Relationship of Managed Care to Medicaid and DHS Operations

Health Care Reform Committee

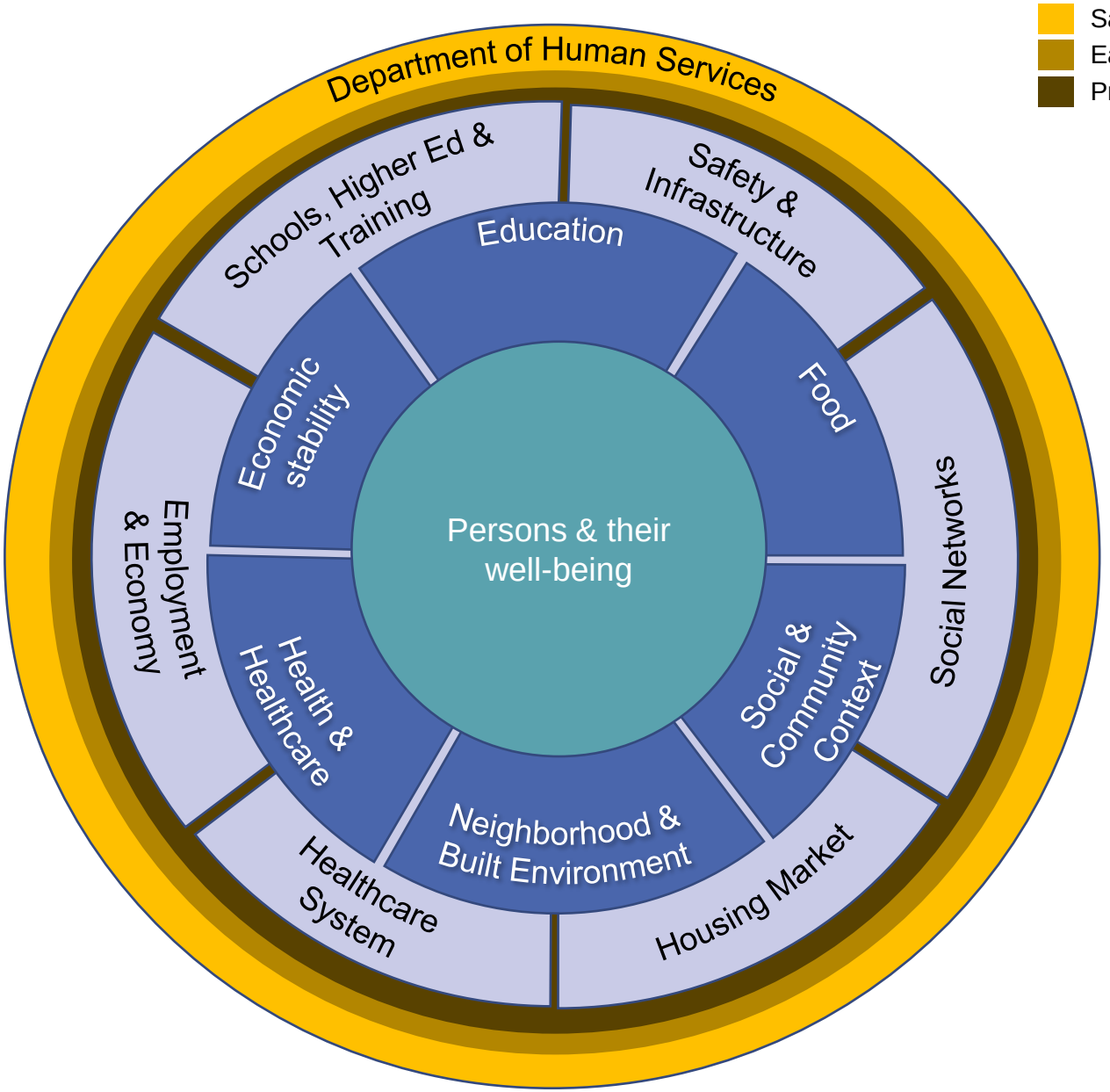
August 22, 2018

north dakota department of human services

The mission of DHS is to provide quality, efficient, and effective human services, which improve the lives of people

Mission	Principles
Quality services	▪ Services and care should be provided **as close to home as possible** to – Maximize each person's independence and autonomy – Preserve the dignity of all individuals – Respect constitutional and civil rights ▪ Services should be **provided consistently across service areas** to promote equity of access and citizen-focus of delivery
Efficient services	▪ Services should be administered to **optimize** for a given cost **the number served** at a service **level aligned to need** ▪ Funding in DHS should **maximize ROI for the most vulnerable** through prevention, early intervention and safety net services, not support economic development goals ▪ Cost-effectiveness should be considered holistically, acknowledging **potential unintended consequences** and **alignment between state and federal priorities**
Effective services	▪ Services should help vulnerable North Dakotans of all ages maintain or enhance quality of life by – Supporting **access to the social determinants of health**: economic stability, housing, education, food, community, and health care – **Mitigating threats** to quality of life such as lack of financial resources, emotional crises, disabling conditions, or inability to protect oneself

To improve lives, DHS enables access to social determinants of health when community resources are insufficient



- **Social determinants of health are all necessary and mutually reinforcing** in securing the well being of an individual or family: **they are only as strong as the weakest link**
- **Community resources** shape and enable **access to the social determinants** (e.g., schools provide access to education, employment provides access to economic stability)
- **Investing in community resources** can in many cases **prevent individuals from needing to access DHS safety net services** to obtain the social determinants of health

