

Olivia Puckett

Report on Medicaid Managed Care Conference

November 05, 2012

Location: Sheraton Four Points Washington D.C
Global Media Dynamic: Medicaid Managed Care Conference

Abstract

The goal of the conference is to realize the impact of the Affordable Care Act will have on states. Presenters discussed the impact of the Supreme Court Decision and the Affordable Care Act.

Key Questions

1. How will state and Medicaid health plans need to adapt to the new Medicaid Population?
2. How will proposed delivery system models affect Medicaid Health Plans?
3. Where are the biggest opportunities?
4. How will the election impact health reform?

Presentations by Order:

Rhode Island: Waivers

Nebraska: Managed Care and Medicaid Population- Dept. of Health and Human Services

Washington State Health Care Authority- Network Development Strategies- Expanding Medicaid Managed Care Eligibility Enrollment

Utah: Examining Medicaid Expansion Implications for Consumers, Exchanges and Goals of the Affordable Care Act

Texas: Do Medicaid Cost Containment Initiatives Work- A Texas Lesson - Key Concepts: Innovative Cost Containment Strategies, Budget Balancing, Hospital Payment Reform, OB Birth Outcomes as Cost Containment, 1115 Waiver for Hospital Reform and Quality.

New York: Using 3M Clinical Risk Group for Medicaid Managed Care Risk Adjustment: A Perspective from New York State

Accountable Care Organization Features and Medicaid Managed Care- PWC Price Waterhouse Cooper, Gary Jacobs

Health Insurance Exchange: Long on Options, Short on Time-PWC

Dual Eligible Integration Bids: An Insiders' View on Recent Responses and Upcoming RFP'S – HEOPS

Aetna Medicaid: Long Term Care for Dual Eligible Populations

Methodologies for Building a Medicaid Provider Network- Cook Children's Health Plan

Connecting the Coverage Dots for Low-Income Health Care Consumers – Association for Affiliated Plans

UPMC for You: Implementing a Medical Home Model for Medicaid Managed Care Setting

Power Point Presentations Included in Packet

The Medicaid managed Care Landscape after the Supreme Court Decision and Medicaid Expansion- Medicaid Health Plans of American

How Affordable Care Act 2.0 and the Supreme Court Decision Impact the Medicaid Managed Care Landscape- AmeriHealth Mercy

Preparing your Health Plan to Serve Medicare/ Medicaid Members- Neighborhood Health Plan of Rhode Island

Managing Medicaid Expansion with Partnership to States- United Health Care

Well Care Health Plans: Medicaid Role within Health Insurance Exchanges & Health Plan's Role within States that Elect out of Medicaid Expansion.

Integrating Medicaid managed Care with Community Based Practice- new Delivery Models for Urban Accountable Care- Integrated Physician Network

Is Case Management Meaningful?

Topics Covered:

State Government Perspective

Affordable Care Act Implementations

Budget Implementations for States- Cost Containment

Managed Care Organizations

Consulting Firms

Health Care Firms

Insurance Companies

Affordable Care Act and Supreme Court Decision

Dual Eligibles

Low Income Adults

Patient Centered Medical Homes

Network Development

Waivers

Risk Adjustments

Private Insurers Perspective

Rhode Island: Waivers

- Steve Costantino- Executive Director of Office of Health and Human Services
- **1115 Global Waiver Proposed in August 2008 and approved in January 2009**
- Program flexibility, program design, administrative processes
- Better access to Community Based Care
- Enrollment in Coordinated and Managed Care Delivery Systems
- Streamlined Review and Approval Processes
- **Recent Waivers Approved: Begin Medicaid Expansion Sooner, Simplify Enrollment and Renewal Processes managed care for Special Needs Populations, Support of Safety Net Systems**
- Recent Waivers Denied: Eligibility Restriction, Enrollment restrictions, increased premiums
- Blue State
- **Flexibility is a partnership and must be accompanied by accountability, transparency and program improvement.**

Nebraska: Managed Care and Medicaid Population

- Vivienne M. Chaumont, Director of Nebraska Department of Health and Human Services
Division of Medicaid & Long-Term Care
- **Nebraska Population- 1.7 Million**
- **Medicaid Population- 237,534**
 - 152,032 Children enrolled Medicaid and CHIP
 - CHIP is a Medicaid Expansion in Nebraska
 - Stand-alone CHIP program for unborn children of pregnant women not eligible for Medicaid implemented on July 19, 2012 pursuant to Legislative Mandate
 - Managed Care Population- 185,000
- **Exclusions:** Populations not included, Dual Eligibles, Long-Term Care Clients (nursing facility and Home and Community Based Services), and Transplants. Services not included: Dental, Pharmacy, Long-term Care, Non-Emergency Transportation, Behavioral Health
- State Wide Managed Care- Physical Health
- Behavioral Health Managed Care: State-wide ASO, fall 2012 RFP Statewide at-Risk Single Contractor. Fall 2013 Implementation of at risk managed care for behavioral Health.
- **Medicaid Expansion: Nebraska does not currently cover adults unless they are caretaker relatives under AFDC, Aged, and Disabled.**
- Supreme Court Ruled that states can choose whether or not to implement Affordable Care Act expansion.
- **Governor has stated that he will not support expansion of the Medicaid Program.**
- Gave examples of a scenario by Millman- 64,000 New Medicaid/CHIP Clients in January 2014. 113 Million Increase to aid, 4.3 Million in administration, 7.6 Million in Health Insurer Fees, 18.3 Million in Primary Care Fee Increase.
- Managed Care Enrollment will increase
- Legislature will consider expansion next session.
- Long Term Care Population not currently covered by managed care program.
- Approximately 53,000 Medicaid Clients are aged or Disabled
- Most Expensive- Least Managed Clients
- Move to at risk managed care in July 2014
- Develop programs for Dual Eligibles

