

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.**

The What, Why, and How of Flexibility

Steven Costantino
RI Executive Office of Health and Human Services
Presentation to Medicaid Managed Care Conference
October 4, 2012

Why am I here?

- House Finance Chair
- Secretary of Health and Human Services
- 1115 Global Waiver:
proposed in August
2008 and approved in
January 2009



What is flexibility?



"I love you, but, hey, I'm flexible."

- different than current rules allow
- 1115 Waivers propose flexibility in:
 - program design
 - spending
 - administrative processes



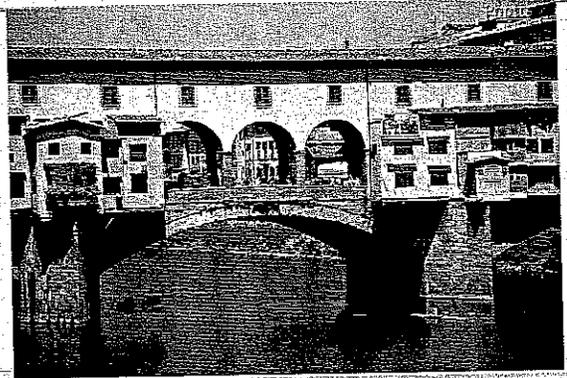
"I'm not interested in preserving the status quo; I want to overthrow it."

Niccolo Machiavelli

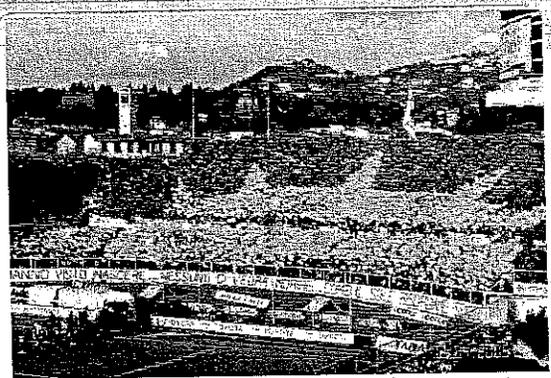
Lesson #1

- Be very clear about what you are asking for...
- your request for more flexibility may result in more restrictions!

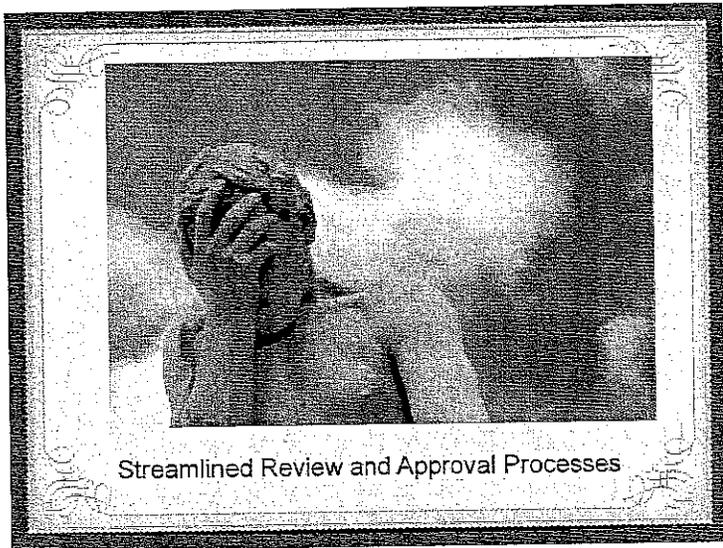
Why do we need flexibility?



Better Access to Community-based Care



Enrollment in Coordinated and Managed Care Delivery Systems



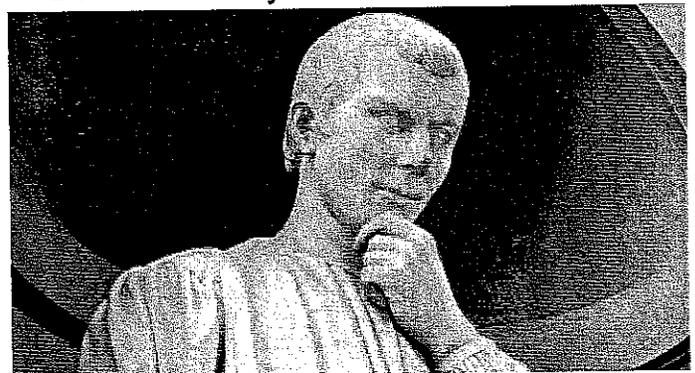
Recent Waivers

✓ Approved	Denied
✦ begin Medicaid expansion sooner	✦ eligibility restrictions
✦ simplify enrollment and renewal processes	✦ enrollment restrictions
✦ managed care for Special Needs Populations	✦ increased premiums
✦ support of Safety Net Systems	

Lesson #2

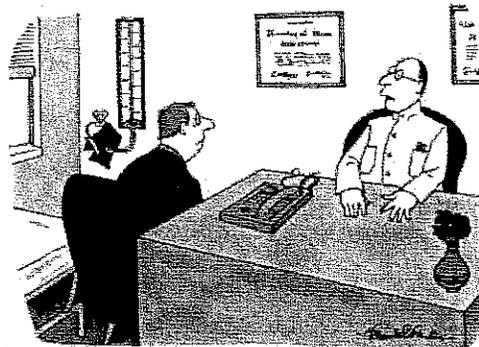
- Flexibility is a partnership; it is only possible if there is agreement on the end goal.

Does Flexibility work?



"It must be considered that there is nothing more difficult to carry out, nor more doubtful of success, nor more dangerous to handle, than to initiate a new order of things."

Rite Care

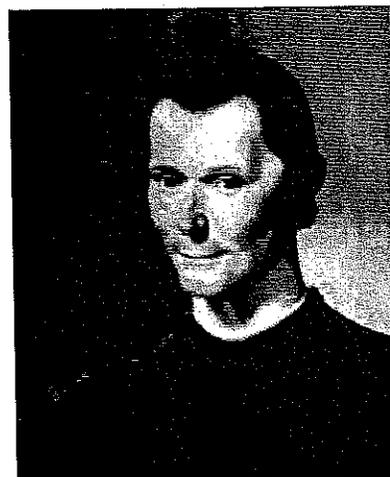


"I wish I could help you. The problem is that you're too sick for managed care."

Lesson #3

- Flexibility must be accompanied by accountability, transparency, and program improvement

“Whosoever desires constant success must change his conduct with the times.”



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

2012 MEDICAID MANAGED CARE CONFERENCE

Nebraska Department of Health and Human Services
Division of Medicaid & Long-Term Care
Vivianne M. Chaumont, Director

Background

- Nebraska population – 1.7 Million
- Medicaid population – 237,534
 - 152,032 children enrolled in 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

Nebraska Managed Care Physical Health

- July 1995 -- Nebraska implemented Managed Care program for physical health in 3 county area
- Managed Care program offered choice between 1 MCO and Primary Care Case Management (PCCM) Plan
- November 2009 – Expanded to 10 counties

Physical Health

- August 2010 – PCCM plan was discontinued
- August 2010 – Full risk Managed Care with 2 MCOs in the 10 counties
- July 2012 – Statewide Managed Care

Exclusions

- Populations not included:
 - Dual eligibles
 - Long-Term Care clients (nursing facility and Home and Community Based Services)
 - Transplants
- Services not included:
 - Dental, Pharmacy, Long-Term Care, Non-Emergency Transportation, behavioral health

Behavioral Health Managed Care

- Currently, statewide Administrative Services Organization
- Fall 2012 – RFP for statewide at-risk single Contractor
- Fall 2013 – Implementation of at-risk managed care for behavioral health

Medicaid Expansion

- Nebraska Medicaid does not currently cover adults unless they are:
 - Caretaker relatives under AFDC
 - Aged
 - Disabled
- Supreme Court ruled that States can choose whether or not to implement ACA expansion
- Governor has stated that he will not support expansion of the Medicaid program

Medicaid Population Increases

- Milliman Report published in November 2010
- Based on a mid-range scenario:
 - Approximately 64,000 new Medicaid/CHIP clients expected starting January 2014
 - Woodwork adults and children who are currently eligible for Medicaid or CHIP
 - Insured switchers who would be eligible for Medicaid or CHIP
 - Approximately 4,900 adults and 58,100 children

Budget Implications

- November 2010 Milliman Report for State Fiscal Year 2014:
 - \$113 Million increase to aid (\$4.07 Million GF)
 - \$4.3 Million in administration (\$2.1 Million GF)
 - \$7.6 Million in health insurer fees (\$3.4 Million GF)
 - \$18.3 Million in Primary Care fee increases (all Federal funds)
- One half of a fiscal year and NO expansion

Future Managed Care

- Managed care enrollment will increase
 - Populations we expect to see increase, children and adult relatives are mandatory managed care
- Legislature will consider expansion next session
 - Should expansion pass over a veto, additional population expected to be added to managed care program

Long Term Care

- Long Term Care population not currently covered by managed care program
- Approximately 53,000 Medicaid clients are Aged or Disabled
- Most expensive clients = least managed clients
- Move to at-risk managed care July 2014?
- Develop programs for dual eligibles

2012 MEDICAID MANAGED CARE CONFERENCE

Nebraska Department of Health and Human Services
Division of Medicaid & Long-Term Care
Vivianne M. Chaumont, Director

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.

Washington State
Health Care Authority

Network Development Strategies

— Expanding Medicaid Managed Care Eligibility and Enrollment —

Preston W. Cody
Assistant Director
Health Care Services
October 2012

Primary health care purchasing agency
— Serving 1.6 million clients, state employees, and retirees —



- Basic Health
- Health Technology Assessment
- Medicaid and Medical Assistance Programs
- Prescription Drug Program
- Public Employees Benefit Board
- Uniform Medical Plan
- Washington Health Program
- Washington Wellness

Overview

— A sustaining vision and long-term commitment —

Brief history
Authority to build a provider network
Ensuring network adequacy
State successes
State challenges
Lessons learned

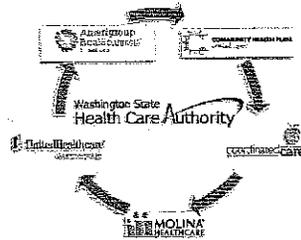
Brief History

MANAGED CARE EXPANSION

Managed Care Expansion

— A solid foundation for a seamless transition to 2014 —

- In July 2012, the agency consolidated the Medicaid managed care program, Healthy Options (HO), with the state's Basic Health Plan (BH) to:
 - Improve care
 - Reduce costs by expanding managed care
 - Expand service delivery options
 - Implement payment reform and quality control



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Managed Care eligibility

- Basic Health eligibility does not change
 - Not open for new enrollment – 34,000 members
- Healthy Options will continue to include:
 - TANF families and children up to age 19
 - Pregnant Women (eligible for Medicaid)
 - Children's Health Insurance Program (CHIP)
 - **683,402 enrollees as of June 2012**
- New population to be added
 - 120,000 Categorically Needy Blind/Disabled non-Medicare
 - Optional enrollment for foster care children

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New population

— Medicaid Only, Blind/Disabled clients enroll —

Exceptions:

- Living in institutional settings
- Enrolled in Chronic Care Management Programs
- Enrolled in the Program of All-Inclusive Care for the Elderly (PACE)
- On hospice
- American Indians/Alaska Natives
- Enrolled in the Washington Medicaid Integration Partnership (WMIP)
- Enrolled in Private Duty Nursing (PDN)
- Enrolled in the Medically Intensive Children's Program (MICP)
- Third Party Insurance

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Assigning new populations

— Three-phase approach —

- Eastern WA – July 1
- Western WA – September 1
- Clark, King, and Pierce Counties – November 1

Month	Enrollment	All Assignments
July	743,380	248,893
September	762,811	56,301
November	Unknown	27,000*

*Projection as of September 15, 2012

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Authority: Federal, State, and Managed Care Contract requirements

BUILDING A NETWORK

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Federal requirements

Requires the State to ensure:

- Managed Care Organizations' (MCO) are in compliance with federal regulations
- Services and benefits are consistent with the State Plan
- MCO provider network/enrollee ratio compliance

Federal Law Requirements: 42 CFR § 438.207(d), 42 CFR §438.206(a), 42 CFR §438.206(b)

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Washington State Law

Requires the MCO:

- Meet State network and quality standards
- Contract with providers to comply with the Washington State Office of Insurance Commissioner (OIC) regulations

State Law Requirements: WAC 182-538-067(1)(c), WAC 284-43-200(1), WAC 284-43-200(4)

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Managed Care Contract

MCO provider contracts must :

- Provide all medically necessary specialty care in and out of health plan network
- Ensure no balance billing for covered services
- Ensure enrollees' timely access to all covered services within established distance standards
- Consider cultural, ethnic, race, and language needs
- Ensure comparable provider access to commercial markets or Medicaid's Fee-for-Service

State Contract Requirements: Sections 5.1 through 5.12.1

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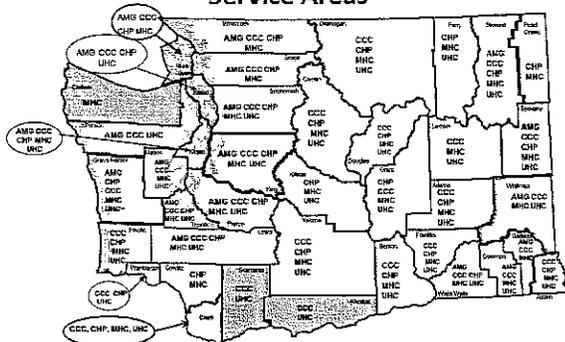
Ongoing monitoring of MCOs

ENSURING NETWORK ADEQUACY

Monitoring Health Plans

- Weekly updates
 - Various statistics – call center, outreach activities
 - Network adequacy reports (approx. everyday 10 days)
 - State outreach and education
- Monitor complaints to resolution
 - MCOs required to report on enrollee/provider complaints regarding access to care
- Plan monitoring visit – comprehensive plan review 2013

Service Areas



County enrollment in managed care is voluntary.

Effective 9-1-2012 Service Areas for Healthy Options, Children's Health Insurance Program, Healthy Options Blind/Disabled and Healthy Options Foster Care Programs

Receiving Medicaid assignments

- Submit proof of entire network in all service areas (county) awarded
- MCO must be able to serve anyone eligible and lives in the given service area
- Report on resolution of access to care complaints
- MCO must maintain in compliance with Managed Care contract adequacy levels
- MCO are assigned clients based on results of proposal scores:
 - 40% will be made based on Rates scores
 - 20% will be made based on Quality Assurance Performance Improvement (QAPI) scores
 - 20% will be made based on Access to Care and Provider Network scores
 - 15% will be made based on Care Coordination Scores
 - 5% will be made based on all other Program Section Scores combined

Analysis of Network

Assignment	Demonstrates sufficient provider network to receive all eligible enrollees. Plan name appears on enrollment form. HCA auto-enrolls.
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Enrollment only	Demonstrates a <i>mostly</i> sufficient provider network to receive all eligible enrollees, but lacks <i>sufficiency in one or more categories</i> . Plan name appears on enrollment form. HCA won't auto-enroll.
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Emerging network	Does <i>not</i> demonstrate a sufficient provider network to receive eligible enrollees, but <i>may in the future</i> . Plan name <i>will not</i> appear on enrollment form.
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Top 5 provider categories include:

1. Hospital
2. Primary Care Provider
3. Pharmacy
4. Obstetric/Gynecologist
5. Pediatrics

Top 10 specialty provider categories include:

1. Cardiologist
2. Gastroenterology
3. General Surgeon
4. Neurologist
5. Oncologist
6. Ophthalmologist
7. Orthopedics
8. Otolaryngology
9. Physical Medicine Rehab
10. Pulmonologist

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STATE SUCCESS

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Moving in the right direction

- Helps better prepare for Medicaid expansion
- Three new plans with extensive national experience in serving low-income populations
- Greater enrollee choice in most service areas
- Potential cost savings through transition from Fee-for-Service (FFS) to managed care
- Expect improved health outcomes, especially for the highest risk, highest cost enrollees
- Greater oversight and strengthened program integrity for publicly-funded programs

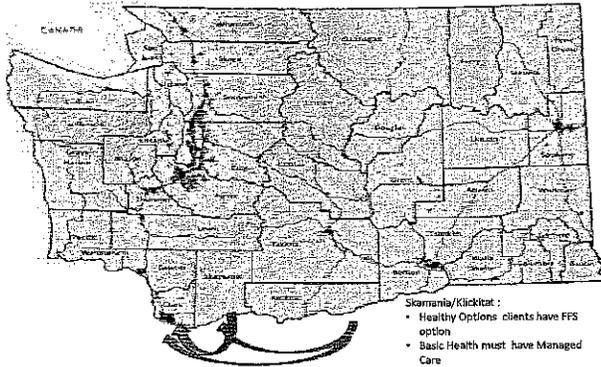
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STATE CHALLENGES

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Where do they go?

— Geography and provider limitations —



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Limited provider participation

— Impact to networks —

- Federal distance standards are not limited to a specific service area geographically (meaning they can cross county or state borders)
- Rural areas where limited physicians practice (provider shortage)
- Provider reimbursement
- Even distribution of enrollees for health plans viability (assignments)
 - Reconnects and family unit issues
 - Exempted groups (i.e., COB, Children with Special Healthcare Needs, Foster children)

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Availability of Primary Care Physicians

— Impact to networks —

- About 20% of Primary Care Physicians (PCP) care for some patients covered by Medicaid
- Close to 80% of PCPs are accepting new patients
 - Only 30% of this group are not including Medicaid covered clients in their expansion plans
 - Just over 20% reported that all their new patients could be Medicaid covered
 - Office of Financial Management June 2012 report:
http://www.ofm.wa.gov/healthcare/deliversystem/2013_PCP_survey_frequency_report.pdf

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LESSONS LEARNED

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Lessons learned

- Focus on how changes will benefit enrollees first
- Continuously monitor provider networks
- More resources need to be devoted to 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

http://www.hca.wa.gov/managed_care

MORE INFORMATION

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?

Examining Medicaid Expansion



*Implications for Consumers,
Exchanges, and Goals of the ACA*

Norman Thurston, Ph.D.
10/4/12

What are States Thinking About?

- Technology Issues
 - Medicaid System
 - Exchange Platform
 - Insurance Regulation
- Insurance Market Stability
 - Strategy for Risk
 - Planning for Disruption

What are States Thinking About?

- Public Programs
 - Children's Expansion
 - Maintenance of Effort
 - Simplified (MAGI) Eligibility
 - Adult Expansion is just One of Many Worries

Possible Goals of the ACA

- Reduce the Number of Uninsured
 - Close the Coverage Gaps
 - Simplify the Application Process (Exchanges)
 - More People on Government Programs
 - *Massive New Government Spending
- Reducing Pressure on the Market
 - Insurance Market Reforms
 - Tax on the Uninsured

Insurance Market Issues

- Guaranteed Issue with no Pre-Existing Conditions
- Modified Community Rating
- Potential Impacts
 - Individual Market Rates
 - Carrier Viability
- Risk Management

What About Adult Expansion?

- State Budget
- New Federal Program
 - APTC
 - CSR
- 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
- 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

User Interface or Portal

- No Wrong Door
- World Class Experience
- Collect Screening Information
- Refer to Proper Tool(s) for Action
- Note: Everyone seeking APTC will need a Medicaid determination

Medicaid Eligibility System

- Determine Medicaid Eligibility
 - Federal Poverty Level
 - Categorical Eligibility
- Verify Income, Citizenship, Residency
- Client Management

Tax Administration

- Issue Certificates of Exemption (month-by-month)
- Assess Appropriate Taxes

What Might States Want to Own?

- APTC determination (No)
- Tax Administration (No)
- IT Solutions & Tools (Not clear)
- Plan Management (Yes)
- Medicaid Eligibility (Yes)
- Insurance Regulation (Yes)

A Vision for Reform

- “Our health system reform efforts have been targeted to respond to Utah’s unique business and demographic needs.”
- Governor Gary R. Herbert

UTAH'S EXPERIENCE

Utah’s Approach to Health System Reform

- The overarching philosophy of Utah’s approach to health reform is the invisible hand of the marketplace, rather than the heavy hand of 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
 - Employer
 - Government
 - Other
- Consumers get enhanced control and choice
- Applicable to both Employment & Public Program Settings

Challenges

- Accurate Data
 - Impact on Budgets
 - Impact on People
 - Impact on Economy
- Uncertain Future
 - November Election
 - Legal Issues
 - Unanswered Questions

Now What?

- Exchange Decisions
- Insurance Market Decisions
- Medicaid Decisions
 - Whose Priorities?
 - Can we get Flexibility?

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 payment s 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.**



State Budget: 2012-2013 Biennium



Do Medicaid Cost Containment Initiatives Work - A Texas Lesson

Joe Vesowate
Deputy Director, Medicaid/CHIP
Managed Care Operations
Texas HHSC

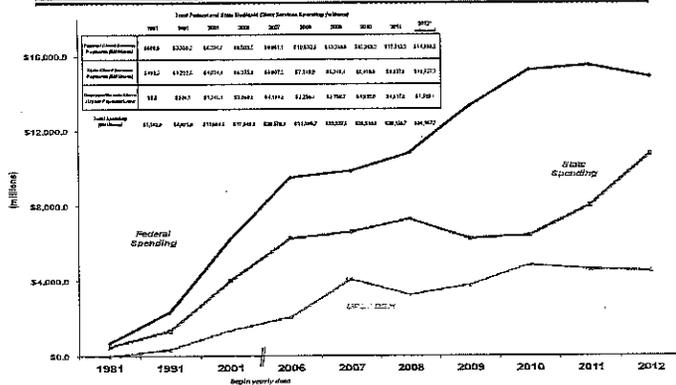
Michelle Apodaca, JD
Vice-President, Advocacy,
Legal & Public Policy
Texas Hospital Association

- 2010-2011 Budget: State leadership approved \$1.25 billion in General Revenue cuts (\$182.2B All Funds, \$80.6B GR)
- \$183 million in state funds cut from health and human services budget
 - A 1% rate cut was put in place for acute care services, including hospitals. This rate cut was effective September 1, 2010, and will cause an additional loss of \$115 million in federal matching funds
- Early December 2010 leadership asked agencies to cut current budget GR another 2.5%.
 - HHSC announced another 1% rate cut for all acute care services, effective February 1, 2011. Additional 2% cut for SNFs and ICF/MRs.

2



Medicaid Trends: Historical State & Federal Medicaid Spending

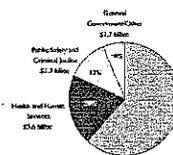


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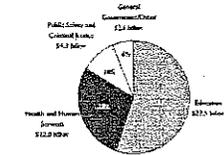
Growth of Medicaid in State Budget



FY 2010 State GR Spending by Article, Total Spending = \$27.3 billion



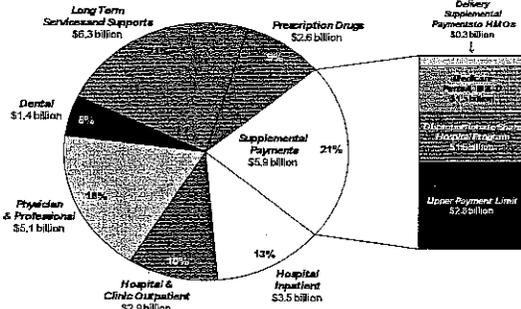
FY 2010 State GR Appropriation by Article, Total Appropriated = \$42.4 billion



- ACA 133% FPL = 2 million more to Medicaid Rolls (state budget 10% after 2020)

4

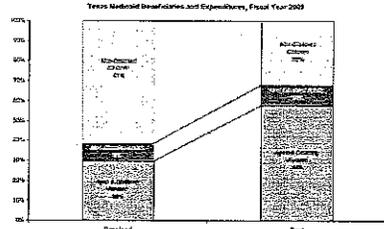
Texas Medicaid Expenditures, SFY 2011* by Service Type — Total \$28 billion



*Texas Medicaid Management Information System (MMIS)
Prepared by the Health and Human Services Commission, Texas Health and Human Services Commission, April 2012.
Note: Data coverage is based on SFY 2011 actuals.

Medicaid Expenses

Medicaid Beneficiaries and Expenditures:

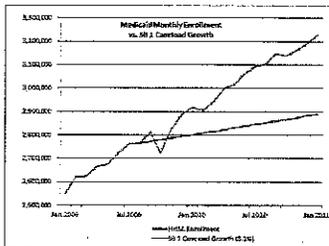


SOURCE: 2009 FISCAL YEAR DATA. FROM MEDICAID/COMMUNITY ASSISTANCE CENTER, 14000 DFW, 4941527-1001.DWG. COSTS ARE REPORTED BY THE HEALTH AND HUMAN SERVICES COMMISSION. COSTS FOR MEDICAID ARE REPORTED BY THE HEALTH AND HUMAN SERVICES COMMISSION. COSTS FOR NON-MEDICAID ARE REPORTED BY THE HEALTH AND HUMAN SERVICES COMMISSION. COSTS FOR NON-MEDICAID ARE REPORTED BY THE HEALTH AND HUMAN SERVICES COMMISSION.

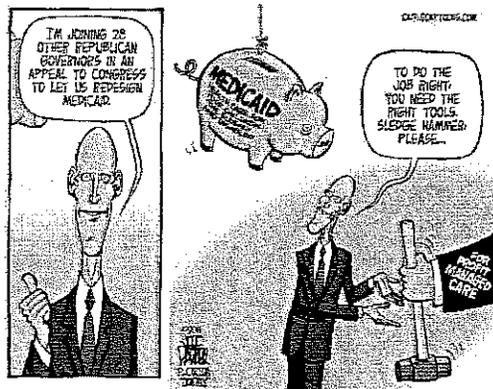
65 and older/disabled = 30% caseload, 60% cost

Factors Driving the Medicaid Shortfall

- Missed projections for Medicaid caseload, service utilization in 2010-2011



Balancing the HHS Budget



How Did They "Balance" Art. II?



