HEALTH MANAGEMENT ASSOCIATES

2/19/2015

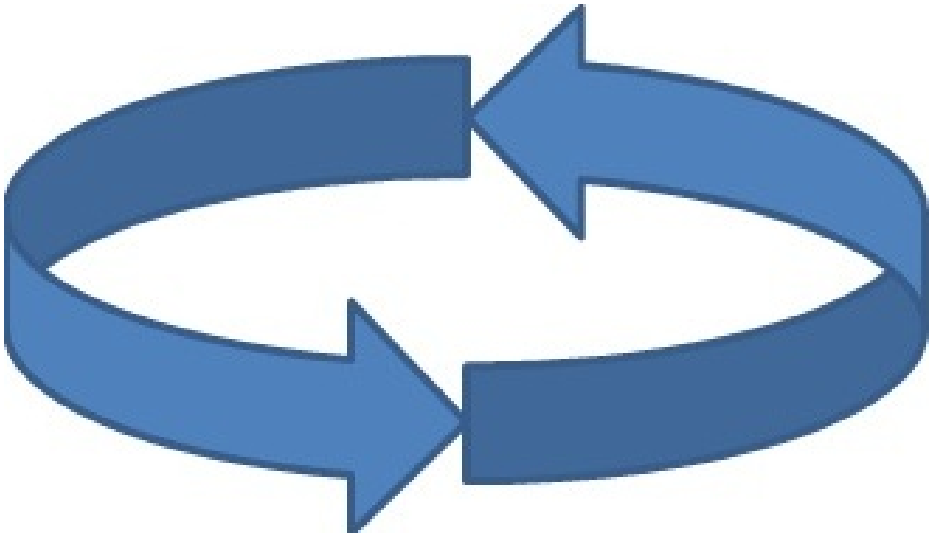
Medicaid Managed Care

Art Jones, MD

Accountable Care Institute

It's About Total Transformation

Delivery System Transformation



Payment Transformation

Medicaid Managed Care

- Have states saved money?
- Do Medicaid managed care beneficiaries have better access to care?
- Do Medicaid managed care beneficiaries receive higher quality care?

Difficulties in the Assessment

- Vast programmatic variation in how states structure their managed care programs
  - Health plan competition
  - For-profit vs. provider owned plans
  - Medicaid population inclusion/exclusion
  - Benefit carve outs
  - Financial incentives
- Managed care environment for other payers
- Literature on impact is sparse, especially academic studies in peer-reviewed journals
- Disparate metrics to determine success

Medicaid Director Survey

(https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8220.pdf)

- Perceived benefits
  - Vast majority reported improved access to primary and specialty care
  - Many perceived improved quality of care, reduced ED usage and improved beneficiary ability to navigate the health care system
  - Over half attributed some or significant savings although very few quantified these savings
  - A few cited higher costs usually associated with a cash flow issue due to prepayment of MCOs but still often indicated improved value

Academic Literature Review: Savings

(http://www.rwjf.org/content/dam/farm/reports/reports/2012/rwjf401106)

- There are a few studies that find modest savings
- States with relatively high historical fee-for-service reimbursement rates are more likely to save money
- The majority of studies that do find cost savings are not peer-reviewed and conducted on behalf of interested parties
- Managed care does offer predictability and stability around expenditures

Why are Savings Difficult to Achieve

(http://www.rwjf.org/content/dam/farm/reports/reports/2012/rwjf401106)

- FFS Medicaid rates are usually low already
- States have already implemented utilization management including restricted formularies
- Unlawful to impose significant beneficiary co-payments
- Requirement for actuarially sound rates
- Inability of health plans to unilaterally change the delivery system
- Health plan administrative and profit costs often exceed previous state administrative costs
- Savings may materialize as higher risk beneficiaries become included in managed care

Academic Literature Review: Access

(http://www.rwjf.org/content/dam/farm/reports/reports/2012/rwjf401106)

- Some national studies show improvement in:
  - Likelihood of having a usual source of primary care
  - Lower rate of emergency room use
  - Reduction in potentially preventable hospitalizations
- Some conclude that access is either reduced or unchanged at least partly due to limited provider networks

Academic Literature Review: Quality

(http://www.rwjf.org/content/dam/farm/reports/reports/2012/rwjf401106)