Providing access to social determinants involves administering, paying for, providing, and supporting numerous services

Administrator[1] **PAYOR** (state[2]) Provider Partner

Social Determinant	Components	Social Services & Eligibility	Medical, DD & Long-term care	Behavioral Health Policy & Services[1]
Economic Stability	▪ Employment ▪ Income ▪ Expenses ▪ Debt	TANF, LIHEAP, Child Support, Vocational Rehab, Child care assist.		**EXTENDED SERVICES** for those with SMI
Education	▪ Early Childhood ▪ Literacy/language ▪ Vocational ▪ Higher EDU	Child care licensing		
Food	▪ Hunger ▪ Access to healthy options	SNAP/ Food stamps	Nutrition Services	**RECOVERY SUPPORT SERVICES** (including Free Through Recovery, PATH for those experiencing homelessness, and other programs)
Neighborhood & Built Environment	▪ Housing ▪ Transportation ▪ Safety ▪ Parks	CPS, Foster care, **FOSTER CARE (IV-e)**	**NURSING FACILITIES, ICFs**	
Social & Community Context	▪ Integration ▪ Support ▪ Inclusion	In-home supports	**DD, HOME & COMMUNITY BASED SERVICES**	
		CASE MANAGEMENT		
Health & Healthcare	▪ Coverage ▪ Providers ▪ Quality of care ▪ Cultural competency		**TRADITIONAL, WAIVERS, VOUCHERS, CHIP,** Expansion, LSTC	**SBIRT, Parent's LEAD, STATE HOSPITAL, LSTC, HSCs[3]**

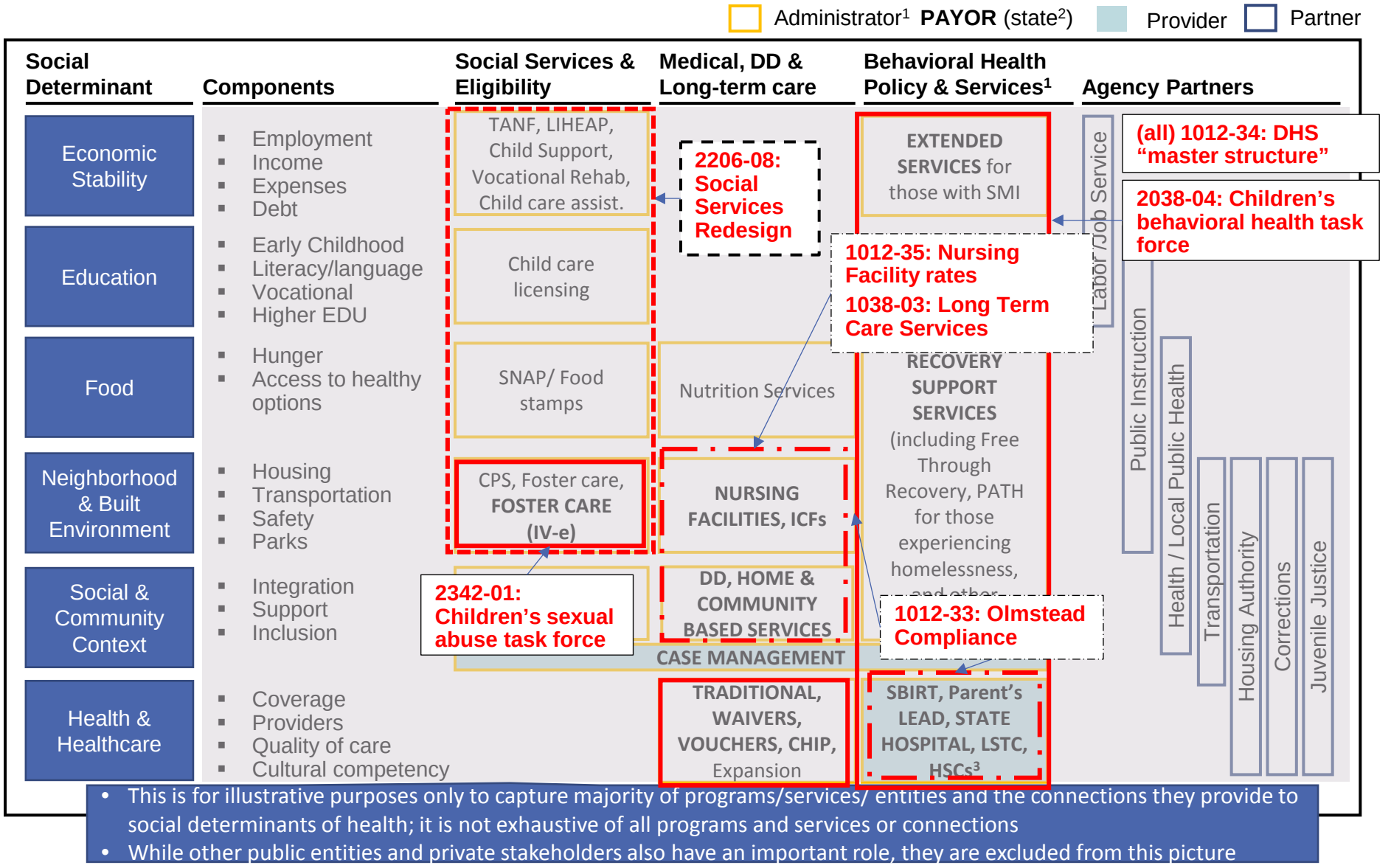
Agency Partners

- Labor /Job Service
- Public Instruction
- Health / Local Public Health
- Transportation
- Housing Authority
- Corrections
- Juvenile Justice

