



Easy Read Edition

A Self-Advocate's Guide to **Managed Long-Term Services and Supports**

Part 2: Medicaid & Managed
Care

Words to Know in Part 2



fee-for-service

When a state pays a health care provider every time someone on Medicaid gets health care.



health care providers

People or places that give health care. Some types of health care providers are doctors , hospitals, or social workers.



health insurance

A way that people pay for health care. People pay a health insurance company some money every month. Then, the health insurance company pays for people to get health care.



home and community-based services (HCBS)

What it is called when people get LTSS in their community.



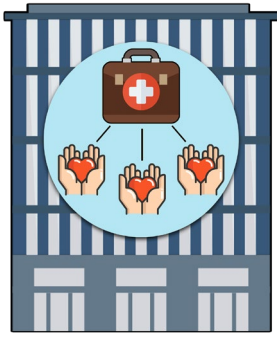
long-term services and supports (LTSS)

Services that help disabled people live our everyday lives. Some kinds of LTSS are job coaches or in-home helpers.



managed care

When a state pays an insurance company to run their Medicaid program. Then, the insurance company pays for the health care for people on Medicaid.



Managed Care Organization (MCO)

Private insurance companies that work with the state to run the state's Medicaid program.



managed long-term services and supports (MLTSS)

When a health insurance company runs a Medicaid LTSS program.



Medicaid

A health care program in the United States. It gives health care to people who can't pay for health insurance.



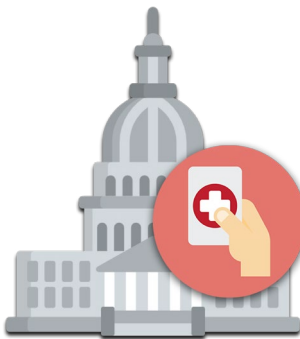
private health insurance

Health insurance run by insurance companies.



Protection and Advocacy agencies (P&A)

Places that help people with disabilities fight for our rights. There is a P&A in every state.



public health insurance

Health insurance run by the government.



quality measures

A way to figure out if something is good or bad. In managed care, they are used to see if a program is doing a good job.



request for proposals (RFP)

When states let private insurance companies know that they want to switch to managed care.

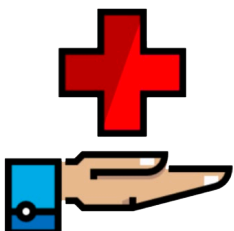


risk

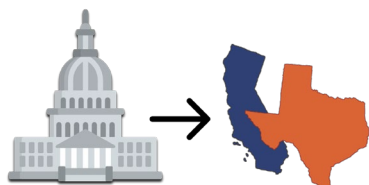
The chance that someone could lose money.

2. Medicaid & Managed Care

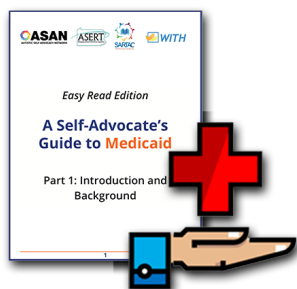
What is Medicaid?



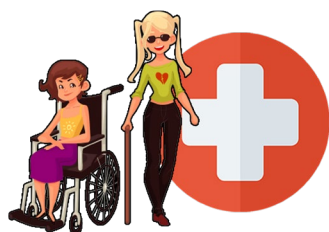
Medicaid is a health care program in the United States.



The government runs Medicaid. Every state has its own Medicaid program.



You can learn more about Medicaid in our [Medicaid Toolkit](#).



Many people with disabilities get help from Medicaid.



Medicaid helps people get health care.
It helps people who can't pay for health
insurance.

What is health insurance?



Medicaid is a kind of **health insurance**.



Health insurance helps people pay for health care.



People can buy health insurance. Or, they can get it from their job.



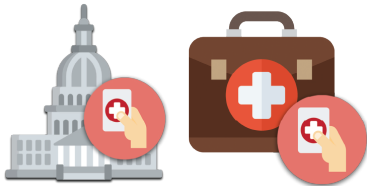
People pay a health insurance company some money every month.



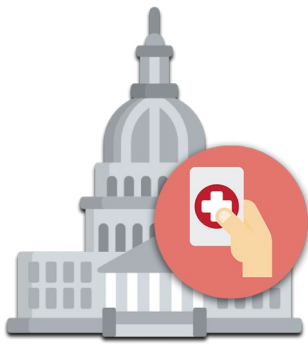
Then, the health insurance company pays for people to get health care.



There are 2 kinds of health insurance.



