Missouri Department of SOCIAL SERVICES
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MoHealth Net

COMPARING PERFORMANCE:

MANAGED CARE AND FEE-FOR-SERVICE

June 16, 2015

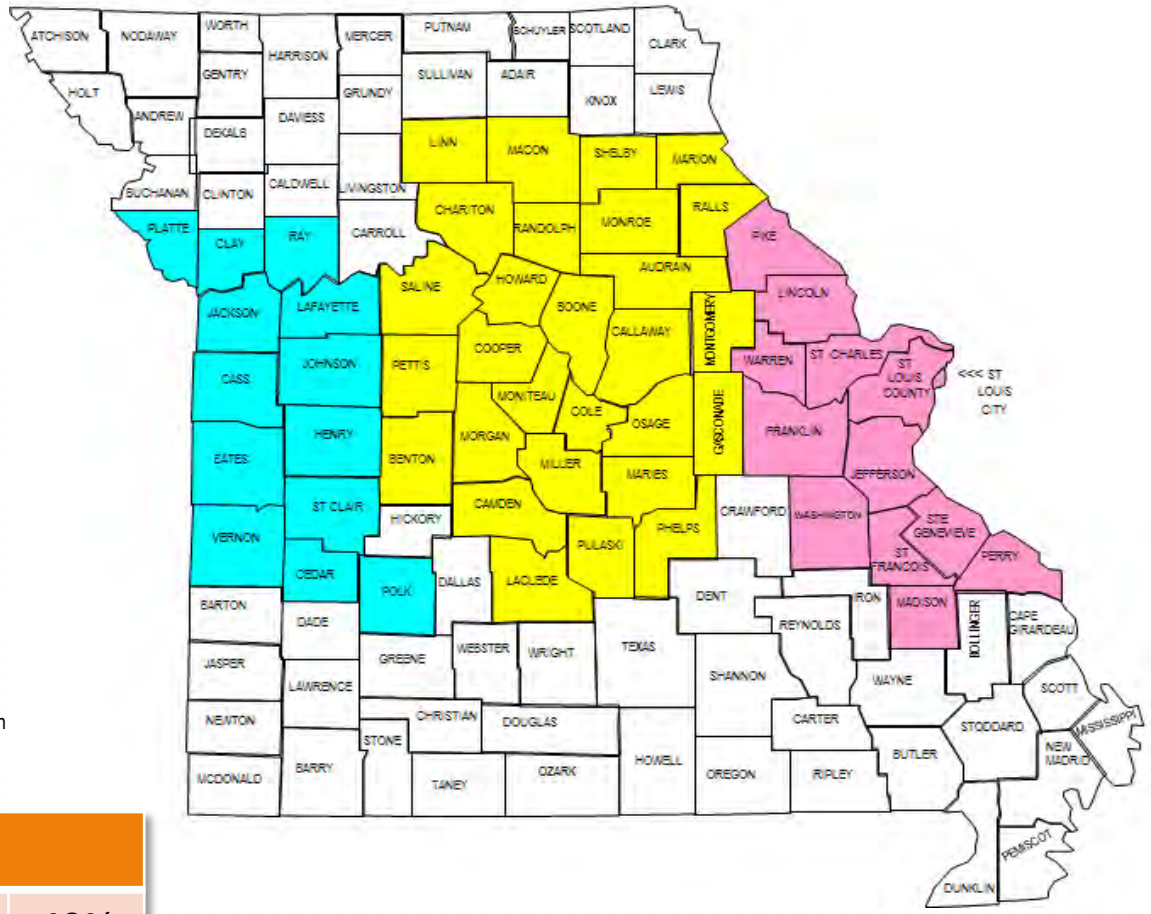
MANAGED CARE IN MISSOURI

Number of Counties

- Eastern Region (13)
- Central Region (28)
- Western Region (13)

Current Health Plans

- HealthCare USA
- Home State Health Plan
- Missouri Care Health Plan



Size of Populations		
MC	458,338	49%
MC–like FFS	238,165	25%
ABD FFS	240,320	26%

COMPARING MANAGED CARE AND FEE- FOR - SERVICE

- **Comparing Similar Populations**
  - Include MC eligibility groups with the same eligibility groups in FFS
    - All currently in MC (TANF, CHIP, and Pregnant women)
    - TANF, CHIP, and Pregnant women in non-MC areas of the state currently in FFS
  - Exclude the ABDs

- **Three Areas of Comparison**
  - Cost
  - Utilization of Services
  - Quality Performance

COMPARING PERFORMANCE: *COST*

RETROSPECTIVE COST COMPARISON BY MERCER

- Review last done by Mercer for SFY 2009 found MC saved 2.7% ($38 million) compared to FFS
- Compared MC and FFS costs with adjustments
  - MC total cost = capitation payments + FFS services carved out + MHD admin costs of managing contracts
  - FFS total costs = FFS costs + MHD admin costs for operating FFS
- Compared MC eligibility groups with the same eligibility groups in FFS.

CATEGORIES OF SERVICES REVIEWED

MC covers standard benefit minus carved-out services provided through FFS

- Medical Services Covered under MC
  - Inpatient, outpatient, physician services, dental, mental health, transportation, etc.
- Medical Services Carved out from MC
  - Pharmacy, specialty mental health, some adult dental and transplants
- Other Medical Transactions Included
  - FQHC and RHC wrap-around
- Other medical costs transactions excluded
  - Hospital direct payment and waiver services

5% GEOGRAPHIC ADJUSTMENT

- Rationale: Medical care is more expensive in urban areas than in rural areas
  - The previous Mercer report comparing MC to fee-for-service (FFS) costs in 2008 used a 5% adjustment factor
  - For the ABD population the rural/urban difference for CY2005-2008 was 9.6%
  - When managed-care expanded in the central region and 2008 Mercer's total adjustment was 6%.
    - 3% adjustment area
    - 3% lower cost in the central region than the Eastern and Western regions
  - Medicare per capita expenditures or St. Louis and Kansas City are 4.6% higher than the surrounding rural areas
- The current SFY 2010 – 2013 analysis uses a 5% adjustment factor

RE-ALLOCATION ADJUSTMENTS

- Retroactive Eligibility and the first 15 days allowed for MC plan enrollment
- Special health care needs opt out population
- Specialty Behavioral Health Services - CPR, CSTAR, TCM
- Pharmacy and Transplants
- MHD Administrative and IT services supporting MC contracting and payments

MC & FFS RETROSPECTIVE COSTS

AMOUNTS REFLECT TOTAL GR AND FEDERAL EXPENSE

	SFY 2010	SFY 2011	SFY 2012	SFY 2013	Average
Fee for Service (FFS)	$1.524 Billion	$1.517 Billion	$1.579 Billion	$1.644 Billion	**$1.566 Billion**
Managed Care (MC)	$1.501 Billion	$1.481 Billion	$1.578 Billion	$1.596 Billion	**$1.539 Billion**
Savings	23 Million	36 Million	2 Million	48 Million	**27 Million**
Percent	1.5%	2.4%	0.1%	2.9%	**1.7%**

Source: MANAGED CARE COST AVOIDANCE MODEL - December 2014

KEY FINDINGS

- Annual savings in MC ranged from 0.1% to 2.9% ($2 to $48 million) over the four-year period. Much of the variation between years is due to rate increases.
- The four year average annual savings was 1.7%
  - $5.33 PMPM
  - $27 million average
- Compared to FFS, MC….
  - Reduces medical costs/payments to providers by $23.81 PMPM (8% decrease)
  - Increases administrative costs by $18.48 PMPM (149% increase)
- For every $1 PMPM of reduced state costs due to MC, medical costs/payment to providers is reduced by $4.47 PMPM and administrative costs are increased by $3.47 PMPM

COMPARING FFS AND MANAGED CARE ADMINISTRATIVE COSTS

RETROSPECTIVE COST COMPARISON BY MERCER

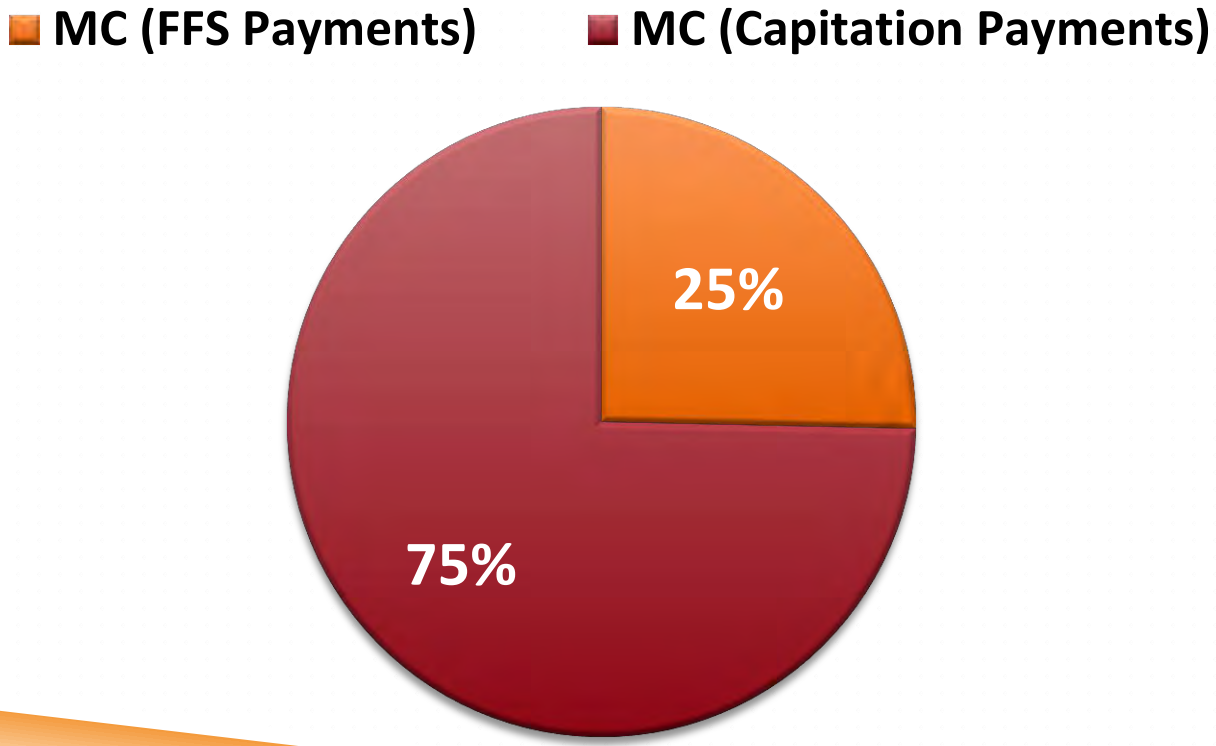
- Compares MC eligibility groups with the same eligibility groups in FFS.
- MC total cost = capitation payments + FFS services carved out + MHD admin costs of managing contracts
- FFS total costs = FFS costs + MHD admin costs for operating FFS