Washington State Health Care Authority- Network Development Strategies- Expanding Medicaid Managed Care Eligibility Enrollment

- Presentation by : Preston W. Cody- Assistant Director Health Care Services
- Primary Health purchasing Agency- Serves **1.6 Million clients, state employees, and retirees.**
- **Managed Care Expansion-** July 2012 Agency consolidated Managed Care Program, Health Options (HO), with the State's Basic Health Plan to: Improve Care, Reduce Costs by Expanding managed care, expand service delivery options, and implement payment reform and quality reform.
- **Managed Care Eligibility-**
 - Basic Health eligibility does not change- 34,000 Members.
 - Healthy Options will continue to include- TANF families and children up to age 19
 - Pregnant Women(Eligible for Medicaid)
 - Children Health Insurance Program (CHIP)
 - 684,402 enrollees as of June 2012.
 - New Population added
 - 120,000 Categorically needy blind/disabled non-Medicare
 - Optional enrollment for foster care children.
 - **NEW POPULATION:** Medicaid Only, Blind/Disabled Clients Enroll” Exceptions: Living in Institutional Settings, Enrolled in Chronic Care Management Programs
 - **State Success:** Prepare for Medicaid Expansion, expect improved health outcomes for highest risk, highest cost enrollees, Potential Cost savings through transition from Fee for Service to Managed Care, greater oversight and strengthen program integrity for public funded programs.
 - **State Challenges:** Geography and provider limitations, limited provider participation, rural areas, provider reimbursement, Available of Primary Care Physicians- about 20 PCP care from some patients covered by Medicaid. Close to 80% accept new patients
 - **Lessons learned:** Focus on how changes will benefit enrollees first, continuously monitor provider networks, more resources needed to devoted stakeholder management including enrollees’ taxpayers, and political advocate and provider communities.
 - Large systems with multiple components and varied parties affected can be successfully changed through consistent communication, leadership and transparency.

Utah: Examining Medicaid Expansion Implications for Consumers, Exchanges and Goals of the Affordable Care Act

- Presented by Norman Thurston, Ph.D.
- **What are States thinking about?: Technology Issues-** Medicaid System, Exchange Platform, Insurance Regulation- **Insurance Market Stability**, Strategy for Risk, Planning for Disruption- **Public Programs-** Children's Expansion, Maintenance of Efforts, Simplified MAGI Eligibility, Adult Expansion is just one of Many Worries.
- **Insurance Market Issues:** Guaranteed Issue with No Pre-Existing Conditions Modified Community Rating, Potential Impacts- Individual Market Rates, Carrier Viability, Risk Management.
- **Adult Expansion:** State Budget, New Federal Programs, and The new "Gap" Population.
- **Net Effect on State Programs:** Move from Uninsured to public Programs, Increased Case Loads, Increased Medical Costs- Expanded Children's Programs, Woodwork Effect, and Upward Pressure on Private Markets.
- **What about Exchanges:** User Interface or Portal, Individual Shopping, Small Business, Insurance Plan Management, Medicaid Eligibility, APTC Calculation, Tax Administration, Consumer Information.
- **UTAH's Experience:** Health Care System Reform: Philosophy of Utah's Approach to health reform is the invisible hand of the marketplace, rather than the heavy handoff the government is the most effective means whereby reform may take place.
- **Market Based Approach:** A farmer's market approach- Consumers- enhanced choice, Health Plans- Access to consumers, Public Programs- Supporting Role. Facilitate Market-Based Outcomes. Everyone Enrolled in "Best" Program.
- **Defined Contribution Concept:** Consolidate all available resources. Consumers get enhanced control and choice. Applicable to both employment and public program settings.
- **Challenges:** Accurate Data: Impact on Budgets, People and Economy. Uncertain Future: November Election, Legal Issues, Unanswered Questions.
- **Now What?** Exchange Decisions, Insurance Market Decisions, and Medicaid Decisions- Whose priorities, can we be flexible?

Texas: Do Medicaid Cost Containment Initiatives Work- A Texas Lesson

Key Concepts: Innovative Cost Containment Strategies, Budget Balancing, Hospital Payment Reform, OB Birth Outcomes as Cost Containment, 1115 Waiver for Hospital Reform and Quality.