- This is for illustrative purposes only to capture majority of programs/services/ entities and the connections they provide to social determinants of health; it is not exhaustive of all programs and services or connections
- While other public entities and private stakeholders also have an important role, they are excluded from this picture

1 Administrative role also includes the function of licensing professionals 2 Those programs for which the state pays a large share
3 SBIRT = Screening Brief Intervention & Referral to Treatment, LSTC = Life skills & transition center, HSCs = Human Service Centers

During interim, Legislative Management Studies and Task Forces are examining most of DHS operations



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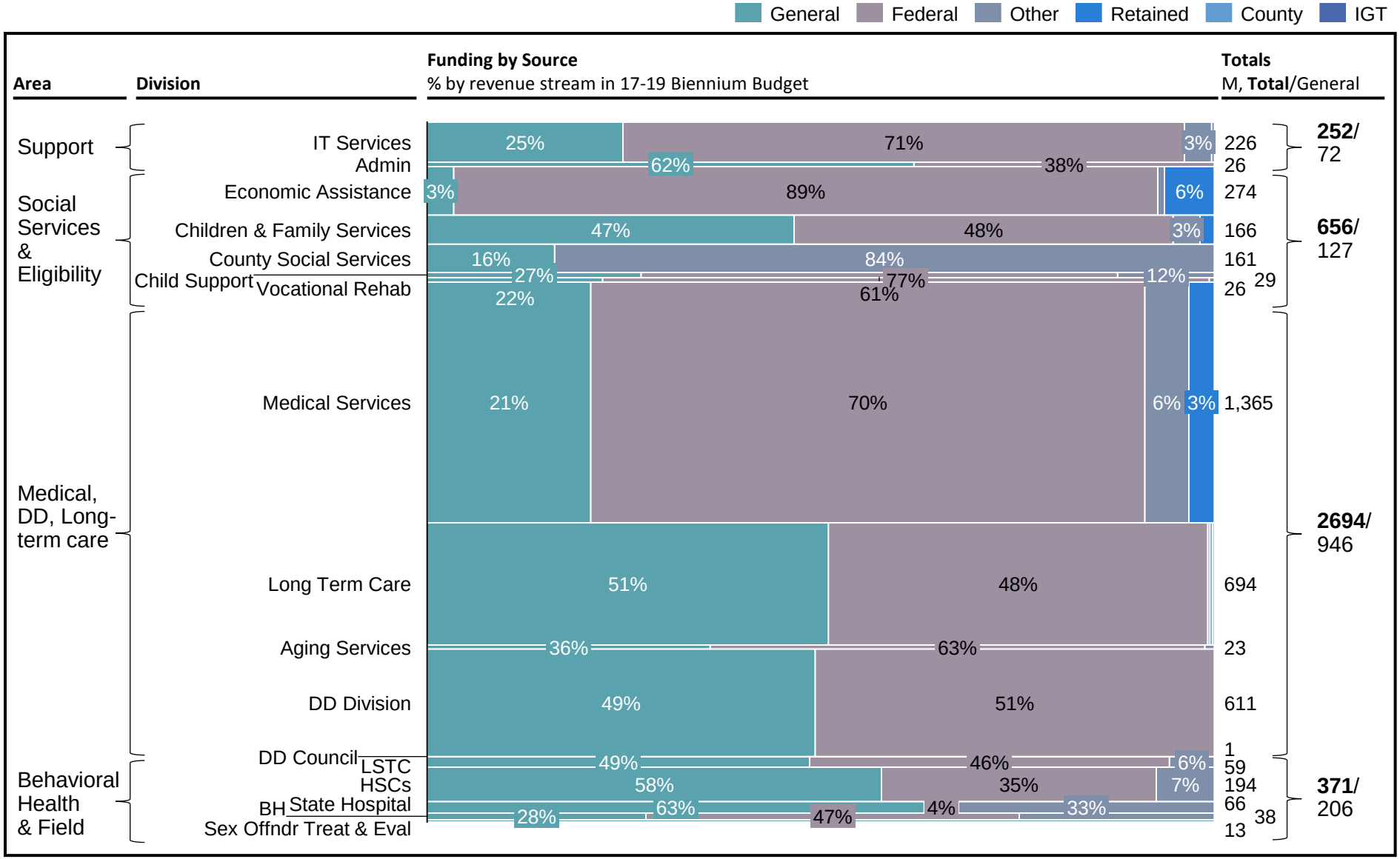
As a payor DHS spends majority on medical, DD, & long-term care services, a significant share of which is from General fund