- Many small case studies in which health plans have improved clinical outcomes
- Scant if any rigorous and reliable peer reviewed studies on clinical effectiveness in health outcomes

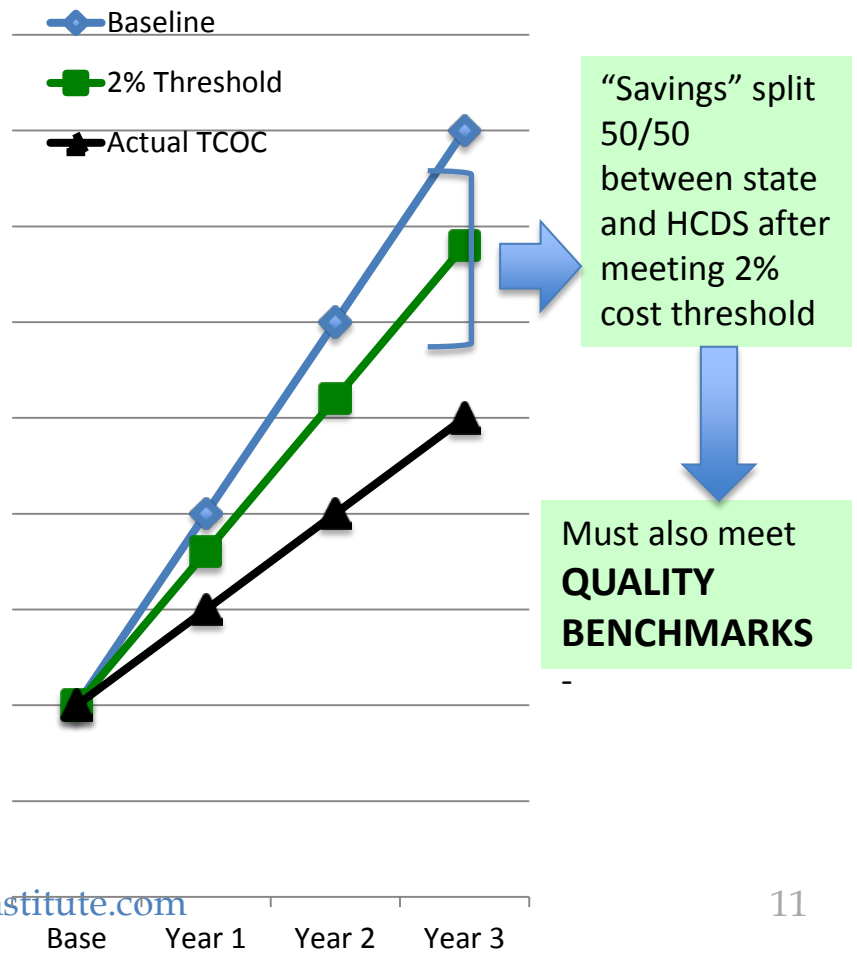
Academic Literature Review: Conclusion

(http://www.rwjf.org/content/dam/farm/reports/reports/2012/rwjf401106)

- "It is hard to generalize with any certainty about the impact of Medicaid managed care on costs, access or quality."