CATEGORIES OF SERVICES

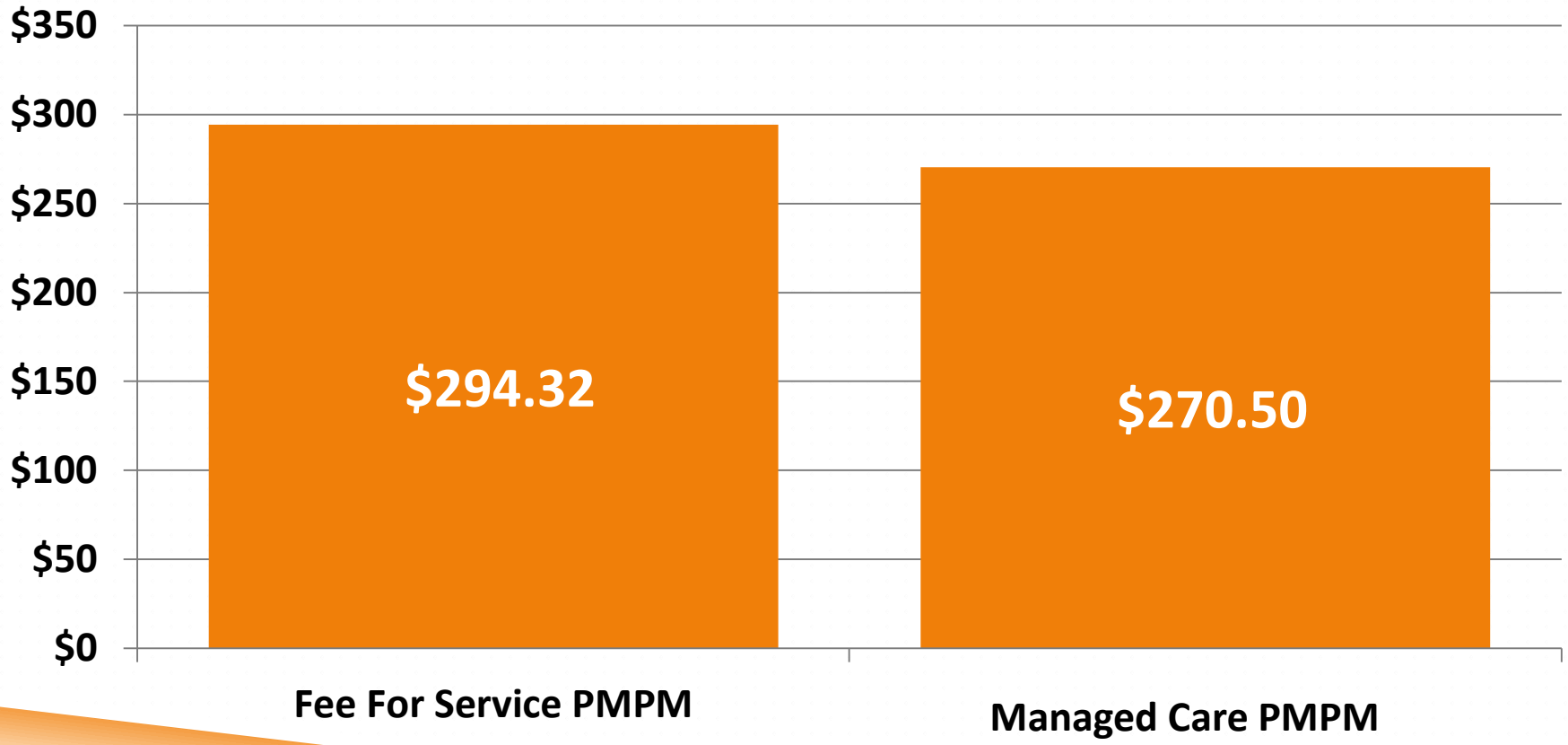
- Medical Services Covered under MC
  - Inpatient, outpatient, physician services, dental, mental health, transportation, etc.
- Medical Services Carved out from MC and Paid by FFS
  - Pharmacy, specialty mental health, some adult dental and transplants
- Other Medical Transactions Included
  - FQHC and RHC wrap-around

TYPES OF PAYMENTS MADE FOR MANAGED CARE POPULATIONS

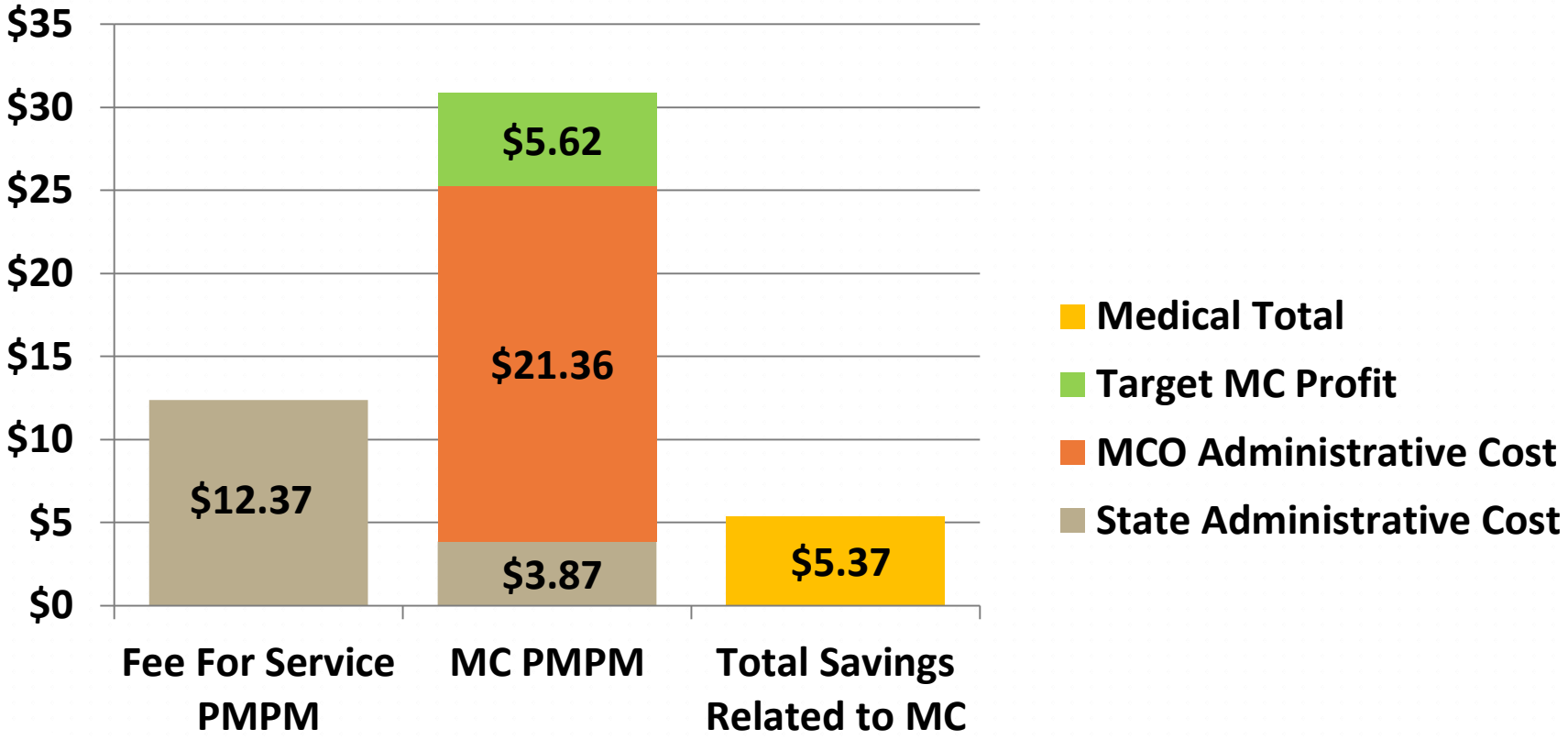
SFY13



TOTAL MEDICAID COST



FEE FOR SERVICE ADMINISTRATIVE COST AND SAVINGS RELATED TO MANAGED CARE



HOW DOES MISSOURI COMPARE?

- Mercer reports that “typical” MC savings are 3-6%
- Why lower savings in MC?
  - Missouri carves-out specialty behavioral health services and pharmacy services.
  - Missouri runs a FFS program with strong management of pharmacy and Health Homes, similar to MC.
  - Missouri’s unique reimbursement structure for facilities may impede the ability of MC to manage cost and utilization.
  - FFS provider rates that are already as low or lower than MC provider contract rates.

ESTIMATING PROSPECTIVE IMPACT OF EXPANDING MC IN CY 2015

- Mercer estimated 2.2% savings ($14.2 million) for a typical and mature MC program expanded to serving the remaining non-elderly, similarly participating women and children currently in FFS.
- Expected savings would be lower for at least the first two years of program.
- The estimate deducts from savings 2.814% factor due to administrative costs of the ACA health insurer fee.
- Mercer also noted that achieving "typical" MC savings levels would be limited by:
  - Missouri's policy of carving out certain services such as specialty behavioral health and FFS provider rates that are already as low or lower than MC provider contract rates.