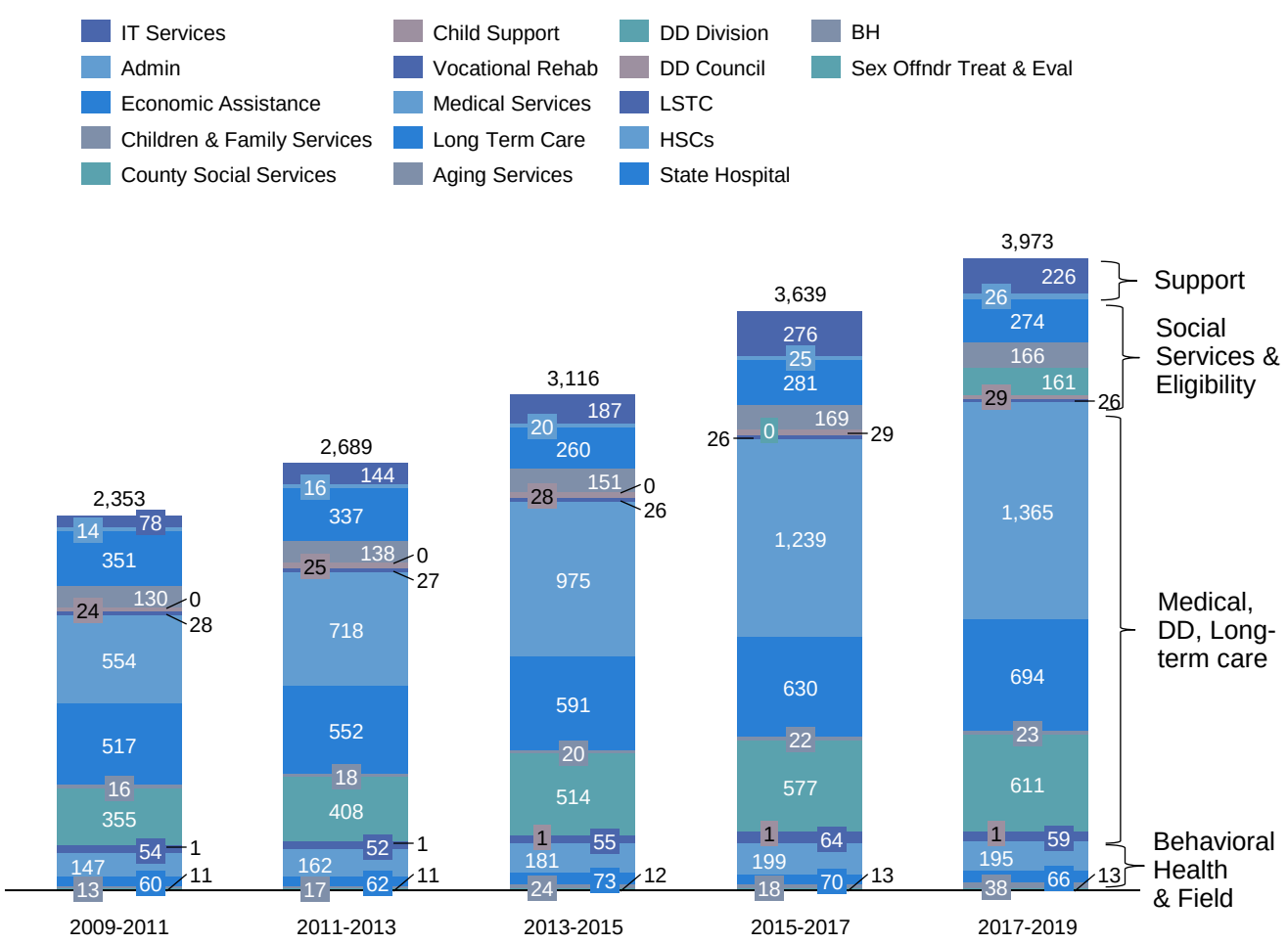


1 Life Skills and Transition Center 2 Behavioral Health

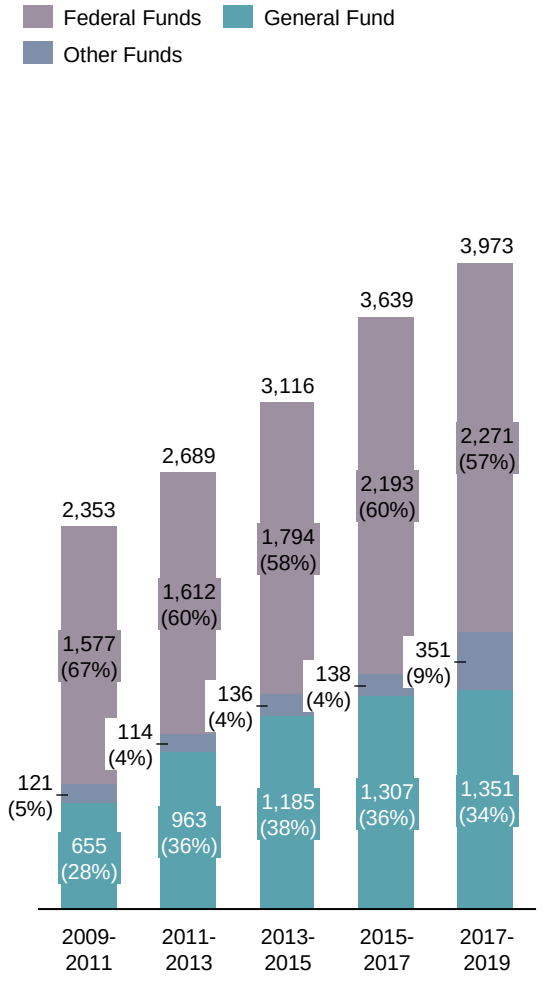
Source: Department of Human Services * Summary by Divisions with Class Items and Major Funding Sources

