Highlights Managed Care Rebid

Plan Viability and Stability

1) **Limit awards to three plans**
   - CMS requires participant choice of plans; with three plans, one plan may quit or fail and there is still choice.
   - Plans with more covered lives are more stable and successful.

2) **Right-size the market share across the three plans by lowering the max market share per plan cap and raising the minimum share through auto enrollment.**
   - Caps by region allow for a more even distribution of risk, resulting in more actuarially stable plans.
   - Lower the maximum market share from 65% to 60%.
   - Open enrollment same as previously; enrollees not evidencing a choice will be re-enrolled in their current plan.
   - Raise the minimum market share by directing auto enrollees (except those that were previously enrolled in a plan that is still available) to plans with less than 20% market share.
   - New enrollees who do not actively choose a plan are auto enrolled. If there is one or more plans in a region with a market share of under 20% all auto enrollments would go to the plan(s) under 20% market share.
   - Lowering the maximum market share cap and raising the minimum market share may make the Missouri Medicaid market more attractive for new plans.

3) **Use risk adjusted rates when determining future payments**
   - Risk adjusted rates reflect the acuity of the patients enrolled in each plan, discouraging plans from “cherry picking” enrollees and rewarding plans for taking care of patients with higher acuity levels.
   - A transition to risk adjusted rates has begun under the current contract and will be complete for the next managed care contracting period starting July 1, 2015.

4) **Separate Rate Cell for Pregnant Women**
   - Instituting a separate rate cell for pregnant women will more completely and accurately cover the actuarial risk of the mal-distribution of pregnant women across plans.

Highlights Managed Care Rebid

Emphasis on Better Health Outcomes and Health Care Reform Initiatives

1) **Require managed care plans to implement a provider-based care management approach such as Health Homes, Person Centered Medical Homes, or Primary Care Case Management.**
   - MHD has implemented health homes primarily with the FFS population.
   - Patients are more likely to respond to care management through a personal relationship with a provider rather than through an anonymous relationship with an employee of the managed care company.

2) **More emphasis on health care reform in the evaluation process**
   - The new RFP will add reform and transformation requirements to the RFP evaluation.
   - Reform and transformation initiatives would include:
     - ✓ Providing case management or provider-based care coordination (health home);
     - ✓ Incentivizing personal responsibility including no co-pays, promotion of healthier habits, like not smoking or managing obesity, and reducing emergency room utilization;
     - ✓ Pay for performance to primary care and behavioral health providers with a preference to plans with defined scope and clear measurement of outcomes;
     - ✓ Ensuring fraud and abuse is being detected; and
     - ✓ Providing transparency.
   - Plans will be allowed to present a phased-in roll-out over three years for reform and transformation; however, evaluators will be allowed to award more points to plans with quicker and more extensive roll-outs.

3) **Capitation withhold amount tied to administrative performance metrics**
   - Withholds will be between 2% -3% of the capitation payments
   - Withholds are returned when plans meet full contract requirements around identified performance metrics, which may include:
     - ✓ Encounter data accuracy and completeness
     - ✓ EPSDT screening performance against the 80% goal
     - ✓ Provider panel accuracy and completeness
     - ✓ Case management

Highlights Managed Care Rebid

Administrative Efficiencies and Transparency

1) Statewide bid

- It is simpler to bid and manage three contracts versus nine.
- A statewide bid may attract new competition in the Missouri Medicaid market.

2) Require managed care plans to pay FQHCs and RHCs 90% of their prior-year cost settled rate

- FQHCs and RHCs are paid according to federally required cost settlement rate methodologies.
- MHD makes additional quarterly payments to reimburse the FQHCs and RHCs closer to prior-year cost settled rates.
- Will result in more transparent accounting of the cost of care under managed care.

3) Require managed care plans to pay CMHC's upper payment limit for CMHC clinic fees

- Aligns managed care payment methodologies with Fee-For-Service (FFS) payment methodologies.
- The state match to include these payments in the managed care rates would come from the CMHC provider allocation in the DMH budget.

Timeline for New Managed Care RFP

Late September/Early October 2014	RFP, Data Book, and Rates Released
Mid October 2014	Pre-Proposal Conference Harry S. Truman Office Building, Jefferson City, MO Rooms 492/493
Mid November 2014	Bids Due
January and February 2015	Evaluation of Bid Proposals
Early March 2015	Contracts Awarded
Mid April 2015	Open Enrollment Begins
Mid June 2015	Open Enrollment Ends – Auto-Assignments Occur
July 2015	Services Begin