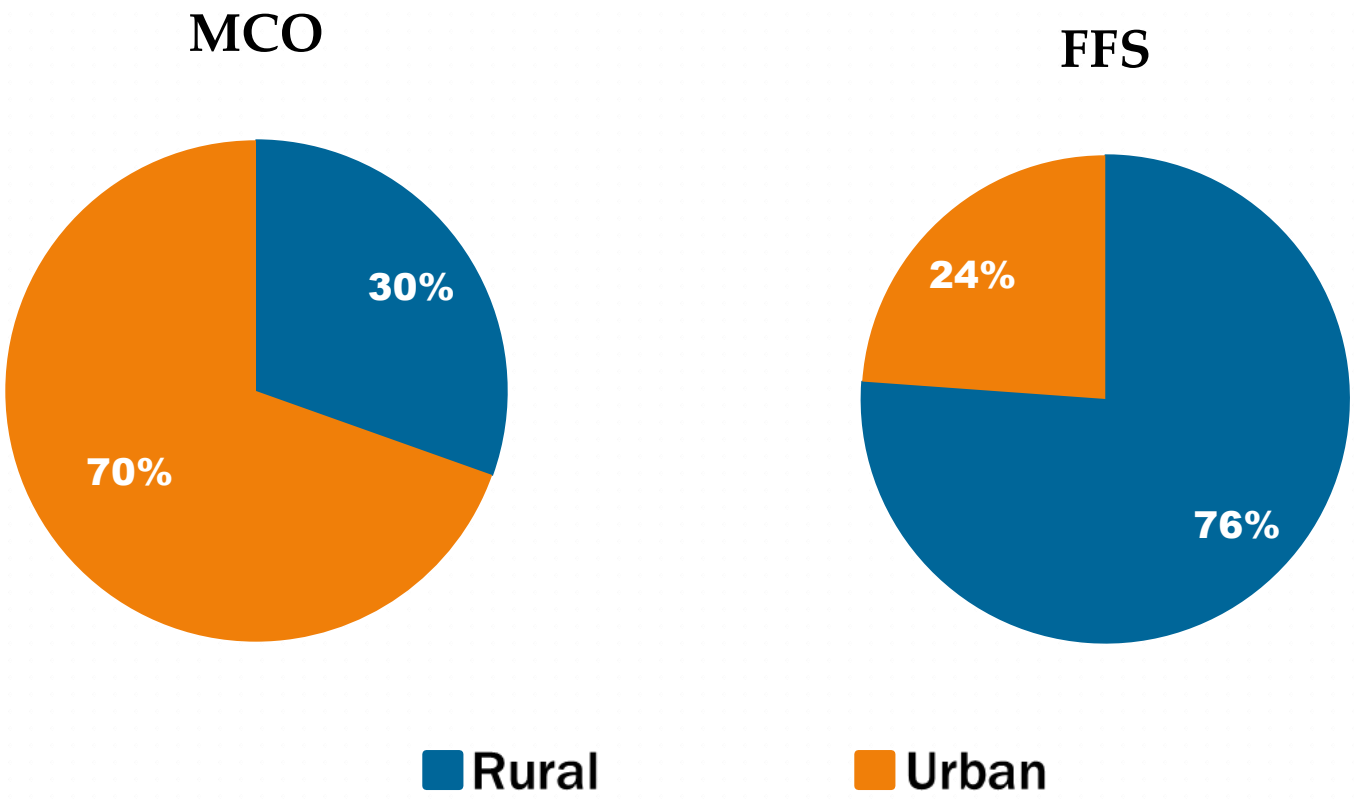
COMPARING PERFORMANCE:

UTILIZATION

UTILIZATION AND QUALITY COMPARISONS

- The results following our initial analysis by MHD in the process of being cross checked by MERCER
- The cause of the variation in results could be due to several different explanations
- Further analysis is in process

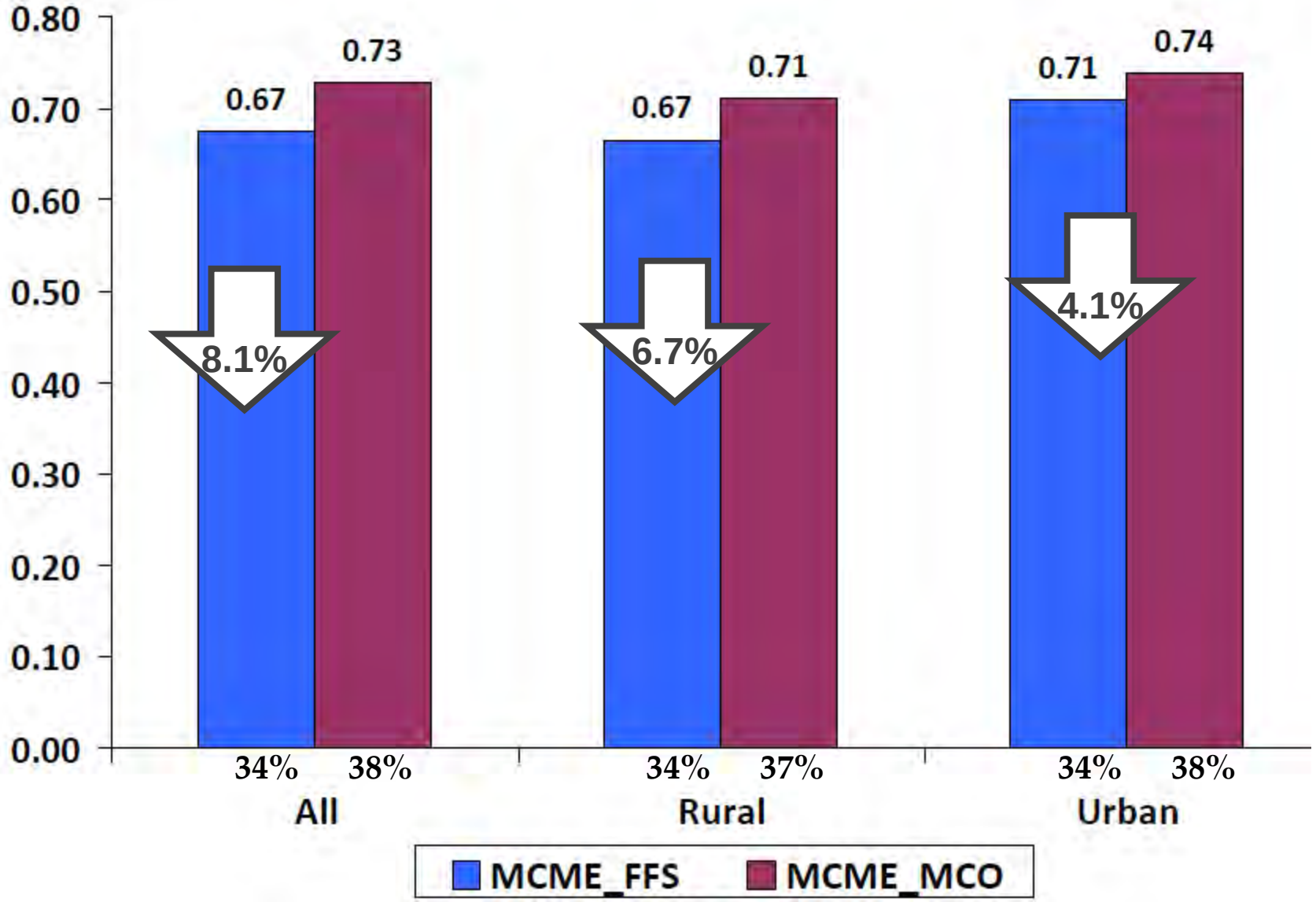
RURAL VS. URBAN



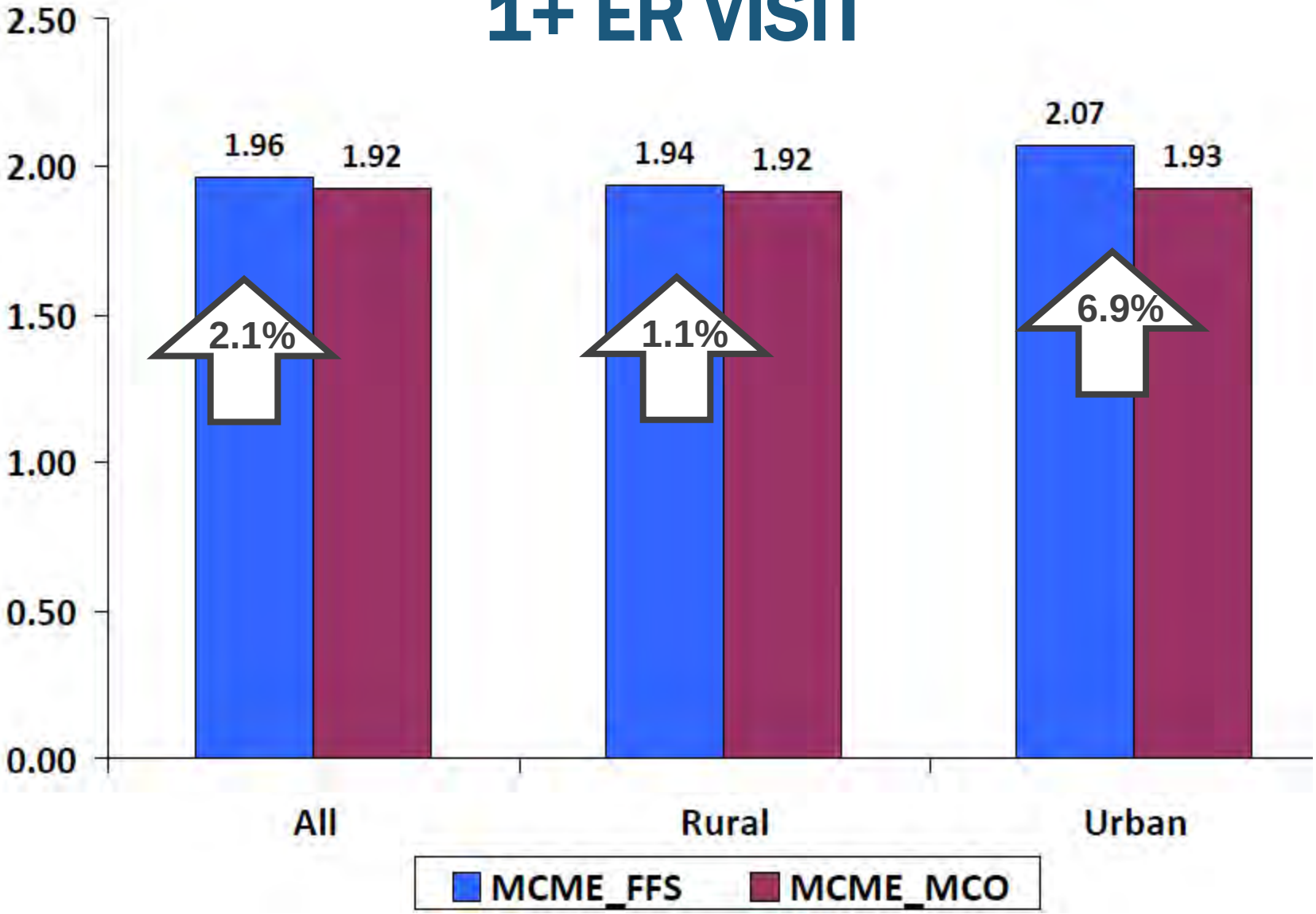
THE UTILIZATION MEASURES

- ER visits – fewer is better
- Inpatient Admissions – fewer is better
- Inpatient Days – fewer is better
- Hospital Length of Stay (LOS) – fewer is better,
  unless Hospital re-admissions are higher
- Out-Patient (E&M) Visits - fewer is better,
  unless ER visits are higher or
  Quality Performance Measures are lower

