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Division of Health Care Financing and Policy

Managed Care in Nevada

February 4, 2016



Background

- Centers for Medicare and Medicaid Services (CMS) established the Triple Aim
 - Better care for individuals
 - Improved population health
 - Reduced costs by improving health outcomes
- Ensuring Medicaid program sustainability
- Passage of SB514

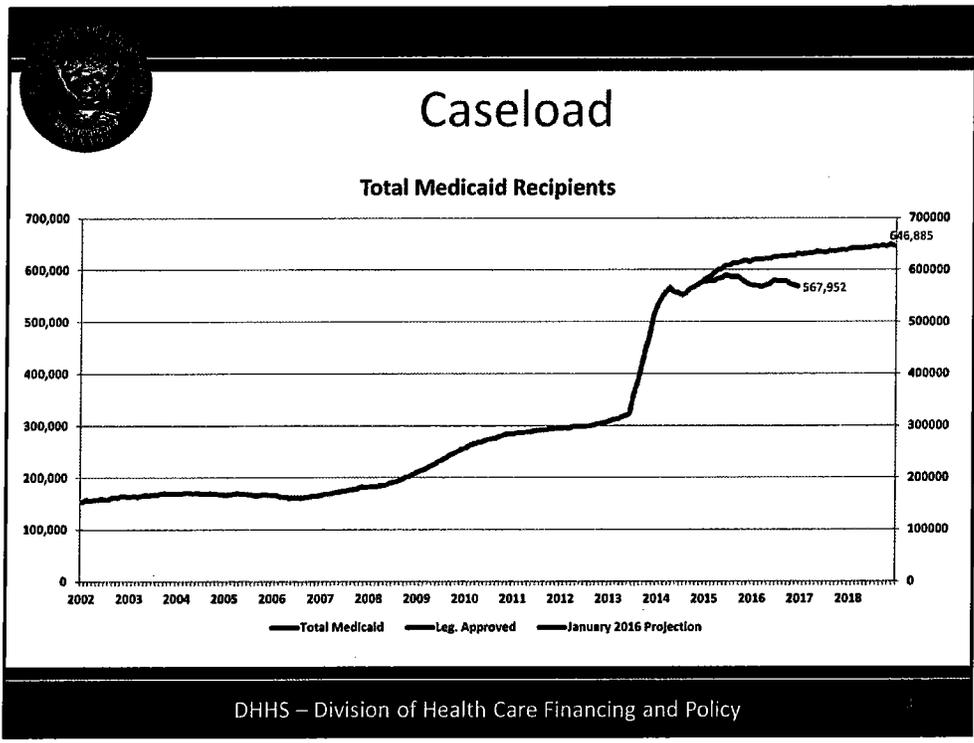
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State efforts

- Maximizing reimbursable services
- State Innovation Model Planning (SIM)
- Health Information Technology initiatives (HIT)
- Telehealth, Community Paramedicine, CHW
- Workforce Development

SB514 – Enabling language DHHS to explore new methods of delivering long-term support services to Nevadans.

LTSS services + Services and Other eligibility groups not covered by managed care.



December 2013 323,531

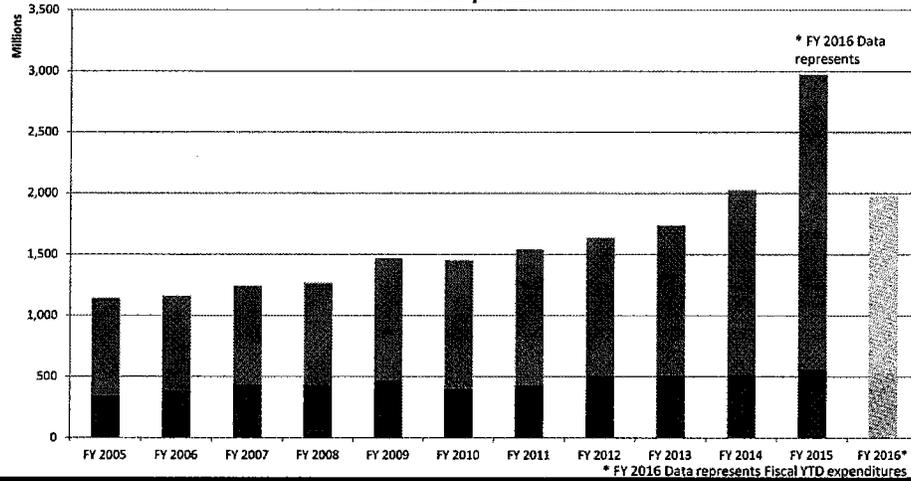
December 2015 608,790

Cover roughly 20% of the state population



Costs

Fiscal Year Expenditures



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FY 2005 Annual= \$1.1Billion

FY 2015 annual = \$2.9 Billion

BLUE is state share 5.64 million 2015

Newly Eligible FMAP

FY17 97.5

FY18 94.5

FY19 93.5

FY20 91.5



Purpose Statement

The Department of Health and Human Services is evaluating alternative service delivery models aimed at achieving better care for patients, better health for our communities and lower costs through improved health outcomes.