- Substantial \$4.8B under-funding of Medicaid
 - Expected to be made up through supplemental appropriation in 2013 (Rainy Day Fund)
- Spending reductions
 - Medicaid managed care expansion statewide
 - Cost-containment initiatives
- Gray area
 - Cost-containment for federal "flexibility"

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Cost Containment: Overview

HHS Cost Containment Initiatives
2012-13 General Appropriations Act, H.B. 1
General Revenue (\$ in mil.)

Cost Containment Initiative	H.B. 1 Target
HHSC Rider 61: Medicaid Funding Reduction	\$450.0
Special Provisions, Section 16: Provider Rates	\$571.3
Special Provisions, Section 17: Additional Cost Containment Initiatives	\$705.0
HHSC Rider 51: Managed Care Expansion	\$385.7
Other Initiatives	\$85.6
Total, Cost Containment Initiatives	\$2,197.6
Estimated Premium Tax from Managed Care Expansion	\$238.0
HHSC Rider 59: Federal Flexibility	\$700.0
Total, Cost Containment Initiatives, Premium Tax, and HHSC Rider 59	\$3,135.6

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Cost Containment Riders in Budget



- Rider 61 requires THHSC to achieve \$450M GR funds through: (of 30 items)
 - Payment reform and quality based payments
 - Increasing neonatal intensive care management
 - More appropriate ER rates for non-emergent care
 - Resulting in 40% cut in reimbursement (see next slide)
 - Maximizing copays in Medicaid
 - Improving birth outcomes by reducing birth trauma and elective inductions
 - Resulting in OB modifier requirement for all Medicaid births (see next slide)
 - Increasing fraud, waste and abuse detection

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Cost Containment Riders in Budget



- Rider 59 requires THHSC to save \$700M GR funds by pursuing a waiver from CMS to allow Medicaid flexibility including:
 - 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

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Budget – Physician Impact



- Physician rates cut cumulative 2%
 - No rate cut in 2012-2013 but 2011 2% cut retained
- Medicare equalization – cuts
- Loan repayment and workforce funds slashed
 - Shortage area loan program cut 78% (\$25M to \$5M)
 - Children’s Medicaid loan repayment eliminated
 - GME and medical student formula funds slashed
 - Family medicine residency program funds slashed

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Budget – Hospital Impact



- Expansion of Medicaid managed care (\$386M GR in savings)
- 8% rate cut for hospitals (added to 2% cut in 2010-11)
- Statewide hospital SDA implementation for 9/1 (\$30M savings - \$20M mitigation)
- Medicaid cost savings implemented (non-emergent care, OB, NICU)
- Medicare equalization – cuts
- Non-emergent services in ER

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Rider 51 Medicaid Managed Care – Budget Certainty

- \$386 million in GR savings
- MCO model offers improved utilization management:
 - Improved utilization achieved through internal MCO processes.
- Premium tax:
 - Premiums paid to Medicaid MCOs are subject to state premium tax.
 - As part of HHSC’s check and balance on the MCOs, HHSC caps the amount of profit that may be earned.

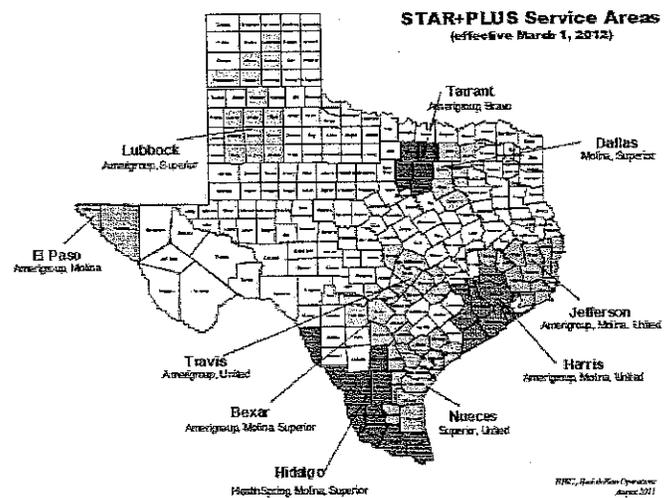
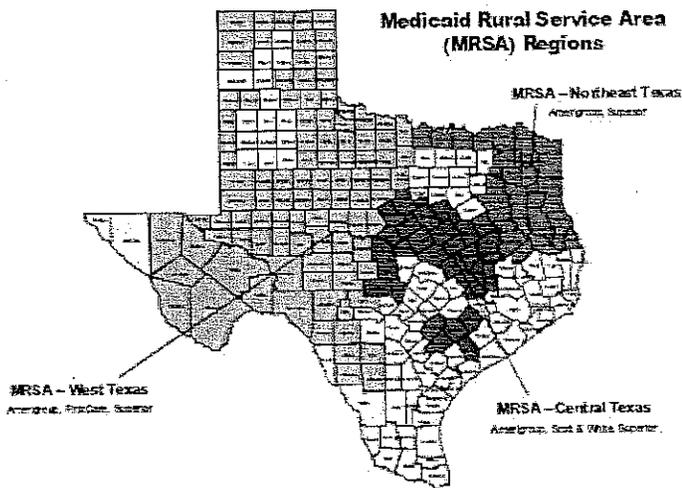
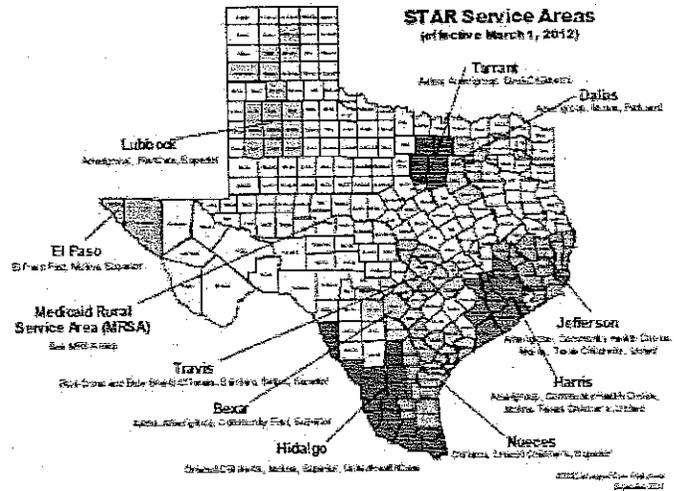


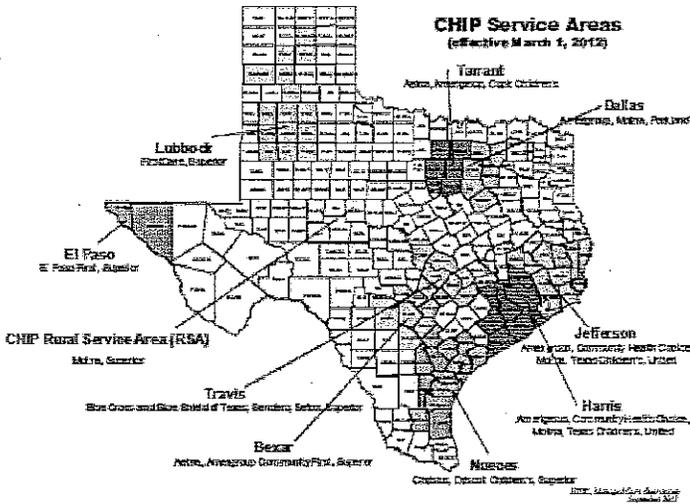
Medicaid Managed Care Expansion

- Expand existing service delivery areas to contiguous counties (9/11)
- Expand STAR+PLUS to Lubbock and El Paso (3/12)
- Expand STAR and STAR+PLUS to South Texas (3/12)
- Convert PCCM areas to the STAR program model (3/12)
- Include in-patient hospital services in STAR+PLUS (no carve-out) (3/12)

Texas Medicaid Managed Care Delivery Models

- **STAR (State of Texas Access Reform)**
 - Capitated, Managed Care Organization (MCO) model for people receiving Temporary Assistance for Needed Families (TANF), non-disabled pregnant women and low income families and children.
 - Provides acute care services.
- **STAR+PLUS**
 - Capitated MCO model for disabled Medicaid clients and dual eligibles (Medicaid and Medicare).
 - Provides acute and long-term services and supports (LTSS).
- **STAR Health**
 - Capitated MCO model for foster care children.
 - Provides acute care services with emphasis on behavioral health and medication management.





Medicaid Managed Care Status

- March 1, 2012, HHSC implemented statewide Medicaid managed care.
 - 3 million covered people in capitated managed care.
 - Major expansion in Hidalgo Service Area (HSA) and rural areas.
 - Administration of Medicaid and CHIP prescription drug benefit added to managed care model.
 - Implementation of a statewide, risk-based dental managed care model to 2.5 million children.
 - Coverage of in-patient hospital services added to STAR+PLUS managed care model.



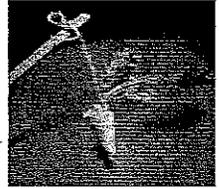
Other Cost Containments Initiatives

- Electronic Visit Verification (EVV)
- Maximizing Co-Pays
- Independent Assessments – Private Duty Nursing
- Amount, Duration and Scope
- Medical Transportation
- Early Childhood Intervention (ECI) Cost Containment Strategies
- Immunizations
- Increasing Fraud, Waste, and Abuse
 - Detection and Claims
 - Orthodontic Enforcement

Hospital Payment Reform



- Pay for Quality – P4Q Adjustment
 - Adjusts payments by linking quality to payment
- Hospital Acquired Conditions
- Potentially Preventable Events (Readmissions, Complications, Admissions)



Healthcare Transformation and Quality Improvement Program "1115 Waiver"



- Promotes critical systemic design
- Managed care expansion
 - Allows statewide Medicaid managed care services
 - Includes legislatively mandated pharmacy carve-in and dental managed care
- Hospital financing component
 - Preserves upper payment limit (UPL) hospital funding under a new methodology
 - Creates Regional Healthcare Partnerships (RHP)



1115 Waiver – Funding Pools



- Under the Waiver, trended historic UPL funds and additional new funds are distributed to hospitals through two pools:
 - Uncompensated Care (UC) Pool:
 - Costs of care provided to individuals who have no third party coverage for the services provided by hospitals or other providers (beginning in first year)
 - Delivery System Reform Incentive Payments (DSRIP)
 - Support coordinated care and quality improvements through RHPs to transform care delivery systems (beginning in later waiver years)

1115 Waiver – RHP Stakeholder Participation



- RHPs shall provide opportunities for public input in plan development and review
- HHSC is seeking broad local plan engagement including:
 - County medical associations/societies
 - Local government partners
 - Other key stakeholders



Questions?

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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.

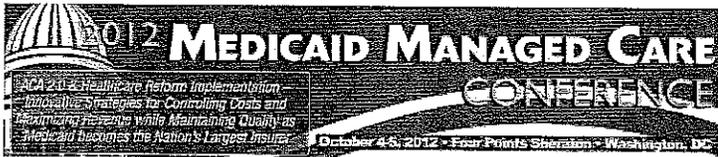
3 Health Status	% of Total Enrollment	% of Total Medicaid Spending	Avg PMPM (\$)
Healthy / Minor	62.0	21.9	297
Single Chronic	16.6	17.9	909
Pairs Chronic	16.8	38.8	1,948
Triples Chronic	2.2	9.7	3,770
Malignancies	0.6	2.1	2,906
Catastrophic Condition	0.8	5.5	5,882
HIV / AIDS	1.1	4.2	3,067
Total	100.0%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



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

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 Director, Bureau of Health Informatics
 Office of Quality and Patient Safety
 New York State Department of Health
 Albany, New York



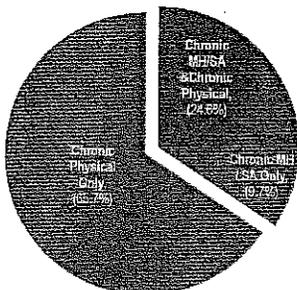
New York's Medicaid Program

- New York's Medicaid program spends approximately \$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 (CY2011)
- New York ranks first nationwide on per capita spending, almost twice the national average.

Medicaid Program Snapshot

- Beneficiaries with 2 or more chronic conditions represent 19 percent of enrollment and 49 percent of overall spending.

Physical & Behavioral Chronic Conditions



Note: NYS Medicaid Program, CY2011

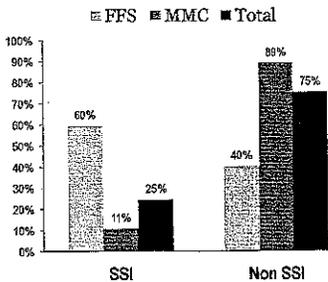
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Medicaid Managed Care

- 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.

Medicaid Managed Care Snapshot

- Beneficiaries with 2 or more chronic conditions represent 14 percent of enrollment and 39 percent of overall costs.



Health Status	% of		MMC PMPM (\$)
	Total MMC Enrollment	% MMC Spending	
Healthy	59.7	25.8	180
Minor Conditions	9.3	8.0	363
Single Chronic	16.4	19.8	504
Pairs Chronic	12.8	32.6	1,068
Triples Chronic	1.0	6.8	2,872
Malignancies	0.3	3.3	4,584
Catastrophic Condition	0.2	2.0	3,651
HIV/AIDS	0.4	1.8	1,862
Total	100.0	100.0	\$ 418

Risk Adjusted Rates

- Provides insight into the acuity of the Medicaid program
- Eliminates adverse selection issues ('cherry picking') by aligning payment to risk
- Meets the needs of a changing program
 - Mandatory managed care enrollment of persons that are SSI, SPMI/SED and HIV/AIDS
 - Medicaid Redesign: 'Care Management for All'
- Streamlines and simplifies the annual rate setting process
- Creates a transparent methodology
- Provides a framework for quality improvement and targeted case management initiatives

Payment Reform Alignment

- Risk Adjustment
 - Group individuals into CRGs
 - Develop weights for each CRG
- Regional Base Payment
 - Based on:
 - Cost Report Data
 - Program Changes
 - Trend

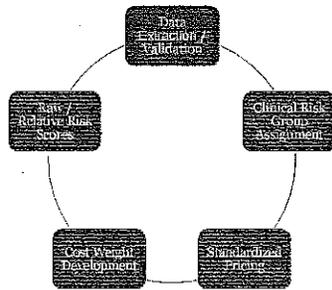
Final Rate Calculation



- The acuity factor ("risk score") is applied to the regional base rate.
- Similar payment design for other NYS Rate Reform Initiatives.
- Four Year Blended Risk Phase In: (25%; 50%; 75%; 100%)

Risk Rate Development Process

- The multi-step methodology used for risk rate development has remained consistent over time, with only minor modifications.



Description of Clinical Risk Groups (CRGs)

- CRGs are a categorical clinical model which assign beneficiaries to a single mutually exclusive risk category.
 - Hierarchical model
- Each CRG is clinically meaningful and provides the basis for the prediction of health care utilization and cost.

CRGs (vs) APGs (vs) DRGs

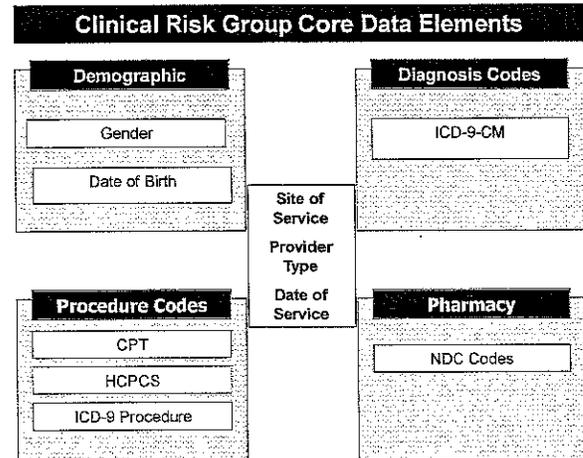
- APGs & DRGs are retrospective and classify an event:
 - APGs classify an institutional outpatient event
 - DRGs classify an inpatient hospital admission
- CRGs can be used both retrospectively / concurrently and prospectively to classify an individual:
 - CRGs analyze the temporal relationships between inpatient, ambulatory, and pharmacy data over a 12 month period of time.

CRG Applications

- Estimating future expenditures
- Understanding the reasons for any increases in expenditures
- Targeting interventions for case management and health homes
- Comparing and evaluating provider performance
- Monitoring and improving quality of care
- Determine and track chronic disease prevalence and progress over time
- Track quality of care
- Address both chronic and multiple medical conditions and the level of severity

The CRG Software is Updated Annually

- Update occurs in July of each year
 - New diagnosis, procedure and pharmacy codes are incorporated
 - The existing base CRGs may be modified
 - New base CRGs may be added
 - Severity level assignment may be modified
- CRG Version v1.10 July 2012 is the current release.
- ICD-10 Compatible

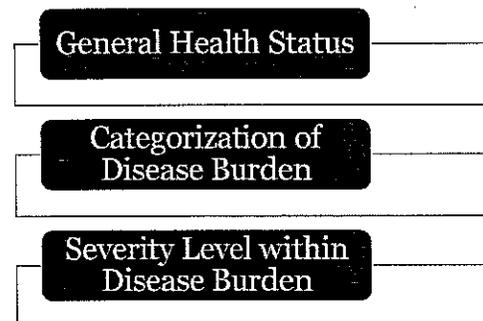


CRGs use standard demographic, diagnostic, procedure, and pharmacy data.

CRGs Use Pharmacy Data

- CRGs look at drugs or combinations of drugs to identify most likely or conditions under treatment.
- From drugs, a diagnosis code is generated for group assignment.
- Not all drugs are linked to specific diseases. For example,
 - Insulin. With the exception of women with gestational diabetes, anyone receiving insulin is almost certainly is a diabetic.
 - Albuterol. Albuterol is a common drug given for asthma and other pulmonary problem, however, it is not definitive. CRG logic looks for a sustained pattern of use.

The Process of Assigning a CRG uses a Clinically Precise Hierarchical Model



CRG Assignment

1. Assignment to one of nine hierarchical health statuses
2. Assignment to one of 304 base CRGs
 - Method of determining base CRGs is health status specific
 - All high volume diseases or combinations of chronic diseases are assigned a unique base CRG, for example:
 - Diabetes
 - Diabetes with CHF
 - Diabetes with CHF and COPD

CRG Status Hierarchy

The Nine CRG Statuses	Example Base CRG	# of Base CRGs	Severity Levels	Total CRGs
1. Healthy	Healthy	18	None	18
2. Significant Acute Disease	Pneumonia	22	None	22
3. Single Minor Chronic Disease	Migraine	41	2	82
4. Minor Chronic Disease in Multiple Organ Systems	Migraine & Hyperlipidemia	1	4	4
5. Single Dominant or Moderate Chronic Disease	Diabetes	107	6	400
6. Pairs - Significant Chronic Disease in Multiple Organ Systems	Diabetes & CHF	61	6	328
7. Triples - Dominant Chronic Disease in Three or More Organ Systems	Diabetes & CHF & COPD	21	6	126
8. Malignancies - Dominant, Metastatic and Complicated	Met Colon Malignancy	22	5	88
9. Catastrophic Conditions	HIV	11	6	44
Total		304		1,112

Assignment Phases

1. Create a health profile from past medical history
 - Major Diagnostic Category (MDCs): 37 levels
 - Episode Diagnosis Category (EDCs): 557 levels and 6 types
 - Episode Procedure Category (EPCs): 639 levels
2. Identify most significant chronic disease (if any) and relative severity
 - Primary Chronic Disease (PCD)
3. Assign a risk group and severity level
 - Base CRG, Severity Level Assignment
4. Assign an aggregate risk group
 - ACRG1, ACRG2, ACRG3
5. Assign alternative risks for prospective and retrospective applications.
 - PCRG, QCRG aggregations

Aggregated CRGs

- The 1,112 CRGs are consolidated into three tiers of aggregation (ACRGs)
- Each successive tier of aggregation has fewer base CRGs
 - QCRG: 1,112
 - QACRG1: 448
 - QACRG2: 183
 - QACRG3: 44
- Severity levels are maintained

Example:

Level of Aggregation	QCRG Code	Description
QCRG	52661	Inflammatory Bowel Disease Level - 1
QACRG1	506111	Dominant Chronic - Digestive Level - 1
QACRG2	5251	Dominant Or Moderate Chronic - Digestive, Hepatobiliary, and Kidney - Level 1
QACRG3	51	Single Dominant Or Moderate Chronic Disease Level - 1

CRG Severity Matrix

Percent of NYS Mainstream Medicaid Managed Care Population, CY2010

Base Health Status	Severity of Illness						Total
	0	1	2	3	4	5	
Healthy	38.08						38.08
Non User	10.62						10.62
Delivery without Other Significant Illness	1.36						1.36
Pregnancy without Delivery	0.62						0.62
Sig. Chronic or Acute Dx	4.20						4.20
History Of Significant Acute Disease	4.80						4.80
Delivery with History of Significant Acute Illness	1.38						1.38
Pregnancy w/o Delivery w/ Hx of Sig. Acute Illness	0.17						0.17
Sig. Chronic or Acute Dx w/ Hx of Sig. Acute Illness	1.88						1.88
Single Minor Chronic	5.41	1.37					6.79
Minor Chronic Disease In Multiple Organ Systems	0.75	0.13	0.56	0.22			1.66
Single Chronic	10.59	3.41	1.05	0.17	0.07	0.02	15.24
Pairs Chronic	5.40	2.65	1.70	1.17	0.44	0.07	11.43
Triples Chronic	0.18	0.16	0.33	0.09	0.08	0.04	0.90
Malignancies	0.02	0.07	0.09	0.08	0.04		0.28
Catastrophic	0.05	0.05	0.05	0.02	0.01	0.03	0.21
Catastrophic - HIV/AIDS	0.24	0.06	0.08	0.01			0.39
Total Medicaid Managed Care	63.11	22.35	8.06	3.83	1.83	0.85	100.00

Relative Payment Weight Development

- Enrollee CRG assignment is combined with eligibility information and health care expenditures into a normative, relative weight by Aggregated CRG (QACRG3).
- Four premium group stratifications of Cost Weights
 - **Family Health Plus** (Medicaid expansion program for 19-64yrs)
 - **SSI (Adults and Children Combined)**
 - **TANF/SN Adults (21 Years and Older)**
 - **TANF Children (0 to 20 Years)**
- Only enrollees with 3+ months of Medicaid enrollment are included in cost weight development.

Relative Payment Weights

- After standardized pricing is applied to the encounter data, the total cost for each member is summed.
- The CRG cost weight is calculated by dividing the average cost for the QACRG3 group by the average cost for members in the premium/age group combination.
- In computing averages, a member's experience is weighted by their member months of eligibility.

Relative Payment Weights: SSI

Base Health Status	Severity Level						
	0	1	2	3	4	5	6
Healthy	0.0713						
Non-User	0.0000						
Delivery without Other Significant Illness	0.2137						
Pregnancy without Delivery	0.2137						
Sig. Chronic or Acute Dx	0.1500						
History Of Significant Acute Disease	0.1559						
Delivery with History of Significant Acute Illness	0.8673						
Pregnancy w/o Delivery w/ Hx of Sig. Acute Illness	0.2887						
Sig. Chronic or Acute Dx w/ Hx of Sig. Acute Illness	0.3074						
Single Minor Chronic	0.2195	0.3333					
Minor Chronic Disease In Multiple Organ Systems	0.3497	0.5044	0.5044	0.6907			
Single Chronic	0.3182	0.5123	0.7866	1.7502	1.7502	2.3465	
Pairs Chronic	0.6980	1.0118	1.3210	1.8356	2.8936	3.6403	
Triples Chronic	1.2664	1.6817	2.4944	3.7836	6.6752	6.6752	
Malignancies	1.4568	2.9092	4.1134	7.4926	10.3098		
Catastrophic	0.7281	1.6988	3.0904	7.5855	7.5855	10.9092	
Catastrophic - HIV/AIDS			2.1826	2.8051	3.6458	7.7984	

^a NYS Medicaid Managed Care, CY2010.

Case Mix Index

- The plan's raw risk score is computed by combining their distribution of members across the CRG groups with the CRG weights.
- This calculation is performed separately for each region and premium group.
- A regional risk score is computed for each premium group using the CRG distribution of all plans operating in that region.
- A relative risk score is computed for each plan by comparing their raw risk score with the regional risk score for each premium group.
- The relative risk scores are used to risk adjust a plan's payment.

Case Mix Index

Health Plan Risk Scores	Plan A	Plan B
Plan Specific Raw Risk Score (A)	1.50	0.90
Regional Risk Score (B)	1.20	1.20
Health Plan Relative Value (A/B)	1.25	0.75

Within each region, health plan CMI's will be above and below 1.0. Plans with a CMI greater than 1.0 have a higher case mix (enrollees with more need); plans with a CMI lower than 1.0 have a lower case mix (enrollees with less need).

