

Utah Medicaid Reform Proposal

Given that annual Utah Medicaid growth rates have exceeded the State's annual revenue growth rate for the past two decades, the State is concerned about the long-term sustainability of the Medicaid program. While Medicaid is a unique entitlement health care program that has various federal mandates and regulations associated with it, much of the increased costs are due to conditions prevailing in the health care industry as a whole. Health care industry costs continue to outpace overall inflation due to many factors, among those is a reimbursement structure that provides financial incentives for overutilization of health care services. In an effort to preserve the long-term viability of the Medicaid program and to establish a standard for better control over increasing costs in health care, the State of Utah is proposing a Medicaid reform proposal that implements payment reforms and more appropriately aligns financial incentives in the health care system. If successful, this model will not only be adopted in various forms by other Medicaid programs around the country but also by commercial health plans.

Accountable Care Organizations (ACOs)

The State of Utah has contracted with managed care organizations under a variety of different contracting arrangements over the past two decades. While the State believes that these contracts have added value in delivering quality care to Medicaid clients in controlling costs over the years, the State also believes that converting these contracts to an Accountable Care Organization (ACO) model can better align financial incentives to control costs and to deliver appropriate care to clients. The reform proposal would replace all existing Medicaid managed care contracts with ACO contracts.

The ACO contracts would essentially provide the ACOs with monthly risk-adjusted, capitated payments based on enrollment and ask that the ACOs deliver the necessary and appropriate care, while demonstrating that quality of care and access to care is not suffering. ACOs would have more flexibility to distribute payments throughout their network of providers. Rather than reimbursing providers based on the units of service delivered, the ACO would make payments for delivering the necessary care to a group of Medicaid enrollees for a specified period of time. By reforming payments at each level of health care delivery, the ACO will better align the incentives of all participating providers.

While an ACO contract may at first seem quite similar to a traditional managed care contract, the key differences are (1) that the ACO contract payments eliminate the incentives to provide excess care and (2) the contracts will be maintained only if the ACO meets established quality and access criteria.

A centerpiece of the ACO care delivery model is a "Medical Home." Each Medicaid client would have access to a primary care provider or a group of primary care providers who would provide care and also coordinate the client's use of medical services throughout the ACO network of providers. The client would be expected to utilize services within the ACO provider network. Each ACO would create, through contract or employment, a sufficient network of health care providers to deliver the necessary care for the enrolled Medicaid clients. Medicaid clients would be able to select from at least two ACOs at their time of initial program enrollment and have an option once per year of switching health plans during an "open enrollment" period.

Risk-Adjusted, Capitated Payments

The State plans to use risk-adjusted, capitated payments for all of its Accountable Care Organization contracts. These payments consist of actuarially certified rates based on major categories of Medicaid eligibility (i.e., children, pregnant women, elderly, etc.) and the severity of illness prevalent in the enrolled population.

Actuarial certification of rates is made by actuaries who calculate historic cost and trend amounts for enrollees' health care utilization in the various categories of eligibility. These calculations are based on claims and/or encounter data from the providers delivering the care.

The State wants to ensure that after the initial round of actuarial rate setting has been completed for the implementation of this reform, that the resulting capitated rates can serve as the baseline for future years' reimbursement rates. As a foundational principle of this reform, the State wants to eliminate the incentive for providers to deliver care based on reimbursable or billable services. As a result, the State wants and expects that ACOs and their associated providers will begin delivering care in a manner that will not result in as many billable services being delivered. However, under the current actuarial rate setting process, this would result in ongoing reductions in reimbursement rates. Consequently, the State is looking to work with CMS to establish future years' rates in a manner that will preserve the initial baseline payments through the rate setting process.

Quality of Care Standards

The National Committee for Quality Assurance (NCQA) recently issued Accountable Care Organization draft criteria for public comment and plans to finalize the criteria in mid-2011. The State proposes to adopt these soon-to-be-established criteria. Each organization that plans to contract with Utah Medicaid will need to demonstrate that it is seeking NCQA accreditation as an ACO as a condition of participation in the program.

ACO Provided Benefits

The current managed care contracts generally include only inpatient hospital, outpatient hospital, physician services and other ancillary services. Pharmacy, dental, mental health and long-term care services are "carved out" of or excluded from these contracts.

The reform proposal looks to include pharmacy with the current managed care benefit package in the reform proposal. The State believes that including pharmacy coverage in the ACO contracts will better align the incentives of prescribers with the goals of the State.

Out-of-Network Payment Limits

Another way to reduce health care costs is to place limits on out-of-network charges for Medicaid clients. Currently, when an individual seeks urgent care out of his or her selected managed care network, the treating provider will charge the client's health plan a higher fee. This reform proposal seeks to place limits on such charges for Medicaid clients.

Individual Accountability

Medicaid clients should participate more in the cost of their health care. The State is interested in replacing archaic limits on Medicaid copayment amounts with a sliding-scale copayment schedule based on the Medicaid client's income.

Geographic Implementation

The State currently has three managed care organizations providing services to Medicaid clients in the State's four most populous counties: Salt Lake, Davis, Utah and Weber. The reform proposal looks to implement the ACO contracting model in these same four counties.

Waiver Authority

The State currently has a 1915(b) Freedom of Choice Waiver to operate this program. In an introductory discussion with Cindy Mann, Deputy Director of CMS and Director of CMCS, about this proposal, the State was informed that it may be able to convert its model of managed care contracts to ACO contracts by revising the existing 1915(b) waiver. If that is the most appropriate waiver authority to accomplish this reform, then the State is agreeable.

Special Considerations

In the implementation of this reform proposal, the State is interested in keeping the current provider reimbursement levels intact. There is no interest in reducing the reimbursement levels for providers willing to venture into this new reform proposal with the State. In general, the State wishes to keep the current level of Medicaid funding in the system and realign incentives with the expectation that future program growth will be more comparable with State revenue growth.

One way the State supports current reimbursement levels is a hospital provider assessment. Additionally, the State makes supplemental payments to its teaching hospital. The State wants to make sure that the federal funding associated with these payments is not jeopardized as a result of this reform proposal's use of ACOs. The State looks to work with CMS to ensure the preservation of these federal funds.

Budget Management Strategy

One of the overall goals of this reform is to bring Medicaid growth more in line with overall State revenue growth. In addition to the reform proposal's conversion to ACO contracts is a budget management strategy that sets specific Medicaid growth targets. Those targets would be linked to long-term State revenue growth figures.

It is the intent of the State that in years when Medicaid's growth was not as high as the targets that the difference would be deposited into a Medicaid Rainy Day Account. In years when Medicaid growth exceeds general fund growth targets, then the State would like to use a plan similar to that used by the Oregon Medicaid program to reduce benefits on a pre-determined schedule.

Premium Subsidy Option

Under a federal waiver, the State currently offers a health insurance premium subsidy to low-income individuals who are not eligible for Medicaid coverage. Medicaid-eligible individuals do not have the option to enroll in this premium subsidy program. This reform proposal seeks to allow a Medicaid client the option to receive a premium subsidy and purchase a health insurance product through the State's Health Insurance Exchange as an alternative to enrolling in the Medicaid ACO product.

Implementation Timetable

The proposed date for implementation is **July 1, 2012**. This timetable should allow the State and health care providers some planning and implementation time for realigning models of care delivery and updating payment and monitoring systems.