Minnesota Medicaid Integrated Health Partnerships Demonstrations

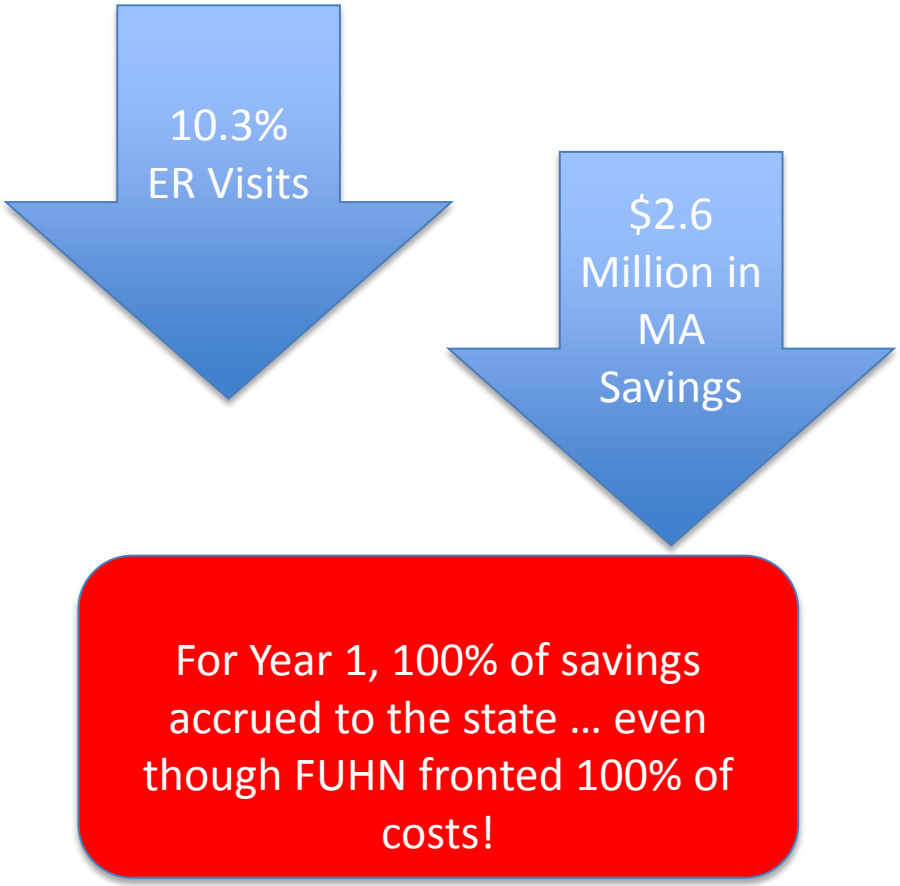
- Total Cost of Care (TCOC) or Accountable Care Organization (ACO) approach to delivering health care to specific set of patients.
- Move away from Fee-For-Service to provider group assuming risk.
- 6 organizations initially serving **100,000 Medicaid enrollees**.



FQHC Urban Healthcare Network

- 10 FQHCs in the Twin Cities with an attributable population of 24,000
- Based on historical under-spending in primary care, and overspending in hospital/ER care
- Secured business partner (Optum) to assist with infrastructure and data analytical support
- **Upfront investments costs borne solely by IHPs= $0 state support**

Year One Results



Colorado Regional Care Collaborative Organizations

- PCPs are signed up with one of 7 RCCOs to serve the Medicaid population
- RCCOs receive $11.53 PMPM for PCMP support and care coordination, PCMP paid a $3 PMPM for medical home services.
- Incentive payments are also available if the RCCO provider reduces ER utilization, 30 day hospital readmissions & use of high-cost imaging services
- Shared savings paid on top of FFS
- State net savings totaled between $29,330,495 to $32,997,329 (gross savings minus administrative expenses)
- ER visits decreased 21% and readmits 33% for adults

Oregon Care Coordination Organizations

- CCOs are local health entities governed by a partnership among health care providers, community members, and stakeholders in the health systems that share financial responsibility and risk in caring for the Medicaid population
- Emergency department visits have decreased 21% since 2011 baseline data.
- 30 day readmissions have dropped 6.5%
- Decrease in potentially avoidable hospitalizations
- Inpatient PMPM costs have decreased 5.7%
- Outpatient costs have also decreased 4%

Illinois Accountable Care Entities

- Provider owned and governed (PCPs, Specialists, Hospitals, BH providers)
- Serve the TANF and ACA adult population
- $9 PMPM care coordination/admin fee
- Age/sex/ aid category risk adjustment
- 50% upside shared savings potential mos. 1-18
- 50% upside/downside risk with a risk corridor mos. 19-36 and catastrophic stop loss
- Global risk beginning month 37
- Quality threshold to accessing savings