Case Mix Index

- Use CRG groups and weights to determine a case mix index (CMI)
 - By health plan
 - By region (9 financial regions)
 - By premium group (4 premium groups)

Health Plan	TANF Child		TANF/SN Adult		SSI		Family Health Plus	
	Raw	Relative	Raw	Relative	Raw	Relative	Raw	Relative
PLAN A	1.1370	1.1229	1.2208	1.1159	1.0949	1.1986	1.2096	1.2203
PLAN B	1.0394	1.0265	1.0394	0.9935	0.8857	0.9696	1.0391	1.0483
PLAN C	1.0195	1.0068	1.0384	0.9949	0.9137	1.0002	0.9831	0.9918
PLAN D	0.9956	0.9832	1.0997	1.0052	0.8961	0.9810	0.9872	0.9960
PLAN E	0.8916	0.8805	0.9715	0.8880	0.8417	0.9214	0.9211	0.9293
Regional Total	1.0128	1.0000	1.0940	1.0000	0.9135	1.0000	0.9912	1.0000

Regional Base Payment: MMCOR Cost Report Data

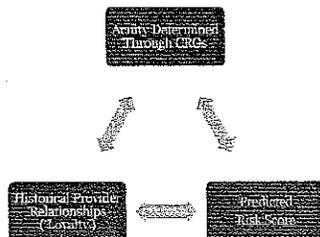
- Using the cost data and encounter data reported by plans, a regional base is created for each premium group
- All covered benefits included in the base
- Uses the previous year's cost report

Regional Base Payment: Program Changes and Trend

- The base payment is increased/decreased based upon program changes
 - New benefits into plan capitation (e.g. Pharmacy carve-in)
 - Efficiencies in reducing Potentially Preventable Readmissions (PPRs) are reduced the regional base
- All adjustments must be made at a regional level (9) by premium group (4)
- Using information on national health care trends, NY State MMCOR data, and program changes, Mercer (NY's Actuary) develops a proposed annual trend

Health Home Assignment Overview

- A combination of three distinct analyses are conducted at the eligible enrollee level to help prioritize and classify Medicaid enrollees for Health Homes:
 - Clinical Risk Groups (CRG)
 - "Loyalty" to existing providers
 - Predictive model risk score



Quarterly Monitoring

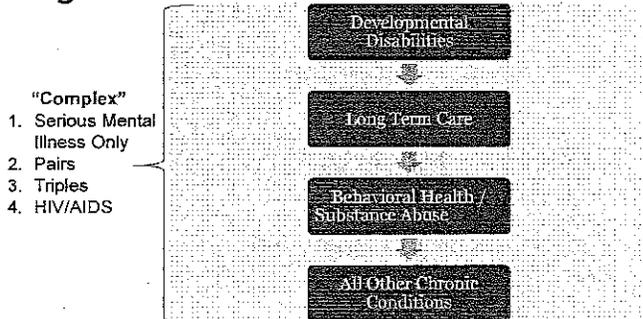
- Risk Payment is done once a year – however -
- On a rolling quarter, data are extracted and 'rolling risk' is monitored for informational purposes only
- Raw and Relative Value CMI's by region, by premium group, are shared with health plans
- Actuarial Review/Consultation

Attribution Methods

- In 12 month service periods (CY 2009, CY 2010, July 2010-June 2011)
 - Severity of Illness / Clinical Acuity ("High Need")
 - Medicaid Claim Spending ("High Cost")
 - Eligibility/Enrollment
 - Socio-demographics
 - Historical Service Utilization

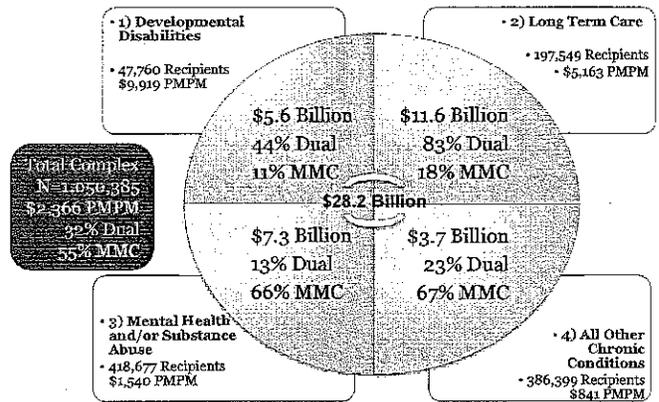
As a predictive modeling application, CRGs provide granular level detail on specific chronic conditions and severity of illness.

Mutually Exclusive Hierarchical Assignment Based on Service Utilization



* Long Term Care includes: more than 120 days of consecutive LTC needs and/or enrollment in Managed Long Term Care (PACE, Partial MLTC and MAP).

Complex Populations: All Ages



Time Period: July 1, 2010 – June 30, 2011

Framework for Quality Improvement

- Quality Improvement Research
Morris LS, Schettine A, Roohan PJ, & Gesten F (2011). Preventive Care for Chronically Ill Children in Medicaid Managed Care. *American Journal of Managed Care*. 17 (11): e435-e442
- Disease Measurement (e.g., Diabetes, HIV/AIDS, Asthma, Serious Mental Illness)
- Health Plan Quality Incentive
- Identification of MMC Enrollees for Targeted Case Management Initiatives
- Dual Integration Analytics (Chronic Disease Prevalence, etc.)

Additional Information

NYS Department of Health:

Mary Beth Conroy, MPH
Bureau of Health Informatics
Office of Quality and Patient Safety
Phone: 518-486-9012
E-mail: mbm07@health.state.ny.us

3M Clinical Risk Groups:

http://solutions.3m.com/avps/portal/3M/en_US/3M_Health_Information_Systems/HIS/Products/CRG/

John S. Hughes, MD, Richard F. Averill, MS, Jon Eisenhandler, PhD, Norbert L. Goldfield, MD, et al., "Clinical Risk Groups (CRGs), A Classification System for Risk-Adjusted Capitation-Based Payment and Health Care Management" *Medical Care* Vol. 42, No. 1, January 2004, pp.81-90.

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.

ACO Organization Features and Medicaid Managed care

Gary Jacobs, Managing Director of Government Programs
 Killeen Gebreyes, MD, MBA, Director
 PwC
 October 4, 2010

pwc

Overview

The State of Medicaid Managed Care

- Current Situation
- Medicaid and managed care initiatives (PCCM, PCMH, MCOs)
- Managed LTCSS

State ACO Development Initiatives

ACOs and the Evolving Government Programs Market

- The Rules of Engagement
- 7 Pillars of Success
 - Foundation Competencies for all Government Program
- Care Management Programs in Shared Risk Programs
 - ACOs and Quality Metrics
 - Care Management Models

Winning in the Evolving Marketplace

PwC

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The State of Medicaid Managed Care

Situation and Opportunities

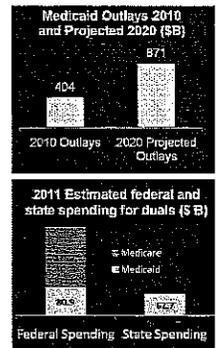
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The costs of Medicaid are projected to double over the next 10 years

ACA provisions will add nearly 26 M lives and \$619 B in costs over the 10 year timeframe

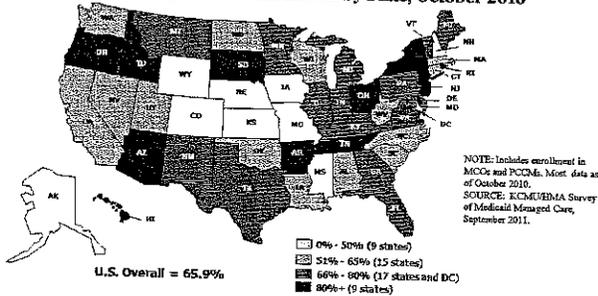
- Average Medicaid enrollment in 2010 was 54 M
 - 68 M were enrolled for at least one month
- By 2020, average enrollment is expected to increase to 85 M
- 2010 Medicaid outlays reached \$404 B and are expected to increase by nearly 5% per year thru 2020
 - In 2010, the federal government paid 68% of Medicaid costs
- Today, dual eligibles represent a \$320 B expenditure
 - Duals projected to increase from 9 M to 18 M lives over the next 20 years



PwC

Faced with budgetary challenges, States have increasingly relied on forms of managed care to organize and deliver Medicaid services
 All states except Alaska, New Hampshire and Wyoming operated comprehensive MMC programs, YE 2010

Medicaid Managed Care Penetration by State, October 2010



Medicaid Managed Care programs have developed along two parallel tracks
 States have relied on both capitated programs using MCOs and enhanced fee for service models (PCCM)

Capitated Programs

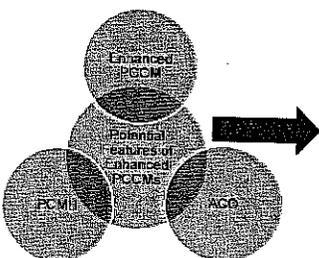
- 36 States contract with MCOs on a risk basis
- Over 26 million enrolled in MCOs (800,000 duals in 2010)
- Payments to MCOs account for only 20% of total Medicaid spending on services
- Disabled and elderly remain in fee for service
- Nursing home care typically excluded

Enhanced Fee for Service

- 31 States operate PCCM programs
- 8.8 million enrollees
- Dominant form of managed care in rural areas
- Payments to PCPs include small PMPM to manage and monitor primary care and authorize referrals
- States using PCCM programs as basis for developing enhanced PCCMs and Medical Homes

Starting in the 1990s, PCCM programs began incorporating a variety of enhancements

Enhanced programs moved in the direction of PCMHs and include elements common to an ACO



Enhanced PCCM programs support care coordination with payment incentives, information sharing, and performance reporting
 State examples

State	Care Management and Coordination	Provider Reimbursement	Performance Monitoring and Reporting
OK	<ul style="list-style-type: none"> • State employed nurse care managers and social services coordinators • Health management program for 5,000 high cost enrollees • Office based PCPs 	<ul style="list-style-type: none"> • \$4 to \$9 PMPM care management fee • Additional P4P payment incentives 	<ul style="list-style-type: none"> • HEDIS • CAHPS • Provider profiles
NC	<ul style="list-style-type: none"> • Local community based networks made up of physicians, hospitals, local health and social services departments 	<ul style="list-style-type: none"> • \$2.50 PMPM to PCPs (\$5 for ADB enrollees) • \$3 PMPM to local networks (\$5 for ADBs) 	<ul style="list-style-type: none"> • HEDIS • CAHPS, consumer focus groups, disenrollment surveys • Practice profiles
PA	<ul style="list-style-type: none"> • Disease management and care coordination vendor • In-state Medicaid agency for intense medical case management 	<ul style="list-style-type: none"> • Additional P4P payment incentives for PCPs 	<ul style="list-style-type: none"> • Care coordination process and utilization measures • HEDIS • Chronic illness survey
IN	<ul style="list-style-type: none"> • Two care management organizations (CMOs) • Office based PCPs 	<ul style="list-style-type: none"> • \$15 PMPM administrative fee to PCPs • \$40 per patient fee for care coordination conferences • \$25 PMPM to CMOs, 20% contingent on quality performance 	<ul style="list-style-type: none"> • CMS quality related performance measures

Today, at least 41 states have moved beyond the EPCCM to medical homes for Medicaid and CHIP
Key features of state medical home models

Provider compensation

- Maryland has established a PMPM that varies by provider type and Medical homes, paying more for higher NOQA recognition.
- Oklahoma and parts of PA use performance based payments.
- Alabama and Maryland have payment strategies rewarding PCMH recognition criteria or performance standards.
- Alabama and Iowa adjust PMPM to foster collaboration among other service providers.
- Iowa pays PCPS for remote consultation with hospital based specialists.
- Washington is using a full capitation model.

Elements of Medical Home Model

Care Coordination

- States place a high priority on ensuring that patients and practices have access to care coordinators.
- Alabama's networks share a platform to share care coordination resources.
- PA, RI, NE make payments specifically to fund care coordinators.
- Iowa directs practices to use a portion of the PMPM to hire care coordinators.
- Maryland and several other states are exploring the use of state resources to train care coordinators.

Improving Performance

- Alabama works with providers to use an EHR and provides quarterly utilization reports.
- Iowa has explicitly directed participating practices to use a portion of the per-member per-month payment made by the state to establish and maintain a registry for tracking key information and develop a system for sharing clinical information with a key hospital.
- Nebraska is offering funding for a patient registry and assistance in implementing it, and providing access to data from Medicaid claims for services provided to their patients.

Mature state PCMH programs have demonstrated improved cost and quality outcomes

Utilization

- Vermont Medicaid pilots saw a 21% and 19% decrease in emergency department visits.
- North Carolina ADB hospital admissions decreased 2% while admissions for unenrolled ADB population increased 31%.

Quality

- Vermont Blueprint improved lung-function assessment for asthma and self-management for diabetes.
- North Carolina in top 10% on national quality measures for diabetes, asthma, heart disease.
- Oklahoma has improved HEDIS quality measures including diabetes screening, breast cancer screening.
- Oklahoma access complaints decreased from 1,970 in 2007 to 13 in 2009.

Costs

- North Carolina saved nearly \$1.5 B between 2007 and 2009.
- Colorado had a 21.5% reduction in median annual costs for children in a medical home compared to non medical home participants.
- Vermont saw a 12% decrease in PMPM costs for commercially insured from 2008 to 2009.

To further promote PCMH development, ACA established a state plan option for Medicaid health homes for beneficiaries with chronic conditions
Key parameters of the health home initiative

- Builds on the patient-centered medical home model
- Medicaid beneficiaries are eligible if they have
 - 2 or more chronic conditions
 - 1 chronic condition and at risk for a second
 - 1 serious and persistent mental health condition
- Home health services are
 - Comprehensive care management
 - Care coordination and health promotion
 - Comprehensive transitional care
 - Patient and family support
 - Referral to community and social support services
 - Use of HIT to link services and facilitate communication
- Health home must develop a care plan for each person that coordinates and integrates all clinical and non clinical services and have a continuous QIP

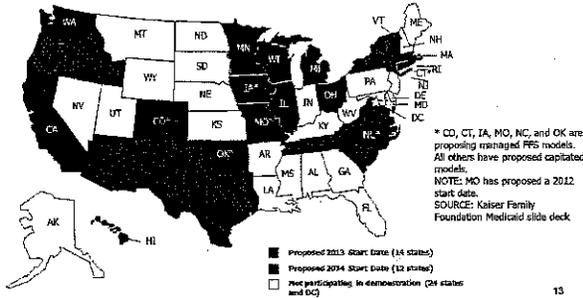
20 states have indicated their interest in the program
 CMS has approved 6 states so far: MO, RI, NY, OR, NC, IO

3 of the first 4 state health home programs continue to use PMPM payments for care management services

State	Target population	Providers	Payment
MO	Two programs statewide: 1) beneficiaries with serious and persistent mental health conditions; 2) beneficiaries with 2 or more chronic conditions above and at risk for a second. Auto assignment with opt out.	For the mental health population: community mental health centers. For the chronic condition population: FQHCs, rural health clinics and hospital operated primary care clinics. Must meet federal and state criteria and NCOA PCMH requirements.	PMPM for clinical care management for service delivery, admin support services in addition to FFS payments.
RI	Two statewide programs: 1) individuals with serious and persistent mental illness; 2) children and youth with special needs. Auto assignment with opt out.	For the mental health population: designated the 9 CMHOs. For the special needs program designated CEDARR family centers.	CMHOs are paid a case rate. CEDARRs are paid FFS for certain services and hourly rate for others.
NY	Individuals with 2 or more chronic conditions in NYMMS and a risk of developing another chronic condition or mental illness. (Does not include those receiving LTC or with intellectual disabilities. Roll out in 3 phases. Auto assignment with opt out).	12 entities selected in Phase 1 counties based on state standards and federal requirements for health home model.	PMPM adjusted by region by case mix with payment tiers based on whether beneficiary is in the active case management group or not.
OR	Individuals with 2 or more chronic conditions, one chronic condition and risk of developing another, or one serious mental illness. Assignment voluntary with right to opt out.	Providers can include PCPs, NPs, PAs, group practices, FQHCs, rural clinics, CHCs, CMHOs, drug and alcohol treatment centers. Providers must meet minimum standards and are classed in tiers based on degree to which they meet standards.	PMPM based on home health tier. Tier 1 \$10 PMPM, Tier 2 \$15 PMPM, Tier 3 \$24 PMPM. Must provide services at least 1 time per quarter to receive funds.

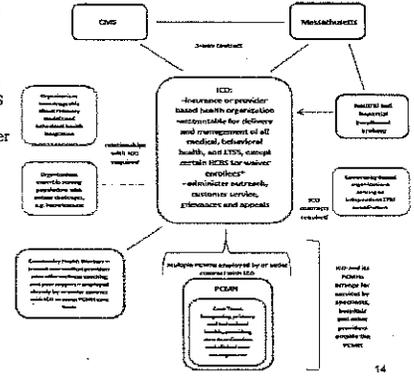
CMS dual demonstrations provide another opportunity to expand managed care features in a market historically dominated by FFS

Of the 26 states that submitted proposals to participate in the financial alignment demo, 14 proposed 2013 start dates (7 of these states proposed capitated demos to cover 1.4 M lives)



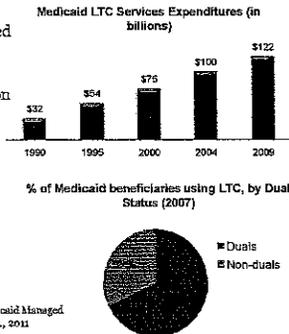
Massachusetts is the first state to have an MOU with CMS for the dual financial alignment demo
An overview of the MA proposal

- Focuses on full benefit duals age 21-64 (estimated 115,000)
- Enrollment voluntary supported by brokers
- Covers Medicare A, B, D and Medicaid state plan benefits except certain LTSS for waiver participants
- Uses ICOs (insurance-based or provider based organizations) in a capitated model
- ICO receives risk adjusted global payment with shared savings
- ICO performs all admin functions
- ICO must offer care coordination
- ICO will contract with PCMHs providing team based primary and behavioral health
- PCMH will provide clinical care management for duals with complex medical needs



Dual demos have sparked increased interest in operating managed LTCSS programs
LTCSS account for 70% of state Medicaid spending on duals

- In 2009, Medicaid LTC expenditures accounted for approximately half of all Medicaid expenditures
- Dual eligibles account for 2/3 of LTC utilization
- Today, only 11 states operate capitated managed long term care programs
- Current research indicates that when compared to fee for service programs, MLTSS programs reduce the use of institutional services and increase access to HCBS, but there is little evidence if the model saves money or improves outcomes.*



* Kaiser Commission on Medicaid and the Uninsured, "Examining Medicaid Managed Long Term Service and Support Programs: Key Issues to Consider", Oct., 2011

In 2011, 11 States operated capitated managed LTCSS programs
Only 5 State programs were integrated with Medicare

State	Target Population	Enrollment Type	Scope of Services Beyond Community Based LTSS
AZ	Fragile elderly, people with disabilities except developmental disabilities	Mandatory	Institutional LTSS, medical
FL	Fragile elderly	Voluntary	Institutional LTSS, medical
HI	Fragile elderly, people with disabilities except developmental disabilities	Mandatory	Institutional LTSS, medical
MA	Fragile elderly	Voluntary	Institutional LTSS, medical
MN	Fragile elderly	Voluntary	Limited institutional LTSS, medical
NM	Fragile elderly, people with disabilities except developmental disabilities	Mandatory	Institutional LTSS, medical
NY	Primarily frail elderly, some younger adults with physical disabilities	Voluntary	Institutional LTSS, limited medical
TN	Fragile elderly, younger adults with physical disabilities	Mandatory	Institutional LTSS, medical
TX	Fragile elderly, younger adults with physical and mental disabilities	Mandatory	Limited institutional LTSS, limited medical
WA	Fragile elderly, younger adults with disabilities	Voluntary	Institutional LTSS, medical
WI	Fragile elderly, younger adults with physical or developmental disabilities	Voluntary	Institutional LTSS

* Program is integrated with Medicare

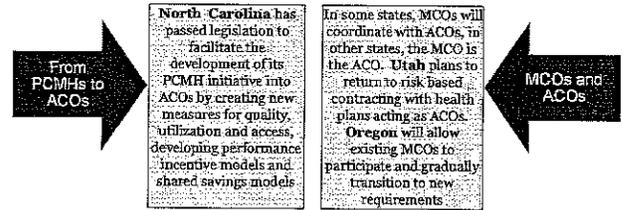
Medicaid ACO Development

State Initiatives

ACOs are the next logical step in the evolution of Medicaid managed care



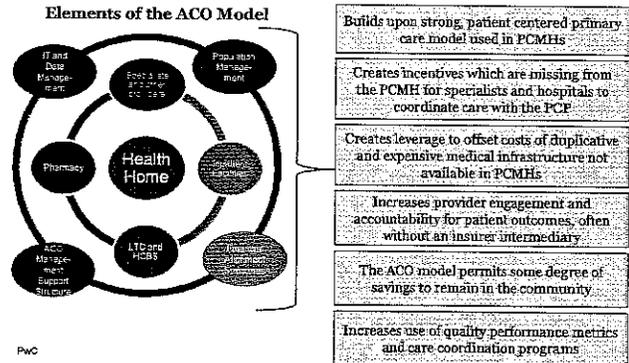
State ACO programs build upon their Medical homes and often incorporate MCOs in a major way thus minimizing distinctions between PCMHs, MCOs and ACOs



States are creating their own definitions of ACOs based upon historic experience with MMC. As a result, a variety of Medicaid ACO payment models and organizational structures are emerging

State	Payment model	Organizational Structure	Delivery System	Service Area	Target Population
CO	F2M/FM payment to ACO and PCPs	Hybrid MCO/provider led ACO	Fee for Service	Statewide	Initial phase excludes duals and psychiatric and LTC residents; expands to all Medicaid
MN	Shared savings with upside risk only or upside and downside risk	Provider led ACOs, hybrid MCO/ ACO	Fee for Service and managed care	Statewide	Excludes dual eligibles
NJ	Shared savings with upside risk	Provider led ACOs	Fee for service and managed care	Statewide	Excludes dual eligibles
OR	Global payment	Hybrid MCO/ ACO	Fee for service and managed care	Statewide	Excludes PACE
Utah	Global payment	MCO led ACOs	Managed care	4 counties in Salt Lake area	Excludes nursing homes or other inpatient facilities

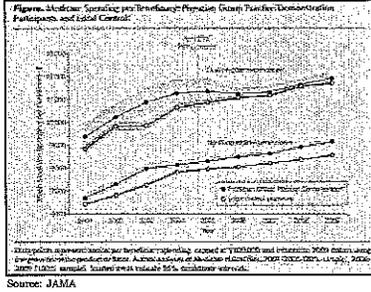
Why move to ACOs in a market where 2/3 of enrollees are already in some form of managed care? States see ACOs as an opportunity for further coordination, improved outcomes, and greater efficiency and value



A new study concludes that ACO features can produce cost savings for the most costly populations
The Physician Group Practice Demonstration, a precursor to the ACO, shows significant improvements in costs for duals

The study, appearing in the Sept. 12 Journal of the American Medical Association, shows initiative's developed by participating physician groups generated:

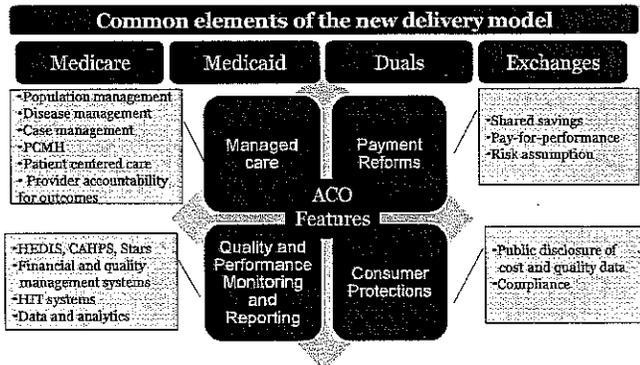
- \$114 annually in average savings per patient overall;
- \$532 annually in average savings for dual eligibles



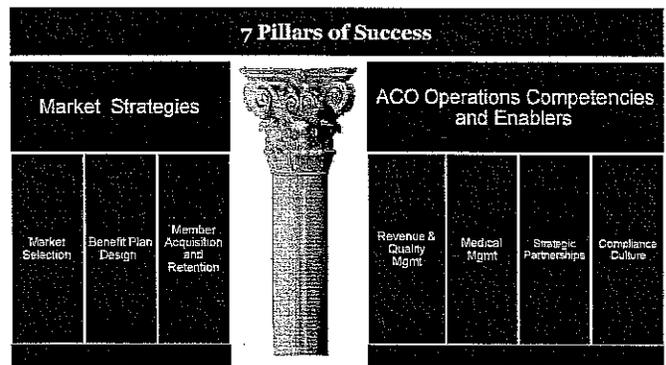
ACOs and the Evolving Government Programs Market

Rules of Engagement and Pillars of Success

The rules of engagement for the Medicaid market and other government programs are evolving and ACO features will be integral to success in all markets

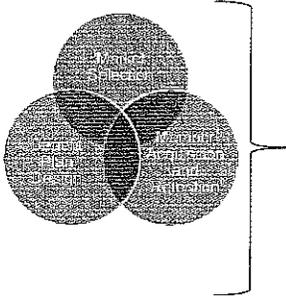


Success in Medicaid managed care (and other government programs) necessitates embracing ACO core competencies and targeted market strategies



Medicaid managed care market strategies will be driven by State design features and key product differentiators

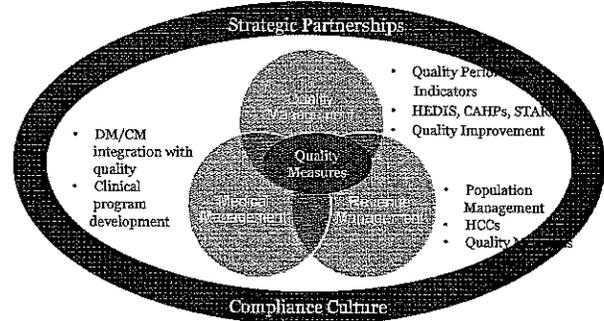
MMC Market Strategies



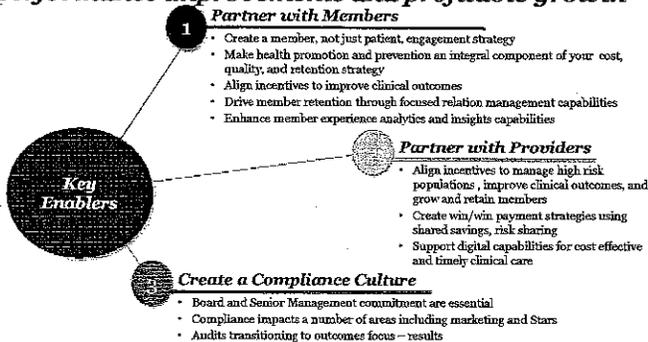
- Key Medicaid Managed Care Issues**
- State reimbursement strategy**
 - Enrollment Issues**
 - Mandatory or voluntary
 - Auto assignment
 - Opt out
 - Turnover
 - Networks will be key differentiators**
 - Need to meet needs of high risk members
 - Frail elderly
 - AIDS
 - Chronic conditions
 - LTSS
 - Quality will be a key product differentiator**

ACO operational competencies will form the foundation for achieving quality and cost performance goals

