THE STEPHEN GROUP

Summary of Medicaid Managed Care Plans Response to Task Force Questions
Prepared by The Stephen Group for The Arkansas Legislative Health Care Task Force
8-18-15

Ameri-Health	Molina	Magellan	Anthem	Centene	Meridien	United Health	Aetna	Ark BCBS Shared Health
States operated in								
PA, SC, LA, DC, MI, NE,	State Plans: CA, FL, IL, MI, NM, OH, SC, TX, UT, WA, WI, PR; MMP Dual-Eligible: ID, LA, WV, NJ, ME, VI	IA, FL, NY, AZ, NE, PA, LA, VA,	CA, FL, GA, IN, KS, KY, LA, MA, MD, NV, NJ, NY, SC, TN, TX, VA, WA, WV, WI	AZ, CA, FL, GA, IL, IN, KS, LA, MA, MS, MO, NH, OH, SC, TX, WA, WI	MI, IL, IA	AZ, DE, FL, HI, IA, KS, LA, MD, MA, MI, MS, NE, NV, NJ, NM, NY, OH, PA, RI, TN, TX, WA, WI	AZ, FL, IL, IA, KY, LA, MD, MI, MO, NE, NJ, NY, OH, PA, TX VA, WV (Transition FFS – MC)	TN, DE
Core services provided								
Primary care, physical services; DME; emergency services; home health care; pharmacy; dental, vision, rehab, dialysis; nursing facility; physical/speech/ occupational therapy; hospital; translation/ interpretation; smoking cessation; fitness incentives; transportation	Physical, Behavioral Health, Chemical Dependency, Dental, LTC, Transportation	Integrated Medical and Behavioral Health Services; Physical, LTSS Services	Medicaid Managed Care; Acute Care; Integrated physical/ behavioral health services , LTSS, Pharmacy	Medicaid Managed Care; Acute Care; Physical services, behavioral health services; community based services; vision, dental; skilled nursing, assisted living, LTSS; advice line; pharmacy; non emergency transportation	Physical and Behavioral Health Services, Pharmacy (inpatient and outpatient), Pharmacy, Long Term Supports and Services, Home and Community Based, Dental	All Medicaid services	Managed Care Services for Medicaid, including acute care and waivers; integrated Medicare, LTSS, ABD, Dual eligibles, CHIP, including: operations, medical management, ancillary support; physical/behavioral health, pharmacy, dental, vision, transportation	Medicaid managed care; home and community-based services, nursing facilities; LTSS; Pharmacy
Population Experience								
• Medicaid	• TANF	• Medicaid	• Medicaid	• Medicaid	• Medicaid	• Medicaid	• Medicaid	• Traditional

• SSI without Medicare • TANF • Optional coverage for women and infants • Children health • Foster children • HCBC Waiver • Breast Cervical Cancer • Assistance to Aged and Blind	• Medicaid physical health/ Acute care • Aged, Blind or Disabled (ABD) • Long-term Care (LTC) • CHIP • Medicare Advantage Special Needs Plan (SNP) • QHP Market-place	physical health/ acute care • Long Term Care • Medicare Advantage • Prescription Drug (MAPD) plan • Dual Eligible Special Needs Plan (DSNP) • Fully Integrated Duals • Adults and Children	physical/ health/acute care • SSI/ABD • LTSS • Behavioral health • Developmental Disability • CHIP • TANF • Foster Care • HIV	• LTC • TANF • CHIP • SSI/ABD • Child Welfare • Behavioral Health • Developmental Disability • Pregnant Women • Infants	• TANF • CHIP • Foster Care • SSI/ABD • ACA • Dual Eligible SNP • Child Welfare • Disabled	• TANF • CHIP • SSI/ABD • LTSS • Expansion • Dual Eligible SNP	physical health/ acute care • SSI/ABD • LTSS • Behavioral Health • Developmental Disability • CHIP • TANF	Medicaid • LTSS • I/DD • SCHIP (ASO) • D-SNP
Improvement of access to and quality of services for populations served								
• Integrated Care Management • Data analytics to establish provider network; • Interpretation/ translation services • Community outreach • Transportation services • Mobile health vans • Community wellness centers	• Outcome-based Quality Assessment and Performance Improvement (QAPI) • Community Health Worker program and Community Connectors (NM) to improve access to services and support; • Pay for Value programs to reduce health	• Developed first Medicaid specialty health plan for persons with serious mental illness (FL) • Provider Optimization Delivery System provides integrated service delivery • Increased qualified providers by 112% (LA) • Telehealth programs	• Disease management program that reduced ER/inpatient admissions – 116% increase in outpatient BH visits in Tenn.; 59% decrease in ED; 15% decrease in inpatient; 17% increase in screenings for diabetes (TN) • Telepsychiatry • Provider Collaboration	• Rural strate-gies – rural southwest Georgia • Comprehensive Diabetes Care • Improved transitions of care • Outreach activities for disease mgmt • Increased pre-natal care • Reduced costs by providing phones to	• Full range of primary and specialty care • Childhood immunizations • Health literacy • Available access to necessary services • Well-credentialed in-network providers • Member outreach	• Engaging providers for Medicaid populations • Supporting expanded hours and patient management • Improve services by using actionable data and technology for member engagement and clinical support • Performance	• Statewide provider networks • Outreach via community, agencies, faith-based services • Transportation • Mobile health care services • Aetna Metter Health app • Telehealth and Telemedicine • Integrated Care Management to reduce readmissions	• Telemedicine • Bundled payments • Quality driven reimbursement incentives • 600+ annual community health events • PCMH