MEDICAL HOME NETWORK

Building Partnerships for Better Health

Actuarial Results *Performance Year 1*

Summary of Performance Measure Changes, Performance Year 1 vs. Prior Year

Performance Measures	Unadjusted Change		Risk-Adjusted Change		MHN vs. Non-MHN Variance	MHN Year/Year Change	MHN vs. Non-MHN Risk-Adjusted Change
	MHN	Non-MHN	MHN	Non-MHN			
Total Hospital Inpatient Days[1]	-8.3%	-6.0%	-6.9%	-3.2%	-3.7%	Favorable	Favorable
Total Hospital Inpatient Admits[1]	-6.0%	-8.6%	-4.6%	-5.9%	1.3%	Favorable	Unfavorable
Total Hospital Inpatient Average LOS[2]	-2.4%	2.8%	-2.4%	2.8%	-5.2%	Favorable	Favorable
Number of ER Cases[1, 5, 6]	3.7%	1.2%	2.0%	0.7%	1.3%	Unfavorable	Unfavorable
% of IP Admits with PCP Visit within 7 Days	1.3%	-12.1%	1.3%	-12.1%	13.4%	Favorable	Favorable
% of ER Cases with PCP Visit within 7 Days[4]	12.7%	-4.9%	13.0%	-4.6%	17.6%	Favorable	Favorable
% Of IP Admits readmitted to any hospital[7]	-12.4%	-20.0%	-12.4%	-20.0%	7.6%	Favorable	Unfavorable
Total Cost of Care PMPM[8]	-3.1%	-2.0%	-1.8%	1.3%	-3.1%	Favorable	Favorable

Source: Actuary Client Report

1. Per 1,000 members per year.
2. Average length of stay in days.
3. As a percentage of IP admits per 1,000 members per year.
4. For MHN members, PCP visits are flagged if the member visits any provider in the same entity as the member's PCP at the time of time claim. For non-MHN members, PCP visits are flagged if the member visits any provider contained in the PCP visit.
5. ER admits include only those that did not end in a hospital admission. ER to Inpatient Hospital cases are identified as members that had an Inpatient Hospital claim within 1 day of an ER claim, where both the IP and ER claims had the same provider ID. For ages less than 3 months, measuring PCP visits within 11 days of the member's date of birth.
6. As a percentage of ER admits per 1,000 members per year.
7. Defined as the percentage of IHC inpatient admits who return to the hospital within 30 days of discharge following an initial inpatient stay, regardless of diagnosis or admitting hospital, including transfers. Only non-maternity inpatient admissions were included. The readmission is attributed to the assigned clinic at the time of the initial hospital admission.

Legislature Oversight & Evaluation

- Clearly defined objectives in the solicitation and contract
- Metrics: process and outcomes
- Liquidated damages
- Management infrastructure that ensures the States can manage the Managed Care Program
- Three year plan with annual updates from the Medicaid agency

Implementation Framework

- Process Medicaid Agency will use to ensure that MCOs are ready to go live
- Who will perform the readiness review?
- Operational dashboard to be used to provide reports to Legislature
- Financial consequences for failure to "go live" by the target implementation date

Access Framework

- Provider network adequacy/accuracy standard (geographic and timeliness of care) and monitoring process
- Goals to improve over current access
- Integrating and coordinating care
- Drug formulary requirements
- Member enrollment process (voluntary and auto-assignment) with adequate phase-in
- Facilitating continuity of care
- Member appeal and grievance process
- Financial consequences for failure to meet standards or member discrimination
- Medicaid Advisory Committee oversight

