

MO HealthNet Managed Care

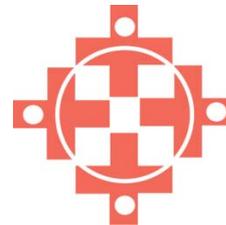
*the right care
at the right time
for the right cost*

Presenting on Behalf of the
Missouri Association of Health Plans:

Dan Paquin
President and CEO, HealthCare USA
Chair, Missouri Association of Health Plans

Joanne Volovar
President, Molina Healthcare of
Missouri

MO HealthNet Managed Care Stakeholder
Meeting
July 30, 2010



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Missouri Association of Health Plan Members



Blue-Advantage Plus
of Kansas City, Inc.

An Independent Licensee of the
Blue Cross and Blue Shield Association



History of Medicaid Managed Care

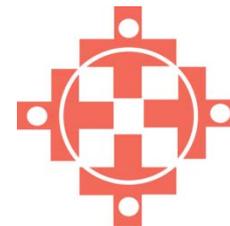
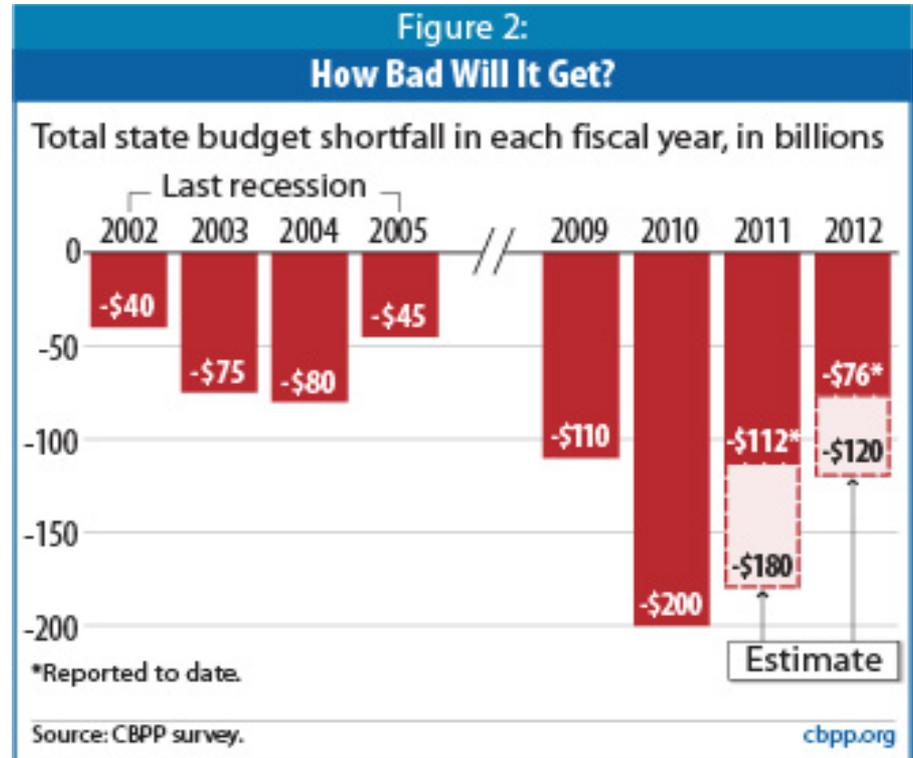
- 1995 - The Missouri General Assembly voted to implement Medicaid Managed Care as a viable, long-term solution to *contain cost* by ensuring recipients receive the **right care**, at the **right time**, at the **right cost**.
- Missouri is one of 48 states across the nation providing Medicaid through Managed Care.
- 420,000 Missourians receive their health care through the Medicaid Managed Care Plans.



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Why Expand Managed Care Now?

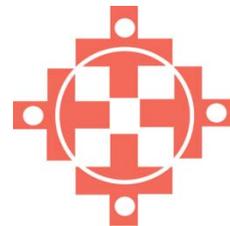
- State facing unprecedented revenue shortfall of \$700 million
- High unemployment
- Growing number of uninsured
- Federal health care reform requirements



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Value of Medicaid Managed Care

- Improve **access to care**
- Improve and assure **quality of care**
- Establish and promote the use of a **medical home**
- **Control cost** through the payment of capitated rates, giving the state budget predictability



Medicaid Health Plans vs. Fee-For-Service

	Health Plan	FFS
Benefits to Members		
Identification card proving coverage	●	●
A designated primary care physician	●	
Case management of primary care	●	
Disease management	●	
Comprehensive case management	●	
Quality standards and continuous quality improvement programs	●	
Cost Containment		
Claims analysis	●	
Utilization review	●	
Improved generic utilization		
Using lower cost services were available	●	
Cost predictability	●	

Medicaid Managed Care

Improves Access to Care

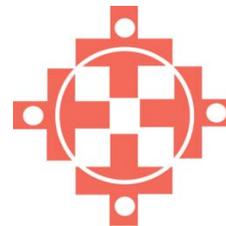
Access Standards

Service Standards

- Provider network, distance to get to a doctor
- Days to get an appointment
- 24 hour telephone availability
- All members have a Medical Home