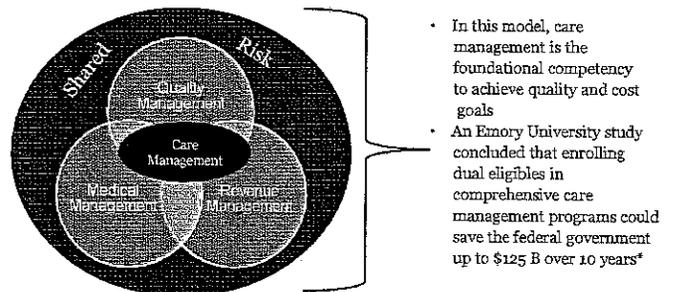
Operational Competencies and Enablers



Strategic partnerships and a compliance culture will enable the operational competencies leading to performance improvements and profitable growth



The combination of ACO operational competencies integrated in a shared risk arrangement will become the norm as the government sector evolves



* Source: Kenneth Thorpe, Ph.D., Emory University, *Estimated Federal Savings Associated with Care Coordination Models for Medicare-Medicaid Dual Eligibles*

Care Management in Shared Risk Programs

ACOs and Quality Metrics Care Management Models

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Executive Summary

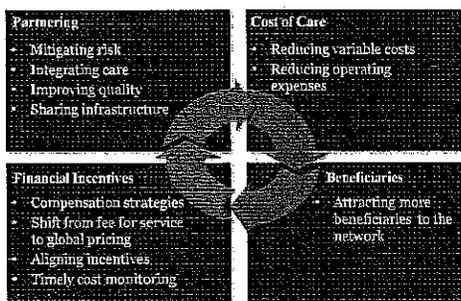
- Providers and payers generally consider outcomes to four factors prior to adopting a shared risk program:
 - Partnering
 - Cost of Care
 - Financial Incentives
 - Beneficiaries
- These factors link quality improvement metrics with ROI
- There are numerous demonstration projects and initiatives that highlight successful care management models

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Providers consider four key factors when evaluating the cost and benefits of adopting an ACO model

ACO Adoption Considerations

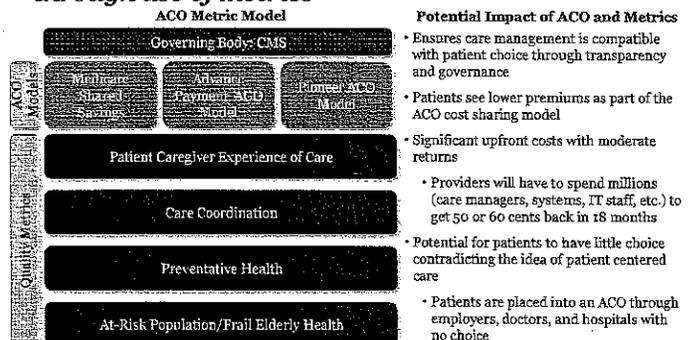


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Source: PwC Health Research Institute

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Adopting an ACO model can have immediate upfront costs but long term improvement in quality of care through use of metrics

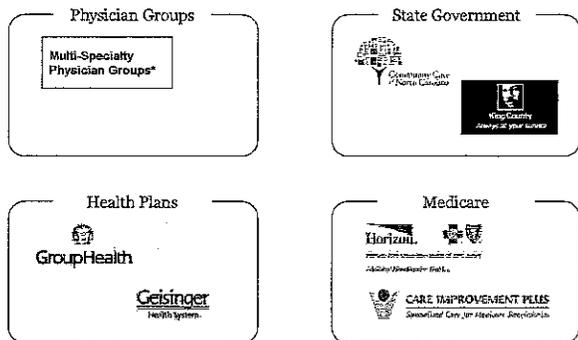


Source: PwC analysis; Wall Street Journal interviews with Donald Benwick, Former CMS Administrator, Tom Scully, Partner at Welsh Carson Anderson & Stowe, and Jeff Goldsmith, President of Health Futures

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Payers and providers have leveraged quality metrics to identify key improvements in care



*Case Study Hospitals: Billings Clinic, Dartmouth Clinic, The Everett Clinic, Forsyth Medical Group, Geisinger Health System, Marshfield Clinic, Middlesex Health System, Park Nicollet Health Services, St. John Health System, Univ. of MI Faculty Group Practice

Majority of payers and providers have seen improvement in Care Coordination and At-Risk initiatives

Grouping	Organization Name	Patient Care Giver (PCG)	Care Coordination (CC)	Preventative Health (PH)	At Risk (AR)
Physician Groups	Multi-Specialty Physician Groups*		✓	✓	✓
	Group Health	✓			✓
	Geisinger Health Plan	✓	✓	✓	
State Government	Community Health North Carolina		✓		✓
	Washington State King's County			✓	
Medicare	Horizon BlueCross Blue Shield		✓		✓
	Care Improvement Plus		✓		✓

*Case study is comprised of 10 hospitals
Source: PwC analysis

Case Study: Multi-Specialty Physician Group Practice Demonstration

Model Description

Model used to identify successful health care redesign and care management models that can be replicated and spread across the health care system. Physicians are rewarded for:

- Improved patient outcomes through coordinating care for patients with chronic illness, multiple co-morbidities, and transitioning care settings

Process Measures

- Issued Diabetes Report Cards
- Implemented "Best Practice Guidelines"
- Utilized E-Prescribing
- Maintained Disease Registries

Return on Investment

- Earnings over the 5 year demonstrate:
- MSPGPs earned a collective \$107.5 million in performance payments
 - Medicare savings totalled \$134 million

Impact Achieved

- Performance increase in quality metrics from baseline year 1 to performance year 5:
- 11% on diabetes measures
 - 12% on heart failure measures
 - 6% on coronary artery disease measures
 - 9% on cancer screening measures
 - 4% on hypertension measures



Case Study: Medical Home Initiative

Model Description

Multidisciplinary team of physicians, registered nurses (RN), nurse practitioners, case managers, etc. that coordinate care prior to a physicians visit. Coordination includes:

- Review of patients records prior to appointments to highlight acute, chronic, or preventative care needs
- Arrangement of care needs is completed prior to visit

Process Measures

- Phones answered by doctors, RNs, and licensed practical nurses
- Physician/Patient created, care plans
- After-visit summaries created for patients

Return on Investment

- Pilot ROI 21 months following implementation was 1.5:1

Impact Achieved

- Quality measures at both the pilot site and nonparticipating sites showed improvement
- Improvements at the pilot clinic continued to be 20-30 percent greater for three of the four composites
- All-cause inpatient admissions were 6 percent less over 21 months at the pilot site

Case Study: Proven Health Navigator Initiative

Model Description	
<p>Proven Health Navigator medical home initiative to improve primary care for patients and physicians by increasing patients' access to health care through implementation of innovative technology and streamlining administrative functions, such as:</p> <ul style="list-style-type: none"> Sharing Electronic Health Records, leveraging predictive modelling, enhancing discharge transitions and on-site medical home support 	
Process Measures	Return on Investment
<p>Emphasized teamed coordination featuring:</p> <ul style="list-style-type: none"> Pre-visit nurse care coordinators EHR decision-support tools Annual performance incentives 	<ul style="list-style-type: none"> Estimated ROI of more than 2 to 1 for the initiative
Impact Achieved	
<ul style="list-style-type: none"> 18% reduction in hospital admissions 7% reduction in total PMPM costs (\$500 per enrollee per year) Statistically significant improvements in quality of preventive (74.0% improvement), coronary artery disease (22.0%), and diabetes care (34.5%) 	

Source: AHP Center for Policy Research: Innovations in Reducing Preventable Hospital Admissions, PwC Readmissions, and Emergency Room Use, June 2010

Case Study: Medicaid Sponsored Patient Centered Medical Home Interventions Initiatives

Model Description	
<p>Public-private partnership initiative that brings together regional networks of physicians, nurses, pharmacists, etc. to support an innovative delivery model</p> <p>Model links beneficiaries to a primary care home, provides technical assistance to improve chronic care services, and adds a patient care coordination fee to help improve care</p>	
Process Measures	Return on Investment
<ul style="list-style-type: none"> Provided chronic care service assistance Hired a core group of nurses to collaborate on high-risk patients Added \$2.50 PMPM care coordination fee 	<ul style="list-style-type: none"> Cumulative savings of \$974.5 million over 6 years (2003-2008) Saved nearly 1.5 billion dollars in Medicaid claims from 2007-2009
Impact Achieved	
<ul style="list-style-type: none"> 93% of asthmatics received appropriate maintenance medications 15% improvement on diabetes quality measures 40% decrease in hospitalizations for asthma 16% lower emergency department visit rate 	

Case Study: Wellness Health Initiative

Model Description	
<p>Pilot to incentivize healthy behaviour through a disease management program, enhanced patient case management, patient nurse advice line, and benchmarking provider best practices</p>	
Process Measures	Return on Investment
<ul style="list-style-type: none"> Conducted a health risk appraisal Targeted follow-up health behavioural change programs Action plans to reward healthy lifestyles 	<ul style="list-style-type: none"> Projected to yield potential annual ROIs of 2.0 to 3.0 from 2005 through 2009 from: <ul style="list-style-type: none"> Disease and case management Nurse line and high-performance network
Impact Achieved	
<ul style="list-style-type: none"> ~90% of King County employees and their covered partners are enrolled in the health benefit plan Employees have taken the health assessment showing a commitment to healthy lifestyles 	

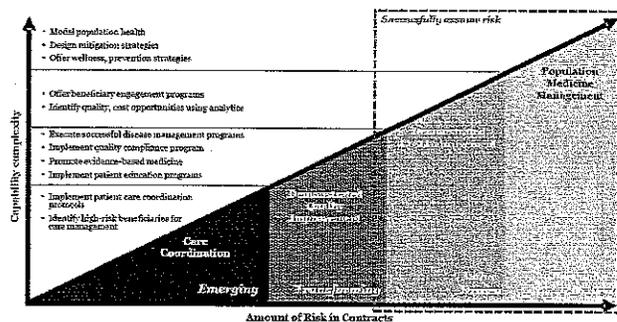
Case Study: The Medicare Advantage Emergency Room Initiative

Model Description	
<p>Multidisciplinary teams convene monthly to review records of Medicare Advantage members who account for the greatest portion of ER visits in an effort to reduce emergency room visits by Medicare members</p>	
Process Measures	Return on Investment
<ul style="list-style-type: none"> Pharmacists and MDs find safe alternatives to problematic medications Patient outreach by disease management nurses to those with chronic conditions 	<ul style="list-style-type: none"> 36% reduction in ER use among Medicare members
Impact Achieved	
<ul style="list-style-type: none"> In 2009, ER use declined by 35.9% among Medicare Advantage members who had eight or more emergency room visits during the previous year 	

Case Study: Medicare Advantage Chronic Special Needs Plan Initiative

Model Description	
Model uses a collection of population-based and individualized patient outreach programs under the umbrella of a regional preferred provider organization to identify gaps in care and promote primary care	
Process Measures	Return Investment
<ul style="list-style-type: none"> Registered nurses and physicians make house calls 24/7 care mgmt and coaching hotline Offering end-of-life planning services 	<ul style="list-style-type: none"> Enhancing primary care produces long term net cost savings for the special-needs plan
Clinical Outcomes	
<ul style="list-style-type: none"> Participants had lower rates of hospitalization and readmission compared to fee-for-service Medicare 19% lower risk-adjusted hospital days per enrollee compared to fee-for-service Medicare 7% higher risk-adjusted physician office visits compared to fee-for-service Medicare 	

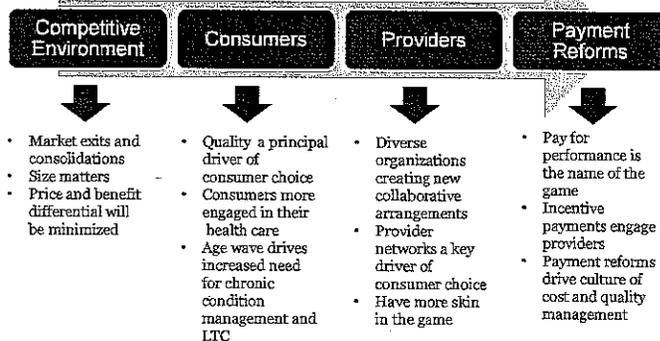
Success in Care Delivery Transformation requires development of increasingly complex capabilities



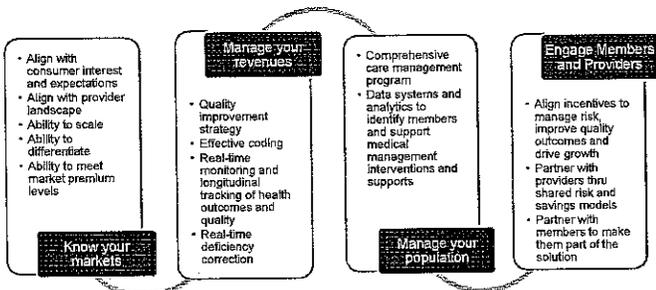
Winning in the Evolving Marketplace

A Formula for Success

The marketplace of the future is taking shape today Cost and quality performance requirements will drive change



The future belongs to those who prepare for it today
The best way to predict the future is to create it.
Peter Drucker



Strategic partnerships with providers, members, and other organizations necessary to create a high performance, value based organization are fundamental to winning in the future government marketplace.

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

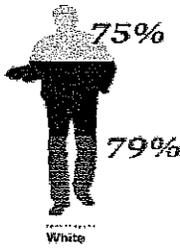
- Price and risk selections are top concerns for insurers but a broader consumer strategy should also be developed.
- Providers should prepare for a new population that may have pent up demand for services.
- Employers are contemplating whether exchanges present a viable option to employer managed coverage.
- 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



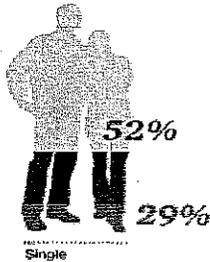
Health status

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



Marital status

...more likely to be single



Language

...less likely to speak English



Educational attainment

...less likely to have a college degree



Employment status

...less likely to have full-time employment



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/en/health-coverage

	Median age	Median income
● Newly insured	33	166% FPL
■ Currently insured	31	333% FPL

What will the individual exchange members look like?

Race

The majority are white.



Health status

The majority are in relatively good health.



Marital status

Most are not married.



Language

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



Educational attainment

Three-fourths do not hold a college degree.



Employment status

More than half are employed full-time.



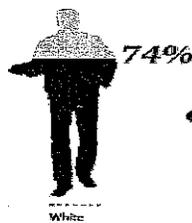
Sources: PwC HRI analysis for year 2021, Current Population Survey, Medical Expenditure Panel Survey and CBO

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

What will the new Medicaid population look like?

Race

The majority are white.



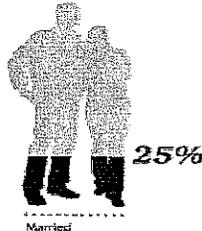
Health status

The majority report being in relatively good health.



Marital status

Most are not married.



Language

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



Educational attainment

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



Employment status

A minority are employed full-time.



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

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

Health Insurance Exchanges: Long on options, short on time

October 2, 2012

pwc

Agenda

- 1 Introduction
- 2 An emerging customer base
- 3 The public and private faces of insurance exchanges
- 4 Health industry implications

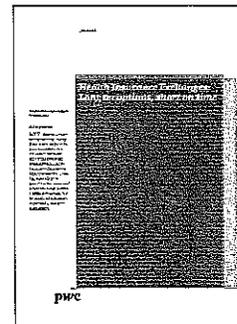
Introduction

1

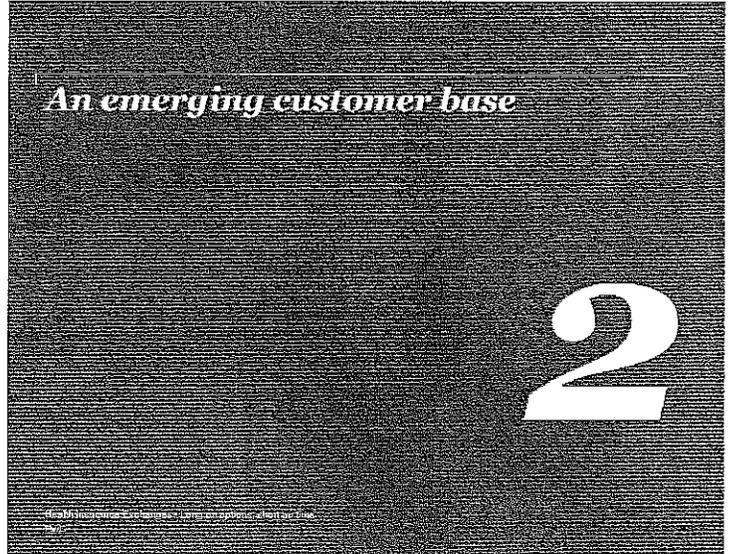
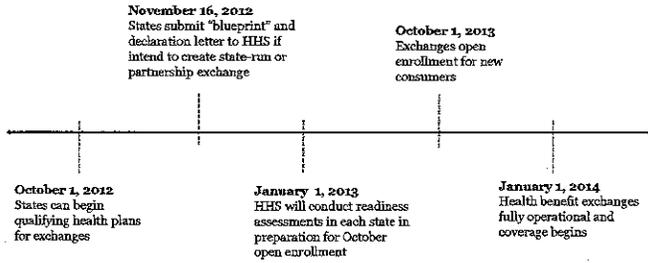
Section 1 – Introduction

About this research

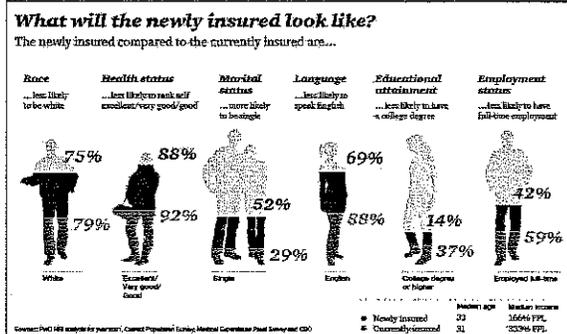
- Analyzed data from the Current Population Survey, Medical Expenditure Panel Survey and Congressional Budget Office publications
- The demographic profile describes the newly insured and individual exchange population in 2021
- Interviewed 15 health industry and government leaders



In 2014, 12 million Americans are expected to begin purchasing health insurance through exchanges



The newly insured will be less educated and less likely to speak English as primary language



Medicaid expansion may shift the number of enrollees going into the exchanges

	All states expand Medicaid to 138% FPL or above	Some states expand Medicaid to 138% FPL or above	No states expand Medicaid beyond current levels
2012	*11 million enrollees *\$50 billion in premiums	*12 million enrollees *\$55 billion in premiums	*13 million enrollees *\$60 billion in premiums
2021	*27 million enrollees *\$190 billion in premiums	*29 million enrollees *\$205 billion in premiums	*32 million enrollees *\$230 billion in premiums

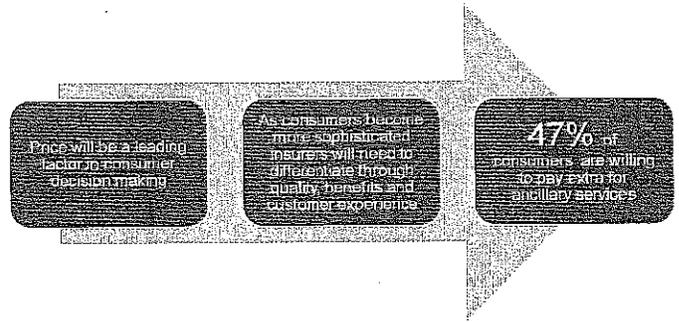
Approximately 40% of the expected individual exchange enrollees in 2021 will come from five states: California, Texas, Florida, New York and Illinois.

The new individual exchange population consists of mainly young, white and relatively healthy individuals



Health Insurance Exchanges • Long on options, short on time
PwC

Price will be a concern for both consumers and insurers, but quality could serve as a differentiator



Health Insurance Exchanges • Long on options, short on time
PwC

The public and private faces of insurance exchanges

3

Health Insurance Exchanges • Long on options, short on time
PwC

Many states will have the federal government directly involved in running exchanges

- 13 states and the District of Columbia intend to establish their own exchanges
- Majority of remaining 37 states will have the federal government directly involved in running their exchanges
 - 8 states have already chosen to have a federally-facilitated exchange
 - 3 states have selected an approach that divides duties in a state/federal “partnership”

Health Insurance Exchanges • Long on options, short on time
PwC

Public and private exchanges will co-exist in several markets

	Public exchanges		
	State run	State/Federal partnership	Federally Facilitated Exchange (FEE)
Eligibility	●	●	●
Enrollment	●	●	●
Customer Service	●	●	●
Plan Management	●	●	●
Financial Management	●	●	●

● State function ● State or federal function ● Federal function

Private exchanges will have the flexibility to experiment with different approaches and innovate to meet consumer demands. Three general categories: insurer run, third-party run and retailer.

Mechanisms to neutralize risk for insurers and the government are either managed by the state or other agencies

	Public exchanges		
	State run	State/Federal partnership	Federally Facilitated Exchange (FEE)
Risk adjustment Permanent program to neutralize effect of risk differences among plans	●	●	●
Reinsurance Offset high cost outliers (2014-2016)	●	●	●
Risk corridors Accurate rate setting; limit variation in gains/losses (2014-2016)	●	●	●

● State function ● State or federal function ● Federal function

States that run their own exchanges will determine how to create the marketplace and run the exchange

13 states and the District of Columbia have declared to HHS that they will create state run exchanges.

These states have received 76% of federal grant funding.

Vermont Grant funding \$158.8M Medicaid Expansion • Working and Jobless: 150% FPL	• Enacted in 2011 as part of law to establish single-payer • Exchange falls under state's Medicaid office • Investing significant resources into new IT infrastructure • State plans to keep current Medicaid levels
Kentucky Grant funding \$66.6M Medicaid Expansion • None	• Established in 2012 by executive order • Executive director has been appointed • Exchange will be governed by an advisory board • Held public forums on state exchange • Leaning toward full Medicaid expansion
New York Grant funding \$183.2 M Medicaid Expansion • Working and Jobless: 100% FPL	• Established in 2012 by executive order • Stakeholder analyses conducted on exchange design • Moving forward with plans for integrated IT infrastructure • Leaning toward full Medicaid expansion

In the federally-facilitated exchange, HHS will oversee five major exchange functions

8 states have announced that they will not create state exchanges so will be governed by the FFE.

These states have received 2% of federal grant funding.

Florida Grant funding \$1.0M (returned) Medicaid Expansion • None	• In July 2012, governor announced Florida would not implement a state exchange • Moving forward to create a new marketplace for small businesses (Florida Health Choices Corporation) • Not likely to expand Medicaid
Alaska Grant funding \$0 M Medicaid Expansion • None	• In July 2012, governor announced Alaska would not create a state exchange • Only state not to apply for exchange planning grant • Evaluating financial impact of a state-funded exchange • Not likely to expand Medicaid
Texas Grant funding \$1.0M (\$0.9 returned) Medicaid Expansion • None	• In July 2012, governor announced Texas would not establish an exchange • Prior to announcement, state had used federal funds to identify subcontractors for preliminary analysis • Not likely to expand Medicaid

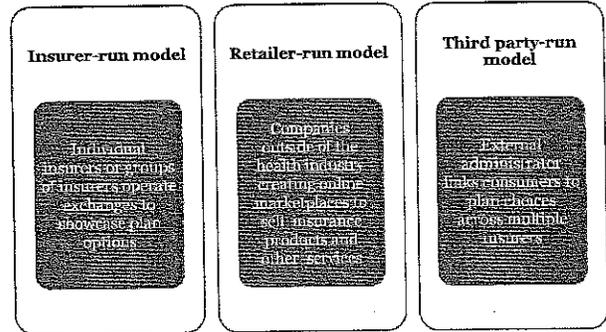
State-federal “partnership” exchanges will split duties between the state and HHS

3 states have announced that they are planning for a partnership exchange.

These states have received 3% of federal grant funding.