- 2010-2011 Budget- State Leadership Approved 1.25 Billion in General Revenue
- 183 Million Is state Funds Cut from health and Human Services budget.
- Medicaid Trends Spending- Growth. Affordable Care Act 133% FPL = 2 million more to Medicaid rolls. State Budget 10% after 2020.
- Texas Medicaid Expenditures FFY 2011 by Service type: 28 Billion.
- **Medicaid Beneficiaries and Expenditures:** 65 and Older/Disabled= 30% caseload, 60% cost.
- **Factors Driving the Medicaid Shortfall:** Missed Projections in Medicaid Case Loads Service Utilizations in 2010-2011.
- **How did they Balance?** Substantial 4.8 Billion Under-Funding Of Medicaid- Spending Reductions- Medicaid Managed Care Expansion State Wide, Cost-Containment Initiatives. Gray Area- Cost-Containment for federal flexibility.
- **Cost Containment: Rider 61 to achieve 450 M GR Fund** through:
 - Payment Reform and Quality Based Payments, Increasing neonatal intensive care management, More appropriate ER Rates for non-emergent care- Cut 40% in reimbursement., maximizing co-pays in Medicaid, Improving birth outcomes by reducing birth trauma and elective inductions- resulting in OB Modifier Requirement for all Medicaid births, increasing fraud, waste, and abuse detection.
 - Rider 59 to **Save 700M GR Funds** pursuing a waiver to allow Medicaid Flexibility
 - Greater Flexibility in standards and levels of eligibility
 - Better designed benefit packages to meet demographic needs of Texas.
 - Use of Co-Pays
 - Consolidation of funding streams for transparency and accountability
 - Assumed responsibility by the feds of 100% of the health care costs of unauthorized immigrants.
- **Budget – Physician Impact-** Physicians rate cut cumulative 2%. Medicare Equalization-Cuts. Loan Repayment and work force funds slash.
- **Budget- Hospital Impact- Expansion of Medicaid Managed Care-** Savings. 8% Rate Cut for Hospitals, Statewide hospital SDA Implementation, **Medicaid Cost Savings implemented-** Emergent Care, OB, NICU. **Medicare Equalization-**Cuts, Non-emergent Services in ER.
- **Discussion on Texas Managed Care System** and Expansion. Similar to Husky in terms of Delivery Models.
- **Managed Care Status:** March 1, 2012 Implementation. 3 Million People covered in capitated managed care. Major expansion in rural areas. Admin of Medicaid and CHIP prescription drug benefit, risk-based dental care model to 2.5 Million children, coverage of in-[patient hospital services.
- **Other Cost Containment Initiatives:** Electronic visit verification, maximizing co-pays, independent assessments-private duty nursing, amount, duration and scope, medical transportation, early child intervention cost containment strategies, immunizations, Orthodontic enforcement, detection and claims for fraud, waste and abuse.

- **Hospital Payment Reform:** Pay for Quality- Adjusts payments by linking quality to payments, Hospital acquired conditions, potentially preventable events (readmissions, complications, admissions).
- **Texas 1115 Waiver:** HealthCare Transformation and Quality Improvement Program. Promotes Critical Systemic Design, Managed Care Expansion state-wide, Mandate Pharmacy and Dental Carve in, Hospital Financing component- new funding methodology-creates healthcare partnerships.
 - **Uncompensated Care Pool (UC)**
 - **Delivery System Reform Incentive Payments(DSRIP)**
 - **Broad Local engagement.**

New York: Using 3M Clinical Risk Group for Medicaid Managed Care Risk Adjustment: A Perspective from New York State

Key Concepts:

- **New York's Medicaid Program:** New York's Medicaid Program spends appx. 53 Billion in Federal, State, and Local Government funding to provide health care on an annual basis to more than 5 million beneficiaries. 13 Billion In capitation spending CT 2011.
- **Medicaid Snap Shot:** Beneficiaries with 3 or more chronic conditions represent 19% of enrollment and 49 % of overall spending. 65.7% Chronic Physical Only. 24.6% MH/Sa and Chronic Physician, 9.7% Chronic MH. SA Only.

3 Health Status	% of Total Enrollment	% of Total Medicaid Spending	Avg PMPM (\$)
Healthy / Minor	62.0	21.9	297
Single Chronic	16.6	17.9	909
Pairs Chronic	16.8	38.8	1,948
Triples Chronic	2.2	9.7	3,770
Malignancies	0.6	2.1	2,906
Catastrophic Condition	0.8	5.5	5,882
HIV / AIDS	1.1	4.2	3,067
Total	100.0%	100.0%	\$ 841

Approximately 72 percent of Medicaid program beneficiaries are enrolled in managed care:

▫98 percent are in full risk Medicaid Managed Care (MMC) health plans;

▫1 percent are enrolled in Managed Long Term Care (MLTC);

▫1 percent are enrolled in Partial Capitation health plans.