Over the last 5 biennums, DD, medical, and long-term care have also driven growth in spending

Biennium budget by use (division)
$M for biennium

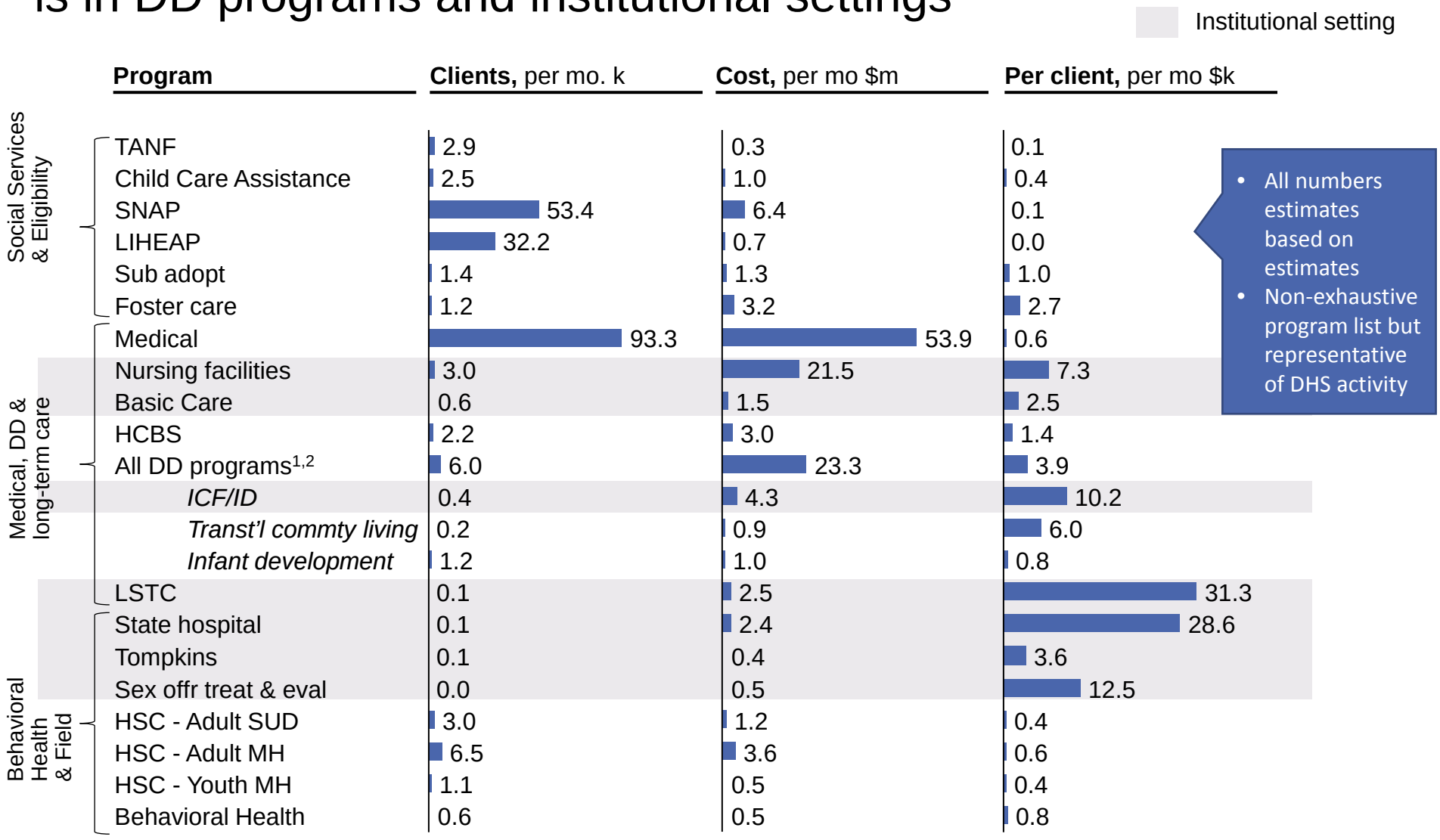


Biennium budget by source
$M for biennium



Source: Peoplesoft

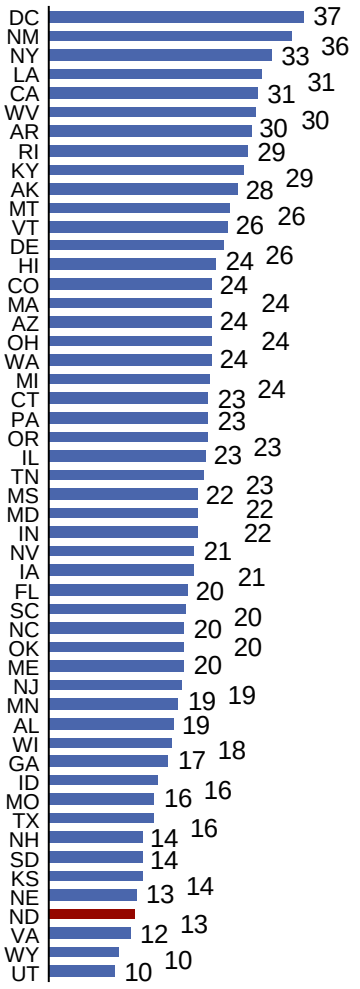
In cost of services, highest spend for care/services per person is in DD programs and institutional settings