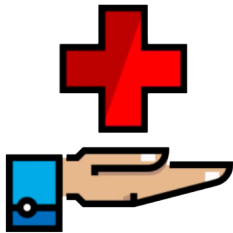
They are public health insurance and private health insurance.



Public health insurance is run by the government.



Private health insurance is run by insurance companies.

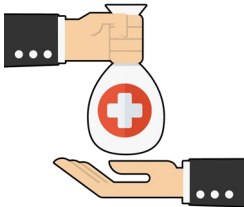


Medicaid is one kind of public health insurance.

How does Medicaid pay for health care?



Medicaid programs work with **health care providers**.



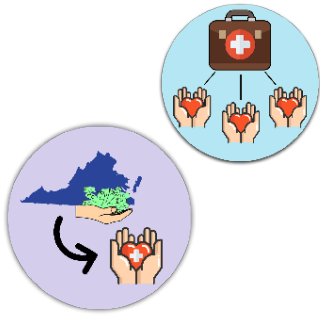
Health care providers are people or places that give health care.



Some types of health care providers are doctors, hospitals, or social workers.

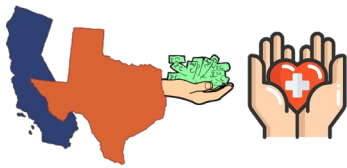


There are 2 different ways that states can pay health care providers.



These ways are called fee-for-service and managed care.

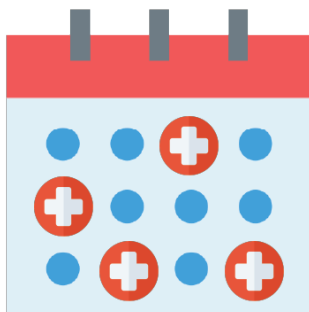
Way 1: Fee For Service



When someone on Medicaid needs healthcare, the state pays the health care provider.



It doesn't matter how much health care someone needs.



It doesn't matter how many times someone needs health care.

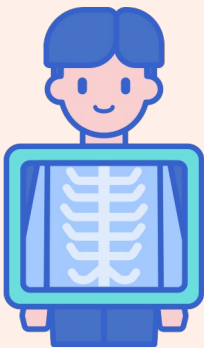


The state has to pay the health care provider every time.



This is called **fee-for-service**.

For example:



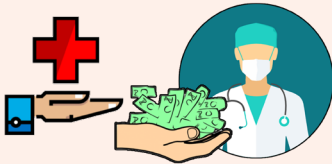
Tom gets Medicaid. He needs an x-ray.



Tom's State Medicaid program pays the doctor that does the x-ray.



Tom finds out from the x-ray that he needs surgery.



Tom's state Medicaid program pays the surgeon to do Tom's surgery.

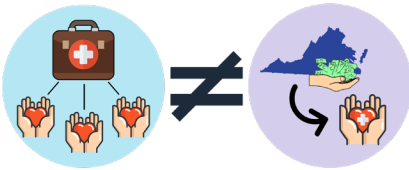


All the health care Tom needs gets paid for by the state.

Way 2: Managed Care



The other way states can pay for Medicaid is called **managed care**.



Managed care is much different than fee-for-service.



The state doesn't pay health care providers.

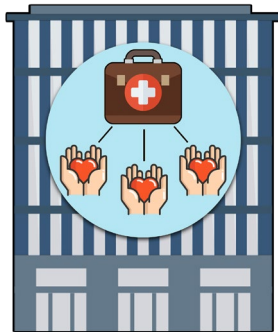


The state pays an insurance company instead.

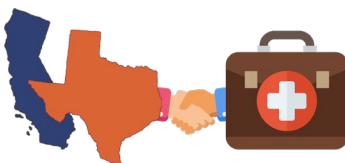


Then, the insurance company pays health care providers.

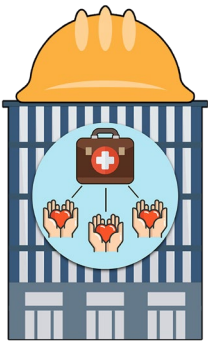
It works like this.



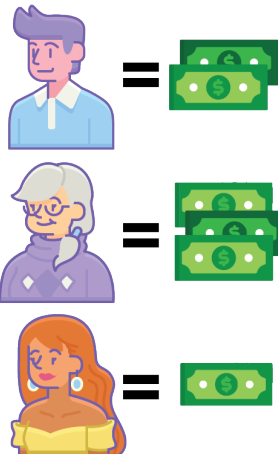
Each state's Medicaid program works with a **Managed Care Organization (MCO)**.