Accountable Care Organization Features and Medicaid Managed Care

- PWC Price Waterhouse Cooper, Gary Jacobs
- **The State of Medicaid Managed Care**
 - The Cost of Medicaid is projected to double over the next 10 Years.
 - Affordable Care Act Provisions will add nearly 26 M lives and 619 B in costs over the 10 Year timeframe.
 - Average Medicaid enrollment in 2010 was 54 M. 68 M were enrolled for at least one month.
 - By 2020 averaged enrollment is expected to increase to 86 M.
 - 2010 Medicaid outlays reached \$404B and are expected to increase by nearly 5% per year thru 2020. In 2010 the Federal Government paid 68% of Medicaid Costs.
 - Today Dual Eligibles represent \$320 B expenditure. Duals projected to increase from 9 M to 18M lives over the next 20 Years.
 - Faced with Budgetary Challenged, States have increasingly relied on forms of managed care to organized and deliver Medicaid services. – Except Alaska, New Hampshire, and Wyoming in MMC in YE 2010.
 - Two Service models: Capitated and Enhanced Fee for Service.
 - In 1990s PCCM programs began incorporating a variety of enhancements. Including elements of Enhanced PCCMH, Accountable Care Organization, and PCMH. State Examples.
 - Today at least 41 States have moved beyond the EP CCM to medical homes for Medicaid and CHIP. Provider Performance, Care Coordination and Improving Performance.
 - Mature State PCMH has demonstrated improved cost and Quality Outcomes.
 - Utilization- Vermont Medicaid pilots saw a 21% and 19% decrease in ED Visits. North Carolina ADB Hospital admissions decreased 2% while admissions for un-enrolled ABD population increased 31%.
 - Quality: Vermont: Blueprint improved lung-function assessment for asthma and self-management for diabetes. North Caroline in top 10% on national quality measures for diabetes, asthma, heart disease. Oklahoma has improved HEDIS Quality Measures including diabetes screening, breast cancer screening. Access Complaints decreased from 1670 in 2007 to 13 in 2009.
 - Costs- North Carolina saved nearly 1.5 B between Years 2007-2009. Colorado has a 21.5 % reduction in median costs for children n a medical home compared to nonmedical home participants. Vermont saw 12% decrease in PMPM costs for commercially insurers from 2008-2009.
 - To further promote PCMH Development, Affordable Care Act established a state plan option for Medicaid Health Homes for beneficiaries with chronic conditions. 20 States have indicated their interest. CMS has approved 6 States so far, MO, RI, NY, OR, NC, IO.
 - Builds on Patient Centered Medical Home Model.
 - Health Homes must develop a care plan for each person that coordinates and integrates all clinical and non-clinical services and have a continuous QIP.
 - CMS Dual Demonstrations provide another opportunity to expanded managed care features in a market historically dominated by FFS.
 - Of 26 States that submitted proposal to participate in the financial alignment demo, 14 Proposed 2013 Star Dates, 7 proposed capitated demos to cover 1.4 M lives.

- CT, CO, IA, MO, NC and Ok are proposing FFS models. Kaiser Family Foundation Source.
 - Mass. is the first state to have an MOU with CMS for the dual financial alignment demo.
 - Duals Demos have increased interest in operated LTCSS programs.
 - LTCSS account for 70% of state Medicaid spending on duals.
 - Dual Eligibles account for 2/3 of LTC Utilization.
 -
- State Accountable Care Organization Development Initiatives
- ACOS and the Evolving Government Programs Market
- Accountable Care Organizations are the next logical step in evolution of Medicaid Managed Care-
- Enhanced PCCM > Medical Homes > ACOs > MCOs
- State Accountable Care Organization Programs build upon their medical homes and often incorporate MCOs in a major way thus minimizing distinctions between PCMHs, MCOs, and ACOs.
- From **PCMH to ACOs- North Carolina** has passed legislation to facilitate the development of its PCMH initiative into ACOs by creating new measures for Quality, utilization and access, developing performance incentive models and shared savings models.
- MCOs and ACOs- In some states, MCOs will coordinate with ACOs in other states, the MCO is the Accountable Care Organization, Utah plans to return to risk based contracting with health plans acting as ACOs. Oregon will participate and gradually transition to new requirements.
- States are creating their own definitions of ACOs based upon historic experience with MMC. As a result, a variety of Medicaid Accountable Care Organization payment Models and organizational structures are emerging.
- CO- PMPM payment to Accountable Care Organization and PCP.
- MN Shared Savings with Upside Risk only with downside risk.
- NJ- Shared Savings with Upside Risk
- OR- Global Payment
- Utah- Global Payment.
- Why move to ACOs in a market where 2/3 of enrollees are already in some form of managed care?
 - States see ACOs as an opportunity for further coordination improved outcomes and greater efficiency and value
- **A new study concludes that Accountable Care Organization features can produce cost savings for the most costly populations.**
 - The Physicians Group Practice Demonstration, a precursor to the ACO, Shows significant impact in costs for duals.
 - Study showed in Journal of American medicine Sept 12 shows initiatives developed by participating physicians groups generated:
 - **\$114 annual in average savings overall**
 - **\$532 annual in average savings for dual Eligibles.**
- **The Rules of engagement for the Medicaid Market and other government programs are evolving and Accountable Care Organization Features will be integral to success in all markets.**
- **Common Elements of the New Delivery Model**
 - **Medicare Medicaid Duals and Exchanges**