Quality Framework

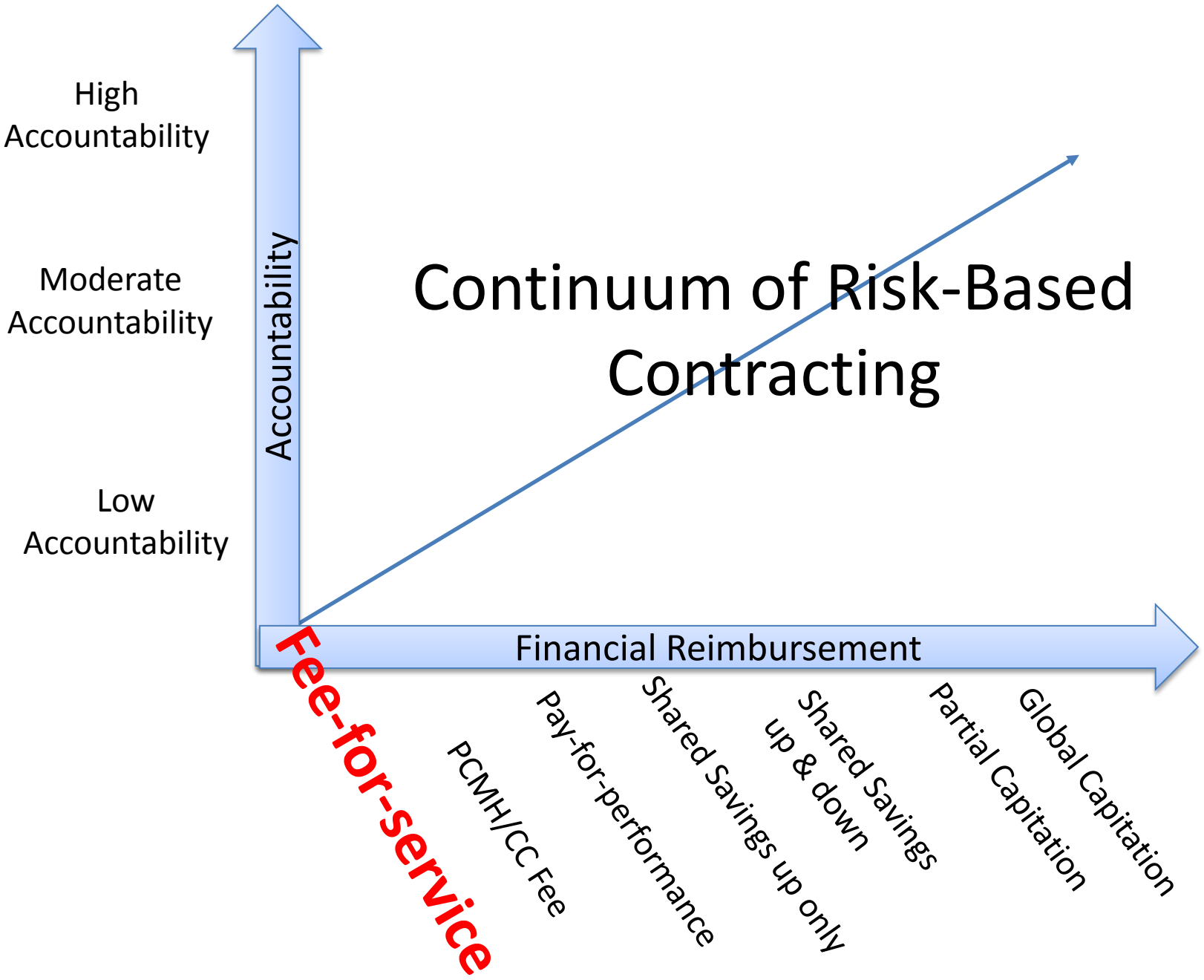
- Choice of metrics
  - Access
  - Preventive services
  - Chronic disease management
  - Member satisfaction and engagement
- Current performance on those metrics
- Setting goals
- Establishing incentives

