 40% penetration rate for BH outpatient services; 9% decrease in BH hospital length of stay

Connect CARRE

- **Population** – High risk adult Medicaid recipients, age 21 and older with complex medical needs, living in the community; high acute care utilization; at risk for recurrent, adverse medical events (230 adults)
- **Challenges** - Inpatient utilization, chronic illness, high incidence of behavioral health co-morbidity, transient consumer group
- **Solutions** – Intensive Case Management, Chronic Care Model focus, link to BH services, continuous relationship with the care team (coordinated, assessment, referral, reassessment and evaluation)
- **Results** – DHS cost savings for first year; inpatient, ER, institutional costs down 14%; total claims down 6%

Optima: Medicare SNP

- **Population** – Medicaid and Medicare “dual eligible” adults (1,700 adults)
- **Challenges** – Market confusion and member fear of change; Part D pharmacy issues; mix of members (seniors and adults with disabilities); managing anticipated 70% of members with significant co-morbidities
- **Solutions** – “High touch” member contact is critical; integrated medical, behavioral and social case management; predictive modeling helps target members in need of case management (CM) before IP hospitalization
- **Results** – 2.7% of Optima members are currently in CM; majority of members in medical CM are elderly with cardiac, respiratory or diabetes issues; 50% of behavioral health CM = elderly with dementia &/or depression, other 50% = disabled with depression, bipolar, post traumatic stress or schizoaffective disorders

Elements for Success

- **Family, member and advocate buy-in**
 - Critical for political success
- **Continuity of care**
 - Working to include existing providers
- **Ongoing input from families**
 - Organize product line advisory groups
- **Incentives for providers to develop new patterns of service** – Step down BH; open access primary care

National Medicaid Reform

- **Encourage Managed Care for Disabled**
 - Add non-waiver options with appropriate protections
- **Encourage Solutions for Dually Eligible**
 - Fast track waivers, blend Medicare and Medicaid funding and savings calculations

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