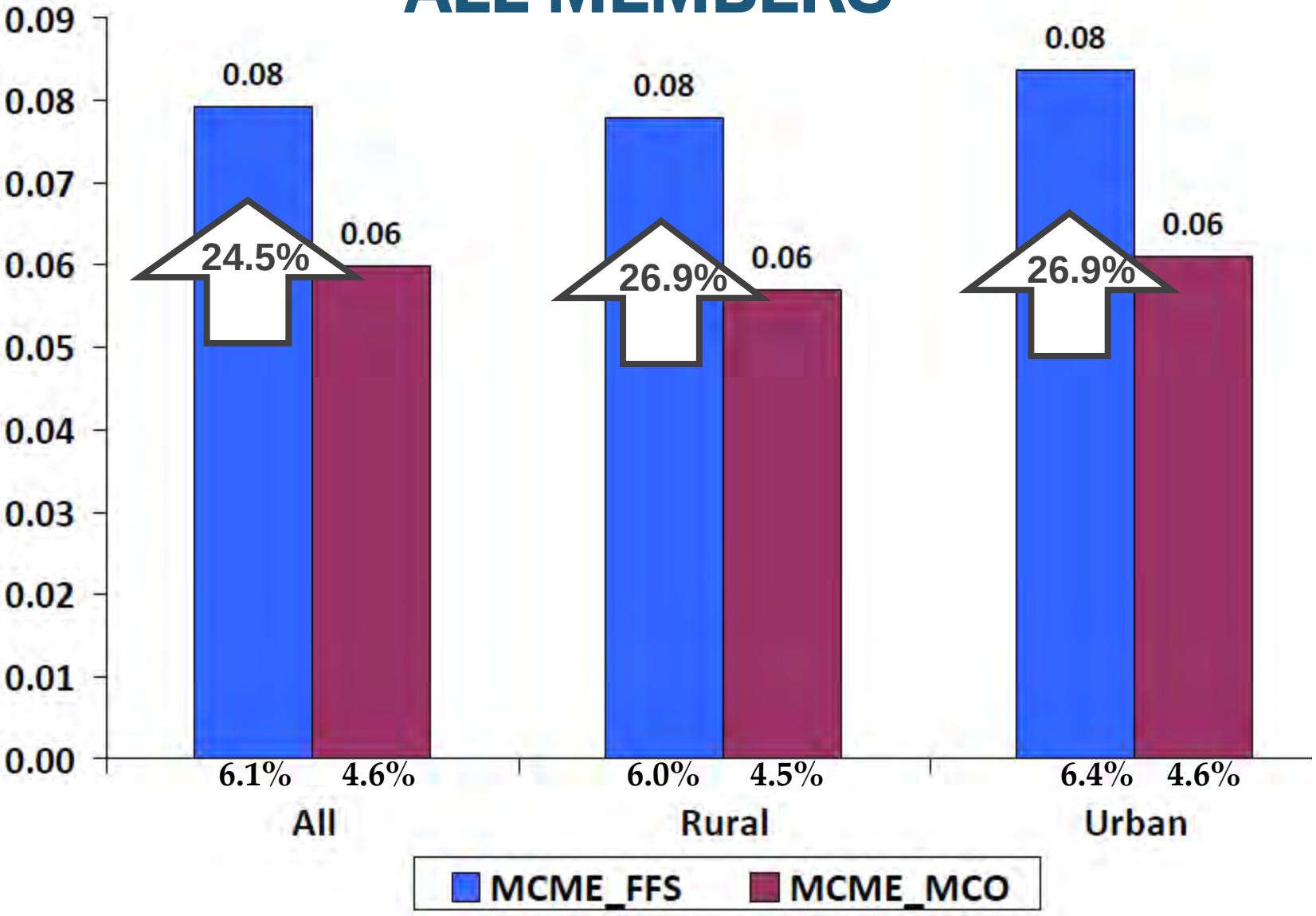
AVERAGE ER VISITS: ALL MEMBERS



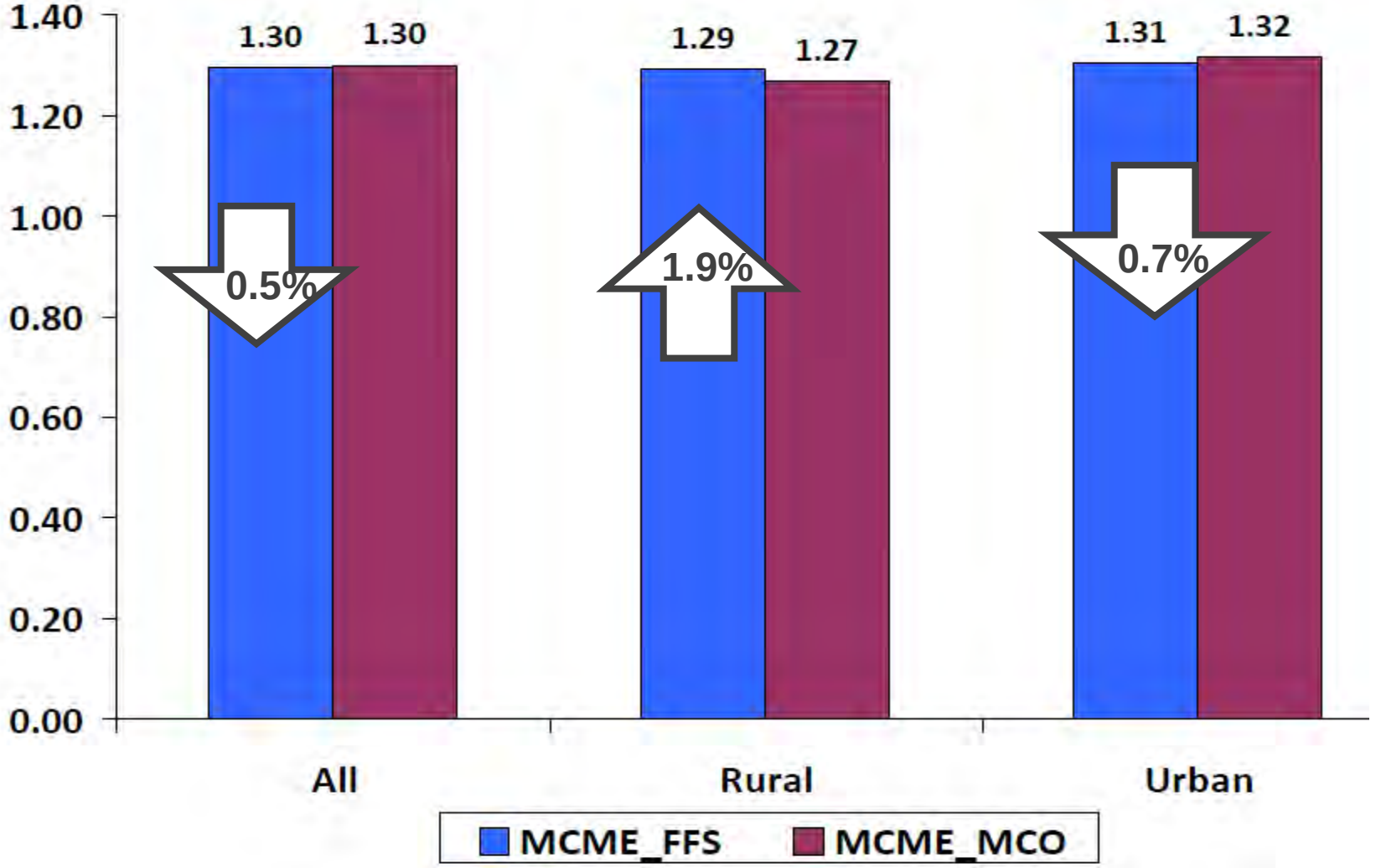
AVERAGE ER VISITS: MEMBERS WITH 1+ ER VISIT



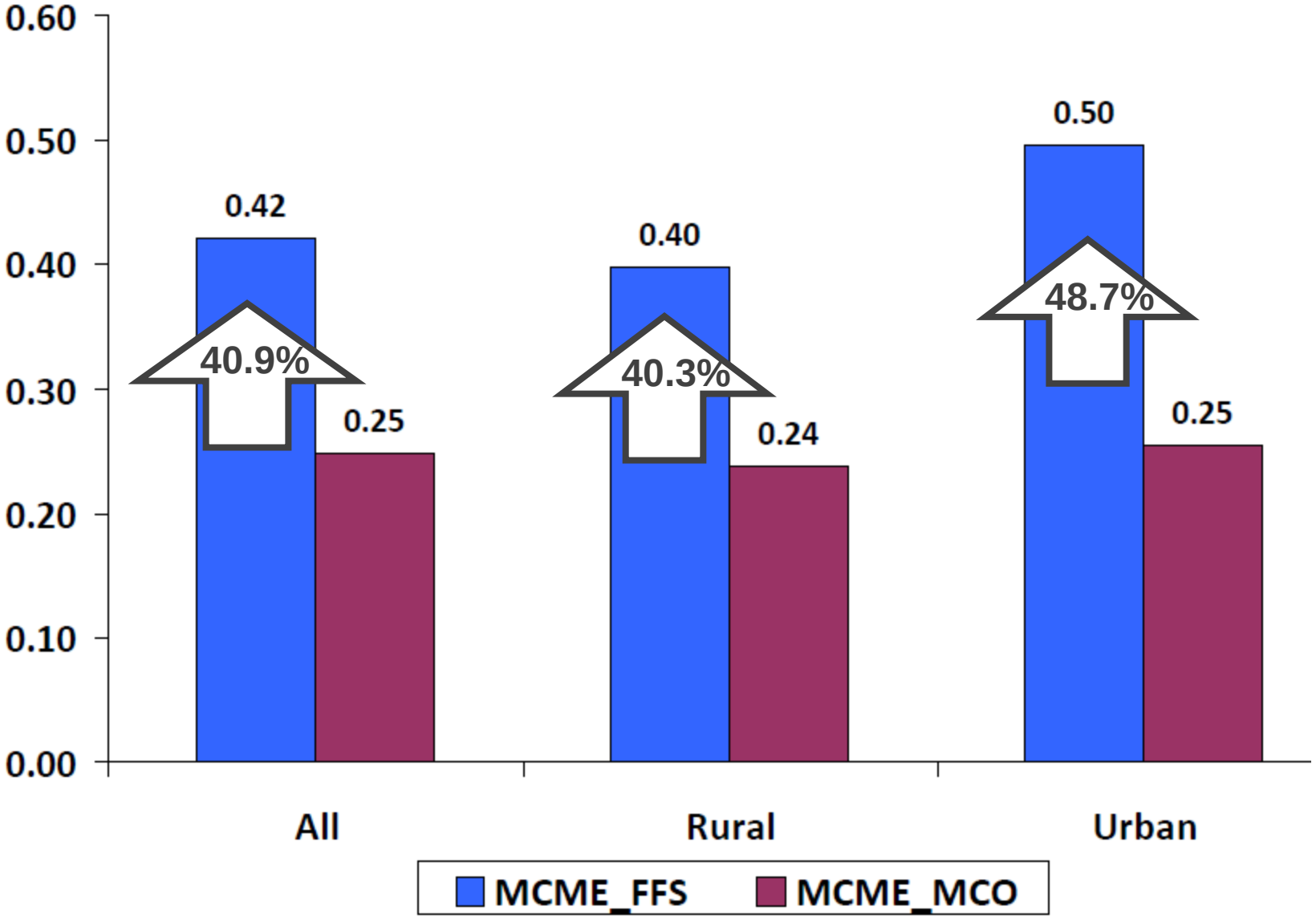
AVERAGE INPATIENT ADMISSIONS: ALL MEMBERS