Performance Standards

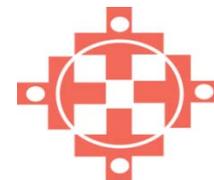
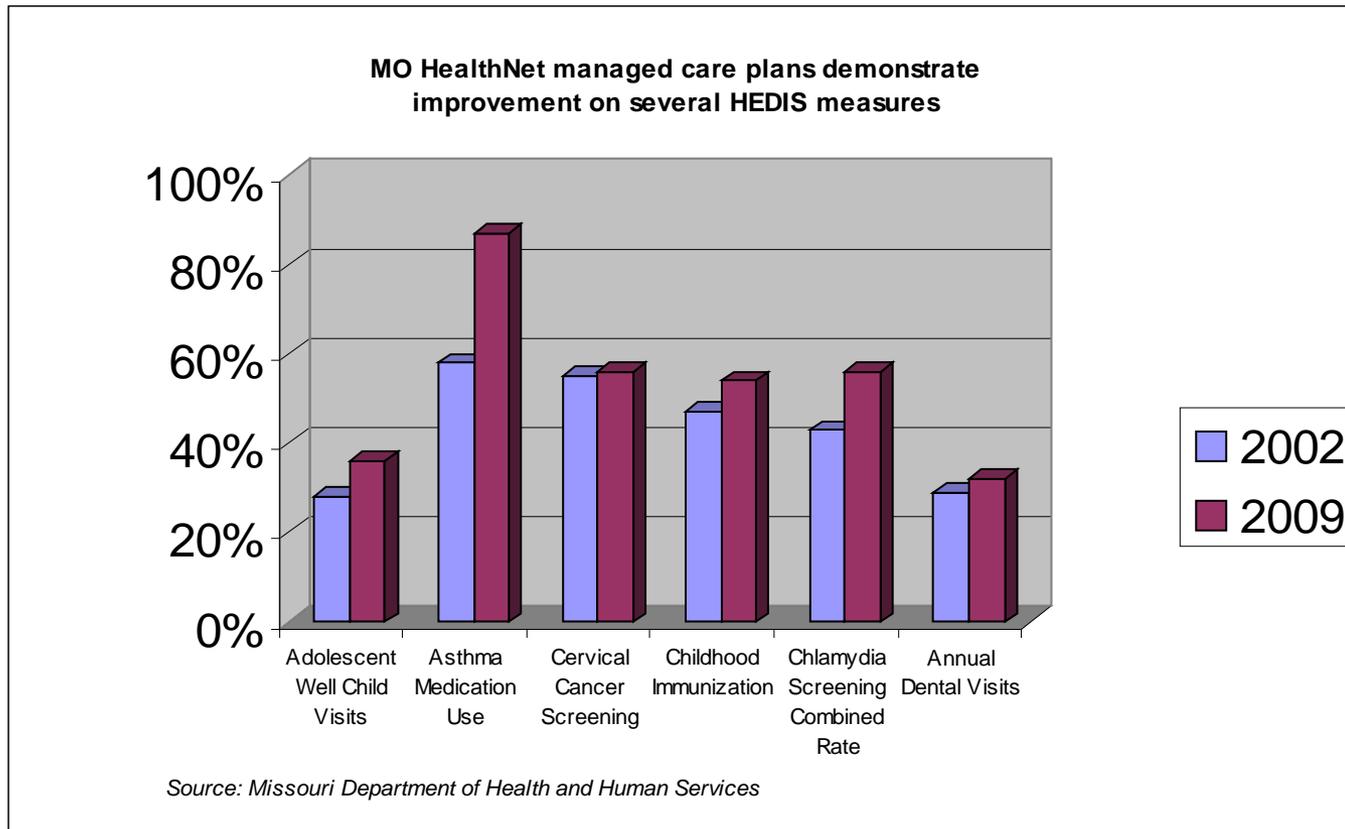
- Well-child visits
- Care Management of Difficult Pregnancy and Chronic Disease
- Health Care Effectiveness Measures (i.e. HEDIS)