- **Managed Care-** Population management, disease management, case management, PCMH, Patient Centered Care, provider Accountability for outcomes
- **Payment Reforms-** Shared Savings, Pay for Performance, Risk Assumption
- **Quality and Performance Monitoring and Reporting-** HEDIS, CAHPS, Stars. Financial and Quality Management Systems, HIT Systems, Data and Analytics.
- **Consumer Protections-** Public disclosure of cost and quality data, compliance.
- **Success in Medicaid Managed Care (and other Government Programs) necessitates embracing Accountable Care Organization Core Competencies and targeted market strategies.**
 - 7 Pillars of Success
 - Market Strategies- Market Selection, Benefit Plan Design, Member Acquisition and Retention.
 - Accountable Care Organization Operations Competences and Enablers- Revenue & Quality management, Medical Management, Strategic Partnerships, Compliance Culture.
- Medicaid Managed Care Market Strategies will drive by State design features and key product differentiators.
- Accountable Care Organization Operational competencies will form the foundation for achieving quality and cost performance goals.
- Strategic partnerships and a compliance culture will enable the operational competencies leading to performance improvements and profitable growth.
 - Key Enablers: Partner with Members, Partner with Providers, Create a Compliance Culture
- The Combination of Accountable Care Organization Operational competences integrated in a shared risk arrangement will become the norm as the government sector evolves.
 - Shared Risk- Care Management is the foundational competency to achieve quality and cost goals.
 - Emory University study concluded that enrolling dual Eligibles in comprehensive care management programs could save the federal government up to \$125B over 10 years.
- ACOs and Quality Metrics Care Management Models
- Providers consider four key factors when evaluating the cost and benefits of adopting an Accountable Care Organization Model
 - Partnering, Cost of Care, Financial incentives, Beneficiaries
- Adopting an Accountable Care Organization Model can have immediate upfront costs but long term improvements in quality of care through use of metrics.
 - Ensures care management is compatible with patient choice through transparency and governance.
 - Patients see lower premiums as part of the Accountable Care Organization Cost Sharing Model.
 - Significant upfront costs with moderate returns.
 - Potential for patients to have a little choice contradicting the idea of patient centered care.
- Case Study.
- Care Management Programs in Shared Risk Programs
- Winning the Evolving Marketplace.+
 - Cost and Quality performance requirements will drive change.
- Competition, consumers, providers, and payment reform
- Preparing: Know your markets, manage your revenues, manage your population and engage members and providers.

Health Insurance Exchange: Long on Options, Short on Time

<http://pwchealth.com/cgi-local/hregister.cgi/reg/pwc-health-insurance-exchanges-impact-and-options.pdf>

- Presented by PWC
- Research: Analyzed data from Current Population Survey, Medical Expenditure Panel Survey and Congressional Budget Office Publications
- Demographic profile describes the newly insured and individual exchange population in 2021. Interviewed 15 Health Industry and government leaders
- **In 2014, 12 Million Americans are expected to be purchasing health insurance through exchanges.**
- **Emerging Customer Base:**
 - The newly insured will be less educated less likely to speak English as their primary language.
 - Medicaid Expansion may shift the number of enrollees going into the exchanges.
 - The new individual exchange population consists of mainly young, white, and relatively healthy individuals
- Price will be a concern for both consumers and insurers, but qualities serve as a differentiator. Price will be a leading factor in consumer decision making. As consumers become more sophisticated insurers will need to differentiate through quality, benefits, and customer experience. 47% of consumers are willing to pay for extra ancillary services.

The Public and Private Faces of Insurance Exchanges

- Many States will have the federal government directly involved in running exchanges.
- Public and Private Exchanges will co-exist in several markets.
- Mechanism to neutralize risk for insurers and the governments are either managed by the state or other agencies.
- States that run their own exchanges will determine how to create the marketplace and run the exchange.
- Private exchanges run by insurers, retailers or other third party may lead in innovation. Insurer Run Model, Retailer-Run mode, and Third Party Run model.

Health Industry Implications

- Price and risk selections are top concerns for insurers but a broader consumer strategy should also be developed.
- Providers should prepare for a new population that may have pent up demand for services.
- Employers are contemplating whether exchanges present a viable option to employer managed coverage.
- Pharma and Life Sciences Firms will need to account for state variation in exchanges and delivering new value.
- Exchanges will remain a hot prospect and shape the future environment.

What will the newly insured look like?

The newly insured compared to the currently insured are...

Race

... less likely to be white



White

Health status

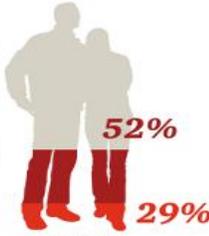
... less likely to rank self excellent/very good/good



Excellent/
Very good/
Good

Marital status

... more likely to be single



Single

Language

... less likely to speak English



English

Educational attainment

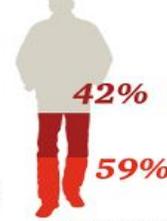
... less likely to have a college degree



College degree
or higher

Employment status

... less likely to have full-time employment



Employed full-time

● Newly insured	Median age	33
● Currently insured	Median income	166% FPL
		313% FPL

Sources: PwC HRI analysis for year 2021, Current Population Survey, Medical Expenditure Panel Survey and CBO
Created by PwC Health Research Institute
pwc.com/us/healthexchanges

What will the individual exchange members look like?

Race

The majority are white.



White

Health status

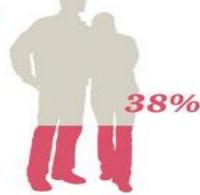
The majority are in relatively good health.



Excellent/
Very good/
Good

Marital status

Most are not married.



Married

Language

One in five speak a language other than English at home.



Non-English

Educational attainment

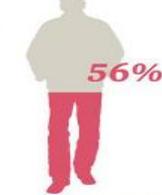
Three-fourths do not hold a college degree.



No college degree

Employment status

More than half are employed full-time.



Employed full-time

● Individual exchange members	Median age	33
	Median income	238% FPL

Sources: PwC HRI analysis for year 2021, Current Population Survey, Medical Expenditure Panel Survey and CBO

What will the new Medicaid population look like?

Race

The majority are white.



White

Health status

The majority report being in relatively good health.