• Telehealth • Mobile technology • Rapid Response Outreach Teams	disparities across all populations while rewarding participating providers for providing high-quality care	• Integrated Health Homes in Iowa	Strategy to encourage preventative and ongoing services reduced ED visits • Txt4health for appt/screening reminders • CareMore increased access to primary care (TN) • Eliminated waitlist for home and community waiver programs (TX)	members in high risk care • Patient Review Coordination program		incentives through contractual requirements	and provider alternatives to emergency care	

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State budget savings experience								
• PA: Where Keystone First Plan operates $2.7 billion saving over 5 years (PA) for Medicaid Managed care program called HealthChoices – AmeriHealth Caritas is a participant *Lewin Group Study*	• Florida able to reduce staff after rolling out Managed Care • Participant Plan in saving State of Texas $3.8 billion over 5 years versus the traditional Medicaid Fee for Service model (TX) Milliman Study	• Nebraska – reduced quarterly out-of-state placements for children and adolescents by 90%. • Louisiana – reduced out-of-home/restrictive placement in the children's system-of-care program by 50 percent; decreased hospital admissions by 18% and reduced the length of stay in hospitals for adults by 13 percent. • Iowa – 18% reduction in mental health inpatient days, 12% reduction in medical emergency department visits	• Reduction of MMIS costs • $3.8 billion savings over 5 years vs.FFS model (TX) • $100 million first year/$1.1 billion 5 year projected savings over 5 years (KS) • 2.4% increase in MLTSS recipient costs vs. 18% increase in FFS HCBS and nursing home recipient costs (NY)	• Asthma Mgmt Program: $2.6 million savings • ER Diversion Program: $500K annual savings • Reduced Inpatient Readmissions: $1.2 million savings expected • Pain Management Program $2.3 million savings • Start Smart for Your Baby: $23 million savings	• Overall program savings in Michigan over four year period from 2001 to 2002 went from 9% in 2001 to 19% in 2004 over the Fee for Service		• Increased use of HCBS, reduced institutional care for LTSS population in AZ, DE	• Significant administrative savings in TN • Medicaid trends of 3.3% (below national average of 6.7%)