<p>Delaware Grant funding \$4.4M Medicaid Expansion • Working: 110% FPL • Jobless: 100% FPL</p>	<ul style="list-style-type: none"> • In July 2012, governor announced state would pursue partnership exchange • Has conducted initial assessments, including IT gap and essential health benefits analyses • Leaning toward full Medicaid expansion
<p>Illinois Grant funding \$39.0 M Medicaid Expansion • None</p>	<ul style="list-style-type: none"> • In July 2012, governor indicated state would pursue partnership model • Plans to move toward a state-based exchange by 2015 • Passed exchange legislation, conducted initial analysis and began IT development • Undecided on Medicaid expansion
<p>Arkansas Grant funding \$8.9M Medicaid Expansion • None</p>	<ul style="list-style-type: none"> • In December 2011, governor endorsed partnership model concept • Has released exchange framework • Leaning toward full Medicaid expansion

Private exchanges run by insurers, retailers or other third party may lead in innovation



Health industry implications

4

Price and risk selection are top concerns for insurers but a broader consumer strategy should also be developed

As the exchange markets continue to develop, insurers should consider:

- Management of product pricing and risk selection
- Qualified health plan and essential health benefit standards
- Increased competition and pricing transparency
- Regional insurers and ACOs could provide tough competition
- Continued focus on administrative costs to meet MLR requirements

Knowing the facts:

- ✓ States can begin qualifying health plans in October, but no states will be ready until early 2013
- ✓ Administrative costs must remain below 15-20% of premiums under MLR requirements
- ✓ As part of the risk corridor function, insurers must relinquish a portion of profits above 3%

Providers should prepare for a new population that may have pent up demand for services

In preparation for newly insured patients, providers should begin to prepare for:

- Exchanges that could speed up expectations of care
- Provider-owned health plans and ACOs that will be well positioned
- An outcomes-based environment requiring value over volume
- Information management improvements
- Demonstration of quality and improved care coordination
- Reevaluation of reimbursement and billing structures
- Development of products to compete with insurers

Employers are contemplating whether exchanges present a viable option to employer-managed coverage

Employers must consider the following for their employee benefits:

- Dropping coverage may increase pressure to raise wages
- Employees view healthcare as a valuable benefit
- Dropping coverage may make the most sense for firms with a high concentration of low-wage workers
- Private exchanges offer an alternative to move toward a defined contribution approach

Knowing the facts:

- ✓ Penalties for dropping coverage for full-time employees start at \$2,000 per full-time employee
- ✓ Starting in March 2013, employers will be required to notify employees about the new exchanges and that it will not provide a contribution toward coverage if an employee enrolls in an exchange plan

Pharma and Life Sciences firms will need to account for state variation in exchanges and delivering new value

To increase profits Pharma and Life Sciences firms will need to plan for:

- Expanded and diversified market access strategies
- Pharmacy benefit structures ranging from restrictive formularies to a comprehensive benefit structure
- State-level variation in developing market access strategies
- Drawing upon experiences in other managed markets
- Evidence that demonstrates superiority to existing medications and devices

Knowing the facts:

- ✓ States have flexibility in defining the requirements that participating plans must follow when designing their benefit structure and formularies
- ✓ Current federal guidance stipulates that exchange plans must offer at least one drug per class

Exchanges will remain a hot prospect and shape the future insurance environment

- Retail strategy to push value and convenience
- Exchanges that start as “open markets” likely to move to “active purchaser”
- Private exchanges will continue to innovate
- Movement away from employer managed coverage to a robust open marketplace

For more information

To download the full report, please visit: www.pwc.com/us/healthexchanges

pwc.com/us/healthindustries

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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

**CliffsNotes for
Dual Eligible Integration Bids:**

**An Insider's View on
Recent Responses and Upcoming RFP's**

Presented by Nancy C Everett, MBA
October 4, 2012 Medicaid Managed Care Conference, Washington DC

The Journey:

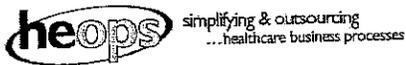
- **Major Themes:** *Bureaucratic Terror, Chaos, Survival, Patient Rights*
- **Summary:** *Overview, Design and Implementation*
- **Character List:** *Stakeholders*
- **Plot:** *Schedules, Responses and Key Activity*
- **Epiphany:** *Findings and Take Aways*

Our Goals:

1. Distill the story.
2. Discuss stakeholder concerns and responses.
3. Review strategies for enrolling non traditional providers and meeting LTSS and HCBS requirements.
4. Identify next steps to program implementation.

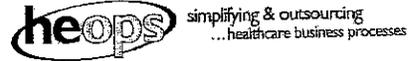
Themes:

- **Bureaucratic Terror**
- **Survival**
- **Chaos**
- **Patient Rights**



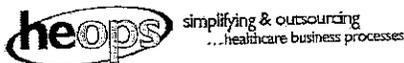
Theme: Bureaucratic Terror

- Complexity
- Timing
- Lack of Standardization
- High Stakes



Theme: Survival

- Changes in reimbursement methodology
- Savings that may not materialize
- Patterns of care
- Provider-Patient relationships



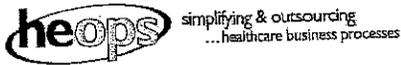
Theme: Chaos

- Timing
- Complexity
- Competency
- Viability



Theme: Patient Rights

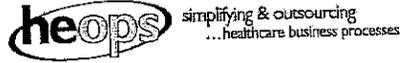
- Opt In/Opt Out
- Passive Enrollment
- Patient Empowerment and Direction
- Provider Relationships (In/Out of Network)



Prologue:

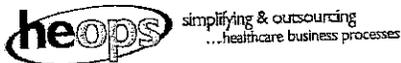
The Numbers:

- 1. 9 Million Duals
- 2. 16% of CARE; 15% of CAID
- 3. 27% CARE Cost; 39% CAID Cost
- 4. CMS Proposed 1-2 Million Duals in Demonstration
- 5. 15 States Awarded Design Grants



Prologue:

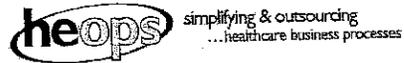
- ACA – Created Federal Coordinated Healthcare Office (MMCO)
- Goal of MMCO – effective program coordination to improve care and lower costs
- Initiative 1: April 2011 – Program Design Awards – 15 States
- Initiative 2: July 2011 – CFAD Program – States to Submit LOI by 10.2011
 - 36 LOI (11 FFS, 6 Both, 20 Capitated)
 - Process Defined



Prologue:

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 & Evaluation



Character List:

- MED PAC (Letter 7.11.2012)
- SEN. ROCKEFELLER (Letter 7.12.2012)
- STATE MEDICAID PROGRAMS
- CMS et al.
- STAKEHOLDERS (Advocates, Providers, Plans, Agencies etc.)
- THE EXPERTS (Weis, Kumpf, Hoetger, Terzaghi)



Plot:

- 36 LOI Submitted
- 36 LOI (11 FFS, 6 Both, 20 Capitated)
- MA - MOU
 - No Plan Selection Yet



Plot:

The Letters

MED PAC	SEN ROCKEFELLER
Size and Scope	Quality Care vs. Guaranteed Savings
Passive Enrollment	Tested New Concepts
Program Costs and Ensuring Savings	Rights of Duals
Monitoring and Evaluation	Broad Implementation w/o Testing
	Size and Scope
	Lack of Transparency
	Benefit and Service Disruption



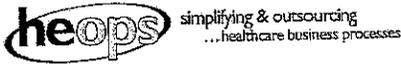
**Epiphany:
Experts:**

- THE EXPERTS:**
- John Weis, CEO, Quest Analytics
 - David Kumpf, CEO, Optimetra
 - Damon Terzaghi, Associate, Marwood's Research Group
 - Tom Hoetzger, SNFist Group, General Medicine PC



**Epiphany:
Experts:**

- PITFALLS:**
- Unlikely Savings for Plans in Y1
 - Enrollment Process
 - Provider Networks - Delays
 - Access to Adequate LTSS Providers
 - Adequacy Not Standardized
 - All Programs Unique



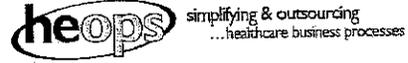
**Epiphany:
Experts:**

SOLUTIONS:

- Unlikely Savings for Plans in Y1

Response for CAPITATION:

- Negotiated carefully.
- Are savings required in Y1 or performance against Quality focus?
- REVIEW the actuarial detail, ensure expanded LTSS has been added in.



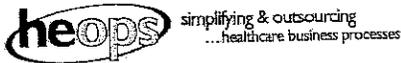
**Epiphany:
Experts:**

SOLUTIONS:

- Enrollment Process

Response :

- Explore OPT/IN, OPT/OUT, Passive enrollment.
- Enrollment brokers
- Triple A's and other community agencies.



**Epiphany:
Experts:**

SOLUTIONS:

- 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



**Epiphany:
Experts:**

SOLUTIONS:

- 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



simplifying & outsourcing
...healthcare business processes



**Epiphany:
Experts:**

SOLUTIONS:

- Adequacy Not Standardized

Response :

- Consider MA best Practices as a standard
- Geographic Disparities
- Scalable
- Flexible and Evolving



simplifying & outsourcing
...healthcare business processes



**Epiphany:
Experts:**

SOLUTIONS:

- All Programs Unique

Response :

- Seek Best Practices and Lessons Learned
- Negotiate Wisely
- Implement with Quality and Competency
- Don't forget -- this is a DEMONSTRATION



simplifying & outsourcing
...healthcare business processes

Audience Comments...

Thank you!



simplifying & outsourcing
... the business of healthcare

Aetna Medicaid: Managing Long Term Care for Dual Eligible Populations

Erhardt Preitauer SVP Mid- America Region

Highlights

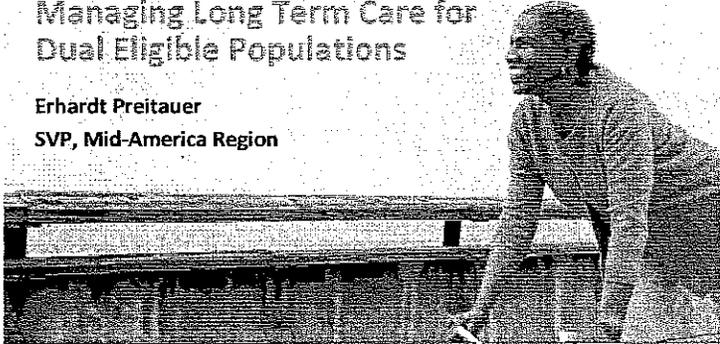
- Over 9 Million Nationally
- 36% of Medicare spend
- 39% of Medicaid Spend
- <2% of Coordinated Care
- Roughly 1/3 have a physical disability
- 2.3 have mental illness and/or substance abuse
- 10 to 15% have intellectual and developmental disabilities
- 2% have Alzheimer's/ Dementia
- Multiple chronic 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.



Aetna Medicaid

Managing Long Term Care for
Dual Eligible Populations

Erhardt Preitauer
SVP, Mid-America Region



Agenda

- **Introduction**
 - You, Me, and Aetna
- **Building the Case**
- **The Roadmap to Success**
- **The Role of Technology**
- **The Case Study: Mercy Care Plan**

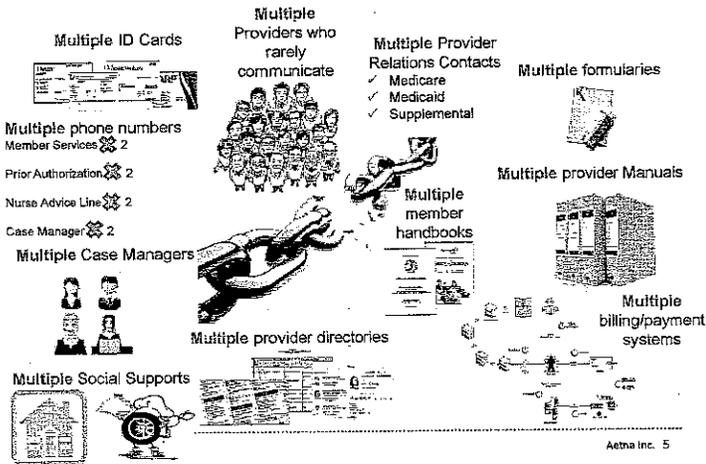
Building the Case...

Dual Eligibles Have High Needs...

- Over 9 million nationally
- ~36% of Medicare spend
- ~39% of Medicaid spend
- <2% in 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**

(Medicare Payment Advisory Commission. Report to Congress: Medicare and the Health Care Delivery System. June, 2011.)

In a Complicated and Fragmented System...



Where Providers are Focused on Volume...

Healthcare System Problems

Between 44,000-96,000 people die in the United States each year as a result of preventable medical errors.

Medicare pays for hospital and doctors' cost roughly \$2 billion annually.

More than 50% of patient health history, diagnosis, test results, prescriptions, lab orders, treatment and clinical vital information are currently missed and unrecorded.

Source: eHealthSource, Aetna, February 2011-2014

Root Causes

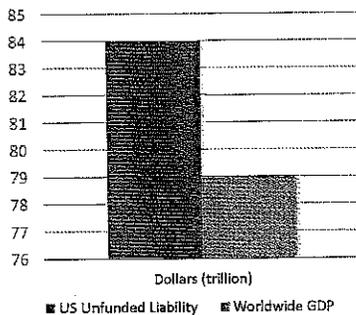
- Data Fragmentation**
Historical claims and non-claims data reside in multiple non-integrated sources.
- Knowledge/Care Delivery Gaps**
The lag between the discovery of more effective forms of treatment and their incorporation into routine patient care averages 17 years.
- Provider(s) and Patient Communication Gaps**
Patients and their provider(s) typically do not have access to up to date and complete medical histories.

Result Costs Crisis



No Surprise - It's Going to Cost a Lot...

US Unfunded Liability 2x World GDP



Largest Percentage of this is Medicare and Medicaid...

The Roadmap to Success...

Key Steps for Success...

1. Have a Clear Vision for the Program
• Develop a clear, concise, and compelling vision statement
• Communicate the vision to all stakeholders
• Align the vision with the organization's mission and values
• Establish a clear, measurable, and achievable vision
• Monitor and evaluate the progress of the vision
• Adjust the vision as needed

Key Steps for Success...

1. Have a Clear Vision for the Program
2. Stakeholder Engagement: Early and Often
• Identify all stakeholders
• Engage stakeholders early and often
• Listen to stakeholder input
• Communicate the vision to all stakeholders
• Monitor and evaluate the progress of the vision
• Adjust the vision as needed

Key Steps for Success...

1. Have a Clear Vision for the Program
2. Stakeholder Engagement: Early and Often
3. Integrate, Integrate, Integrate
• Integrate the program with existing programs
• Integrate the program with the organization's mission and values
• Integrate the program with the organization's resources
• Integrate the program with the organization's culture
• Integrate the program with the organization's stakeholders

Key Steps for Success...

1. Have a Clear Vision for the Program
2. Stakeholder Engagement: Early and Often
3. Integrate, Integrate, Integrate
4. Uniform Assessment and Eligibility Approach
• Develop a uniform assessment and eligibility approach
• Communicate the uniform assessment and eligibility approach to all stakeholders
• Monitor and evaluate the progress of the uniform assessment and eligibility approach
• Adjust the uniform assessment and eligibility approach as needed

Key Steps for Success...

1. Have a Clear Vision for the Program
2. Stakeholder Engagement: Early and Often
3. Integrate, Integrate, Integrate
4. Uniform Assessment and Eligibility Approach
5. Value over Volume; Technology and Tools (continued...)

Key Steps for Success...

1. Have a Clear Vision for the Program
2. Stakeholder Engagement: Early and Often
3. Integrate, Integrate, Integrate
4. Uniform Assessment and Eligibility Approach
5. Value over Volume; Technology and Tools (continued...)
6. The Right Design... Benefits, Financial, Programmatic

Key Steps for Success...

1. Have a Clear Vision for the Program
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4. Uniform Assessment and Eligibility Approach
5. Value over Volume; Technology and Tools (continued...)
6. The Right Design... Benefits, Financial, Programmatic
7. Clear and Aligned Incentives

Key Steps for Success...

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5. Value over Volume; Technology and Tools (continued...)
6. The Right Design... Benefits, Financial, Programmatic
7. Clear and Aligned Incentives
8. Quality, Oversight, and State Partnership

Key Steps for Success...

1. Have a Clear Vision for the Program
2. Stakeholder Engagement: Early and Often
3. Integrate, Integrate, Integrate
4. Uniform Assessment and Eligibility Approach
5. Value over Volume; Technology and Tools (continued...)
6. The Right Design...Benefits, Financial, Programmatic
7. Clear and Aligned Incentives
8. Quality, Oversight, and State Partnership
9. Focus on Culture

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Aetna Solutions: The Role of Technology

MEDICITY

- Clinical Data Integration
- Secure Data Exchange

iNexx

- Real time provider interface
- Application Store
- Rapid Distribution

ACTIVE HEALTH
MANAGEMENT

- Population based clinical intelligence
- Decision support
- Care management

Triage

- Popular mobile based application
- User (symptom) to provider link
- Apptmnts, registration, alerts, cost

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Putting It All Together...

Analysis of Care Coordination Outcomes

A Comparison of the Mercy Care Plan Population to Nationwide Dual-Eligible Medicare Beneficiaries

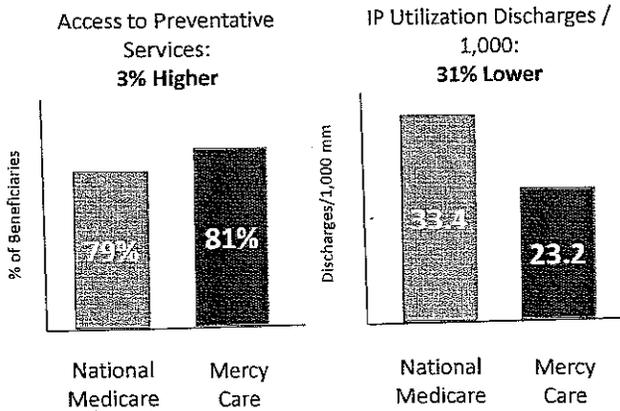
Study Design:

- 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. Emergency Department Usage
 4. All-Cause Readmissions

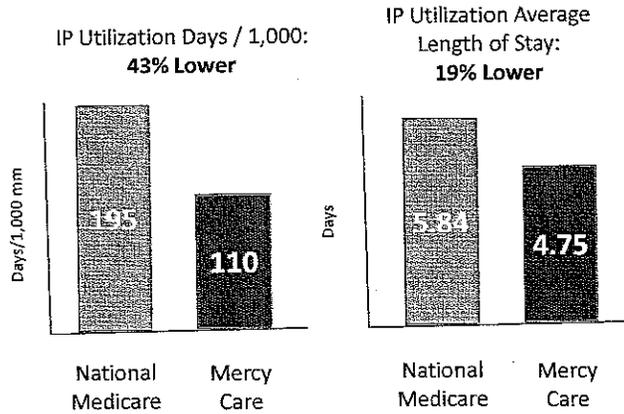
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Aetna Inc. 20

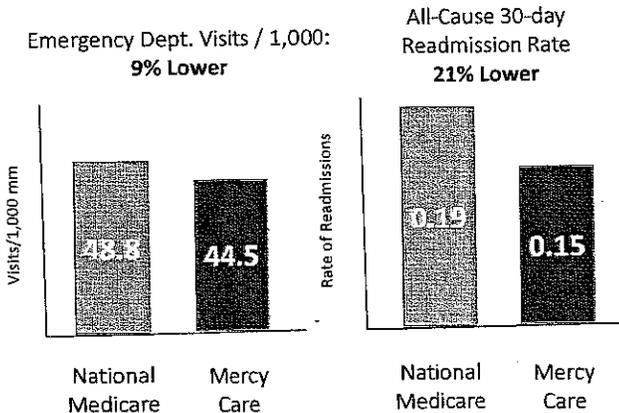
Results:



Results:

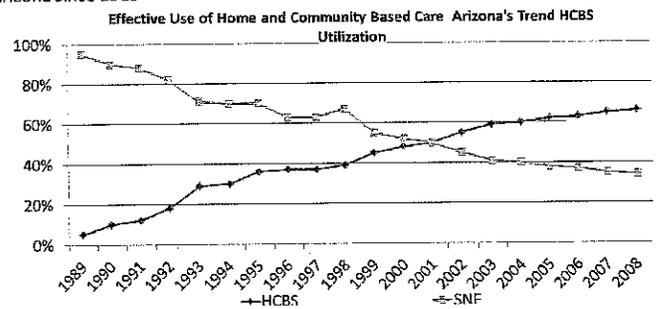


Results:



Getting Results By Rebalancing Institutional and HCBS Services

Aetna's Integrated Long-Term Care Model has been successful in the state of Arizona since 1989



Questions??

Erhardt HL Preitauer
SVP Medicaid,
Mid-America Region
preitauere@aetna.com

aetna

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

Methodologies for Building a Medicaid Provider Network

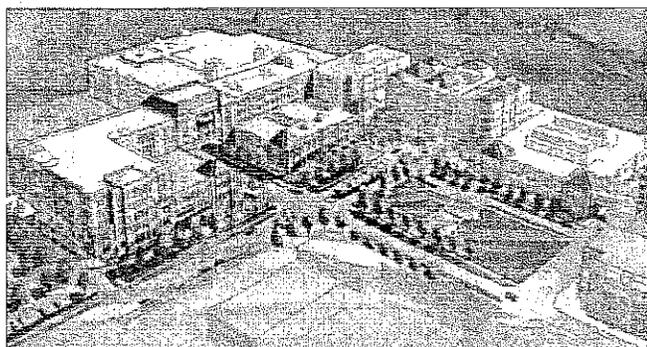
Robert Robidou
Director, Network Development
Cook Children's Health Plan

October 4, 2012
Washington DC



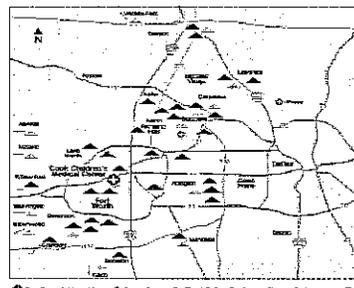
Goals

- Forge partnerships with providers
 - Provide a network of providers to provide 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



Who we are

Cook Children's Health Care System is a not-for-profit, nationally recognized pediatric health care organization comprised of seven entities – a Medical Center, Physician Network, Home Health company, Northeast Hospital, Pediatric Surgery Center, Health Plan and Health Foundation. Based in Fort Worth, Texas, the integrated system has more than 60 primary and specialty care offices in north Texas.



Cook Children's Health Plan

- Locally managed and operated Non-Profit Health Plan located in Fort Worth, Texas.
- Locally based Care Management, Provider Relations, Member Services and Claims staff.
- Service oriented health plan. We know we are not perfect but we will work with you to try and resolve any issues which may arise.



Develop a Plan and Review it

PROVIDER SERVICE PLAN

The following table outlines the key elements of the Provider Service Plan. Approved for implementation by the Board of Directors on 10/15/2013.

Area	Goal	Key Elements	Key Elements	Key Elements
Administration	Administer the Plan in accordance with the terms of the Certificate of Authority and the Plan Document.	• Administer the Plan in accordance with the terms of the Certificate of Authority and the Plan Document.	• Administer the Plan in accordance with the terms of the Certificate of Authority and the Plan Document.	• Administer the Plan in accordance with the terms of the Certificate of Authority and the Plan Document.
Compliance	Ensure the Plan complies with all applicable laws and regulations.	• Monitor the Plan's compliance with all applicable laws and regulations.	• Monitor the Plan's compliance with all applicable laws and regulations.	• Monitor the Plan's compliance with all applicable laws and regulations.
Financial	Ensure the Plan is financially sound and able to meet its obligations.	• Monitor the Plan's financial performance.	• Monitor the Plan's financial performance.	• Monitor the Plan's financial performance.
Member Services	Provide high-quality member services.	• Provide high-quality member services.	• Provide high-quality member services.	• Provide high-quality member services.
Provider Relations	Build and maintain strong relationships with providers.	• Build and maintain strong relationships with providers.	• Build and maintain strong relationships with providers.	• Build and maintain strong relationships with providers.
Quality Improvement	Improve the quality of care provided by the Plan.	• Improve the quality of care provided by the Plan.	• Improve the quality of care provided by the Plan.	• Improve the quality of care provided by the Plan.
Marketing	Attract and retain members.	• Attract and retain members.	• Attract and retain members.	• Attract and retain members.
Risk Management	Identify and manage risks to the Plan.	• Identify and manage risks to the Plan.	• Identify and manage risks to the Plan.	• Identify and manage risks to the Plan.
Technology	Use technology to improve efficiency and effectiveness.	• Use technology to improve efficiency and effectiveness.	• Use technology to improve efficiency and effectiveness.	• Use technology to improve efficiency and effectiveness.
Human Resources	Recruit and retain qualified staff.	• Recruit and retain qualified staff.	• Recruit and retain qualified staff.	• Recruit and retain qualified staff.

Page 1



Why is your Provider Network Important?

*Healthcare is a
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



Membership Breakout

GROUP	Membership	% of Total	Sub-Group	Membership	% of Total	% of Group
Key Group #1	21,274	21.5%	HC	16,742	76.8%	16.9%
			Community Based Private Practice	4,532	21.2%	4.2%
Sub E2	22,328	24.7%	None	10,650	47.7%	16.0%
			None	9,977	28.6%	9.3%
			None	5,000	22.1%	6.0%
Sub 2	1,418	1.4%				
Sub 3	1,176	1.2%				
Sub 4	7,829	8.7%	Office 1	1,100	12.9%	1.9%
			Office 2	1,196	14.4%	1.2%
			Office 3	1,129	12.8%	1.7%
Other	43,800	42.8%	Physician #1	1,094	2.7%	1.0%
			Physician #2	1,698	3.9%	1.7%
			Physician #3	1,128	2.6%	1.7%
			Physician #4	1,421	3.4%	1.4%
			Physician #5	1,883	4.3%	1.8%
			Physician #6	6,192	14.4%	4.7%
			Physician #7	3,677	8.5%	3.6%
			Physician #8	2,470	5.6%	2.4%
			Physician #9	1,322	3.0%	1.3%
Sub Total				72,218	68.9%	
All other				22,214	21.1%	
Total	101,432					100%

CookChildren's
Health Plan

Provider Communication

Communicate and listen to the providers in order to address their needs

CookChildren's
Health Plan

Provider Communication

Quarterly office manager meetings

(PCP's and Specialists)

Annual/Monthly Provider Surveys

Provider Newsletters Provider Service (bi-Monthly)

Representative Visits

Web based information

- Member eligibility, Claims check, Provider Manuals, Provider Directories

• Informative links

- American Medical Association, American Academy of Pediatrics, Texas Medical Boards, CLIA waived Tests Listing

CookChildren's
Health Plan

Provider Communication

During Quarterly PCP office manager meetings we asked what they Liked and Did Not Like.

• Like

- Ease of Specialty Referrals.
- Ease of Phone Access to knowledgeable people (fewer hassels)
 - Provider Services, Claims, Care Management.
- Ease of Claims submission.
- Responsiveness of the plan. (Personal Attention)
- Quarterly visits (Prepared Provider Relations Staff)
- Members who were informed about their coverage.

CookChildren's
Health Plan

Provider Communication

- *Dislikes*

- *Problem with Referrals*
- *Recorded Message for Pre-Certs.*
- *Inaccurate Listings or information*
- *Recoupment letters*
- *Uneducated Staff or members*
- *Untimely Answers*

Provider Communication

- **Provider Visits**

(Exceptions for educational visits)

- **PRIMARY CARE VISITS:**
 - All PCPs with over 150 members visited each quarter
 - All PCPs are visited at least once every six months.
- **Specialists**
 - Once a year.
- **High Volume Specialists**
 - Ob/Gyn, ENT, Ortho, Cardiology, Allergy, Ophthalmology, Neurology, Urology
 - Every six months
- **Ancillaries** - once a year.

Provider Communication

Providers are your customers, They are vital to growth of your membership.

How do you like to be Treated?

Update & align your programs to reward the highest performing physicians.