MCOs are insurance companies. They work with the state to run the state's Medicaid program.



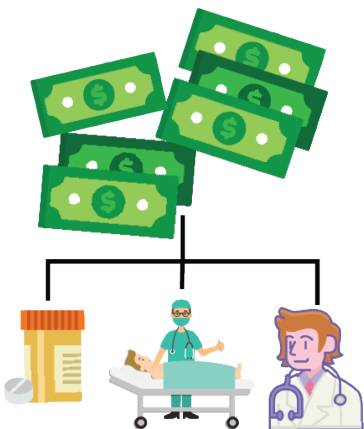
The state is still in charge of the Medicaid program. But the MCO does the work.



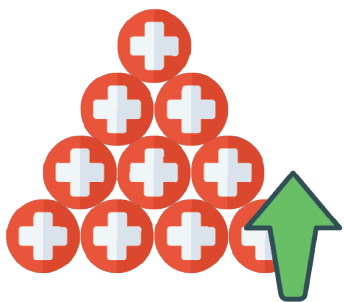
The state gives the MCO money for each person on Medicaid.



The MCO puts all the money together.



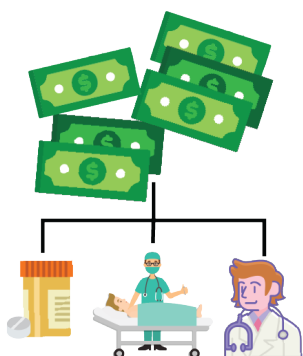
Then, the MCO uses that money to pay for health care.



Some people will need more health care.



Some people will need less.

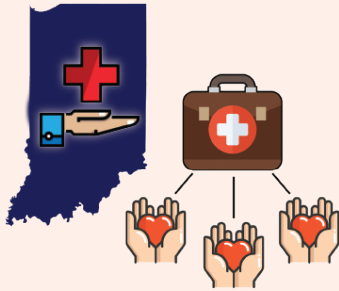


The MCO uses all of the money put together to pay for what everyone needs.



Then, the MCO pays health care providers using this money.

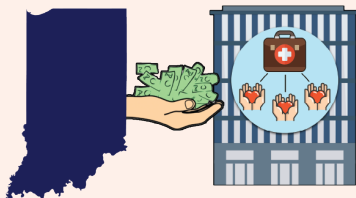
For example:



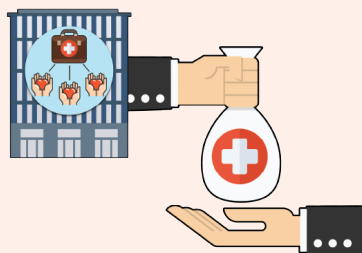
Beth gets Medicaid. Her state's Medicaid program has managed care.



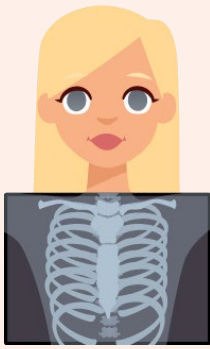
Beth's state works with an MCO called HealthCorp.



The state pays HealthCorp some money for Beth to get health care.



Because Beth gets Medicaid, she gets health care from HealthCorp.



Beth needs to get an x-ray.



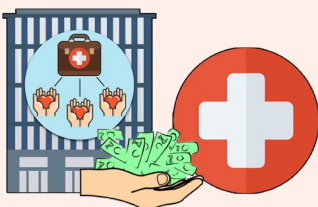
HealthCorp pays the doctor that does the x-ray.



Beth finds out from the x-ray that she needs surgery.



HealthCorp pays the surgeon to do Beth's surgery.



All the health care Beth needs gets paid for by HealthCorp.

What is Risk?



Risk is an important idea in health care.



Sometimes, we think we know how much something will cost.



But we aren't always right.



We might have to pay more than we wanted to. We might end up losing money.



The chance of losing money is called **risk**.



Whoever could lose money is taking the risk.

For example:



Lamar needs to go to the doctor.



Lamar doesn't know how much the doctor will cost.



Lamar thinks the doctor will cost \$50.



The risk is that the doctor might cost more money.



Even if the doctor costs more money, Lamar still has to pay.



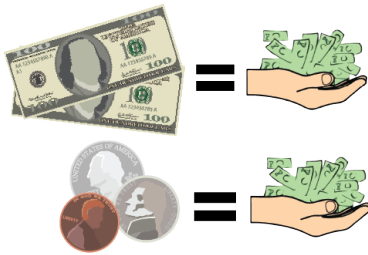
Lamar takes the risk.