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Enhancement of PCMH program or changes								
• Work with physicians to align financial incentives and reimbursement policies – experience in this area • Provide support to providers through data analytics • Support and reimbursement for care managers • Provide resources to sustain medical home practices	• Promoting PCMH Growth through Recognition and Incentives • Monitoring PCMH Outcomes to Improve Member Outcomes	• Garner multi-payer engagement • Focused project leadership • Regular stake-holder input • Technical assistance/ collaboration • Team-based care • Require evaluation • Provide data for improvement	• Increased access to PCMH • Support providers with patient specific data • Improved screening for behavioral health conditions • Incentives and Pay for Performance for providers • Health home programs for high-risk/high cost members	• Emphasize care coordination and communication • Invest in medical homes • Support well-performing PCP practices and clinics	• Develop Meridien's PCMH model • Create medical homes for medically complex enrollees • Electronic tools, evidence based guidelines for chronic conditions, team-based care • Obtain PCMH certification • Enhanced payments through new billing codes and bonus payments	• Collaboration with providers and Value-based reimbursement that encourage active engagement and improved outcomes	• Enhance technology to allow real-time data analytics • Add quality measures such as medication adherence, inpatient readmissions • Reduce required panel size to promote provider participation	• Continue pmpm care coordination payments • Continue aligning patients with primary care physicians • Strong leader-ship and participation in multi-payer public/private approach to funding and support of PCMH • Determine ways "health home" model could benefit special needs populations
Experience with Aged, Blind and Disabled; High Cost Cases; reducing reliance on institutional care								
• Experience in Medicaid risk/ non-risk programs and behavioral health services; Medicare Advantage D-SNP; SCHIP, Integrated Dual Demonstration	• Provide managed integrated care and care coordination for 450,000 ABD, and 170,000 MLTSS members • Serve 55,000 members in 6	• MLTSS (NY) is designed to keep people out of institutions • Dual Eligibility Plans (NY) • Medicaid Health Plan for members with Serious Mental	• 882,000 SMI/ ABD members, 270,000 LTSS participants • Experience with Dual Eligible, ID/DD, Aids/HIV, ACA • Improved utilization of services to	• Serve 414,000 ABD members across 14 states; • Experience with chronic medical conditions, developmental/ physical disabilities, serious mental	• Administers physical and pharmaceutical benefits for ABD (MI) • Administers Medicaid, Nursing, HCBS waivers, LTSS to Seniors and Persons with	• Operate MLTSS waiver programs for aged and disabled in 12 states • Adding complex populations, such as ID/DD • MLTSS	• Experience with ABD (13 states), I/DD, Dual-eligible, LTSS, SMI, providing a wide range of services • Experience with 1915 waiver populations • Use of HCBS has	• LTSS, children in ICF-IID, persons in Section 1915 (c) waiver programs in TN • 21 years in experience in Population Health, Behavioral

MMPs • Subsidiary PerformCare provides 24/7 crisis manage-ment service • Mobile Response and stabilization services for NJ – 98% of 20,000 youth remained in home • Integrated Care Management Model addresses medical/ behavioral conditions to promote mental/ emotional health	MMP demonstrations. • Reduced reliance on institutional care by 8-18% in OH, TX, NM	Illness (FL) • Reductions in residential care for behavioral health through Multi-systemic Therapy (42%), and other home and community based programs	rebalance community and institutional services (KS) • 25% reduction in nursing home stays (TN) • Success transitioning MLTSS to community in KS, TX, TN • 2014 - 120 people from institution in Kansas to community care • Texas – average 360 transitioning from nursing to community for past two years • Tennessee program 25% reduction in nursing home stays	illness thru whole person/person centered, intensive care management • LTSS programs in 9 states support transitions to community setting • Intellectual and Developmental Disability in 3 states • Arizona Plan decreased nursing home placements from 30% in 2009 to 23.6% today • Florida, in six months 59% August 2014 to 56.5% Feb 2015	Disabilities (IL) • Provide intense intervention services for enrollees who are dually eligible or qualify for CMS Medicare Medicaid Alignment Initiatives • Transition of Care program reduces return to institutional care	programs have reduced reliance on institutional care	reduced use of institutional care in AZ, DE	Health, Dual Special Needs, LTSS • Launched LTSS program in 2010 and rebalanced spending from 79% institutional to 55% institutional today