Simple VIP Program

VIP Program

- Start Date: January 2008

Criteria for CCHP/ VIP:

- Providers are not required to participate in both products.
- Average of 200 or more Members in prior Quarter.
- Providers have to have an Open Panel for at least one product.

Community Advisory Committee:

- Made up of leaders within the communities who work with your population.

CookChildren's.
Health Plan

VIP

- Receive Monthly visits by Provider Services.
- Gift card from Office Supply company per Quarter
- Top Office of the Quarter will receive recognition in the Provider Newsletter and Member newsletter.

CookChildren's.
Health Plan

thank you for your dedication
and support

Maria del Pilar Levy, M.D.



Cook Children's Health Plan is proud to recognize

CookChildren's.
Health Plan

- *P4P program*
 - Measured on a Quarterly basis.
 - Health Plan has to be profitable that quarter.

CookChildren's.
Health Plan

Minimum Requirement:

- Average monthly panel size of 300 members
- Must be open to new members

Measures:*Panel Size**Participation in Vaccines for Children program.**Emergency Department visit rate by PCP's members for conditions that could have been treated in ambulatory setting.**Submission rate for Clean Claims*

Summary

- Partnership
 - Align Business Needs
 - Be willing to Give and Take
- Communication
 - Hassle Factors (Know the Likes and Dislikes)
 - Responsiveness
- Network Development
 - Local Issue
 - Know what you ***Want*** and ***Need*** to have.

- Robert Robidou
 - Cook Children's Health Plan
 - Rob.Robidou@cookchildrens.org
 - 682-885-4485

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

Connecting the Coverage Dots for Low-Income Health Care Consumers

Medicaid Managed Care Conference
October 5, 2012

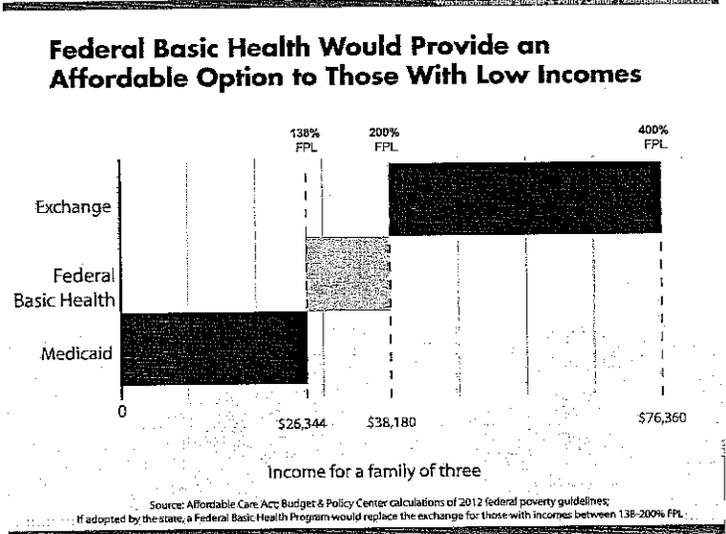
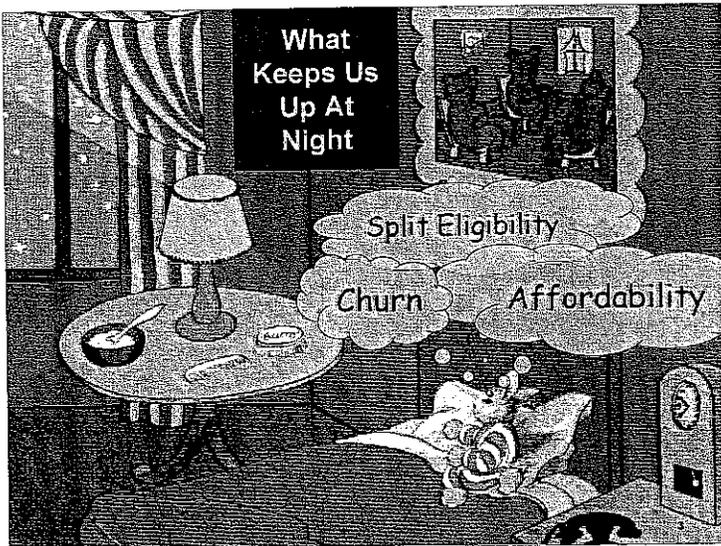
Meg Murray
CEO, ACAP



Agenda

- **What Keeps Us Up At Night**
 - Churn
 - Split Eligibility
 - Affordability

- **ACAP Solutions: How Medicaid Health Plans Connect the Dots for Low-Income Populations**



Eligibility “Churn” in Exchange & Medicaid: The Problem in 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.

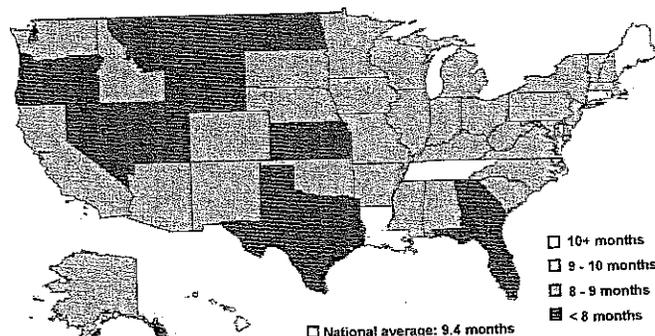
Source: Rosenbaum & Sommers, “Issues in Health Reform: How Changes May Move Millions Between Medicaid and Insurance Exchanges,” *Health Affairs*, February 2011

- **GAO:** About 14% of children in January 2009 who met 2014 PPACA eligibility criteria for Medicaid/CHIP/premium tax credit experienced a change in household income that would affect eligibility within 1 year.

Source: Government Accountability Office, “Opportunities Exist for Improved Access to Affordable Insurance,” Report #GAO-12-646, June 2012.



The Average Medicaid Beneficiary Is Enrolled Only Nine Months Out of the Year Average Enrollment Continuity for State Medicaid Programs, 2006, All Populations



Source: ACAP analysis of Fu et al., The George Washington University, Improving Medicaid's Continuity of Coverage and Quality of Care, July 2009. Data from Medicaid Statistical Information System Dataset, FY 2006. <http://www.lincolninst.org/shumway>

These statistics include disenrollment from the Medicaid program for any reason.



Families with “Split Eligibility”

- Numerous families will have members covered by different programs: Medicaid, CHIP, Exchange (with subsidies).
 - 16.2 million Medicaid or CHIP-eligible children have parents with income in Exchange-eligibility range.*
- It's important to cover families in one plan.
 - Parents need to learn only one health plan's procedures.
 - In some MCOs and with family practitioners, parents & kids can be seen together if enrolled in a common plan.
 - For long-term political viability, reformed system needs to be consumer-friendly – doesn't make sense to split families into separate programs and plans.

* Urban Institute (<http://www.urban.org/UploadedPDF/412341-Affordable-Care-Act.pdf>).



Affordability

- *Bridging the Gap: Exploring the Basic Health Insurance Option for New York*, by NYS Health Foundation, June 2011
- New Yorkers with income below 200 percent FPL have little or no disposable income to pay for health insurance premiums:
 - 40 percent have credit card debt
 - 26 percent have medical debt
 - 32 percent report having no savings



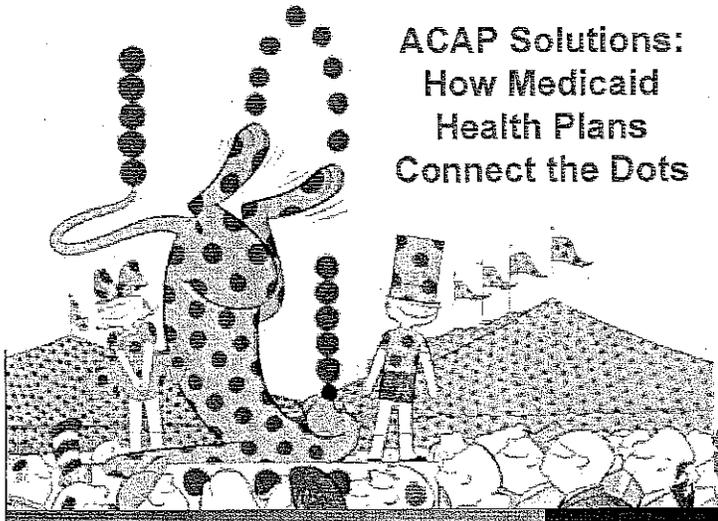
Affordability: Maximum Premium Cost for Low-Income Exchange Enrollees

Income as Percentage of FPL	Maximum Premium Percentage
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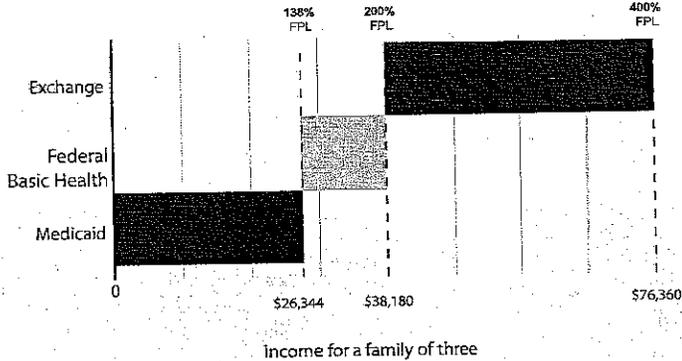
ACAP Solutions: How Medicaid Health Plans Connect the Dots

ACAP Solutions

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



Federal Basic Health Would Provide an Affordable Option to Those With Low Incomes



Source: Affordable Care Act Budget & Policy Center calculations of 2012 federal poverty guidelines.
If adopted by the state, a Federal Basic Health Program would replace the exchange for those with incomes between 138-200% FPL.

1. Continuity of Coverage for Medicaid Enrollees

- 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



1. Continuity of Coverage for Medicaid Enrollees

- **ACAP's Approach: a Medicaid Continuous Quality Agenda**
 - 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**



2. 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



PART IV—STATE FLEXIBILITY TO ESTABLISH ALTERNATIVE PROGRAMS
SEC. 1331. STATE FLEXIBILITY TO ESTABLISH BASIC HEALTH PROGRAMS FOR LOW-INCOME INDIVIDUALS NOT ELIGIBLE FOR MEDICAID.
 (a) ESTABLISHMENT OF PROGRAM.—The Secretary shall establish:
 (1) IN GENERAL.—The requirements of this section shall apply to any State that contracts to offer 1 or more health plans to individuals meeting the requirements of this section.

2. Basic Health Program

■ 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?*

PART IV—STATE FLEXIBILITY TO ESTABLISH ALTERNATIVE PROGRAMS
SEC. 1301. STATE FLEXIBILITY TO ESTABLISH BASIC HEALTH PROGRAMS FOR LOW-INCOME INDIVIDUALS NOT ELIGIBLE FOR MEDICAID.
(a) ESTABLISHMENT OF PROGRAM.—The Secretary shall establish a health program meeting the requirements of this section if—
(1) IN GENERAL.—The Secretary shall establish a health program meeting the requirements of this section if a State may enter into contracts to offer health plans providing at least the essential health benefits to eligible individuals.



3. 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



4. Exchanges 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 to serve Medicaid. (source: <https://www.kff.org/medicaid/220.cfm>)



4. 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



Takeaways

- 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.

Thank you!

Meg Murray

Association for Community Affiliated Plans

mmurray@communityplans.net

202-204-7509



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

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2012 Medicaid Managed Care Conference
October 4, 2012

Implementing a Medical Home Model in a
Medicaid Managed Care Setting
Debra Smyers

Overview

- About UPMC for You
- Why the need for a new model
- Patient Centered Medical Home (PCMH) – integral to Accountable Care Organizations
- UPMC Health Plan's PCMH structure
- Outcomes of our PCMHs

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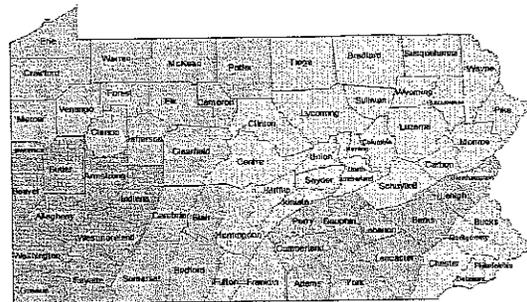
About UPMC for You



- A non-profit Medicaid & Medicare Plan located in Western & Central Pennsylvania
- 180,439 Medicaid members
- Largest Medicaid Plan in Southwestern Pennsylvania
- New rankings of health insurance plans from the National Committee for Quality Assurance (NCQA) show UPMC for You ranked as #8 plan in nation, ranked #1 in Pennsylvania in 7 out of last 8 years

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UPMC for You Service Area



- Southwest
- Southwest Expansion
- Lehigh/Capital
- Lehigh/Capital Expansion
- New West
- Voluntary

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Why the Need for a New Model – Cost of Health Care

- In 2009, healthcare spending reached record high of 17.6% of GNP.
- U. S. experienced consistent declines in rate of spending growth for 8 consecutive years. Despite attention given to healthcare spending, year-on-year growth fell from 9.5% in 2002 to 4.0% in 2009. Trend continued in 2010 to 3.9% - lowest in 50 years.
- Recession appears to have contributed to this slowdown, marking the first time in five decades that an economic downturn has had an immediate and measureable effect on healthcare spending growth.
- Slowdown more pronounced in: inpatient care, drugs, and healthcare administration and insurance.

McKinsey Center for U.S. Health System Reform
Accounting for the cost of U.S. health care Pre-reform and the impact of the recession
September 2011

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Why the Need for a New Model - Many Services used by a few

Agency for Healthcare Research and Quality (AHRQ)

- In 2009, 1% of the population accounted for 22% of health care, an average of \$90,000 per year, these 3 million people consumed over \$270 billion
- Top 5% accounted for 50% of health care costs
- Distribution of expenses by sources of payment:
 - Private insurance – 42.6%
 - Medicare – 23.8%
 - Out of pocket by consumer – 14.6%
 - Medicaid – 9.7%
 - Other 9.3%



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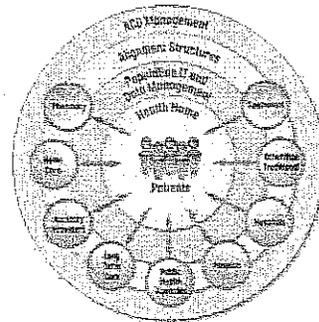
Why the Need for a New Model - Health Care providers

- Health care system primarily specialty driven
- Number of graduating primary care physicians is decreasing
- Higher number of physicians retiring
- Lower number of nurses graduating
- Can't graduate enough advanced practice nurse to keep up with need



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Patient Centered Medical Home (PCMH) is key to ACOs:



ACOs:

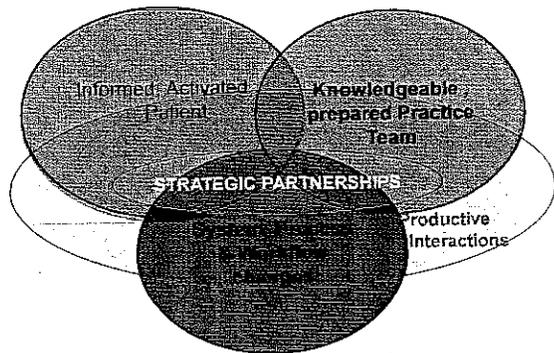
• Accept shared responsibility to deliver medical services to a defined set of patients.

• Are held accountable for quality and cost of care provided through alignment of incentives and distribution of incentive payments to participating providers.

Source: Premier Healthcare Alliance

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Critical Success Factors for the PCMH



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PCMH Model Framework



"A medical home is a medical office or clinic where a team of health professionals work together to provide a new, expanded type of care to patients. Having a medical home feels like having an old style family doctor, but with a team of professionals, using modern knowledge and technology, to provide the best possible care for you ..."

National Partnership for Women and Families:
http://www.nationalpartnership.org/site/DocServer/PCMH_Patient_Brochure_FINAL.pdf?docID=46016&addmcrost=1342

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PCMH Model Framework

PCMH practice meets all patient needs at all stages of life:

- Health & wellness promotion, and Preventive Care
- Acute care
- Chronic disease management

PCMH practice is patient-centered; the personal physician:¹

- Works in partnership with patients and families
- Considers patients' needs, preferences, and culture
- Provides education and support that enables patients to participate in their care

1. Institute of Medicine (U.S.). Hurtado MP et al. *Envisioning a National Healthcare Quality Report*. Washington D.C., National Academy Press, 2001.



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"Productive" Interaction with the Patient

- In addition to clinical status, assessment of:
 - Patient's knowledge & self-management skills
 - Patient's readiness to change
- Not telling the patient what to do, but collaborative management with:
 - Education to fill gaps in knowledge & skills
 - Shared goal-setting & problem-solving
 - Identifying/overcoming barriers to care
 - Written care plan
 - Patient "say it back" method
- Active, sustained follow-up (phone, email, visits)

The Care Model, David Shute, MD, Medical Director, Acumentra Health June 23, 2006

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PCMH Framework for Care Team and Patient Responsibilities

What Should the Care Team Do?

- Learn about you and your family
- About your life and living situation, culture, language, and preferences
- Communicate with you:
- Give you time to ask questions
 - Help you understand and decide about your care options
 - Ask about your experience of care
- Support you in caring for yourself
- Make sure you understand how to care for yourself
 - Help you set and meet your goals
 - Give you information to learn about your condition and stay healthy

What Should the Patient Do?

- Learn about caring for yourself
- Know you're a full partner
 - Learn about your condition
 - Learn how to stay healthy
 - Ask if you have questions
 - Follow the team's care plan
- Communicate with your care team
- Bring a list of questions
 - Bring all your medicines, vitamins, and OTCs
 - Ask for explanations
 - Tell your team when you get care from other providers
 - Talk openly about your experience in getting care

National Partnership for Women and Families
http://www.nationalpartnership.org/af/2007/02/01/PCMH_Edited_Brochure_FINAL.pdf

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PCMH Implementation

UPMC Health Plan's Patient Centered Medical Home Structure

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UPMC Health Plan PCMH Practice Assessment

- In 2007 UPMC Health Plan began to educate our PCPs on the PCMH and provided assistance with structural and process improvement.
- An assessment was created, onsite visits made to our PCP practices to determine level of functioning as a PCMH, and the practice was given one of three levels of PCMH:
 - Basic, Intermediate, or Advanced
- Practice progress incentivized through P4P

6 Categories Assessed

Patient Access	Quality of Care
Care Coordination	Satisfaction
Efficiency (Administrative and Clinical)	Technology

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Implementation of Patient Centered Medical Home

- 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
- Today, there are 126 PCMH sites with 609 physicians, supported by 35 PBCMs, covering over 121,000 members, including 23,500 enrolled in UPMC for You
- By 12-12 expect to have over 300 sites, 750 physicians, supported by 50 PBCMs, covering approximately 188,000 members, with over 38,000 UPMC for You members

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Implementation of Patient Centered Medical Home

- Include Internal Medicine and Family Practice practices, no pediatric practices
- The majority of PCMH sites are in the urban Allegheny county, others in rural counties
- The PBCMs focus only on UPMC Health Plan patients



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NCQA PCMH Recognition

- As part of our PCMH we have provided support to obtain NCQA's PMCH recognition
 - 11 of our PCMH sites have obtained NCQA PCMH recognition.
- This is a labor intensive process
- Our support to the practices have helped them to prepare the documents needed
- Our PCMHs do not need to have NCQA recognition to be in our program

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Changes Identified as Essential to Success of PCMH

Episodic Acute Care ⇒ Population Management

Patient Problem ⇒ Patient-Centeredness

Patient Education ⇒ Patient Self Management

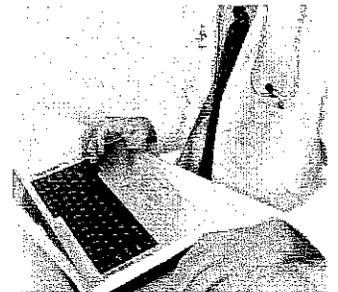
Practitioner Tasks ⇒ Function Within License

Health care team must function under highest level of licensure

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Clinical and Operational Support for PCMH

- Management and Staffing
- Use of technology
- Use of Data
- Quality Improvement



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Practice Based Care Manager Focus

Focus on Members:

- With high utilization
- At risk for high cost
- At transitions between settings (inpatient, SNFs, ED)
- With chronic conditions

Incorporate:

- Physician support
- Clinical teams
- Guideline care
- Data sharing
- Patient self-management, prevention and health coaching

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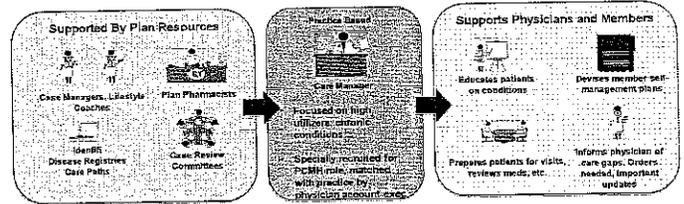
PCMH Support: Practice Based Care Managers

Key member of integrated care team:

- Functions under practitioner lead
- Facilitates communication among various team members
- Determines appropriate and efficient use of team members

Coordinates care:

- Medical, behavioral, & social
- Discusses and updates care plan with multiple providers
- Engages caregivers



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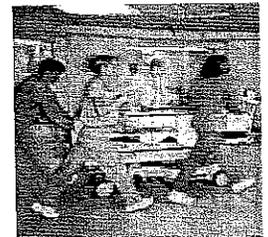
Patient and Care Giver Engagement Tactics

- Employ motivational/behavioral change techniques, understand what will motivate the patient to make changes
- Integration of physical and behavioral health care
- Help patient and caregivers establish goals that are meaningful for them
- See patient in their "home" environment through support of mobile teams
- Beginning to use non-traditional team members (community health workers)

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Strong Transitions Between Settings

- Systems in place to know when members in acute care, SNF, or ED
- Facilitate communication with patient, caregivers, and practitioners
- Assist with identifying barriers and addressing:
 - Follow-up appointments
 - Medication reconciliation
 - Member understanding of condition(s) and self management
 - Care giver support and use of community resources



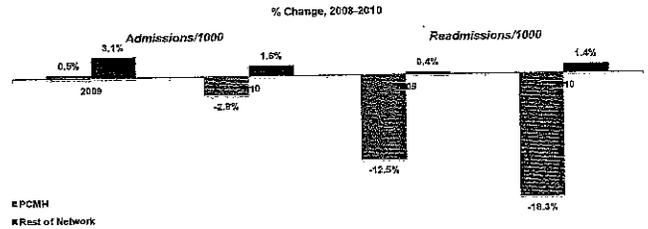
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Outcomes

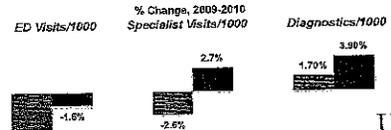
UPMC Health Plan's PCMH Outcomes

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Medical Home Program Reduces Utilization

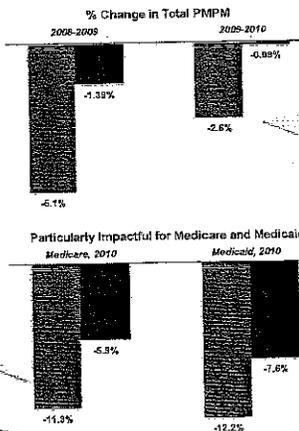


Comparison Holds for Other Utilization Categories



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Financial Impact Summary



Savings Impact
Two-year PMPM change of (7.7%) for PCMH versus (1.6%) for the rest of the network (RON)
2009-2010: Annual savings from PCMH program: \$3.2M, Program ROI: 180%

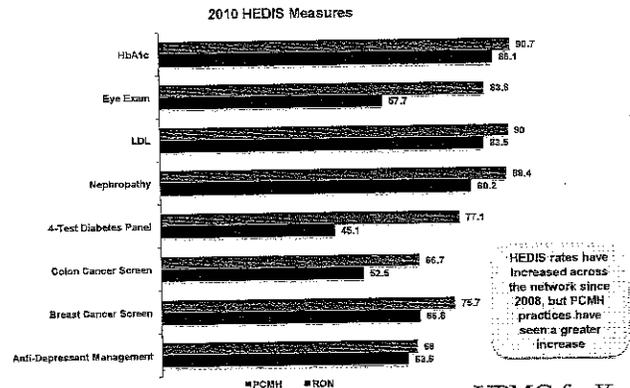
While both PCMH and RON successfully reduced PMPMs for Medicare and Medicaid, the close medical management afforded by PCMH yielded better performance.

Particularly Impactful for Medicare and Medicaid

PCMH
Rest of Network
* Savings figure not inclusive of program costs. ROI figure inclusive of program costs.

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Quality Follows Suit: PCMH Outperforms Rest of Network on HEDIS Measures



HEDIS rates have increased across the network since 2008, but PCMH practices have seen a greater increase.

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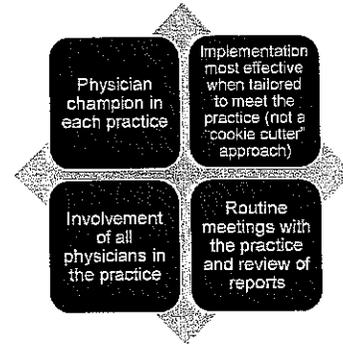
PCMH Outcomes from 2nd Quarter 2012

For all UPMC Health Plan products costs when compared to what expected without PCMH:

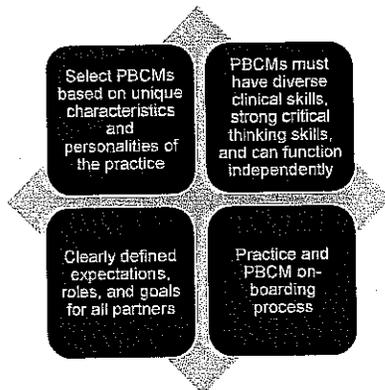
- Total medical and pharmacy pmpm lower
 - Pharmacy savings significant at 18 months ($p=0.026$)

HIGHER	LOWER
<ul style="list-style-type: none"> PCP and specialist 	<ul style="list-style-type: none"> Emergency room
<ul style="list-style-type: none"> Therapies 	<ul style="list-style-type: none"> High tech diagnostics

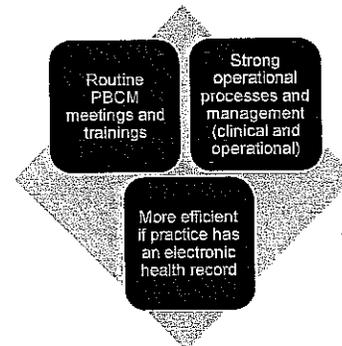
Lessons Learned



Lessons Learned



Lessons Learned



Questions?