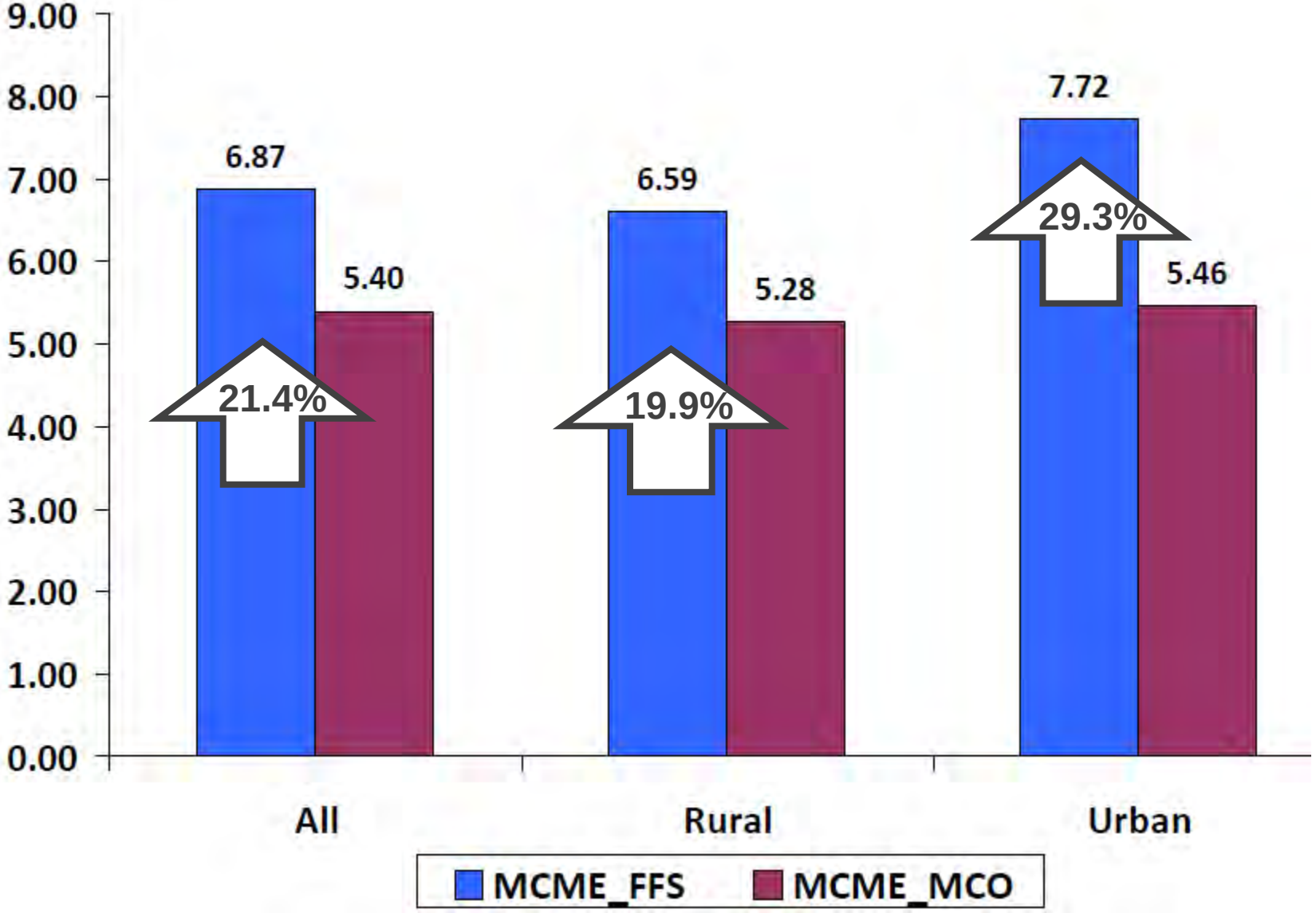
AVERAGE INPATIENT ADMISSIONS: MEMBERS WITH 1+ INPATIENT ADMISSION



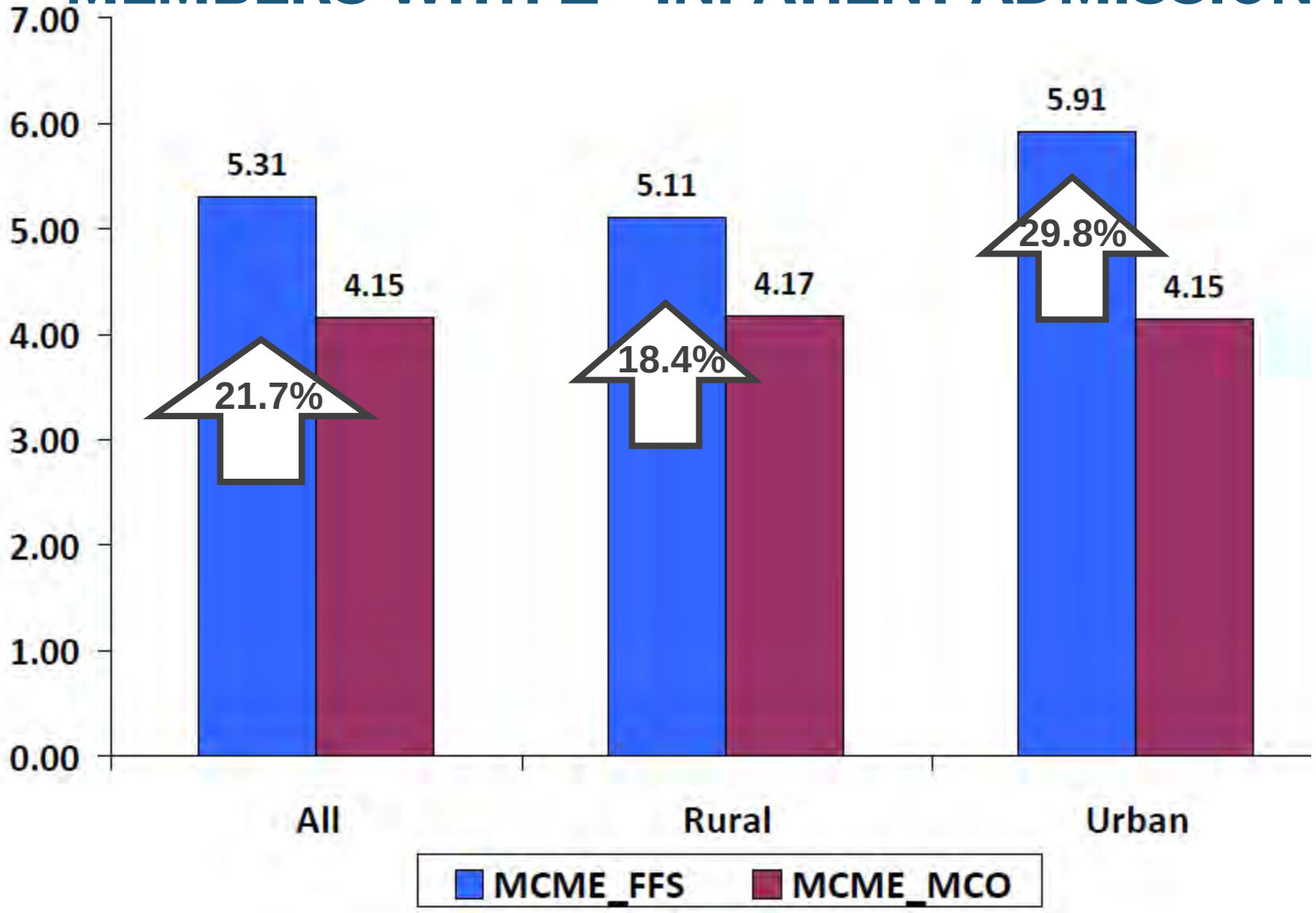
AVERAGE INPATIENT DAYS: ALL MEMBERS



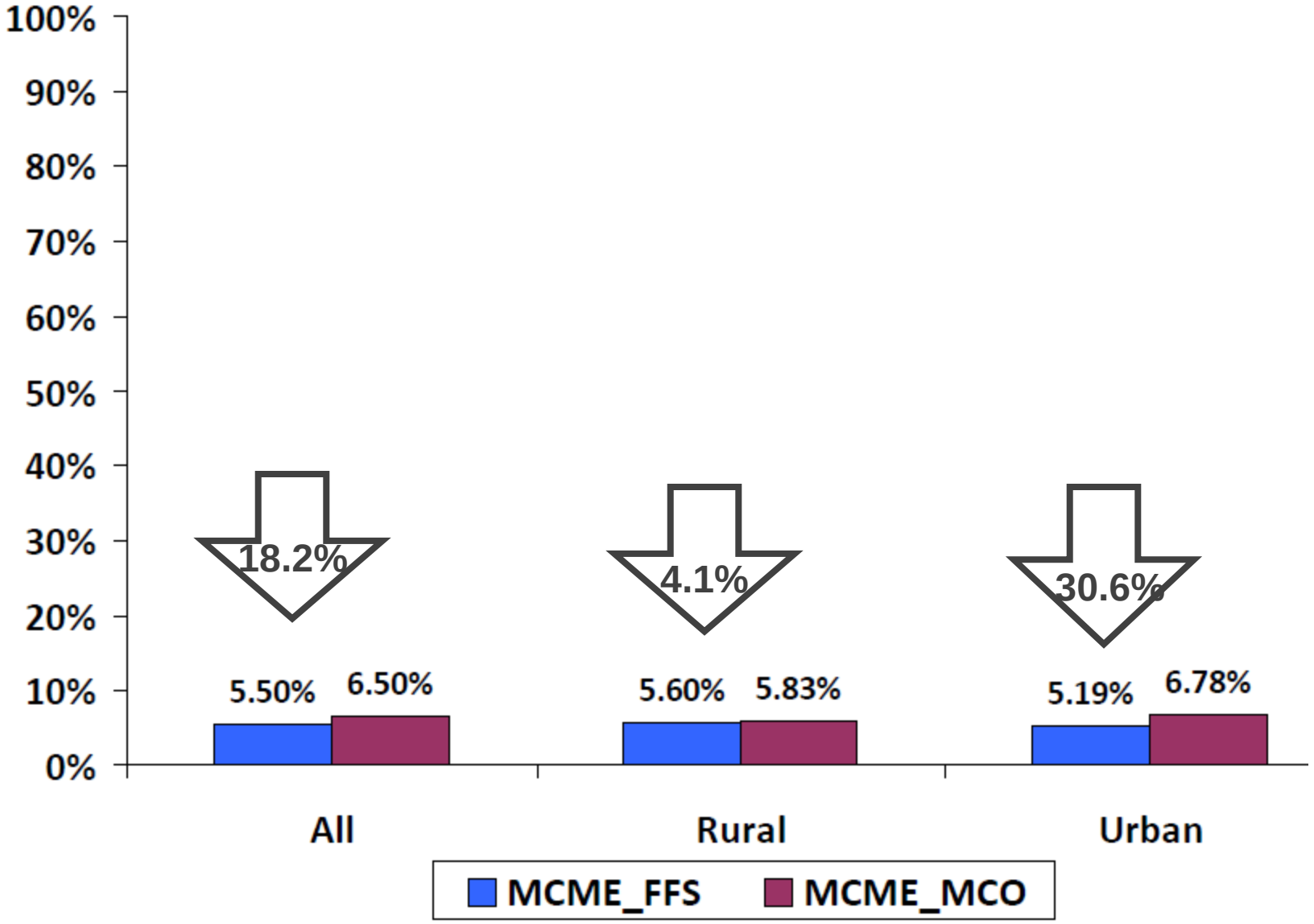
AVERAGE INPATIENT DAYS: MEMBERS WITH 1+ INPATIENT ADMISSION



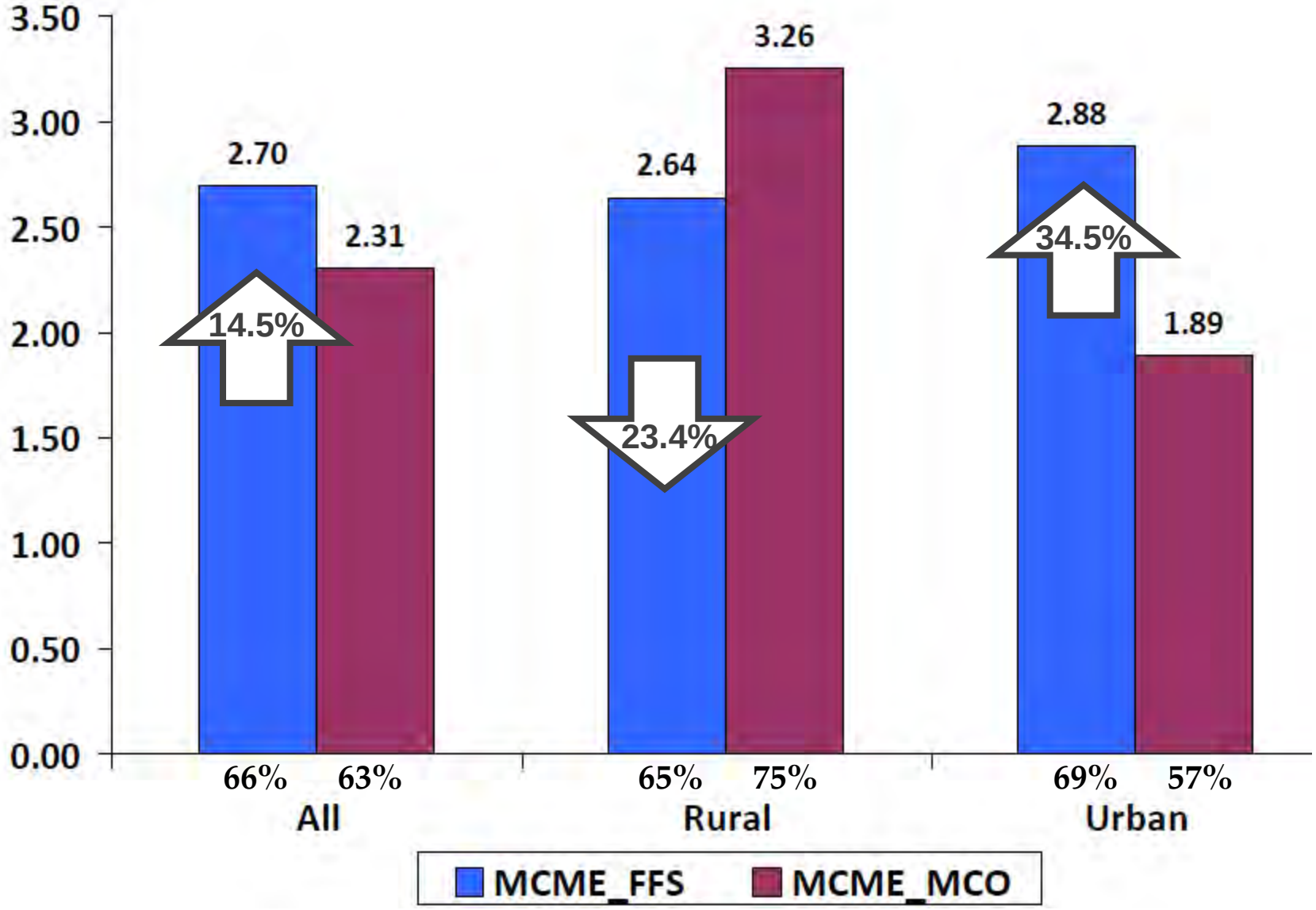
AVERAGE HOSPITAL LOS (COVERED DAYS): MEMBERS WITH 1+ INPATIENT ADMISSION