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Experiences with PMPM over last five years								
Varies across states due to Medicaid expansion, specific risk adjustment scores, additional benefits and services provided, new mandated drugs	Slight increases in PMPM, attributed to changes in Medicaid fee schedule and expansion of managed care to new populations	Overall cost of care trend is 0-2%, higher in areas with mandated provider fee increases	Aggregate Medicaid cost trends over last 5 years averaging 1-4%	Aggregate annual premium rate adjustment has ranged from -0.9% to +2.7%	ABD costs have increased 1.17%, compared to 7.73% increase for national Medicaid expenditures	Rate changes are commensurate with shifts in utilization		Cap rates steady over past 5 years, and fourth-lowest nationwide
Critical success factors for Arkansas to consider with Managed Care								
• Invest time for stakeholder input to program design • Focus on quality of care • Managing churn • Adequate funding	• Stakeholder input • Full Population-based model • Transitional approach to enrollment • Strategic delegation of roles • Care in most-integrated and least-restrictive setting • Member outreach • Access to care	• Stakeholder Communication • Continuity of Care of at least 90 days • Employment support services for disabled members • Outreach/support for providers during transition • Hierarchy for auto assignment for DD, BH, LTSS needs • Realistic implementation timelines	• Collaboration and frequent communication between MCOs, state, and stakeholders • Development of rates by experienced actuarial firm • Flexibility for MCOs to develop value-based reimbursement and care models • Sufficient implementation timeframe • Require accreditation within 2 years	• Set capitation rates to anticipate increases in program requirements • Strong state-MCO partnership • Engaging community stakeholders • Include all services – no carve-outs	• Improved quality of care • Improved access to care • Overall cost savings to program • Reduction in inpatient admissions • Reduction in ER utilization	• Improved outcomes • Improved quality • High member and provider satisfaction • Savings • Impact on expected trends	• Carving in all Medicaid benefits • Weighting experience • No network submission as part of RFP submission • Network adequacy requirements based on recipient population • Auto-assignment based initially on continuity, later on outcomes • MCOs pay 90% of Medicaid to out of network	• Select large, well-capitalized plans. • Appropriate implementation time (at least 1 year). • Operate statewide. • Make sure Contractor Risk Agreement protects the state by including detailed operational expectations. • Maintain control of member eligibility. • Align

							providers • Collaborative transition of care requirements • Formal inclusion of LTSS • Mandatory enrollment • Clear timelines and evaluations • Phase in support for I/DD	incentives to ensure MCOs are thoughtful about cost and quality. • Ensure rate adequacy.

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Things NOT to do if moved to Medicaid Capitated Managed Care								
1. Stay away from fragmented system of care 2. Do not limit program participation 3. Do not allow populations to opt out 4. Do not overlook stakeholder buy-in 5. Do not put cost over quality	1. Do not have non-integrated care model with carve-outs 2. Do not implement without an experienced MCO partner 3. Do not implement without an advisory panel of consumers, stakeholders and providers 4. Do not move too quickly from FFS to Managed Care 5. Do not require rates that are not actuarially sound	1. Do not set reimbursement rates that do not account for full range of services 2. Do not implement on regional basis vs. statewide 3. Do not roll out quickly 4. Do not allow populations to selectively op out 5. Do not manage program with short term contracts	1. Do not create silos of care by carving out services 2. Do not carve out populations 3. Do not bid the contract regionally 4. Do not limit MCO flexibility in developing model of care 5. Do not make uneven selection and operational criteria for bidding entries.	1. Do not regionalize the contract – implement a statewide approach 2. Do not carve out services 3. Do not limit MCO's management of formulary 4. Do not contract with more than 3 MCOs 5. Allow flexibility in operation and do not mandate detailed operational requirements	1. Do not carve out core services from the MCOs 2. Do not regionnalize the program 3. Do not select a single entity to manage the MMC program 4. Do not have a state run formulary 5. Do not use an RFP for procurement of Managed Care Program, but use the Ohio Request for Application Model used in 2012	1. Do not develop a fragmented approach 2. Do not establish unreasonable rates and savings 3. Do not establish fragmented, population-specific model 4. Do not create unreasonable program mandates	1. Do not allow for voluntary enrollment 2. Do not carve out populations or geographic areas 3. Do not carve out Medicaid covered services 4. Do not lose momentum with Arkansas' PCMH program 5. Do not forget pertinent Quality measures	1. Do not pick small unknown plans. 2. Do not pick more than five plans. 3. Do not reduce monitoring of MCOs. 4. Do not use MCO rates as flexible vehicle to balance the budget. 5. Do not turn over eligibility to the plans.