Excellent/
Very good/
Good

Marital status

Most are not married.



Married

Language

Over a third speak a language other than English at home.



Non-English

Educational attainment

Nearly nine out of ten do not hold a college degree.



No college degree

Employment status

A minority are employed full-time.



Employed full-time

● New Medicaid enrollees	Median age	31
	Median income	65% FPL (\$7,261 for a single individual, \$14,983 for a family of four)

Sources: PwC HRI analysis for year 2021, Current Population Survey, Medical Expenditure Panel Survey and CBO

Dual Eligible Integration bids: An Insider's View on Recent Responses and Upcoming RFP's.

Presented by HEOPS

- Major Themes: Bureaucratic Terror, Survival, Chaos, Patient Rights.
- **Bureaucratic Terror:** Complexity, Timing, Lack of Standardization, High Stakes,
- **Survival:** Changes in Reimbursement Methodology, Savings that may not materialize, Patterns of Care, Provider-Patient Relationships.
- **Chaos:** Timing, complexity, Competency, Viability
- **Patient rights:** Opt In/ opt out, passive enrollment, Patient empowerment and direction, provider relationships(in/out of network)
- **The Numbers:** 9 million Duals, 16% of Care, 15% of CAID , 27% CARE Cost 39% Cost, CMS Proposed 1-2 Millions Duals in Demonstration. 15 States Awarded Design Grants.
- Affordable Care Act- Created Federal Coordinated Health Care Office(MMCO)
- **Goal of MMCO- Effective program coordination to improve care and lower costs.**
- **Initiative 1: April 2011** Program Design Awards- 15 States.
- **Initiative 2: July 2011-** CFAD Program- States to submit- Process Defined.

CFAD Process:

1. LOI
 2. Work with CMS
 3. MOU
 4. State Procurement Documents Released
 5. CMS & State Qualify Plans
 6. CMS & State Readiness Review
 7. 3 Way Contract(Cap)/ Financial Agreement (FFS)
 8. Implementation, monitoring and Evaluation.
- **Characters: MED PAC Letters, Sen. Rockefeller Letters, State Medicaid programs, CMS, Stakeholders**
 - **36 LOI Submitted (11 FFS, 6 both, 20 Capitated), MA-MOU no plan selection yet.**
 - **MED PAC:** Size and Scope, Passive Enrollment, Program Costs and Ensuring Savings, Monitoring and Evaluation.
 - **Sen. Rockefeller:** Quality Care vs. Guaranteed Savings, Test New concepts, Rights of Duals, Broad Implementation without testing, size and scope, lack of transparency, benefit and service disruptions.
 - **Pitfalls:** Unlikely savings for plans in Y1, Enrollment Process, Provider Networks-Delays, and Access to Adequate LTSS providers, Adequacy not standardized all programs unique.
 - **Solutions:**
 - **Unlike y savings for year 1: Response:** Capitation, negotiate carefully, are savings required in Y1 or Performance against Quality focus? REVIEW the actuarial detail; ensure expanded LTSS has been added.

- **Enrollment Process: Response:** Explore Opt/In Opt/Out, passive enrollment, enrollment brokers, Triple A's and other community agencies.
- **Provider Networks Delays- Response:** Encouragement from the state for providers to become involved early in the process. Seek to engage hospitals and other key providers early, Transparency.
- **Access to Adequate LTSS Providers- Response:** LTSS need to be engaged and supported, reduce complexity, seek to support and encourage growth and access, focus on quality.
- **Adequacy not Standardized: Response:** Consider MA best Practices as a Standard, Geographic Disparities, Scalable, Flexible and Evolving
- **All Programs Unique: Response:** Seek Best practices and lessons learning, negotiate wisely, implement with Quality and Competency, and don't forget this is a DEMONSTRATION

Aetna Medicaid: Managing Long Term Care for Dual Eligible Populations

Erhardt Preitauer SVP Mid- America Region

Highlights

- Over 9 Million Nationally
- 36% of Medicare spend
- 39% of Medicaid Spend
- <2% of Coordinated Care
- Roughly 1/3 have a physical disability
- 2.3 have mental illness and/or substance abuse
- 10 to 15% have intellectual and developmental disabilities
- 2% have Alzheimer's/ Dementia
- Multiple chronic conditions; 70% of spend on this
- **Source:** Medicare Payment Advisory Commission, Report to Congress: Medicare and the Health Care Delivery System June 2011
- Complicated and Fragmented System where providers are focused on Volume. It costs a lot.
- **Keys to Success:** Have a Clear Vision for the Program. Stakeholder Engagement: Early and Often. Integrate, Integrate, and Integrate. Uniform Assessment and Eligibility Approach. Volume over Volume; Technology and Tools. The Right Design... benefits, financial, programmatic, Clear and aligned incentives, Quality, Oversight and State Partnership. Focus on Culture.
- **Aetna Solutions: The Role of Technology:** Clinical Data Integration, Secure Data Exchange, Real Time Provider Interface, Application Store, Rapid Distribution, Population based clinical intelligence, Decision Support, Care Management, Popular mobile based application, user(symptom) to provider link, appointments, registration, alerts, costs.
- **Provided an analysis of Care Coordination Outcomes-** a Comparison of the Mercy Care Plan population to Nationwide Dual-Eligible Medicare beneficiaries.
 - **Study Design**
 - **100% Sample Size- 17,000 Duals**
 - **Compared to national Medicare Data**
 - **Adjusted for Mix**
 - **Four points of Comparison**
 - **1. Access to Preventative Services**
 - **2. Inpatient utilization**
 - **3. ED Usage**
 - **4. All-Cause Readmissions.**
 - See Results Page in PowerPoint.
- Getting Results by Rebalancing Institutional and HCBS Services. Aetna's Long Term Care Model has been successful in Arizona since 1989. Rise is home and community based care use.