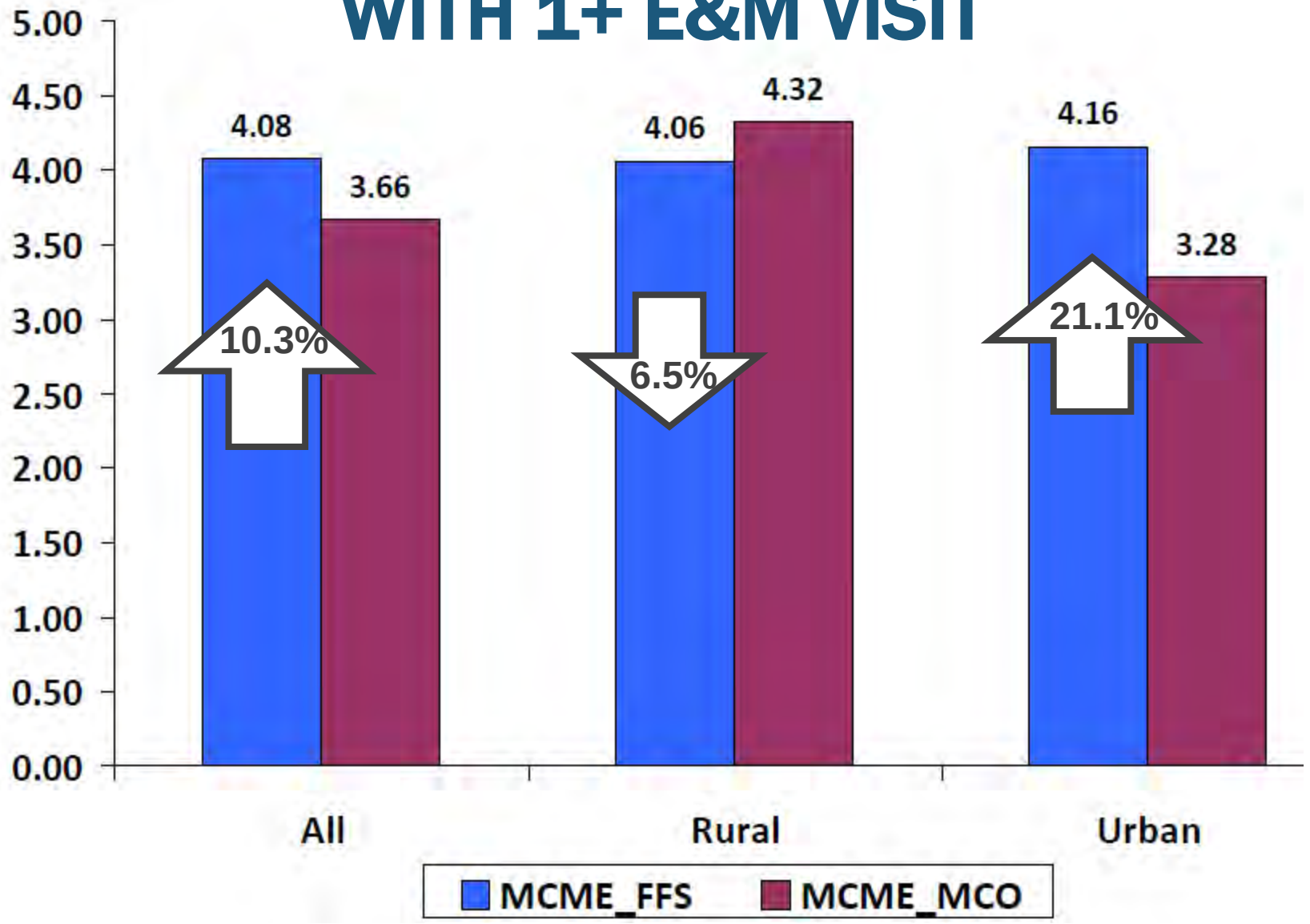
HOSPITAL RE-ADMISSION'S: MEMBERS READMITTED WITHIN 30 DAYS



AVERAGES E&M VISITS: ALL MEMBERS



AVERAGES E&M VISITS: MEMBERS WITH 1+ E&M VISIT



UTILIZATION OF SERVICES AND PROVIDER ACCESS

- Fewer hospital admissions (25%)
- Fewer Average Hospital days (40%)
- Shorter length of stay (19%)
- More Hospital Readmissions (18%)
- More ER visits (9%)
- Fewer outpatient visits (15%)