With fee-for-service, the state takes the risk.



The state has to pay for the health care for people on Medicaid.



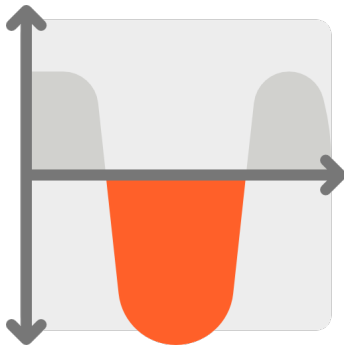
They have to pay no matter how much it costs.



It might cost more than they thought it would.



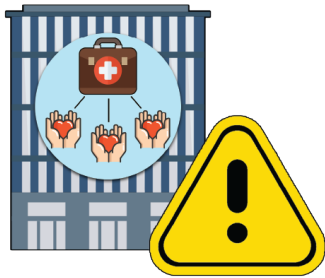
The state will have to cover the extra costs.



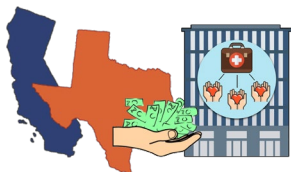
The state might go into debt.



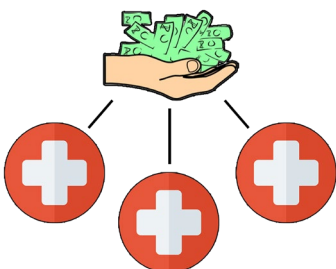
Or, it might have to spend less money on something else.



With managed care, the MCO takes the risk.



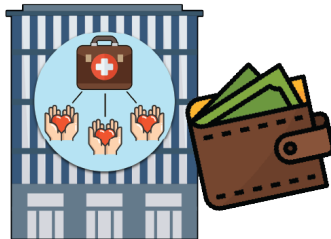
The state gives MCOs a set amount of money.



That money needs to pay for all the health care for everyone on Medicaid.



If health care ends up costing more, the MCO won't get more money from the state.



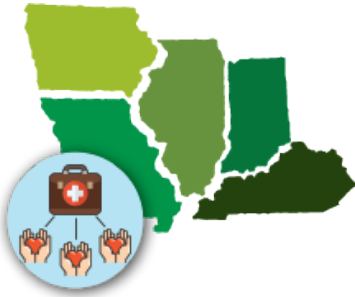
The MCO will have to use its own money.



But sometimes, the health care costs less than the amount of money the MCO gets.



Then, the MCO gets to keep some of the extra money.



This is why some states use managed care.



States like managed care because they don't have to risk losing money.



MCOs like managed care because they get the chance to make money.

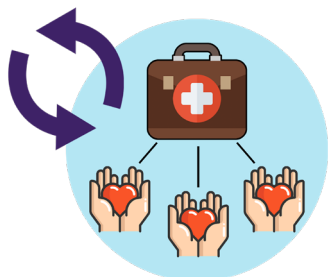
| | Fee-for-service | Managed care |
|--|--|--|
| Who is in charge of the Medicaid program? | Each state | Each state |
| Who runs the Medicaid program? | Each state | The MCO |
| How much money does the state pay? | As much as health care costs for people on Medicaid. | A set amount of money per person on Medicaid. |
| What happens if all of the money gets spent? | There is no limit on the amount of money. The state has to keep paying no matter what. | If the MCO uses it all, they don't get any more money. They have to pay for it themselves. |
| Who takes the risk? | The state | The MCO |

Switching to Managed Care

Why are states switching to managed care?



Right now, many states use fee-for-service.

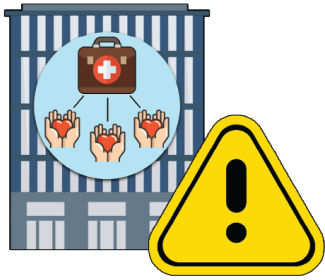


But, a lot of states want to switch to managed care.

Here's why:



- States pay a set amount of money to MCOs. This costs less money than fee-for-service.

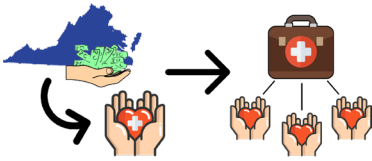


- The risk of paying for extra costs would be on MCOs, not the state.



- Some states are already using managed care. Other states want to try.

How can states switch to managed care?