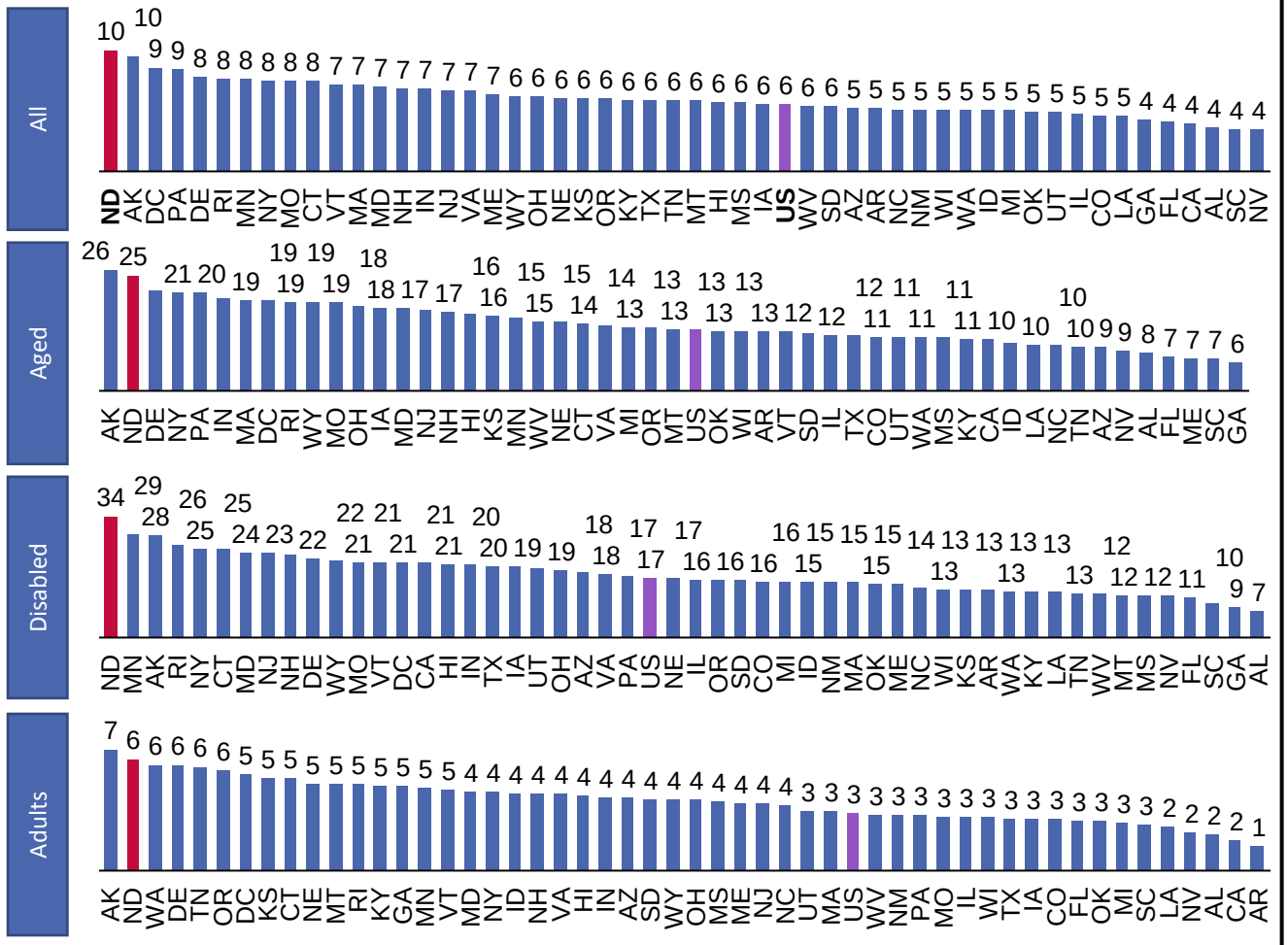
1 Total spend represented here does not include medical care for this population such as drugs or therapies
2 Indented programs shown below are sub-segments of the total population represented in this row
Source: DHS QBI

While the percentage of the population on Medicaid is low in ND at ~13%, spending of ~$10k per enrollee is highest in US

Percentage of Population on Medicaid/ CHIP, %



Spending per enrollee in Medicaid by population segment
Annual spend per enrollee (full or partial benefit), $k in 2014