Methodologies for Building a Medicaid Provider Network

Presented by Robert Robidou Director of Network Development Cook Children's Health Plan

Goals:

- **Forge a partnership with Providers- Provide a network of provider care and access to our Membership**
- Develop a plan to work more efficiently- Are there ways you can become easy to work with?
- Develop a program to strengthen relationships. – Ways to reward Providers without busting the bank.
- Cook Children Health Care system is not for profit pediatric health care organization.

Develop a Plan and Review

Why is Provider Network Important? Healthcare is Relationship Business.

- Why will Providers work with Medicaid/CHIP Programs. Work with you? Current Patients, opportunity to give back to the community(Medicaid/CHIP)
- Reputation
- Hassel Factor
- Network makeup.

How do you find Providers who will work with you?

- Convince providers why they should work with you. Providers should not feel like they are taking all of your members(Medicaid/Chip Programs- minimal Risk)
- Talk about your network
- Create a Partnership
- Possible Providers
- **Possible Providers:** Medicaid Board Listings Available from States, Local Medical Associations, Other Medicaid Plans in Area, Member Requests, Current Provider referral patterns, OON Claims, Marketing Requests., Web-Yellow Pages
- Letter of Interest
- **Provider Communication-** Communicate and Listen to the providers in order to address their needs,
 - Quarterly office manager meetings- PCPs and Specialists, Annual/Monthly Provider Surveys, Representative Visits, Web Based information- Member eligibility, claims check, provider manuals, provider directories. Informative links.
 - Provider Communication: During Quarterly PCP Office Manager Meetings. Like and did not like.
 - Providers are your customers, they are vital to growth of your membership.
 - Update and align your programs to reward the highest performing physicians.
- **Simple VIP Program:** Average of 200 or more members in Prior Quarters, Open panel, community advisory committee, Monthly visits by provider services, Gift Card from Office Supply, Top Office will receive recognition in the provider newsletter and member newsletter.
- **P4P Program-** measured on a quarterly basis, Health Plan has to be profitable that quarter. Minimum Requirement (Panel Size, Open to New members), Measures(Panel Size, Vaccines for Children Program, ED Visit rate, Submission Rate for Clean Claims).

Summary: Partnership, Communication, Network Development

Connecting the Coverage Dots for Low-Income Health Care Consumers

Med Murray ACAP- Association for Affiliated Plans

Federal Basic Health Plan would provide an Affordable Option to Those with Low Incomes- 138 and 200 FPL

2014

Medicaid: Within Six Months, **40% of Medicaid Enrollees will experience Coverage disruption.** After One year, 38% no longer Medicaid-Eligible; 16% more will have lost and regained eligibility.

Exchange: Within six months, 30% of adults will experience disruption in Exchange Eligibility. After one year, 24 no longer eligible; 19% more will have lost and regained eligibility.

GOA Government Accountability office: About 14% of children in January 2009 who met 2014 PPACA eligibility criteria for Medicaid/CHIP/ Premium tax credit experience a change in household income that would affect eligibility within 1 year.

The Average Medicaid Beneficiary is enrolled only nine months out of the year- CT 10+ Months.

Families with Split Eligibility

Numerous Families will have members covered by different programs: Medicaid, CHIP, and Exchange (with subsidies). 16.2 Million Medicaid or CHIP-Eligible children have parents with income in Exchange eligibility Range. It is **important to cover families in One Plan.** Parents need to learn only one health plan's procedures. Practitioners- can see both parents and kids can be seen together. **Consumer friendly-** doesn't make sense to split families into separate programs and plans.

Affordability:

New Yorkers with income below 200 % FPL have little or no disposable income to pay for health insurance premiums.

Affordability: Maximum Premium Cost for Low-Income Exchange Enrollees Income as Percentage of FPL	Maximum Premium Percentage
133%	3%
150%	4%
200%	6.3%
250%	8.05%
300%	9.5%
400%	9.5%

Affordability: Maximum Premium Cost for Low-Income Exchange Enrollees Annual Income in Dollars	Final Premium in Dollars
\$14,484 (133%)	\$290
\$16,335 (150%)	\$653
\$21,780 (200%)	\$1,372
\$27,225 (250%)	\$2,192
\$32,670 (300%)	\$3,104
\$43,560 (400%)	\$4,138

ACAP Solutions:

- **Continuous Eligibility**
- **Basic Health Program**
- **Bridge Proposals**
- **Support for Medicaid-Focused Health Plans in Health Insurance Exchanges.**