States can switch their Medicaid programs from fee-for-service to managed care.

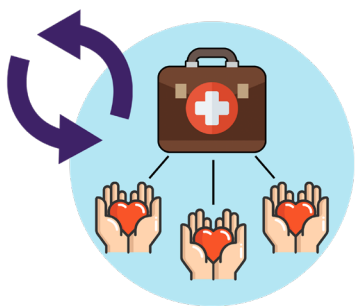


This takes a long time!

Here are the steps a state needs to take to do this:



First, a state needs to put out a **request for proposals (RFP)**.



An RFP lets insurance companies know that a state wants to switch to managed care.



The insurance companies have to write a proposal.



The proposal talks about how the insurance company will run the program.



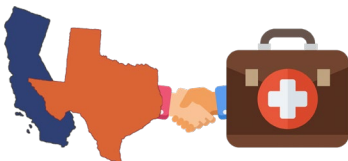
They try to show the state why they are the best choice to run the program.



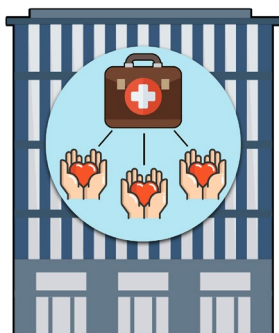
Then, the state chooses the insurance company to run their managed care program.



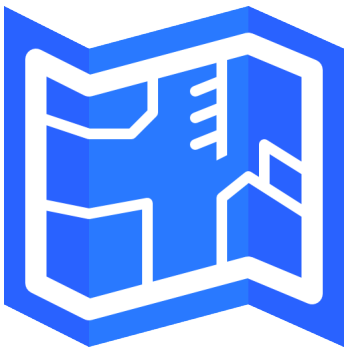
It can choose a few different companies.



The state and the insurance company agree to work together.



The insurance company becomes one of the state's MCO.



After that, the state and the MCO make a plan.



They work together to figure out the details about the managed care program.

They need to figure out:



- What managed care will pay for



- How much money the state will pay the MCO



- How extra money gets spent if the MCO doesn't use it all

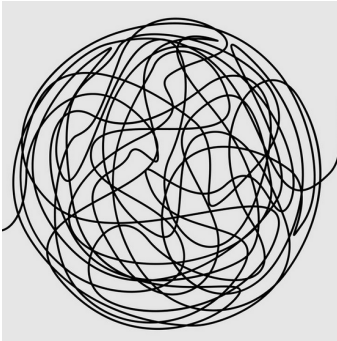


- How to find out if the MCO is doing a good job

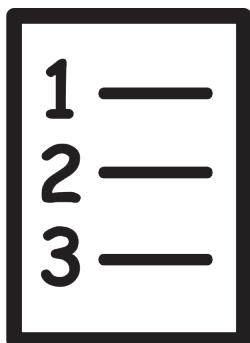
What will managed care pay for?



The state and the MCO need to decide what managed care will pay for.



It is too hard to switch every part of Medicaid to managed care all at once.



So the switch to managed care usually happens in steps.

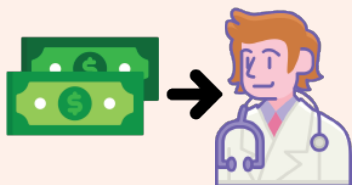


A managed care program might only pay for certain health care.

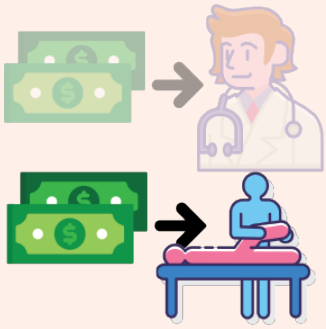


Then, they add more kinds of health care as time goes on.

For example:



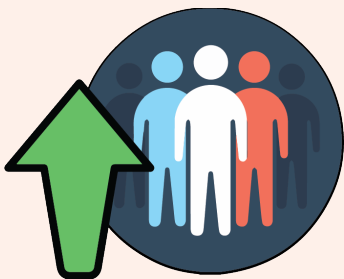
A managed care program may start by only paying for doctor visits.



Then, they could start paying for therapy.



A managed care program might only pay for certain groups of people.



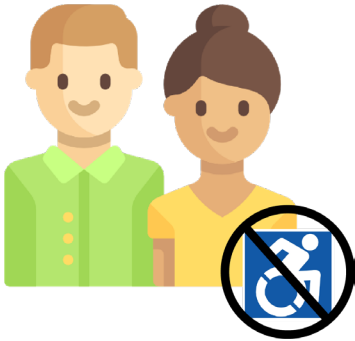
Then, they add more people as time goes on.