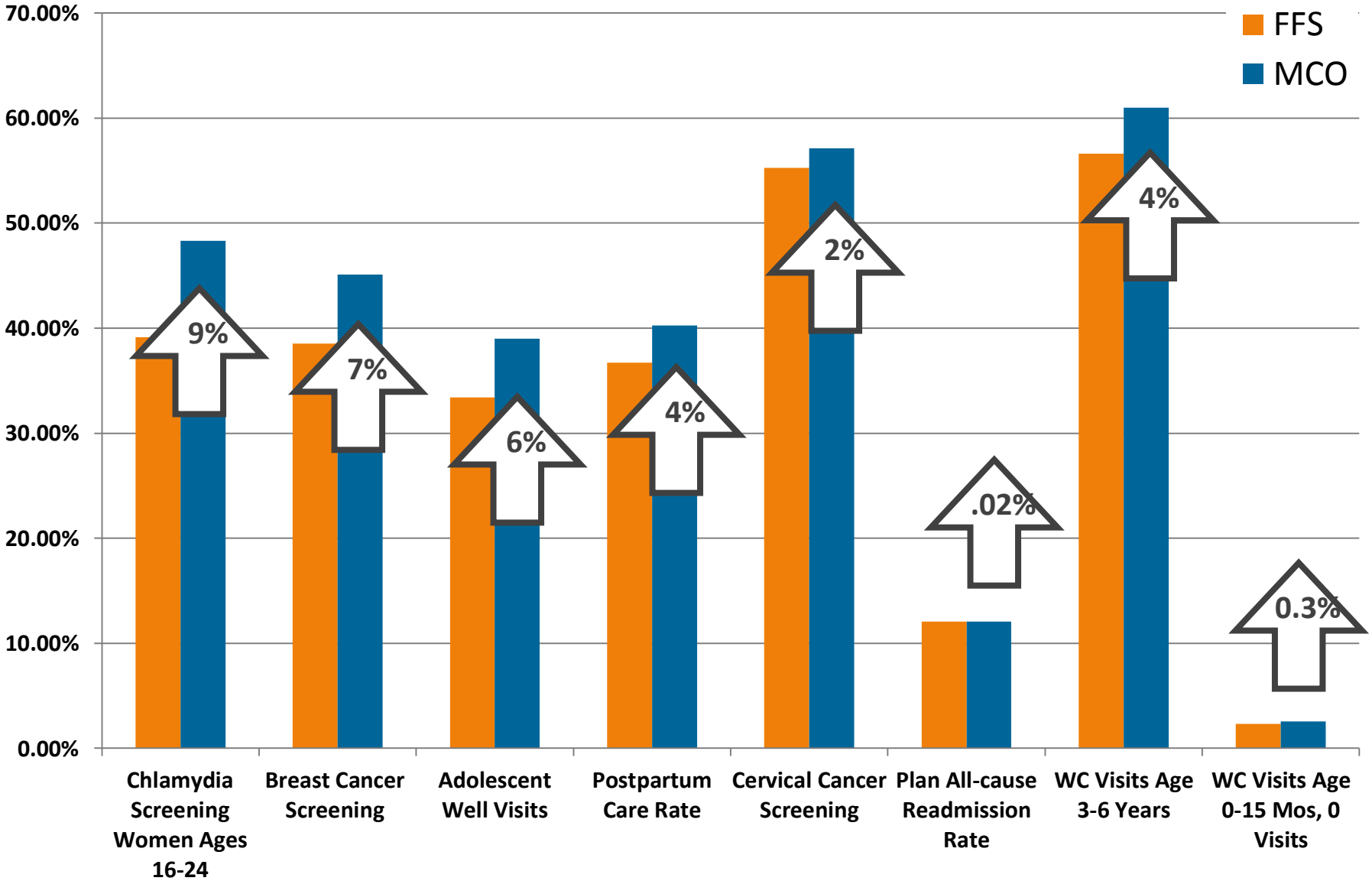
COMPARING PERFORMANCE:

CLINICAL QUALITY

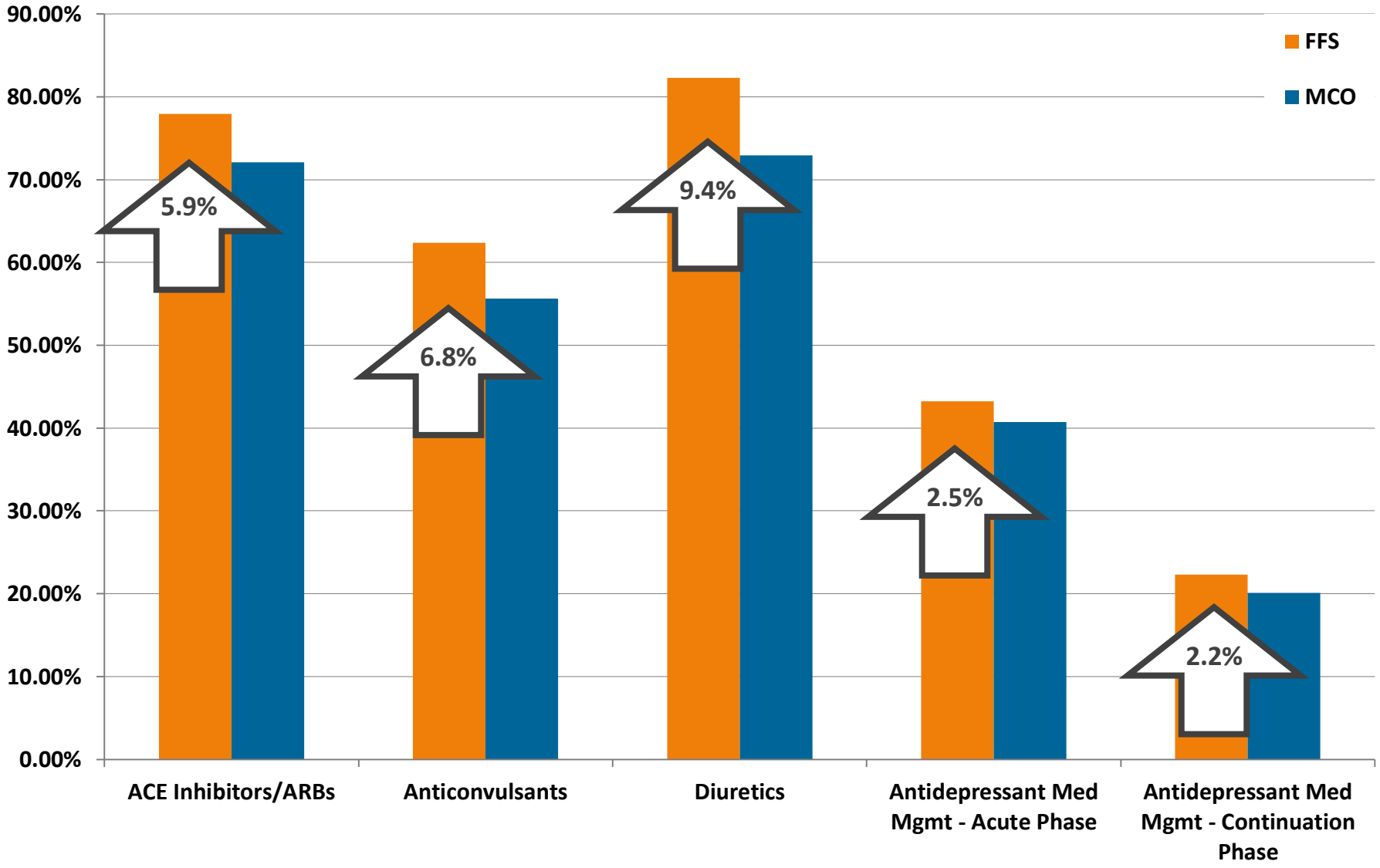
OVERALL

- Managed Care performed better on 8 measures
- Fee-for-Service performed better on 10 measures
- For 3 measures too few persons met criteria to be valid
- Differences were not large (Average difference 4.3 points)
- 1 additional measure under development
  - Initiation/Engagement of Treatment for Alcohol/Drug Abuse