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Medicaid Managed Care

Improves and assures quality of care



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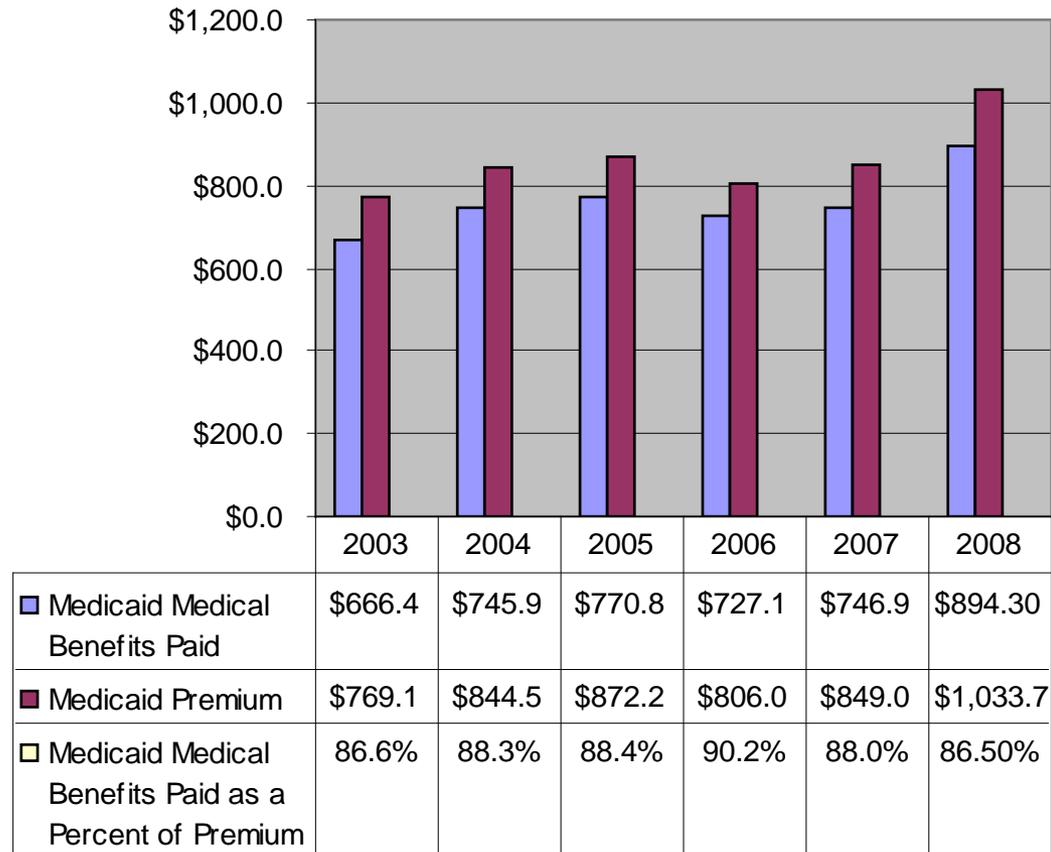
Managed Care contains Cost through the following administrative activities:

Program	Activities	Expected Financial Impacts
Case Management	Coordination of healthcare resources for high utilizing Members; collaboration with treating physicians; facilitating access to care and preventive care services; supporting patient empowerment & education	Increases adherence to treatment plans & access to PCP/specialty srvc; Improves outcomes related to chronic illness & high risk OB care; Decreases utilization of IP & unnecessary ER srvc
Disease Management	Early identification of the at-risk population; Member and Provider education and tools to support self management; Health Coaching to assist members with lifestyle/behavioral changes; Specific clinical metrics to measure outcomes of interventions	Improved clinical outcomes specific to the disease process as a result of better patient education & empowerment (i.e. use of asthma medications; compliance with recommended lab screenings, etc); Improved compliance with recommended treatment protocols; Decreased IP hospitalizations and unnecessary ER services
Member Profiling	Risk Profiling (to identify optimal candidates for case management and disease management programs)	Early identification of high risk members for education, outreach and care coordination, resulting in decreased utilization of healthcare resources and improved member outcomes
Provider Profiling	Providers are profiled on access, quality and outcomes (both clinical and financial) for the members in their care.	Reduced upcoding, identify possible over and under utilization, and encourage preventive services
Concurrent Review	Coordinate inpatient services early to engage members, caregivers, and community resources ensuring smooth transitions to alternative levels of care	Reduce average length of stay and ensure appropriate level of care through proactive discharge planning

* Not exclusive list

Managed Care Premium and Medical Expenses 2003-2008

Aggregate (07-10)
Medicaid Benefits
Paid as Percent of
Premium = **88%**



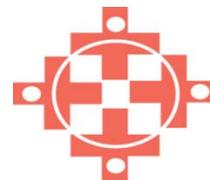
Partnerships

- **Providers**
 - Individualized contracting
 - On-going collaboration and feedback through health plan provider representatives
 - Quarterly meetings with provider groups
 - Annual trainings
- **Members**
 - Health Plan staff in members' communities
 - Quarterly meetings with members
 - Annual independent member satisfaction surveys

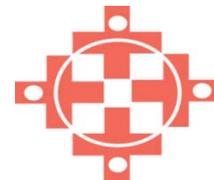


Accountability

- *Dept of Insurance*
 - Network adequacy equal to commercial
 - PCPs – 10 to 30 miles
 - OB/GYNs – 10 to 60 miles
 - Hospitals – 30 miles
 - Solvency standards
 - Prompt pay statutes
 - Annual audited financials
- *MO HealthNet*
 - Encounter data
 - Semi-annual financials
 - EPSDT
 - HEDIS
 - EQRO
 - **NCQA**
- *Federal*
 - Centers for Medicare and Medicaid Services
 - Office of Inspector General



Testimonials



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Questions



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