This doesn't mean there are people not getting health care paid for!



The rest of the people on Medicaid still get their health care paid for with fee-for-service.



Managed care usually starts with people without disabilities.



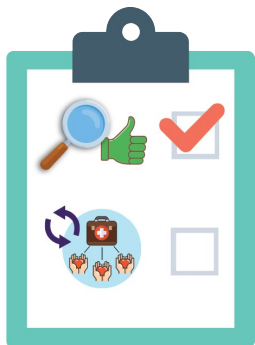
This gives the MCO time to test out managed care.



Then, managed care starts paying for people with disabilities.

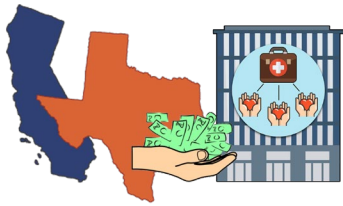


People with disabilities usually need more health care.

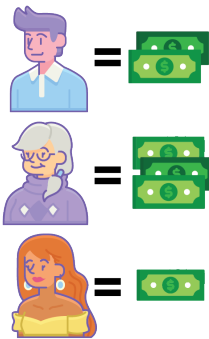


It is good to make sure managed care works before we make the switch.

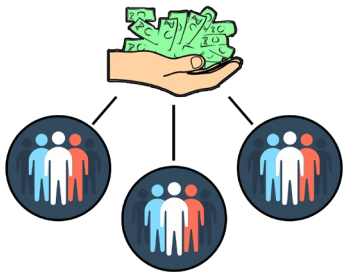
How much money will the state pay the MCO?



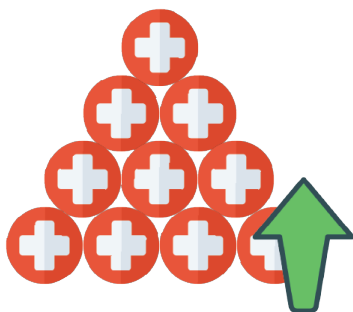
The state and the MCO decide how much money the state will pay the MCO.



They work out how much money the MCO will get per person on Medicaid.



Managed care programs need enough money to pay for everyone.



People with disabilities usually need more health care.



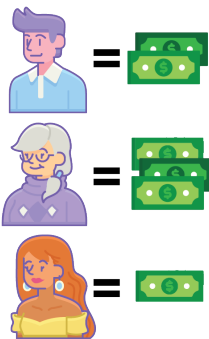
Our health care sometimes costs more money.



Other people need less health care.



Their health care costs less money.

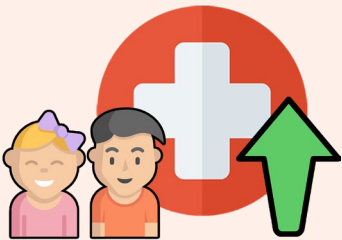


But managed care programs get a set amount of money for each person.

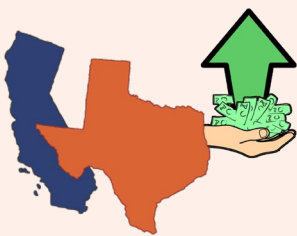


States and MCOs have to figure out the right amount of money for each person.

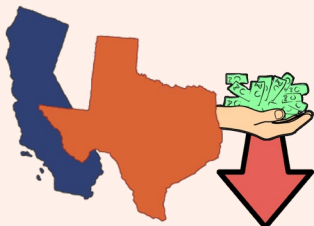
For example:



Kids usually need more health care than adults.



So, a state might decide to pay the MCO \$200 for every kid.

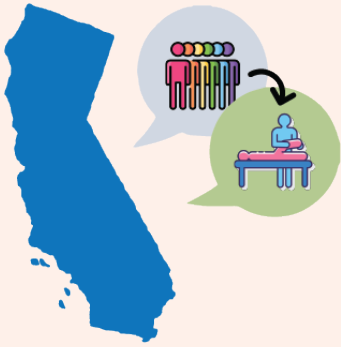


But, the state will only pay the MCO \$100 for every adult.



They also decide how much money the MCO will get for each kind of health care.

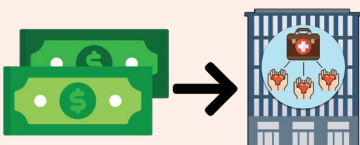
For example:



A state has 200 people on Medicaid who need therapy.