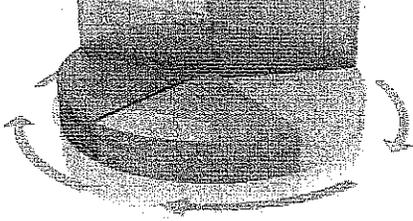
Contact information:

Debra Smyers
Senior Director Program Development,
Medicaid, Special Needs Plan, and CHIP
UPMC Health Plan
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412-454-7755

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Affiliate of UPMC Health Plan

Is Case Management Meaningful?

Tanya Alvord, BSN, MBA, MHA, CCM



Rules, Rules and More Rules

Paperwork Reduction

Meaningful Use

HPAA

Important Message

BBA

Case Managers Are Revenue Managers

- Utilization Review
- Discharge Planning
- Documentation Review
- Transitional Care

Revenue Managers Have To Be Creative

Do the Math...

$$435/6 = 72$$

Readmissions...

Planned?

Related?

Avoidable?

Why?



Transitions in Care

Revitalizing a program that works...



Utilization Management



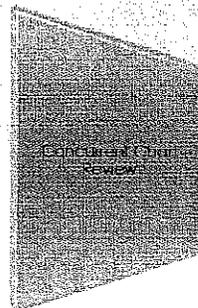
Milliman



BlueCross
BlueShield



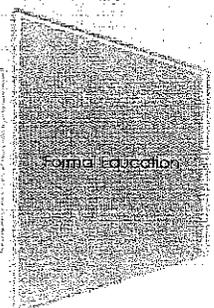
Clinical Documentation



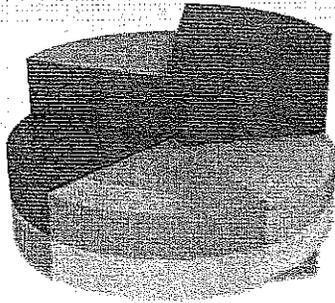
Education & Clinical
Review



Just in Time Training



Formal Education



Case Management Is Meaningful

...Now more than ever.

Medicaid Managed Care Conference Washington, DC

"Integrating Medicaid Managed Care with Community Based
Practice – New Delivery Models
for Urban Accountable Care"

October 4, 2012

Hans Wiik
President and CEO
Centura integrated Physician Network (IPN)

The integrated Physician Network (iPN)

Today's Agenda

- The iPN/Clinica Family Health Services History & Value Proposition
- Community Focus
- The Challenge Before Us
- The Politics of Medicaid – State issues

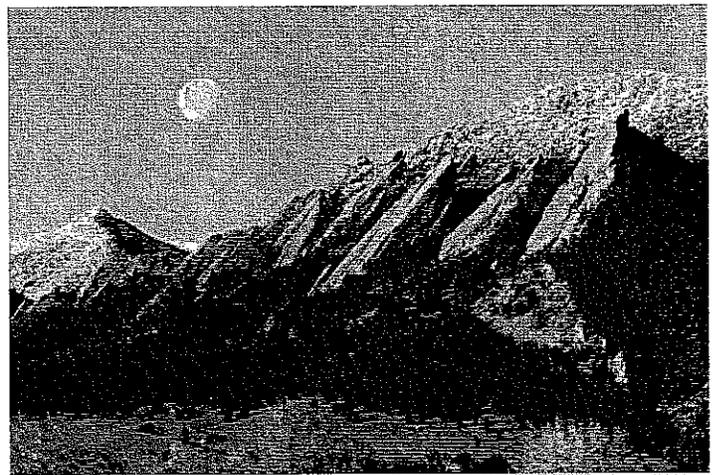
2

The integrated Physician Network (iPN)

- North Denver Market - Colorado

- A Journey of Clinical Integration
- The Importance of Primary Source Clinical Data
- Achieving Practice and Provider Accountability
- Value Proposition for Payers – Insurers and HCPF

3



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 accountability • value • sustainability

IPN Home | About | Services | Contact Us

Welcome to IPN's newest member practices, joining the IPN community as of July 1, 2011:
 Centura Family Practice, Complete Family Care, Centura Family Physicians, New Line Family Medicine, and Rocky Mountain Primary Care

Please direct all calls to these new IPN practices to the IPN website. Through the website, the Centura area will provide a summary of these practices and primary source data. community providers will deliver safer, more efficient and more effective care, across the continuum of care, and demonstrate the value their service brings to their patients and healthcare system.

www.iPN.org

IPN Vision and Mission

IPN Vision
 To demonstrate value-based healthcare through focus on IPN's Triple Aim:

- Improve the health of the population
- Enhance the patient experience of care (including quality, access, and reliability)
- Reduce, or at least control, the per capita cost of care

IPN Mission
 To improve the health of our patients by creating a sustainable, clinically integrated network of independent primary care, specialty care, and hospital service providers. Using a common electronic medical record, an evidence-based quality improvement program, and primary source data, community providers will deliver safer, more efficient and more effective care, across the continuum of care, and demonstrate the value their service brings to their patients and healthcare system.

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IPN Vision:
 "The current vision of the iPN is to successfully position the organization, a clinically integrated network of medical practices and providers supported by Centura Health as an Accountable Care Organization (ACO)."

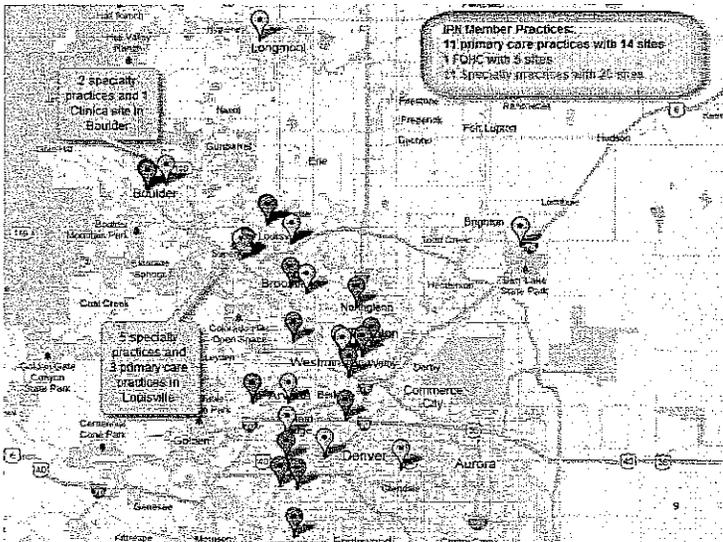
IPN Mission:
 "To improve the health of our patients by creating a sustainable, clinically integrated network of independent primary care, specialty care, and hospital service providers. Using a common electronic medical record, an evidence-based quality improvement program and primary source data, community providers will deliver safer, more efficient and more effective care, across the continuum of care, and demonstrate the value their service brings to their patients and the healthcare system."

integrated Physician Network

- 1990 – 2004 Avista Medical Associates
- 2004 – 2005 iPN Formation: Private Practices, Avista, Clinica Family Health Services – large multi-site FQHC
- Enterprise Community Health Record
- Clinically Integrated Network – FTC
 - The Future for "Narrow Networks"
- Sponsored PHO: Centura Health
- 2010 – NextGen Large Practice Award Winner – EHR Implementation

integrated Physician Network

- North Denver Market – Boulder, Broomfield, Adams, Jefferson and Denver Counties
 - 26 Practices, 40 Sites
 - 200+ Providers, 125+ Primary Care, 75+ Specialists; 1,300+ End-users
 - Family Medicine, Internal Medicine, Pediatrics, OB-GYN, Cardiology, Orthopedics, General Surgery, Neurosurgery, Pulmonology, Plastic/Reconstructive Surgery and Anesthesia
 - 9 PCP Practices/104 Providers – NCQA Level III, PCMH including all Clinica sites and providers



Integrated Physician Network

Member Practices - 2012

- Governing Bylaws, Physician Service Agreements, Policies and Procedures
 - Fully implemented EHR and Practice Management system
 - Active participation in iPN Quality Plan
 - Quality Alignment Meetings
 - Provider and Practice Accountability
 - Quality Boards in every Practice
 - Monthly CQI Committee Meetings with Clinica Leadership

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“Fully Implemented EHR”

What does this mean?
 Does this imply transformational change in healthcare delivery and workflow?

11

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A quote for pondering?

“That it will ever come into general use, notwithstanding its value, is extremely doubtful; because its beneficial application requires much time and gives a good bit of trouble both to the patient and the practitioner; because its hue and character are foreign and opposed to all our habits and associations.”

Possibly - a comment about Electronic Medical Records – EMR's?

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"That it will ever come into general use, notwithstanding its value, is extremely doubtful; because its beneficial application requires much time and gives a good bit of trouble both to the patient and the practitioner; because its hue and character are foreign and opposed to all our habits and associations."

Quote is an editorial from the London Times from 1834 on the advent of the stethoscope.

integrated Physician Network

■ ORGANIZATION:

iPN Board of Directors – 13 members

- 9 Primary Care Physicians
- 4 Specialty Physicians
- Hospital and iPN CEO's – Ex Officio
- Including Clinica Representation - CQI Committee Chair



Voting Power: Physician Board Members

iPN Administration: Health System

iPN Ownership: Health System

Health System CEO Reserve Power: approval only of Board Nominees

integrated Physician Network

• Structure and Organization

■ Administrative Services and Funding

- Single Signature Insurance Contracting for all Payers
 - Medicaid delegated to Clinica Family Health Services
- iPN Office-Administration, MSO Services, IT and CQI Support
- Funding:
 - Physician Membership Monthly Fees – Practices own EMR licenses
 - Grant Support – HRSA / OHIT, Colorado Health Foundation
 - Centura Health – Abiding by Stark Regulations – Expires 12/31/13
 - Value Proposition – the iPN becomes the Practice Support for – "Contracting, Quality, and IT – Information Technology"

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"A Multi-Specialty, Clinically Integrated Clinic Without Walls"

Financial Success

- MSO Services
- EPM – Best Practices
- FFS / P4P Contracting

Clinical Success

- Patient Satisfaction
- Collaboratives on Quality
- Cost Impact



Building Blocks for an Accountable Care Community

- Risk and P4P Contracting
- Value for Employers/Payers/Patients
- Serving all Populations – Medicare, Medicaid, Safety Net/Uninsured and all Commercial Payers

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The keys for success

- Physician Leadership
- Market Perspective / Intelligence
 - Which employers and payers are wanting a different model?
- Hospital or Physician Centric
- Primary Care Focus – Care Coordination
 - PCMH – Level 3 – NCQA
 - Enterprise Chart Functionality – One Medical Record/EMR
- Employed vs. Independent Practices -- including Clinica
 - EMR Support – Consistent Models
 - PCP and Specialty
 - Data and Quality Integration / Clinical Data Warehouse

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Clinical Integration Requires Specific Competencies

Do it right or don't do it at all – 2nd generation clinical integration!

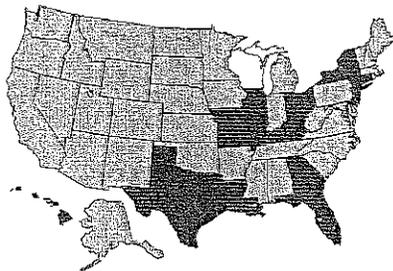
- Digital connectivity of EMR with point of care protocols
 - Portal for submitting all encounter data as a transitional step
- Ability to monitor the cost and quality in near real time
- Primary care capa



Medicaid's Role Within Health Insurance Exchanges
 &
 Health Plan's Role Within States
 That Elect Out Of Medicaid Expansion

David McNichols
 President, WellCare of Georgia

WellCare Health Plans Inc.



- Medicaid, Medicare Advantage & Medicare Part D PDP
- Medicare Advantage & Medicare Part D PDP
- Medicaid & Medicare Part D PDP
- Medicare Part D PDP (48 states & D.C.)

Founded in 1985 in Tampa, Florida:

- A national company with more than 4,300 associates
- Approximately 2.6 million members nationwide
- Offices in Florida, Georgia, Hawaii, Illinois, Kentucky, Louisiana, Missouri, New Jersey, New York, Ohio and Texas

Serves more than 1.5 million Medicaid members, including:

- Temporary Assistance for Needy Families (TANF)
- Children's Health Insurance Plan (CHIP)
- Supplemental Security Income (SSI)
- Aged, Blind and Disabled (ABD)
- Family Health Plans (FHP)

Serves more than 1 million Medicare members, including:

- Prescription Drug Plans (PDPs)

Spearheading efforts on sustaining the social safety net by identifying and addressing gaps in community based services through:

- Community Investments
- Advocacy Programs
- Creation of Public-Private Partnerships

Significant contributor to the national economy:

- A FORTUNE 500 company
- Ranked #18 in the nation on the Barron's 500

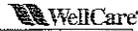


Setting the Stage

Affordable Care Act Implementation

- Medicaid expansion – optional for states.
- State level exchanges.
- Basic Health Program – alternative to exchanges.

Challenges of Optional Medicaid Expansion



Challenge for States:

- Beginning in 2017, the match obligation for states increases.
- Deciding on "principal" has consequences.

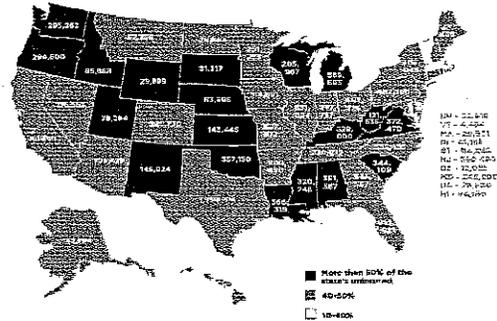
Challenge for Providers, Payers and Patients:

- Failure to expand Medicaid creates a "donut hole."
- Hospitals still required to provide emergency care to the uninsured.
- Costs incurred for treating the uninsured will be passed on.
- Cost shifting will affect everyone.

Medicaid and the Uninsured



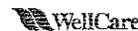
Who would be left uninsured?



Source: Jane Holston, Irene Hoxton of the Urban Institute, "Medicaid Coverage and Spending in Health Reform, National and State-by-State Profiles for Adults at or Below 133% FPL," Kaiser Commission on Medicaid and the Uninsured, May 2010.

Source: <http://progressivestates.org/news/blog/infographic-what-if-24-60-99th-states-refuse-expand-medicad>

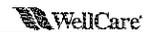
Medicaid Expansion Options for States



State Expansion Options:

- Elect the Medicaid expansion and then drop it.
- Expansion to 100% of Federal Poverty Level (FPL).
- Expand for a subset of all eligible individuals.
- Allow expansion at a sub-state level.

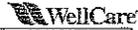
Maintenance of Effort



CMS ruling: the Supreme Court decision does not impact the Maintenance of Effort provisions.

- Opposing views.
- Maine looking at reduction in adult enrollees.
- Coverage reductions will make gap issues worse, with negative consequences for individuals and employers.

The Importance of Coordination



Coordinating Medicaid and the Exchange

States with Medicaid managed care can utilize that experience to:

- Contain costs.
- Increase budget predictability.
- Impose quality goals.
- Require health systems change.
- Utilize strict network adequacy standards.
- Oversee sales and marketing activities.
- Inform choice counseling and drive informed plan selection.

The Importance of Coordination



Why is Coordination Important?

- Medicaid dominates health care purchasing.
- Need to leverage Medicaid's defining role.
- Churn rate.
- Facilitate smooth transitions across coverage categories.

Assuring Medicaid Plan Inclusion



Benefits of Including Medicaid Health Plans in the Exchange:

- Reduces the risk of discontinuity of care, limits disruption in ongoing treatment regimens, preserves provider relationships.
- Assures that entire families can hold coverage through a common issuer.
- Proven ability to induce behavioral changes.
- Delivers network composition.

Assuring Medicaid Plan Inclusion



Key Elements

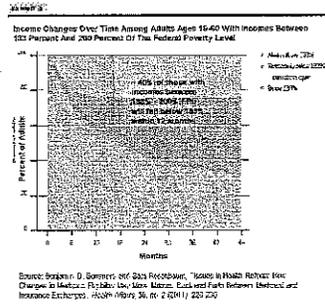
Qualifying Health Plan (QHP) selection criteria:

- Allow all willing and capable plans to participate.
- Encourage participation from many types and sizes.
- Utilize existing Medicaid health plan review processes.
- Align quality measurements.
 - Plans currently held to different standards and serve different populations.
 - Utilize a single set of fair measures.

Basic Health Program



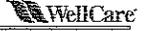
- Separate from the Exchange.
- State option.
- Coverage for <200% FPL.
- Promotes continuity of care for individuals who "churn" between programs.
- Cost-effective.
- More affordable for enrollees.
- Keeps the family together on one plan.
- Benefit package = EHB package.
- 85% MLR.
- States must use a competitive selection process.
- State receives payment = 95% of the average silver plan.



Millman: If BHP based on Medicaid fee schedule, states will have a surplus of funds.

- Average federal BHP payment = \$4,680.
- Average cost of covering a BHP-adult = \$3,624.
- States are required to reinvest any unused BHP funds.

Tennessee Medicaid Bridge Proposal



A Viable Option?: "One Family One Card"

- Alternative to the Exchange.
- Silver-level benefit plans.
- Exclusive to Medicaid health plans.

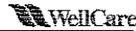
Why is the Bridge Better than BHP for TN?

- No or limited state financial risk.
- Prevents churning for incomes above 200% FPL.
- Medicaid and CHIP income limits.
- Limited impact on Exchange risk pool.
- Limits provider bad debt.
- Prevents individuals from selecting bronze plans.

What's the "Sticking Point" for CMS?

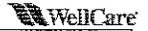
- Consumer Choice: a qualified individual may enroll in QHP if eligible.
- Guaranteed Coverage: plans accept every individual who applies for coverage.

Summing Up



- Medicaid expansion decisions are complex.
- Medicaid and exchanges will be closely linked.
- Medicaid health plans should be deemed as QHP's.
- States should consider adopting a Basic Health Program model.

Discussion



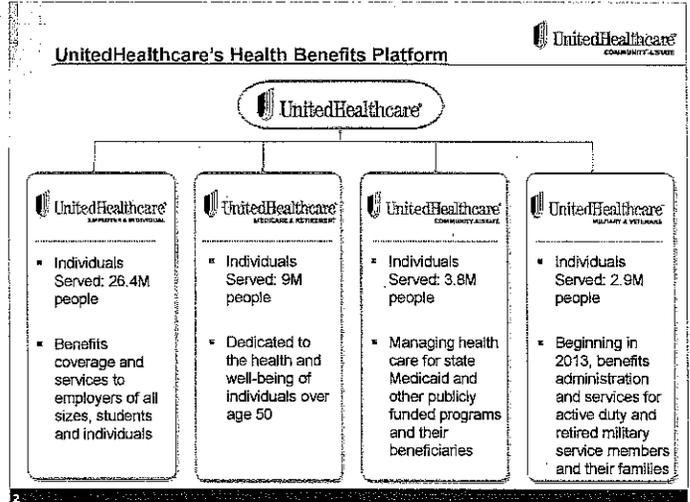
Questions

and

Comments

Managing Medicaid Expansion in Partnership with States

John Kaelin, Senior Vice President of Health Reform
 Presentation to the 2012 Medicaid Managed Care Conference,
 Global Media Dynamics
 October 5, 2012

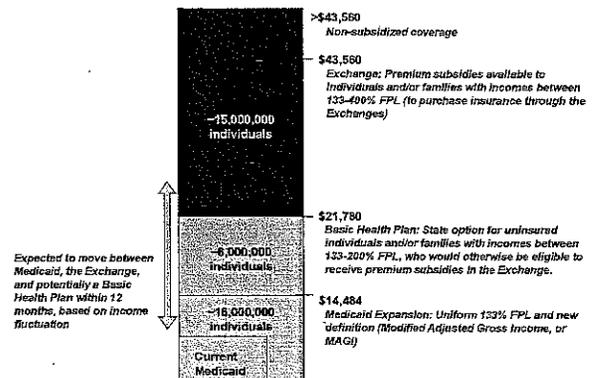


Introduction to the ACA



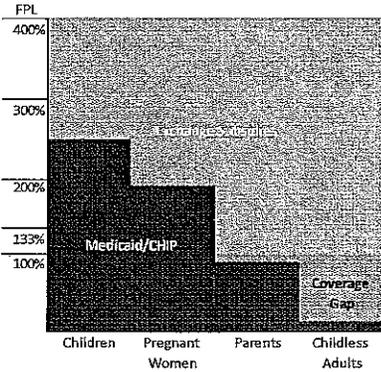
- The ACA seeks to expand insurance coverage to approximately 32 million people.
- The 2 main sources of the coverage expansions will come from an expanded Medicaid program and new subsidized insurance coverage via state based health insurance exchanges.
- The Medicaid Expansion, one of pillars of the Affordable Care Act (ACA), seeks to provide coverage to over 16 million individuals and represents almost half of all those who will become newly insured under the health reform law.
- The Federal Government will pay 100% of the cost related to the expansion population through the year 2016.
- Closely related to the Medicaid expansion, lower income individuals who earn too much to qualify for Medicaid will be provided subsidies to buy private insurance on new health exchanges. There will be many individuals who move between Medicaid and the subsidized program as their incomes change, and it's likely that family members could be split between the two programs.
- The demographic and health needs of these new members will be different from the individuals covered by many programs today.

The ACA Vision for 2019 Improved Access to Health Care



Note: This visual is based on 2011 FPL guidelines for a household size of 1. Numbers do not necessarily reflect all net new coverage. Sourced from CBO estimates, available at: <http://www.cbo.gov/ftpdocs/11xx/doc11402/11-07-ACAHealthCoverageEstimates.pdf>. Reprinted with permission of the Center for Budget and Programs Prioritization, New York, NY, April 2012, p. 2.

The Supreme Court Decision makes Medicaid Expansion Optional



~4.2 million individuals between 100%-133% FPL may qualify for subsidies on the exchange. However, paying even a small amount for health insurance may be hard for an individual making less than \$14,484.

~11.5 million uninsured individuals would not be eligible for Medicaid if all states decide not to expand.

NOTE: National averages are calculated based on an unweighted average of current state eligibility and state populations.

SOURCE: Kaiser 2012 & 2010 D.H. Cloonan, Rural Poverty & Urban Inequality & Poverty

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Medicaid: To Expand or Not Expand?

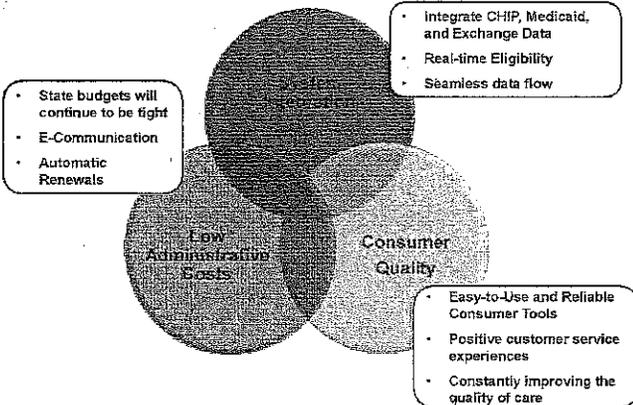


Several important factors will play into a state's decision concerning Medicaid Expansion:

- Will DSH funding to hospitals be eliminated?
- Can the state budget support the expansion in future years?
- Will the federal deficit affect the funding for Medicaid expansion?
- How much will the additional federal funding for newly eligible population help the state's economy? (ie create jobs)
- Will there be savings from the coordinated care projects the federal government is supporting within the state? (ie ACOs, Dual Eligible Demonstrations)

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Medicaid Expansion will involve a partnership between States and MCOs



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Working Together: Implementing a Fee Increase for Medicaid PCPs



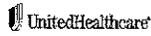
- **Regulation:** The ACA requires MCOs pay specific physicians at the applicable Medicare rates for only 2 years, 2013 – 2014.
- **Why:** To incentivize primary care physicians to expand their practice to include more Medicaid patients
- **Partnering Opportunity:** States and MCOs will need to work together to implement this regulation to ensure PCPs are paid correctly. This may include collaborating on rate-setting, reporting, and technology solutions.
- **Future Opportunities to Partner:**
 - The Association of American Medical Colleges estimates that in 2015 the country will have 62,900 fewer doctors than needed. And that number will more than double by 2025, as the expansion of insurance coverage and the aging of baby boomers drive up demand for care.
 - With millions of uninsured individuals gaining access to coverage, it is imperative MCOs and states assess network capacity requirements to allow access to PCPs and possible incentive programs for PCPs.

"Coverage does not necessarily translate into care."

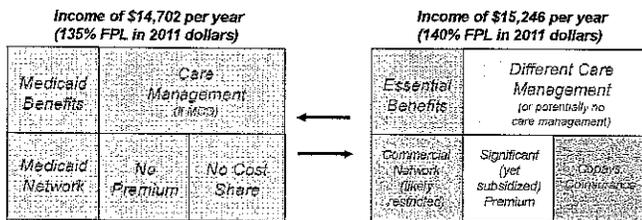
SOURCE: New York Times, "Doctor Shortage Looms for Women with Health Issues"

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Working Together: Solving "Churn" between Medicaid and the Exchange



- As incomes fluctuate, individuals are likely to "churn" between eligibility for Medicaid and the Exchange. A Health Affairs study indicated that 28 million individuals may shift from Medicaid to the Exchange, or vice versa, within a given year.
- States and MCOs will partner to assess and create innovative solutions to solve the "churn" issue since many MCOs will be represented in both Medicaid plans and Exchange plans available to consumers.