Continuous Eligibility: Important access and quality implications for enrollees. Churn results in individuals cycling on and off Medicaid despite actual eligibility. Lost eligibility interrupts care, affecting effectiveness. Churn impacts state and plan ability to measure quality. Research shows that after ACA enactment, **28 million people** will cycle between Medicaid and Exchange programs annually. Continuous Medicaid enrollment is medically and administratively efficient and necessary to accommodate the coverage expansions that will begin in 2014. Continuous eligibility for **children, low-income adults, the elderly, and people with disabilities in Medicaid, Mandatory quality reporting** across FFS and managed care. **Why should Congress address these issues?** Stabilizes Medicaid eligibility for enrollees and states, Maintains continuity of care with plans and providers, Expansions must ensure **QUALITY**, not just coverage, Lowers average monthly medical expenditure, Churning will negatively affect Exchange enrollment, H.R. 669 / 671, introduced by Rep. Gene Green, would establish 12-month continuous eligibility for children in Medicaid, CHIP

Basic Health Program Established in Section 1331 of the ACA for people with income at or below 200% FPL, States contract with at least one “standard health plan” or network of health care providers, States provide the equivalent of the “essential health benefits” (as required in Exchange & Medicaid expansion), Premiums for enrollees must be equal to or lower than what the individual would have paid in the Exchange, Individuals can enroll via Exchange

Funding: States receive equivalent of 95 percent of tax credits and cost-sharing subsidies enrolled individuals would have received if purchased commercial Exchange coverage. Funds go into restricted trust fund only for BHP. *Need guidance from HHS! Can funds be used to administer the program or to enhance provider payments?*

Bridge Proposal: Would allow Medicaid/CHIP plans to serve enrollees who move into the exchange, or cover families with split eligibility. Population served limited to split-eligibility families or people moving to Exchange, Bridge plans will likely need to meet full QHP cert. standards, will be unlikely to be available through FFE in 2014. More guidance needed on a range of issues Impact on premium tax credits. Guaranteed issue.

Exchange Should Include Medicaid Focused Health Plans: Medicaid-focused plans know the population served. 40% of the nation's low-income subsidized Exchange population will have been previously enrolled in Medicaid/CHIP, a premium subsidy program, or uninsured. States understand the value of Medicaid plans serving as Qualified Health Plans. KFF Profile of Medicaid Managed Care Programs in 2010: 8 states are considering requiring Medicaid plans to serve Exchange; 7 are considering requiring Exchange plans.

Challenges to Medicaid-Focused Plans Participating in Exchanges

Provider Network requirements. Requirements around accreditation and reserves. CMS has adopted a phase-in period for accreditation. Safety Net Health Plans in particular may need time to build sufficient reserves to enter exchange market. Uncertainty about new coverage population. Some states have adopted a "lock-out" period; California has waived the lock-out for Medicaid-focused health plans. Risk adjustment/reinsurance

Summary

- Reducing the number of uninsured: a very good thing. Churn, split eligibility, and affordability are major challenges
- Continuous coverage provisions, Basic Health Program, bridge proposals can mitigate churn
- Medicaid-focused plans and Safety Net Health Plans are valuable partners in serving Medicaid, BHP, subsidized Exchange populations; they should be allowed/encouraged to participate

UPMC for You: Implementing a Medical Home Model in Medicaid Managed Care Setting

- Non-profit Medicaid and Medicare Plan located in Western and Central Pennsylvania
Why the need for the new model? Cost of Health Care. Many Services used by a few
- 180,439 Medicaid members
- Health Care Providers.
- Patient Centered Medicaid Home(PCMH) is key to Accountable Care Organizations:
 - Accept Shared Responsibility to deliver medical services to a defined set of patients. Are held accountable for quality and cost of care provided through alignment of incentives and distribution of incentive payments to participating providers.
- PCMH Model Frame Work: meets all patient needs at all stages of life: Health and Wellness Preventive Care, Acute Care and Chronic Disease management. “Personal Physician.” Works in partnership with patients and families, considers needs, preferences, and culture. Education and support that enables patients to participate in their care.
- Productive Interaction with Patient- Patients Knowledge and self-management with readiness to change. Collaborative management- not telling patient what to do. Active, sustained by follow-up.
- Care Team and Patient Responsibilities. National Partnership for Women and Families.
- UPMC Health Plan’s PCMH Structure.
 - Practice Assessment- Educate PCP on PCMH and provided assistance with structural and process improvement. On Site assessment. Practice was given one of three levels Practice progress incentive through Pay for Performance.
 - In **July 2008** implemented Patient Centered Medical Home (PCMH) in six high volume PCP practices supported by six Health Plan Practice Based Care Managers (PBCM) covering **8,300 members 126 PCMH sites with 609 physicians**, supported by 35 PBCMs, covering over **121,000 members**, including 23,500 enrolled in UPMC *for You*
 - **NCQA PCMH Recognition**. Support practices have helped them to prepare documents. Clinical and Operational Support. Includes Internal Medicine and Practices, no pediatric practices.
 - **Changes identified as Essential to Success of PCMH**
 - Episodic Acute Care □ Population Management
 - Patient Problem □ Patient-Centeredness
 - Patient Education □ Patient Self- Management
 - Practitioner Tasks □ Function Within License
 - Health care team must function under highest level of licensure
- **Lessons Learned:** Physician Champion Each Practice, Not a Cookie Cutter Approach, Involvement of all physicians in the practices, Routine meetings with the practice and review of reports, Select PNCM based on Unique characteristics, Clearly defined expectations, roles and goals of all partners, strong operational processes and management, more efficient if practice has electronic health record