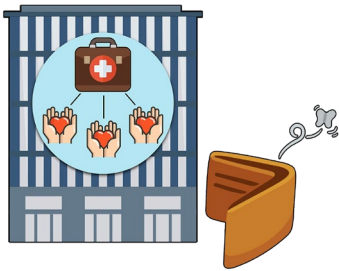
The state decides to give their MCO \$1,000 for each person who needs therapy.



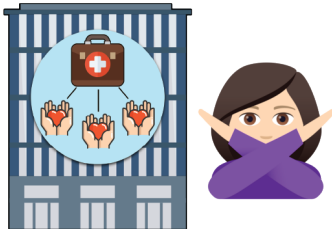
The MCO gets \$200,000 to use for people to get therapy.



Setting the right amount of money is very important!



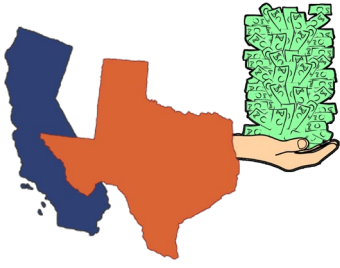
It is bad if the state sets the amount of money too low.



Then, MCOs won't want to run the managed care program.



There won't be enough money for health care.



It is also bad if the state sets the amount of money too high.



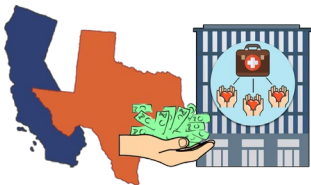
Then, it will cost the state too much money to keep the program going.

How will extra money get spent if the MCO doesn't use it all?



The state decides how to use the extra money if an MCO doesn't spend it all.

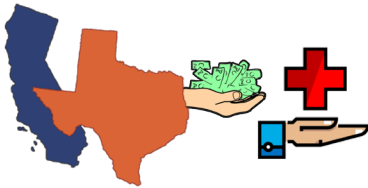
Here are some of the ways they can choose:



States can decide to give the MCO the extra money.



States can decide to give the MCO all the extra money. Or, they can give the MCO only some of the extra money.

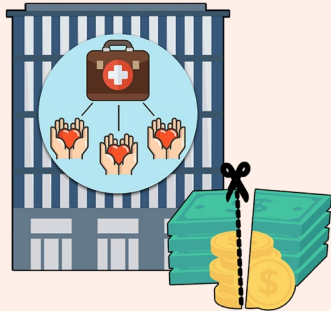


States can also decide to use the extra money to pay for other parts of Medicaid.

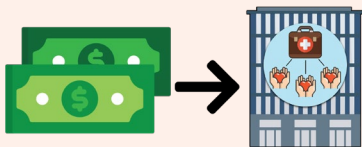
For example:



A state's managed care program has \$500,000 left at the end of the year.



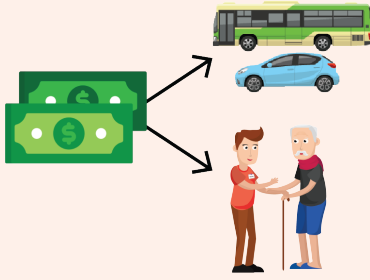
The state decided their MCO would get half of the extra money.



So their MCO gets \$250,000.

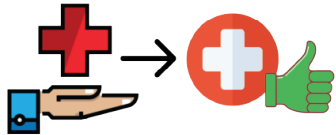


The state decided the other half of the money would go to helping people get services.

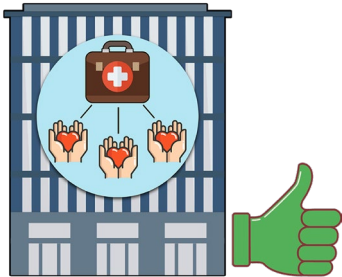


So the other \$250,000 goes to giving people services.

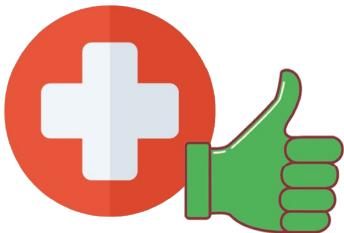
How can states know that the MCO is doing a good job?



States want to make sure people get good health care from Medicaid.



They want to make sure the MCO does a good job running Medicaid.



Health care can be good.



For example, it is good when doctors listen to their patients.



Health care can be bad.



For example, it is bad when doctors ignore their patients.