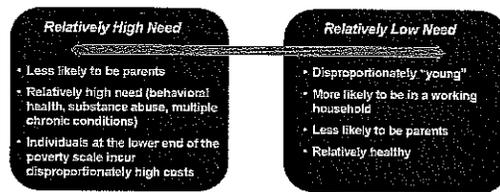


* This diagram assumes that Medicaid covers up to 136% FPL and assumes no Basic Health Plan

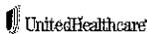
Working Together: Understanding Unique Characteristics of New Members



- Many researchers have studied the anticipated characteristics of individuals who will receive coverage through the Medicaid Expansion in 2014. Results of these studies vary widely.
 - Some predict a higher cost population with a significant need for services to treat multiple chronic conditions, behavioral health, and substance abuse.
 - Others predict a lower cost population that is relatively healthy, predominately young (between the ages of 19-34), and who predominantly reports themselves to be in "excellent or very good" physical and mental health.
- In reality, we are likely to see a blend of these characteristics, but should not expect this population to be homogenous.
- Numerous factors may influence the characteristics of the Expansion population in each market, including state outreach efforts, state sales and marketing requirements, and the extent to which a state already covers a portion of this population.



Considerations for States



- How will states work to ensure a simplified, streamlined process, consistent with the "no wrong door" approach emphasized in the Affordable Care Act in light of:
 - An Exchange's ability to now "assess" vs. determine eligibility for Medicaid?
 - A fully run federal Exchange or a partnership model?
 - Providing staffing for customer service under budget constraints?
- Will state systems be ready, how are they taking advantage of the enhanced (90% match) to "modernize" Medicaid eligibility systems?
- Leveraging the work and lessons learned through the "Enroll UX project" and past program implementations such as CHIP.
- To what extent will the Medicaid eligibility process rely on the Federal Data Hub?
- Under a Federal or Partnership model, or if a state Exchange and Medicaid eligibility process are not combined:
 - How will states / the Federal Government harmonize their systems?
 - Could there be two systems / different eligibility rules engines determining eligibility for APTC and Medicaid?
 - What could be the consequence or risk of such an approach?

Considerations for Health Plans



- Health Plans will play a critical role in providing the infrastructure for both the Medicaid Expansion and Exchanges.
 - Provider Networks:** capacity for both primary care and the specific health needs of the new consumers
 - Clinical Model:** unique clinical models may need to be developed to fit characteristics of new population
 - Technology & Operational Readiness:** enrollment, plan design, the 3 R's, Essential Health Benefits, and ability to meet other state/federal requirements (specific to Exchanges and more broadly)
 - Consumer Information:** health literacy, terminology, benefits, cost obligations, customer service experience and coverage transitions
- States and key stakeholders continue to wait for federal guidance on many ACA provisions. It will be important to work with them to ensure optimal implementations.



The Medicaid Managed Care Landscape After the Supreme Court Decision and Medicaid Expansion

Thomas L. Johnson
President & CEO

October 4, 2012

Medicaid Health Plans' Challenges and Opportunities

- Supreme Court Ruling
 - Medicaid Expansion
- ACA Implementation
- 2012 Elections
- Other Priorities



Supreme Court Decision

June 28, 2012 - the Supreme Court ruled that the federal government cannot withhold all federal Medicaid funding from a state if it refuses to expand its Medicaid program as required by the ACA

- Note: It took 18 years for Medicaid to become available in every single state, with each state finally being on board by 1982 (Arizona being the last).

States weigh the expansion option

- Governors in FL, LA, MS, SC, TX and GA have indicated they do not plan to expand their states' Medicaid programs.

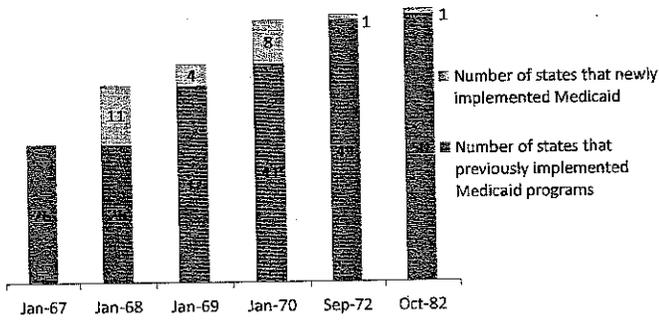
Medicaid Eligibility: Key Findings

Kaiser Family Foundation July 2012 Report:

- The ACA requires Medicaid coverage for the newly-eligible adult population up to 138% FPL, but the Supreme Court essentially ruled that states must have a choice to expand or not.
- Currently, 33 states limit Medicaid eligibility to parents earning less than 100% FPL, and 17 states limit parent eligibility to less than half of FPL. Only 9 states provide full Medicaid benefits to other adults.
- The expansion would increase eligibility for parents in 40 states and in nearly all states for other adults. As of 2010, there were 41.2 million uninsured adults, and 52% (21.6 million) had incomes below 138% FPL.
- If a state does not expand Medicaid, adults with incomes between 100% and 138% FPL will be eligible for subsidies, but those with incomes below 100% FPL will not be eligible to receive subsidies. As of 2010, there were over 16 million uninsured adults with incomes below the poverty level.

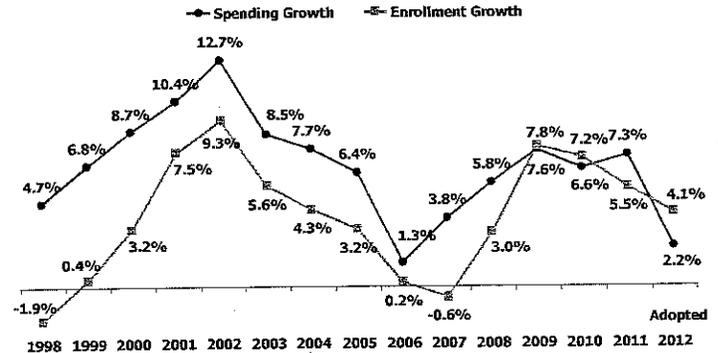


Historic Implementation of Medicaid by State



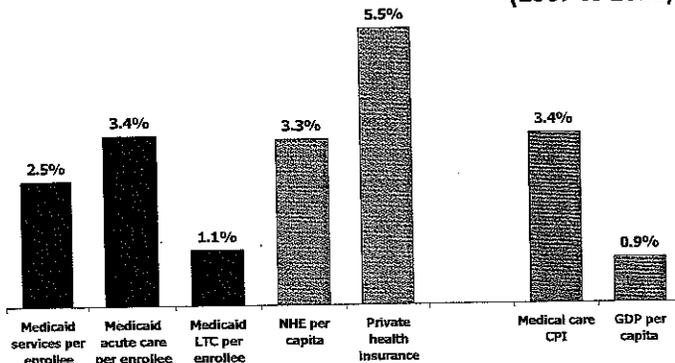
Source: National Bureau of Economic Research, "Means-Tested Transfer Programs in the United States," 2003 Kaiser Commission on the Uninsured, "A Historical Review of How States Have Responded to the Availability of Federal Funds for Health Coverage"

Percent Change in Total Medicaid Spending and Enrollment, FY 1998 – FY 2012



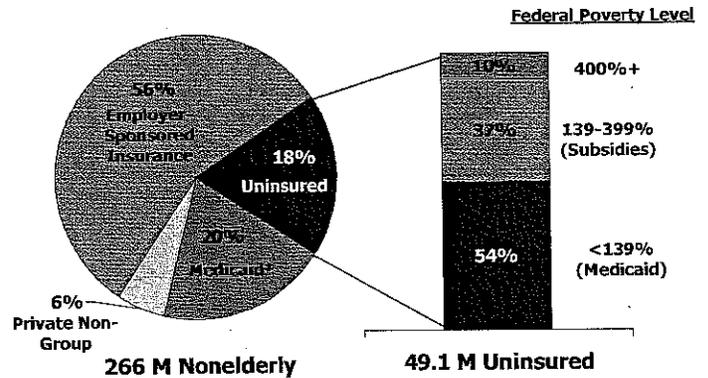
NOTE: Enrollment percentage changes from June to June of each year. Spending growth percentages in state fiscal year. SOURCE: Medicaid Enrollment June 2010 Urban Institute, KCMU, February 2011. Spending Data from KCMU analysis of CMS Form 64 Data for Historic Medicaid Growth Rates. FY 2011 and FY 2012 data based on KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2011.

Medicaid spending growth per capita was slower than private health care spending (2007 to 2010)



Note: Acute Care includes payments to managed care plans. Source: Medicaid estimates from Urban Institute analysis of data from the Medicaid Statistical Information System (MSIS), Centers for Medicare and Medicaid Services (CMS) Form 64, and Kaiser Commission on the Uninsured and Health Management Associates data, 2011. Private health insurance and GDP data from Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group, 2011. Medical care CPI from the Bureau of Labor Statistics, Consumer Price Index Detail Report Tables, 2011.

Expanding Coverage Under the Affordable Care Act

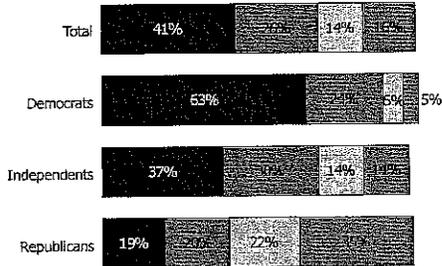


* Medicaid also includes other public programs: CHIP, other state programs, Medicare and military-related coverage. The federal poverty level for a family of three in 2012 is \$19,050. Numbers may not add to 100 due to rounding. SOURCE: KCMU/Urban Institute analysis of 2011 ASHC Supplement to the CPS.

Most Support Medicaid Expansion As General Concept

The health reform law will expand the existing Medicaid program to cover more low-income, uninsured adults. Would you say you feel very favorable, somewhat favorable, somewhat unfavorable, or very unfavorable about that?

■ Very favorable ■ Somewhat favorable ■ Somewhat unfavorable ■ Very unfavorable



Note: Don't know/Refused answers not shown.
Source: Kaiser Family Foundation Health Tracking Poll (conducted July 17-23, 2012)



10

Court Ruling: Projections of Impact on Medicaid Enrollment

- The **Urban Institute** found that 22.3 million uninsured people could be eligible for Medicaid under the ACA (15.1 million newly-eligible adults, 2.9 million children currently eligible but not enrolled and 4.4 million adults currently eligible but not enrolled).
- Of the 15.1 newly-eligible adults, 11.5 million would be below 100% FPL and would not qualify for Exchange subsidies.
 - Of the 11.5 million, 1.4 million live in California, 1 million live in Florida, and 1.3 million live in Texas.
- **CBO** recently estimated that the Supreme Court's decision could reduce Medicaid and CHIP enrollment by 6 million individuals and increase enrollment in the Exchanges by 3 million (considers a broad range of possibilities and is not based on which states have recently announced expansion decision plans).

Court Ruling: Projections of the Economic Impact

- The **Urban Institute** projected in 2011 that the federal government would spend \$704 billion to \$743 billion more under health reform than without it, between 2014 and 2019. The states, however, would spend \$92 to \$129 billion less under the ACA than without it.
- A 2011 **Families USA** report found that even a 5 percent federal Medicaid cut would result in over \$13 billion in funding losses, and would mean close to 30 thousand jobs lost in some of our major states (NY, CA).
- The **State of Arkansas** recently found that the state would experience \$372 million in savings in the first six years, if the state expands Medicaid.
- The University of Maryland, Baltimore County's **Hilltop Institute** recently estimated that implementing the ACA could result in a 1% decrease in the unemployment rate by 2020 as a result of almost 135,000 jobs created across all sectors.



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Court Ruling: Projections of the Economic Impact Cont'd

- Michigan's **House Fiscal Agency** recently released a report containing preliminary estimates that show that \$1.1 billion in state savings could be achieved over a ten year period as a result of the state expanding its Medicaid program.
- The **Center on Budget and Policy Priorities** recently calculated that although state spending may increase by 2.8 percent as a result of the Medicaid expansion, the savings that state and local governments will experience in health care costs for the uninsured could fully offset the cost of expansion.
- **CBO** recently estimated that the Supreme Court decision could mean \$84 billion in federal savings, which assumes less individuals being in the Medicaid program (and only a portion of these being eligible for Exchange participation).



12

Scope of Expansion, Timelines, and FMAP

1. Can states expand eligibility to 100% FPL or other levels less than 133% and how would this impact FMAP?

- CMS has not answered this question directly.
- It appears that the answer to this question could rely on how HHS ultimately defines the newly eligible population that qualifies for the enhanced match in the ACA.
- It's possible that HHS could provide states with flexibility through their existing authorized powers.

 - Although, this seems unlikely, given Secretary Sebelius's stance on the Medicaid expansion to date. ¹³

Scope of Expansion, Timelines, and FMAP

1. Can states begin Medicaid expansion at a date later than 2014 or phase in the expansion?

- CMS responded to the RGA and made clear that there would be no deadline for states to inform CMS of its plans to expand Medicaid.
- Although HHS hasn't said that states can phase in expansion, the enhanced federal match is tied to the calendar years beginning in 2014, as written in statute.
- This fact could encourage states to begin expansion earlier versus later, as the federal match decreases after the third year.



¹⁴

Process

1. Must states proactively submit a SPA for approval of the expansion or decision not to expand and, if so, what are the deadlines?

2. Will CMS work with states to incorporate expansions into waiver programs?

- Again, CMS said there isn't a deadline by which states must choose to expand Medicaid, but the agency has not yet offered guidance on the process through which states can gain approval for expansion.



¹⁵

Funding

1. If a state has expended money to upgrade their eligibility systems at a 90/10 match rate and the state chooses subsequently not to expand to the optional adult group, is the state liable for returning funds?

- CMS wrote to the RGA that states that have received IT funding and funding for establishing Exchanges will not have to return those funds, regardless of their decision to expand Medicaid.



¹⁶

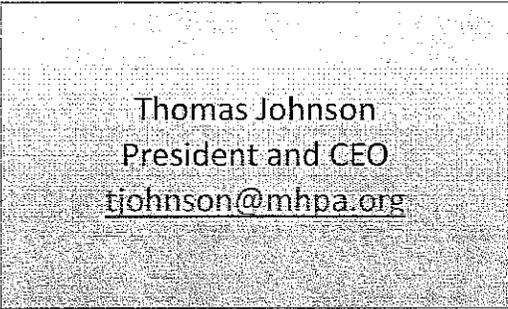
2012 Elections

- What will the 2012 elections bring?
 - ACA fully intact
 - ACA repeal efforts
 - Full repeal
 - Partial repeal or repeal of certain aspect of reform
 - Defunding or lowering funding for portions of the law
 - Regulatory pathways to scaling back ACA
 - Future guidance related to SCOTUS ruling
 - Entitlement reform
 - “Grand Bargain” on deficit reduction, sequestration, and tax reform



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Questions?

A rectangular box with a light gray background and a thin black border containing contact information.

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Medicaid Managed Care Conference

Three Months Later –
How ACA 2.0 and the Supreme Court Decision Impact the
Medicaid Managed Care Landscape

October 4, 2012

Kelly Wechtman
Vice President, Public Policy



Who We Are



Our Mission

We help people get care, stay well
and build healthy communities.
We have a special concern for
those who are poor.

Our Value Proposition

We deliver excellence in publicly
funded managed care services and
products.



Where We Are

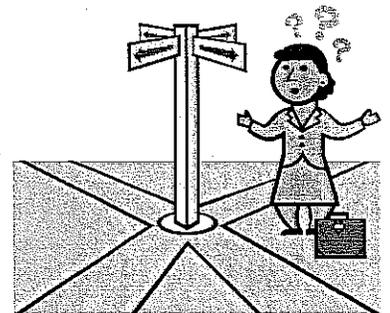


RISK BUSINESS
Arkansas, Arizona, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming.

PHARMACY BENEFIT MANAGEMENT
California, Florida, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming.

BEHAVIORAL HEALTH MANAGED CARE
California, Florida, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming.

Medicaid Health Plan Environment



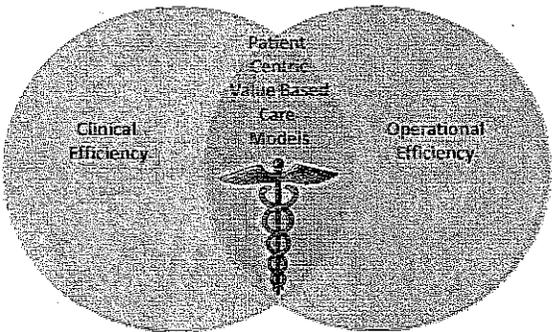
Medicaid Health Plan Environment

- Medicaid expansion (or not)
- New populations (I/DD)
- Dual demos
- Exchanges
- M&A activity
- Insurer fee
- Rate cuts
- Benefit changes
- Provider consolidation
- Medicaid ACOs
- New mandates (ICD-10, HIPPA 5010, Administrative Simplification)
- Block grants???

Medicaid Health Plan Environment

- Health Plan and Provider Convergence
- Medicaid ACOs
- Expected Needs of the Medicaid Expansion Population
- Medicaid as Prudent Purchaser
- Future Expectations

Health Plan and Provider Convergence



Medicaid ACOs

- Regional Medicaid ACO networks (CO)
- ACO Medicaid managed care contracts (MN and NJ)
- Medicaid managed care transition to ACO model (UT and OR)
- Center for Health Care Strategies Medicaid ACO Learning Collaborative

Newly Eligible Profile

AMFC Experience: Healthy Indiana Plan



- Implemented January 1, 2008
- Provides a high-deductible health plan and a health savings account-like POWER Account
- Covers
 - Uninsured adults, including custodial parents of Medicaid and CHIP children, 22 percent of the Federal Poverty Level (FPL) through 200 percent of the FPL
 - Uninsured childless adults up to and including 200 percent of the FPL

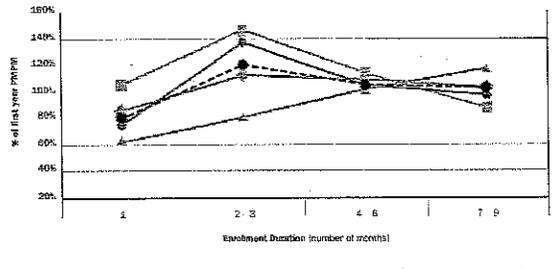
Source: OMNI HEALTHY INDIANA PLAN SECTION 1115 DEMONSTRATION FACT SHEET

Healthy Indiana Program: Outcomes

Population	Relative Morbidity
Caretaker (HIP)	1.25
Non-Caretaker (HIP)	1.65
Commercial	1.00

Source: Indiana Health Reform Institute Paper, "Transitioning to the Healthy Indiana Plan: The State's First Steps, Challenges of Building Leverage to the Mainstream," August 2006

Relative PMPM Costs by Enrollment Duration



Source: Indiana Health Reform Institute Paper, "Transitioning to the Healthy Indiana Plan: The State's First Steps, Challenges of Building Leverage to the Mainstream," August 2006

Medicaid as Prudent Purchaser



- Quality-driven procurement decisions
- Performance based contracting
- Sophisticated risk adjustment

Informatics will Drive Success



- No more mile wide and inch deep
- Connected to HIX with real-time data
- Customized EMR/drill-down analytics
- Population-based predictive modeling and HotSpots
- Shared savings and risk-based provider contracts



The Future

Will not look like the past...

- Block grants?
- Fundamental benefit redesign?

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The AmeriHealth Mercy Family of Companies



The AmeriHealth Mercy Family of Companies



Preparing Your Health Plan to Serve Medicare/Medicaid Members

2012 Medicaid Managed Care Conference
October 4, 2012



Cirque D'ACA!

For Growth: Flexibility and Adaptation



Neighborhood Background

- Incorporated as an HMO in 1994
- Founded by RI's Community Health Centers
- Serve 67 percent of RI Medicaid Managed Care participants
 - 4 distinct groups: Children & Families, Children with special health care needs, Children in substitute care, and Adults with disabilities
- Serve 46 percent of all Medicaid participants in RI
- Committed to NCQA accreditation process since 2001

Our Focus

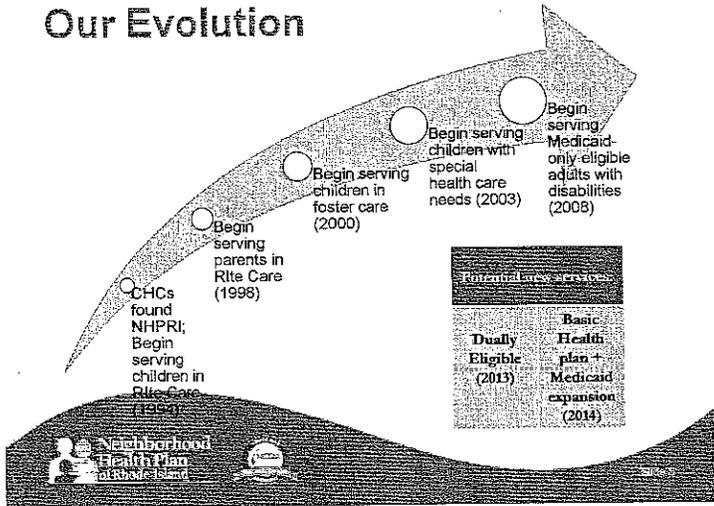
Mission

Neighborhood Health Plan of Rhode Island, an innovative health plan in partnership with the Community Health Centers, secures access to high quality, cost-effective health care for Rhode Island's at-risk populations.

Vision

- Everyone in Rhode Island has comprehensive healthcare coverage and access to high-quality health care.
- Community Health Centers are models for the delivery of high-quality, cost-effective primary care and the building blocks of community health in their respective communities.
- Neighborhood helps transform health care delivery as an essential partner in the state's Medicaid program.
- Neighborhood members are actively engaged in their health and health care.

Our Evolution



State Activities

- Medicaid LTC by April 2013
- Medicare and Part D by January 2014
- Community Work Groups: Services and Supports, Quality and Evaluation, Communication
- Public Hearings

Dually Eligible Beneficiaries in RI

- Approximately 38,000 covered lives
 - Vast majority reside in community; 5,400 reside in institutions
- RI has an imbalance in Long Term Supports and Services
 - RI ranks 48th for its percent of Medicaid LTSS spending going to home and community based services
- Disproportionate part of state Medicaid expenditures
 - 21% of RI Medicaid members
 - 44% of total RI Medicaid budget

Preparing for Growth

- Board of Directors review of all ACA business opportunities by Q2 2012
- Develop business assessments of: Medicaid/Medicare, HBE, Medicaid Expansion and BHP
- Management education
- Secure consulting services; financial analysis, Medicare regulations, Care Management model, HCBS management and service development

Prioritizing Development

- Focus on Medicare-Medicaid
 - Network requirements: contracting for Medicare and LTSS development; use of experienced vendor
 - Model of Care
 - Administrative vendor requirements
 - Preparing for State RFP
 - Infrastructure: Medicare enrollment, claims payment, benefit set-up, CM portal
- Learning from LTSS providers; visits to key groups – intellectual and developmental disabilities, substance abuse, serious mental illness, adult day, assisted living, nursing facilities



A Vision for Serving Duals

Provide integrated, quality care aimed at improving health care outcomes and cost-effectiveness through appropriate use of care coordination and supports, including at PCMHs, through community-based organizations, and plan Care Management.



Care Management Highlights

- Stratification and assessment through HRA
- Provision of a continuum of integrated care management services incorporating physical, behavioral, Rx and social support based on individual need
- CM provided by interdisciplinary, integrated team
- Contract with community-based CM resources



Care Management Highlights

- Moderate and High-risk members receive:
 - robust CM with face-to-face supports
 - Plan of Care Managed by multi-disciplinary team
 - A single, individualized care plan integrated across disciplines and vendors
 - Interdisciplinary team meeting facilitated by lead CM
 - Significant social supports by social worker, community health workers and LTSS workers
 - Specialized services such as: home medication reconciliation, in-home primary care, end of life care, etc.



MASSACHUSETTS MOU

- First Financial Alignment Demo MOU; providing insights to future agreements
- Blend of MA Specific and Duals Office Requirements
- 3-way contract with details; may not be available until December
- Requires a successful Medicare Part C and D application

MA MOU: Enrollment

- Population specific to MA: under 65; ICF-MR residents and HCBS excluded
- Month to month enrollment and opt-out
- Monitoring for marketing violations
- Use of independent third party entity
- PACE and Medicare Advantage members excluded from passive enrollment
- Independence at Home participants with choice
- Demo members not attributed to ACOs



MA MOU: Oversight

- CMS - State Joint Contract Management
- Day to Day Monitoring outlined
- Part D Oversight is CMS responsibility
- Joint Quality reporting will be "at least as rigorous as Medicare Advantage...and Medicaid"
- QIO and EQRO to be coordinated
- Uniform person-level data required(encounter data?)
- CMS contracts for external evaluation

MA MOU: Payment

- State establishes Medicaid baseline spending trended forward; CMS to validate
- CMS establishes "what Medicare would've spent"
- Blend weighted Medicare Advantage (including quality bonuses) and FFS by county
- No coding intensity factor reduction for 2013
- Part D will be the National Average Bid Amount
- Annual savings percentages applied to each program
 - 1% growing to 4% in year 3 (not applied to Part D)
- 1% Quality withholds on each part of the rate



MA MOU: Risk Adjustment

- Medicare A/ B - county based on HCC
- Part D risk adjusted by Part D RxHCC
- Medicaid risk adjusted by state rating categories
 - facility based over 90 days
 - high community needs
 - high community behavioral health
 - other community
- State working on functional adjustment



MA MOU: Risk Mitigation

- High cost risk pool
- A portion of each rate category withheld to fund pool
- Risk Corridors for Year 1 (4/13-12/14)
 - 10%, plans bear 100% of the risk/reward
 - 5-10%, plans bear 50% of the risk/reward
 - 0-5%, plans bear 100% of the risk/reward
- Medicare Risk Corridor Share is Limited
 - maximum Medicare risk payment/recoupment limited to 1%
- Medicaid bears all remaining risk above 1% with federal Medicaid match



Leaping forward into the future...



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