Budget Framework

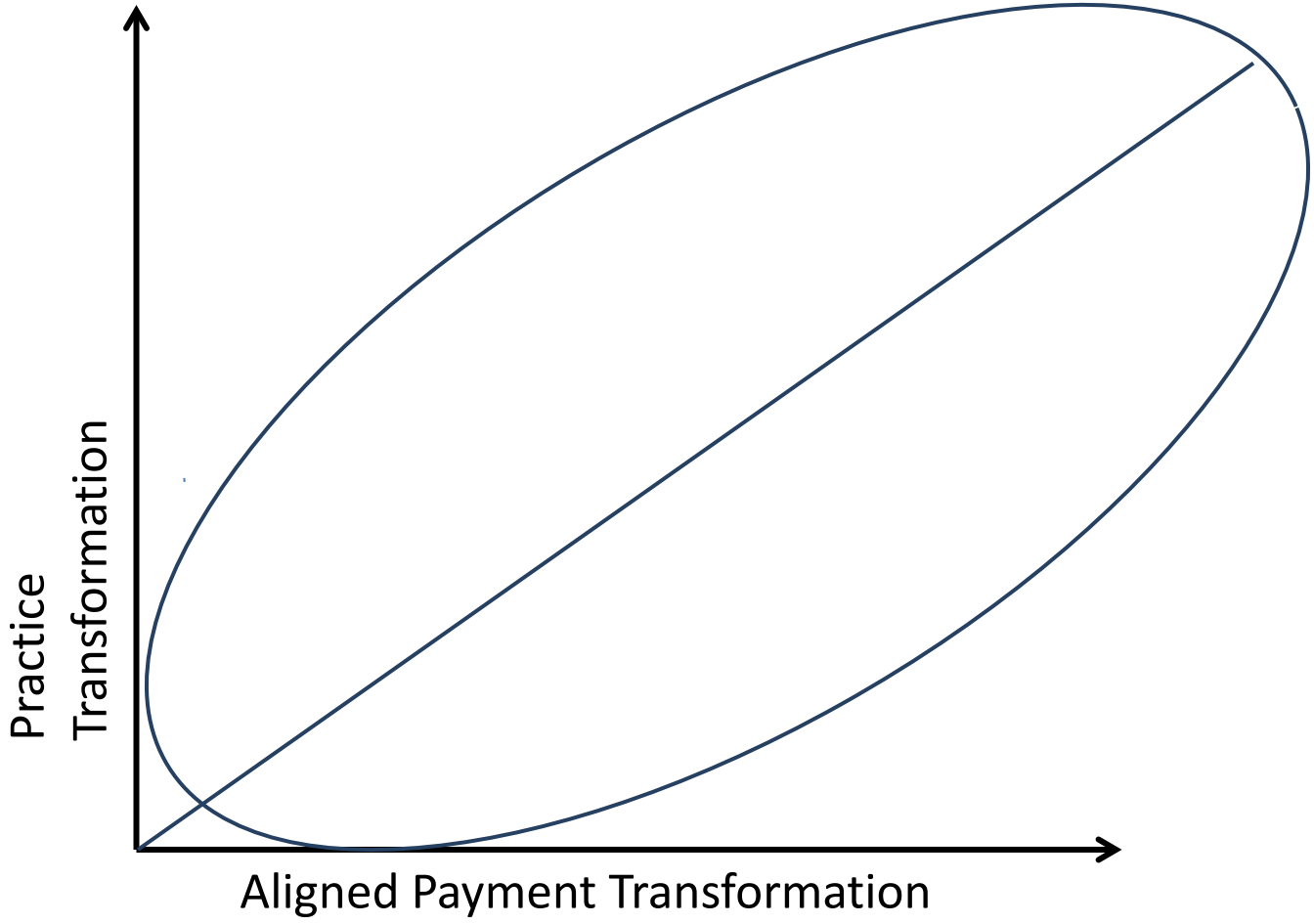
- Actuarial soundness of rates
- Cost and utilization trend projections
- Managed care cost savings assumptions
- Choice of a minimal cost ratio
- Use of a quality premium withhold and/or bonus
- Frequency of reports to the Iowa Legislature

Delivery System Reform Framework

- Requirement to contract with current Medicaid ACOs or other qualified integrated delivery systems
- Delegation of care coordination activities
- Data sharing, provider profiling and technical assistance with providers
- Requirement for plans to adopt alternative payment methodologies that progressively increase provider accountability
- Leveraging existing commercial and Medicare payment reform through alignment


High Accountability
Moderate Accountability
Low Accountability
Accountability
Continuum of Risk-Based Contracting
Financial Reimbursement
Fee-for-service
PCMH/CC Fee
Pay-for-performance
Shared Savings up only
Shared Savings up & down
Partial Capitation
Global Capitation

Transition to Value-Based Care



Potential Use of External Vendors

- Actuarially sound premium rates
- Health plan readiness reviews
- Client enrollment broker
- Compliance tracking
- Verifying performance on quality metrics
- Verifying medical cost ratios
- Data aggregation and analytics
- Technical assistance to the Medicaid Agency

P4P/shared savings/capitation with uniform incentive criteria with aggregated basis for payment

Reimbursement Structure:

- All MCOs/Payers offer P4P with uniform parameters measured in a standardized fashion
- All MCOs/Payers offer shared savings/capitation based on standard set of services
- Contracts cover most if not all of a provider's panel

Integrated Delivery System/ACO

Behavioral Health

Specialists

Hospital

PCP PCP PCP PCP PCP PCP PCP

IDS

- Aggregates data from multiple MCOs/Payers for total actual performance
- Establishes a performance/incentive method to pass rewards to the practice level to providers that are creating value
- Provides performance reports, transparency & consultation to individual practices/providers
- Manages contracting process

Managed Care Organizations & Direct Payers

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