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No decisions have been made
current programs

Goal is to ensure Sustainability of the

Department Perspective – Evaluation of impact to each Division

DPBH programs - Mental Health Services; aligning MCO outcome measures with public health initiatives, identifying safety net providers

DCFS – Specialized care for children in Foster Care and Juvenile Justice Programs. Ensuring Alignment with the System of Care Grant initiatives transitioning the delivery of children’s mental health services

ADSD – Impact on Recipients, Providers, including staff providing direct service, Alignment with No Wrong Door Strategic Plan – single point of entry for LTSS services.

DWSS – Technology improvements, aligning business processes and maximizing available technology

Holistic Approach – Internal and External

- Person centered,
- Integrated and coordinated care approach (Medical, Behavioral, Social)
- Quality and better health outcomes

Complex Changes

Recipients

State Staff

County Programs

Current Contracts

Funding IGT, Supplemental Payments

FCHC's



Medicaid in Nevada

- Nevada Medicaid provides services under two different delivery models:
 - Fee-For-Service
 - Managed Care



What is Fee-for-Service?

- Individuals can receive services from any provider enrolled with Nevada Medicaid
- No referrals from a primary care physician are required to see a specialist
- Individuals must coordinate and manage their own care

Recipients in a waiver or in the CMO receive case management that includes care coordination



What is a Managed Care Organization?

- A health care organization that:
 - Helps people find a primary care physician
 - Helps people navigate the health care system
 - Maintains a network of health care providers

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MCO's assist recipients with health care needs



Managed Care

- Managed Care Organizations:
 - Provide care coordination
 - Provide patient education
 - Provide preventative care
 - Connect individuals with specialty providers
 - Ensure the right service is provided at the right time

Managing Costs: The current FFS Medicaid program is unsustainable, therefore the State is looking at alternative models to ensure there are no reduction in services.



What Does Medicaid Managed Care Look Like in Nevada Today?

- All Medicaid recipients who live in urban Washoe County (Reno) or Clark County (greater Las Vegas area) who are not determined disabled by the Social Security Administration are mandated
- Medicaid currently contracts with two Managed Care Organizations:
 - Health Plan of Nevada
 - Amerigroup

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The Aged Blind and Disabled, children in state or county custody, and Juvenile Justice populations are currently the only groups that are excluded.

Other categories of individuals have the OPTION of opting out of managed care: American Indians/Alaskan Natives, Children determined to be Severely Emotionally Disturbed, Children with Special Health Care Needs, Adults determined to be seriously mentally ill (EXCEPTION: the Childless Adult Population with the SMI diagnosis are NOT permitted to disenroll from managed care)



What Services Are Currently In Managed Care?

- Managed Care covers most of the services that are in the Medicaid-approved State Plan (not all-inclusive):
 - Physician/Hospital Services
 - Pharmacy
 - Behavioral Health Services
 - Personal Care Services
 - Home Health
 - Therapy Services
- Managed Care Organizations have the flexibility to offer additional services based on need and the plan selected

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11/01/03

Additional **Possible** Services Examples (not all inclusive): Podiatry, freestanding inpatient psychiatric hospitals, asthma camp, Boys and Girls Club memberships



What is Not Currently Provided by Managed Care?

- Hospice
- Adult Day Health Care
- Non-Emergency Transportation
- Targeted Case Management
- Home and Community-Based Waiver Services
- Intermediate Care Facilities for Individuals with Intellectual Disabilities
- Nursing Facility Stays more than 45 days
- Orthodontia
- Residential Treatment Center stays more than 30 days

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Many of these services are covered by FFS regardless of managed care enrollment.



What is the Future of Managed Care?

- These are options that the State may consider:
 - Expanding Managed Care statewide
 - Including additional services that are not currently covered by managed care
 - Expanding the population served by managed care to include aged, blind, or disabled individuals
 - Increasing the number of Managed Care Plans to offer greater choice and flexibility of services

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12/11/15

Current Delivery model has been in place since 2000 is this still appropriate in 2015?

Possibility that no change is needed