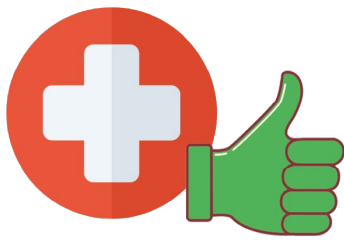
States find out whether health care is good or bad by asking questions.



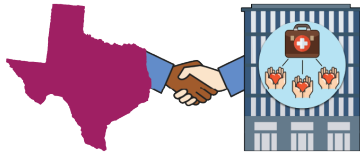
The state calls these questions quality measures.



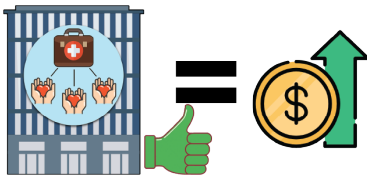
In managed care, they get used to see if the MCO is doing a good job.



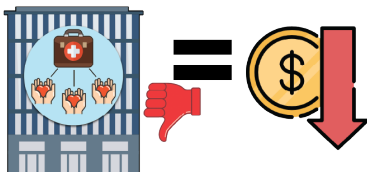
Managed care programs need to take good care of people who use Medicaid.



When states make a managed care program, they make a deal with an MCO.



The MCO will get more money if the MCO does a good job.



The state will give the MCO less money if the MCO does a bad job.



That makes sure MCOs can't take the state's money but not give good care.

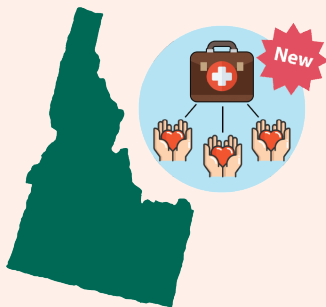


That's why asking the right questions is very important.

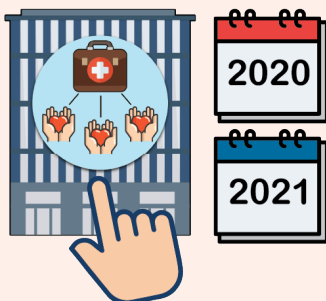


States need to know if the MCO is doing a good job or a bad job.

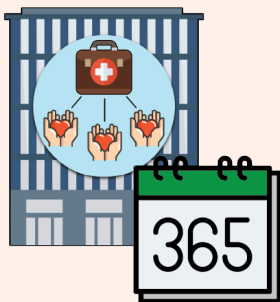
For example:



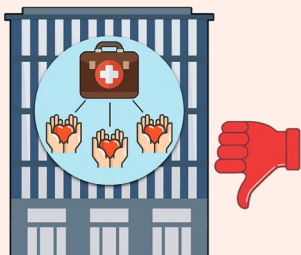
A state starts a new managed care program.



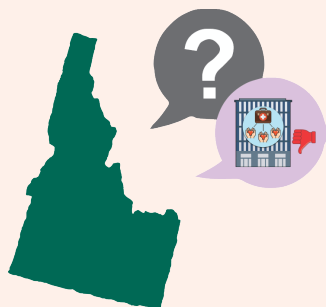
They choose an MCO to run the program for 2 years.



The MCO runs the managed care program for a year.



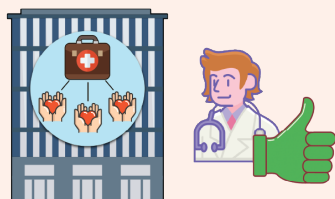
They do a bad job running the program.



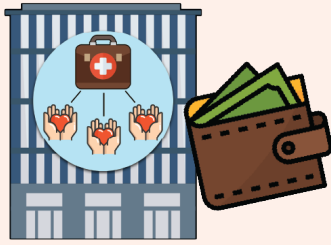
The state asks questions. They find out the MCO did a bad job.



The state pays the MCO less money for next year.



The MCO still needs to give everyone good health care.



They have to use their own money.



States plan out what questions they will ask MCOs.

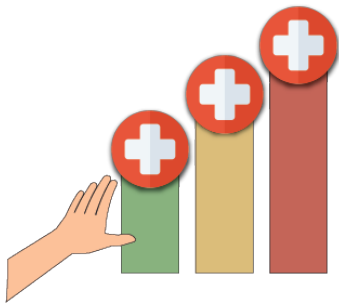


States need to think about different kinds of questions to ask.

For example:



How does each person on Medicaid feel about their health care?



How easy it is for people to get health care on Medicaid? Are certain kinds of health care harder to get than others?



How well do different health care providers work with each other?



How healthy is each person on Medicaid?