

PUBLIC BENEFITS MANAGED CARE STUDY - BACKGROUND MEMORANDUM

STUDY CHARGE

Section 32 of 2017 House Bill No. 1012 ([Appendix A](#)) provides for a study of options to operate the state medical assistance program and other related programs, as managed care. The study must:

- Identify and review populations to consider for managed care, including individuals eligible under traditional medical assistance, Medicaid Expansion, the children's health insurance program (CHIP), and individuals receiving services through the long-term care and developmental disabilities programs;
- Consider the needs of individuals receiving services from managed care programs in similar-sized states, and the alignment of benefit packages;
- Review populations covered by the program of all-inclusive care for the elderly (PACE) in other states;
- Consider options for including services under a managed care arrangement;
- Consider developing a proposed plan, cost estimates, and potential timeline for implementing the managed care options identified; and
- Consider preparing and distributing a request for information from managed care organizations regarding the managed care options identified.

PREVIOUS LEGISLATIVE STUDIES

Although the topic of managed care for public benefit programs has not been the subject of an interim study in recent history, for the previous three interims the Legislative Management's interim Health Care Reform Review Committee has conducted ongoing studies of the state's health care delivery system with an eye to providing North Dakotans affordable health care. In the course of the Health Care Reform Review Committee's studies, the committee received information regarding the state's medical assistance program, Medicaid Expansion program, and CHIP, as well as regarding the provision of medical services through a medical home model.

During the 2015-16 interim, the Health Care Reform Review Committee considered several alternative recommendations with the goal of decreasing the state's financial liability for the Medicaid Expansion program to alleviate the financial impact of removing the July 31, 2017, sunset. House Bill No. 1032 (2017) was one such alternative recommendation made by the committee which would have removed the sunset, provided Medicaid Expansion provider reimbursement rates are the same as under the traditional Medicaid program, and removed the requirement the Medicaid Expansion program be provided through a private carrier or by utilizing the health insurance exchange. In effect, this bill would have moved the Medicaid Expansion from a managed care program to a fee-for-service program. This bill failed in the House and instead, under Section 38 of House Bill No. 1012, the Legislative Assembly extended the sunset to July 31, 2019, without amending the law regarding private carriers and without statutorily setting provider reimbursement rates.

PUBLIC BENEFITS - MANAGED CARE North Dakota

Under North Dakota Century Code Chapter 50-24.1, the Department of Human Services (DHS) administers the state's Medicaid program, known as medical assistance; under Section 50-24.1-37, DHS administers the Medicaid Expansion program, which is scheduled to sunset July 31, 2019; and under Chapter 50-29, DHS administers CHIP, known as Healthy Steps. These programs are federal-state partnerships and subject to changes in federal law. While the state is able to design program services, eligibility, and operational protocols, the federal government contributes funding, dictates the minimum standards, and sets requirements for various program operations. Each of these programs provides health care coverage to qualified applicants and each program has its own set of qualification requirements.

Within these public benefit programs, eligible recipients fall into multiple classifications, and based on these classifications, the type of managed care that may be appropriate or allowed by the federal government may vary. For example, within Medicaid, the following applicants may be eligible:

- Low-income individuals from birth;
- Children in foster care or subsidized adoption;
- Former foster care children;

- Children with disabilities;
- Pregnant women;
- Women with breast or cervical cancer;
- Workers with disabilities;
- Other blind or disabled individuals; and
- Low-income Medicare beneficiaries.

In addition to the various eligibility classifications for these programs, within the programs, DHS is operating under multiple federal waivers. A state change in any of these programs may require federal approval.

There appears to be federal and state support for implementing managed care within the programs. The Center for Medicaid and CHIP Services (CMCS) is one of six centers within the Centers for Medicare and Medicaid Services (CMS), which is an agency of the United States Department of Health and Human Services. The Center for Medicaid and CHIP Services reports:

Managed Care is a health care delivery system organized to manage cost, utilization, and 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 set per member per month (capitation) payment for these services.

By contracting with various types of MCOs to deliver Medicaid program health care services to their beneficiaries, states can reduce Medicaid program costs and better manage utilization of health services. Improvement in health plan performance, health care quality, and outcomes are key objectives of Medicaid managed care.

Some states are implementing a range of initiatives to coordinate and integrate care beyond traditional managed care. These initiatives are focused on improving care for populations with chronic and complex conditions, aligning payment incentives with performance goals, and building in accountability for high quality care.

The Center for Medicaid and CHIP Services publishes managed care profiles for each state. North Dakota's profile ([Appendix B](#)) and DHS's website ([Appendix C](#)) indicate DHS utilizes the following four managed care programs for its public benefit programs:

1. Primary Care Case Management program;
2. Health Management program;
3. PACE; and
4. Medicaid Expansion through an MCO.

Medicaid and CHIP Managed Care Final Rule

Recent federal developments may affect the state's ability to implement managed care or require the state to implement additional managed care provisions. On April 25, 2016, CMS put on display the Medicaid and CHIP Managed Care Final Rule. The reported key goals of the final rule are to:

- Support state efforts to advance delivery system reform and improve the quality of care;
- Strengthen the beneficiary experience of care and key beneficiary protections;
- Strengthen program integrity by improving accountability and transparency; and
- Align key Medicaid and CHIP managed care requirements with other health coverage programs.

The effective date of the final rule was July 5, 2016, with phased implementation of new provisions primarily taking place over 3 years, starting with contracts entered after June 30, 2017. State CHIP and Medicaid programs will be required to comply with this final rule.

STUDY PLAN

In pursuing this study charge, the committee is required to:

- Identify and review populations to consider for managed care, including individuals eligible under traditional medical assistance, Medicaid Expansion, CHIP, and individuals receiving services through the long-term care and developmental disabilities programs;
- Consider the needs of individuals receiving services from managed care programs in similar-sized states, and the alignment of benefit packages;
- Review populations covered by PACE in other states;
- Consider options for including services under a managed care arrangement;
- Consider developing a proposed plan, cost estimates, and potential timeline for implementing the managed care options identified; and
- Consider preparing and distributing a request for information from MCOs regarding the managed care options identified.

In pursuing this study the committee will benefit from receiving background information regarding traditional types of managed care as well as newer and less traditional managed care programs. Upon receipt of this information, it will be important to consider which population groups might benefit from these managed care programs. In addition to consulting DHS, the Kaiser Family Foundation, CMCS, the National Council of State Legislatures, and Leavitt Partners, LLC, may be valuable resources in standardizing terminology and tracking what managed care is taking place in other states.

Once the committee receives basic background information on the use of managed care for public benefits, the committee may consider focusing on North Dakota's managed care efforts, including implementation of the Medicaid and CHIP Managed Care Final Rule, and whether the state's efforts have resulted in the state recognizing cost savings and improved health care delivery.

If, after researching managed care trends, efforts of other states, and efforts being pursued by DHS, the committee determines there may be benefits to increasing or modifying the state's managed care efforts to identified populations, the committee may consider moving forward with designing potential plans, identifying federal requirements relating to the potential plans, and establishing cost estimates and timelines if the state were to pursue these managed care programs.

ATTACH:3