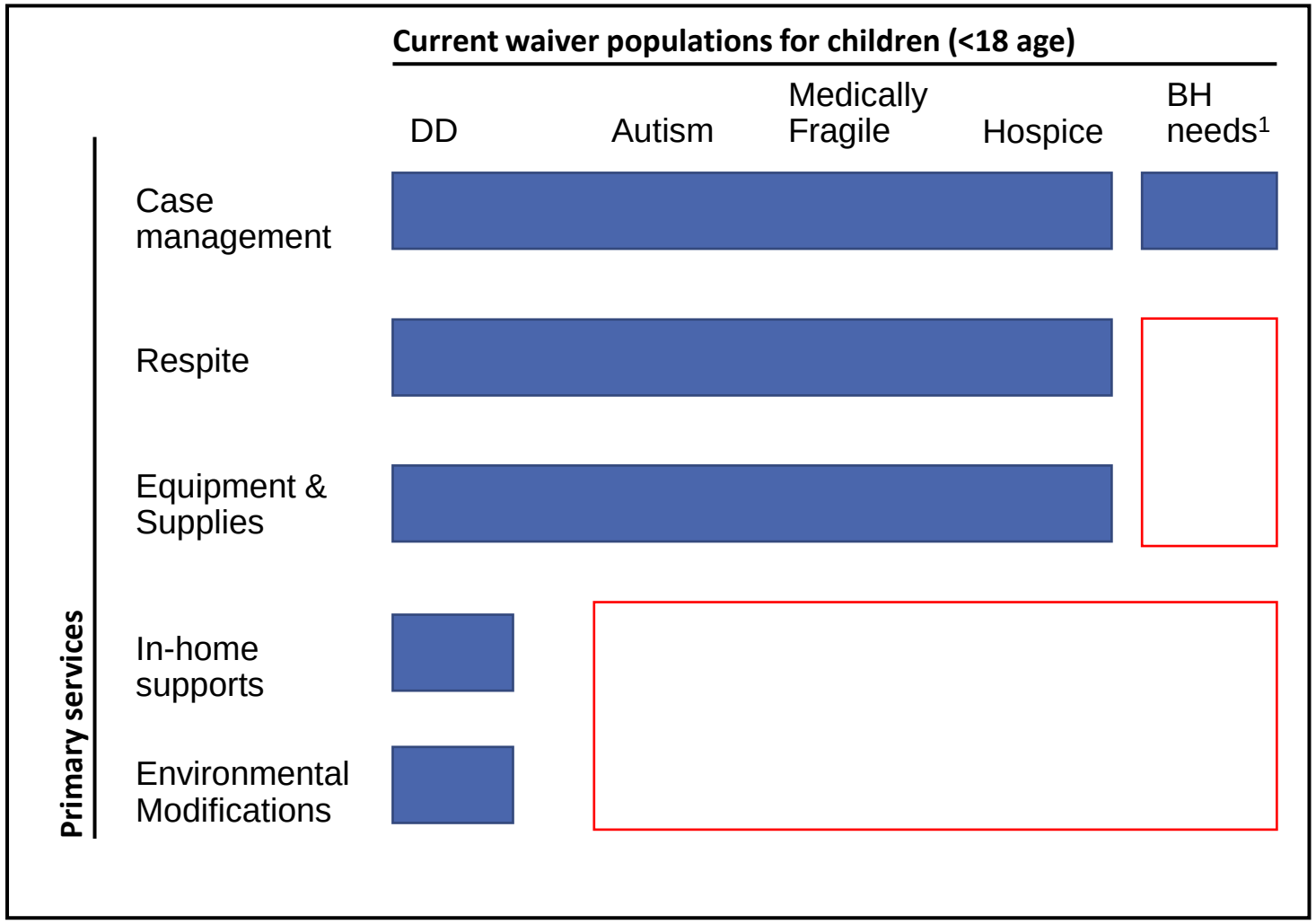
Source: KFF (2014 spending per enrollee), US Census (2017 population by state), Medicaid.gov (Mar 18 enrollment in Medicaid & CHIP)

Several ongoing and strategic initiatives will address costs and additional priorities

Strategic: Grow/ transform | Ongoing: Grow | Study

Initiatives	Description / Rationale	Status / Considerations
MMIS Certification & Upgrades	▪ Achieve CMS certification which is expected to **generate 18.7m of one-time general fund savings** this biennium and **additional ongoing savings as FFP rate increases** 50 to 75%	▪ Expected by June 19 ▪ **First priority upgrades**: Tech stack upgrade, state self-assessment, federal requirements
SPACES eligibility system transformation	▪ Transfer EA eligibility from multiple systems to 1 in order to **streamline experience for clients** and intake workers and improve accuracy ▪ Perform **client eligibility at gross adjusted level**, which was necessary for ACA compliance	▪ **Phase 1:** ACA, Feb 16 ▪ **Phase 2:** EA (xLIHEAP), Spring 19 ▪ **Phase 3:** non-ACA-Medicaid, Fall19 ▪ **Phase 4:** Add LIHEAP, TBD
Simplifying & updating coverage	▪ E.g., Telemedicine policy improvements, payment for preventative services, school policies for kids with IEPs	▪ Policy, code & manual updates ▪ Ensure coverage & benefits are well-defined
Engaging tribes	▪ **Help tribes become enrolled providers** and access reimbursement for the provision of services ▪ Provide **100% FMAP for services to private providers that are part of care coordination** which saves general funds	▪ 2 committed staff **partner with tribal & IHS** ▪ Limited progress on 100% FMAP due to **inability to share savings**
Studying Managed Medicaid	▪ **Considering populations for managed Medicaid** through interim study	▪ **Big 6 putting together a** plan; current study advocated by out of state org
Establish Medicaid Fraud Unit (MFCU)	▪ Primary function would be to **investigate provider fraud** (i.e., over billing) and **provider abuses** (e.g., nursing facility neglect)	▪ In 2017, **CMS requested an implementation plan**

Simplifying around a “children’s waiver” could bring needed services to some that fall outside DD umbrella today

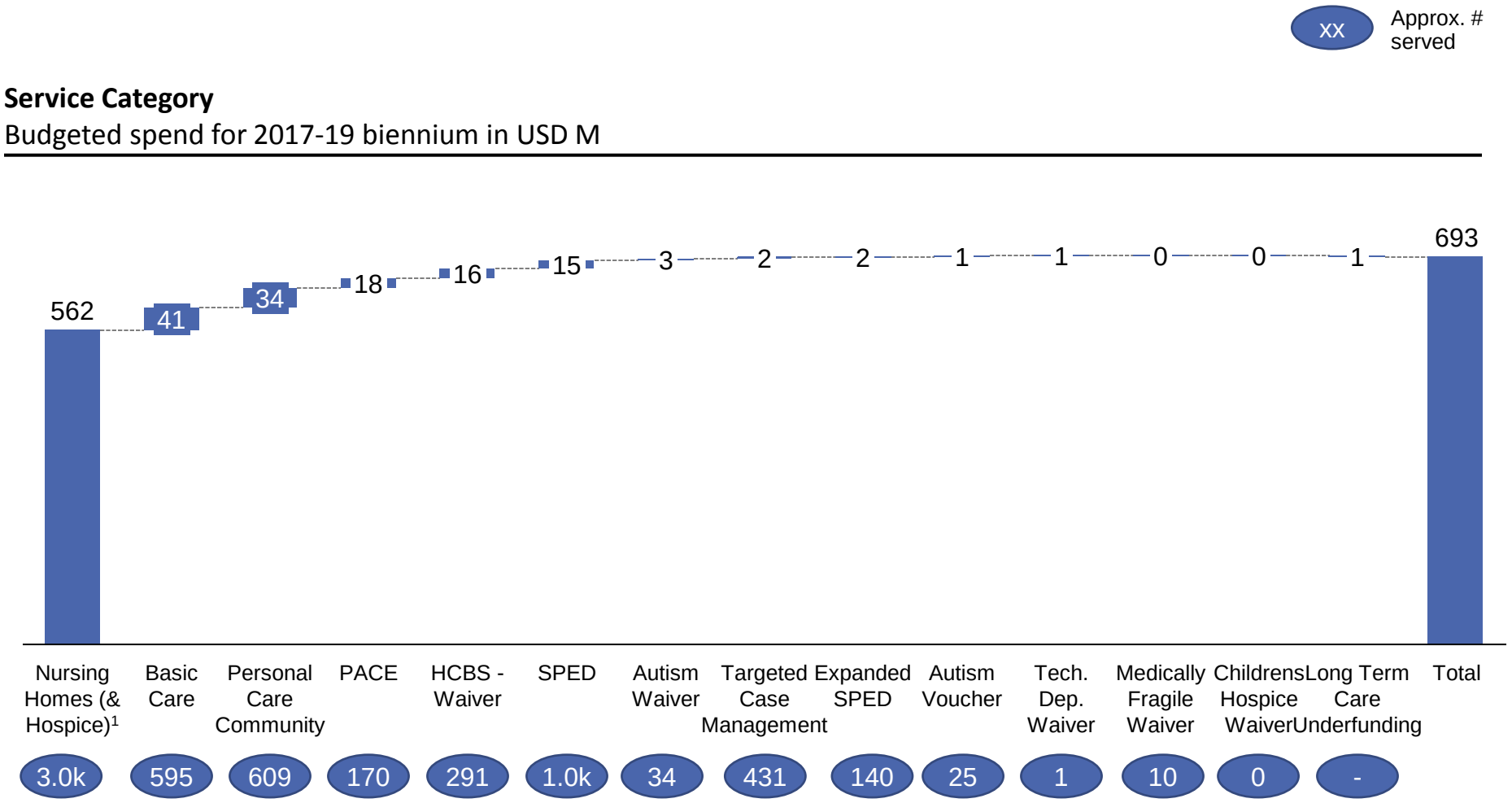


Considerations:

- In-home supports are the most costly service to extend to additional populations, and cost controls may need to be in place to support fiscal model
- In order to combine and simplify coverage, other federal authorities than current 1915c could offer their own benefits and tradeoffs

1 Today the only case management services (targeted case management for this population) supported by Medicaid for those with behavioral health needs are those provided by the HSCs, which may not have capacity to serve full need

Long Term Services and Supports costs are driven by the spend in nursing homes which account for >80% of budgeted spend



1 Hospice accounts for ~2% of spend to date in this category
Source: LTC 2018 04 EMAR Apr

Key Takeaways

Themes

- In the delivery of Human Services, there are multiple components that must be delivered to optimize return on investment.
  - If one component is optimized, it may not be as impactful if other components are not optimized in parallel or correspondingly.
  - The State has been successful in keeping Medicaid enrollment low through multiple community resources and policy
  - However, the cost per beneficiary is significantly higher than national averages
- For system stability, incrementally move from cost, to service, to outcome-based reimbursement across all payment systems.
- Move towards administrative simplification, reduction of complexity, stability for state Medicaid. Much of Medicaid stability relies on IT tools and resources.
- Increase focus on client and needs through functional support, and enhance supports for behavioral health and service in least restrictive environment.
  - Today, there is inconsistency across waivers that do not align services to needs.
  - Behavioral health coverage is inadequate, particularly around targeted case management.
  - Some elderly are having difficulty staying home.
  - Optimize coverage to better align services to needs for children, disabled, elderly.

Major Statutory Implications