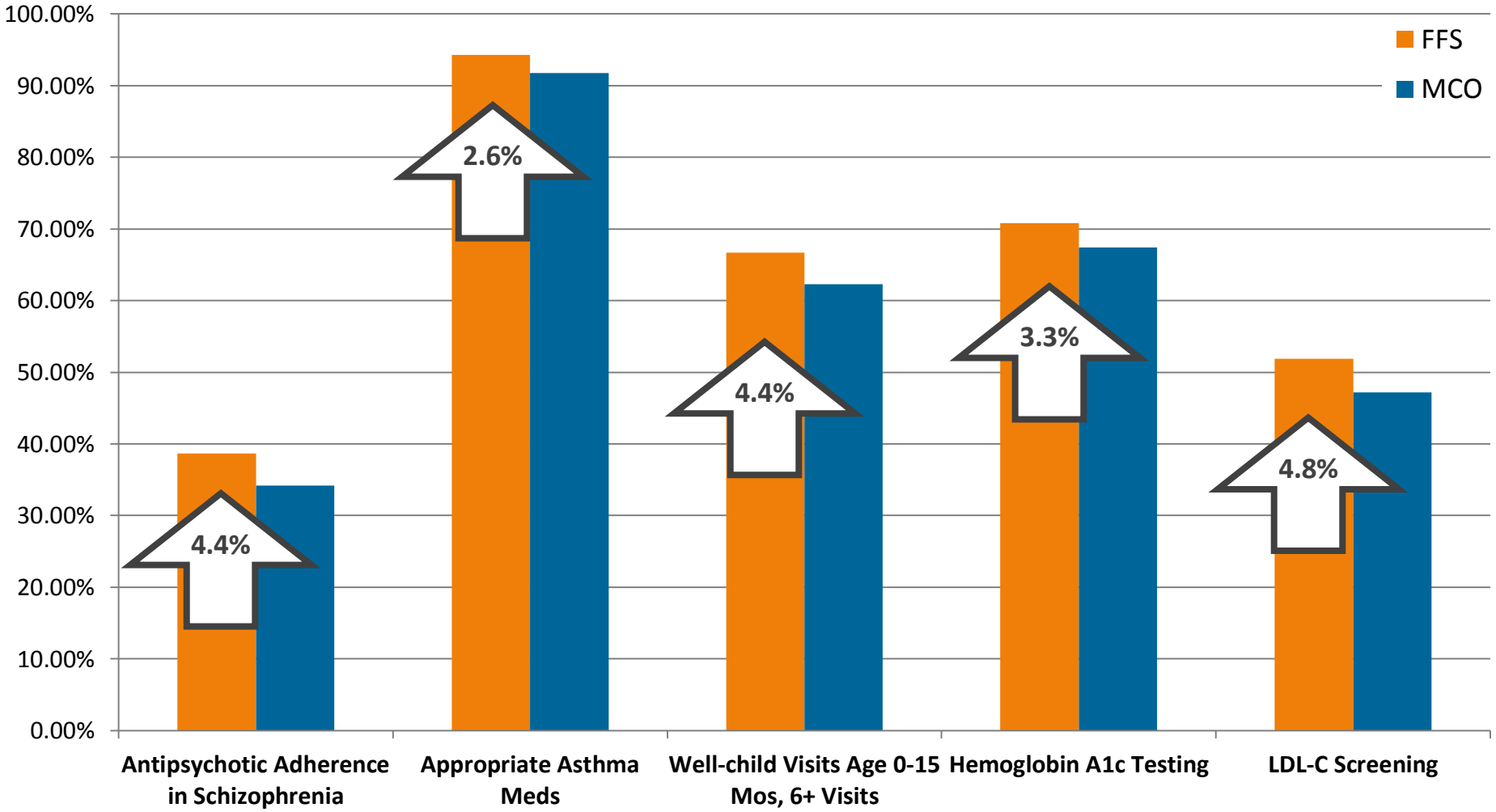
MEASURES WHERE MC PERFORMED BETTER



MEASURES WHERE FFS PERFORMED BETTER



MEASURES WHERE FFS PERFORMED BETTER

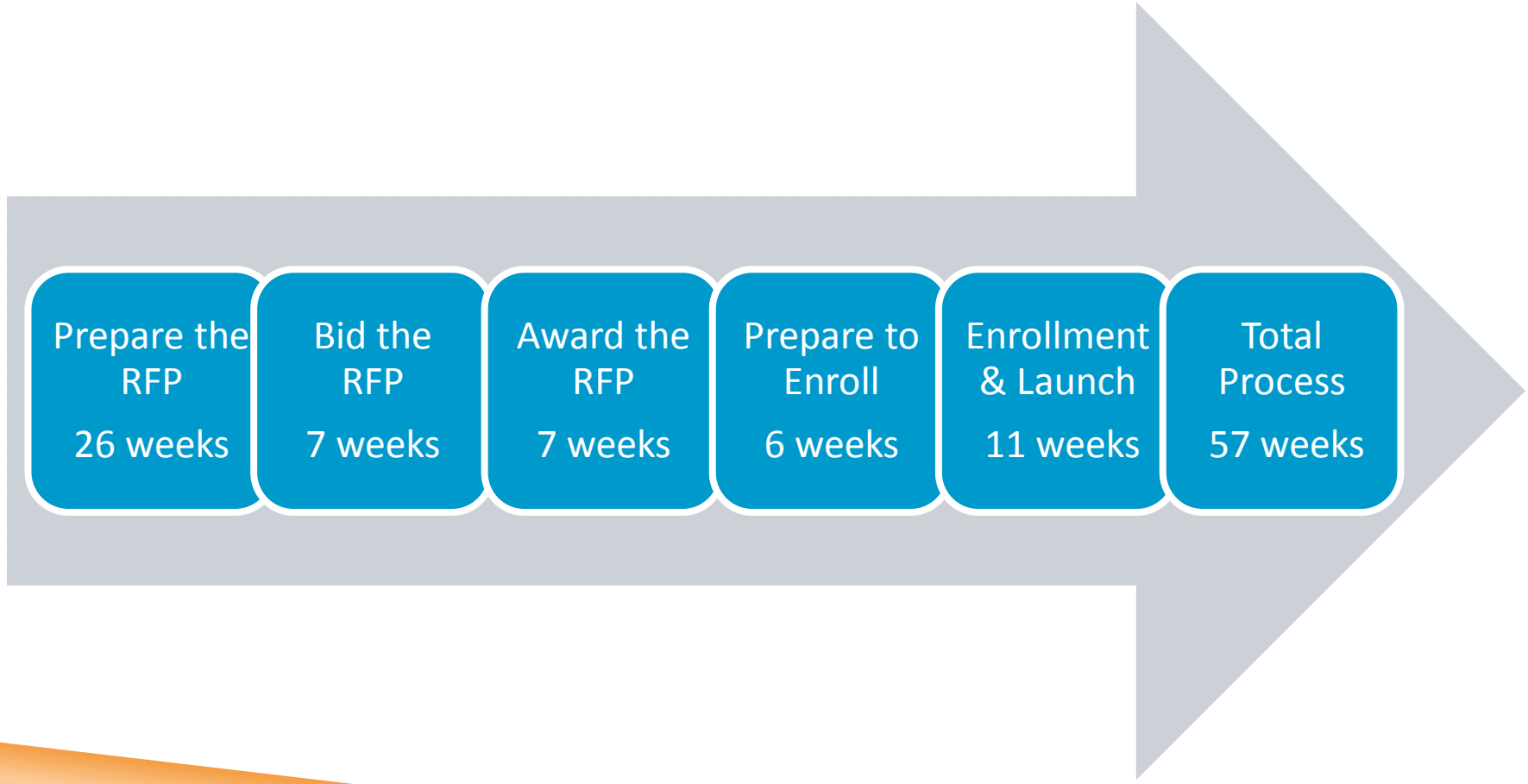


ACTUAL MC PERFORMANCE

- **Cost**
  - Lower overall cost (1.7%)
  - Higher care management and administrative costs (149%)
- **Utilization of Services and Provider Access**
  - Fewer hospital admissions (25%)
  - Fewer Average Hospital days (40%)
  - Shorter length of stay (19%)
  - More Hospital Readmissions (18%)
  - More ER visits (9%)
  - Fewer outpatient visits (15%)
- **Clinical Quality**
  - Lower on 10 of 18 clinical quality measures (1 more pending)

TIMELINE FOR BIDDING MANAGED CARE CONTRACTS

PROCESS REVIEW



ASSUMPTIONS

- Normal procurement takes 18 months.
- Eliminates the review, discussion, changes we would normally conduct with the other departments (DHSS, DMH, DESE.) (Recently did that with the other departments for the SFY16 contract.)
- Assumes there would not be any major contract changes that required policy and rate development.
- Can be shortened by reducing the Open Enrollment phase.

PREPARING THE RFP

26 WEEKS

- **26 weeks**
  - Meetings with MHD and Mercer on decision items
  - Rate development tasks
  - Draft RFP to Mercer
  - Draft to DFAS/OA, review, questions, discussion
  - Review/approve rates from Mercer
  - Systems work
  - RFP and data book release

BIDDING & AWARDING

14 WEEKS

- **Bidding the RFP – 7 weeks**
  - Pre-proposal conference
  - Meet with enrollment broker to plan open enrollment
  - Review/revise enrollment packets
  - Bids due
- **Awarding the contracts – 7 weeks**
  - Evaluation of bids
  - Contract awarded
  - Legal protests to the award decision can prolong this step
  - Contract and rates to CMS for approval
  - Renew 1915(b) Waiver

PREPARING TO ENROLL

6 WEEKS

- **3 weeks**
  - Finalize enrollment broker forms
- **3 weeks**
  - Mail enrollment packets
  - Readiness reviews
  - Preparation of 1915(b) Waiver Amendment
  - Systems work with health plans and state
  - Health Plan provider demographic files to state
  - Begin member and Provider Forums

ENROLLMENT & PREP FOR LAUNCH

11-12 WEEKS

- **8-9 weeks**
  - Open Enrollment occurs for 8-9 weeks
  - Continue member/provider forums
  - Begin processing new/revised marketing materials
  - System work for health plans and state
- **2 weeks**
  - Auto-assignments
- **Services begin**

WHAT IS AN ACCOUNTABLE CARE ORGANIZATION?

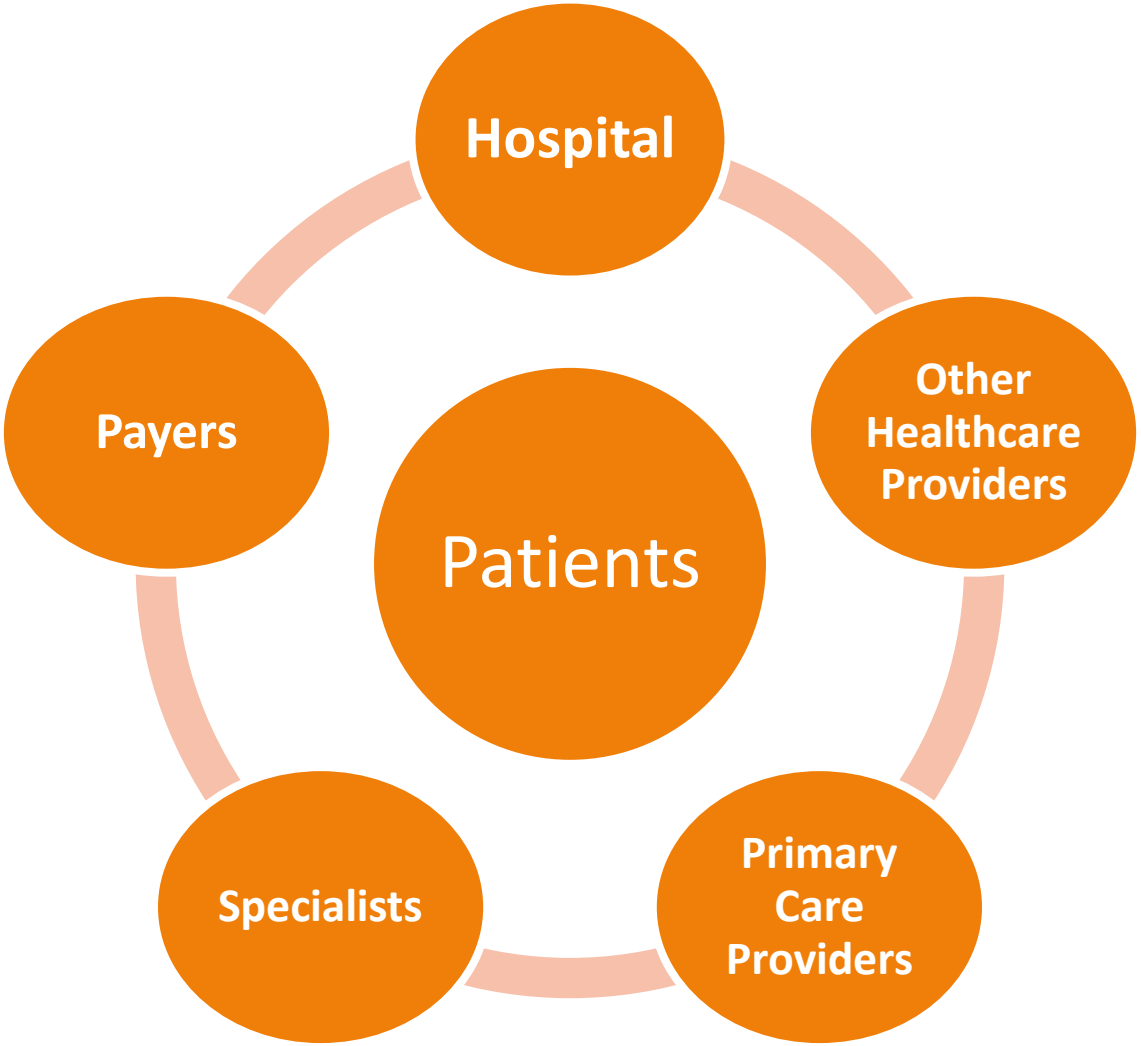
A KEY DIFFERENCE ACROSS PAYMENT MODELS -WHO IS AT RISK FOR THE COST OF CARE

- **Pure Models**
  - Patient – Uninsured People
  - Payer – FFS Medicaid and Companies that self-insure
  - Insurance Company – MC Medicaid and Companies that buy healthcare insurance
  - Providers – Accountable Care Organizations
- **In Practice – Most are mixed Models**
- **Historical Shifts – over past 30 years**
  - More big Companies keep the risk and self-insure
  - More of Medicaid contracts out the risk to Managed Care
  - Since 2010 several States are contracting Medicaid risk directly to providers

ACOs DEFINED

- **Generally** – ACOs are a group of providers who are held accountable for improving health care quality while lowering the rate of growth in health care spending
- **Medicare Shared Savings Program ACO** – a legal entity that is recognized and authorized under applicable State law…comprised of an eligible group of ACO participants that work together to manage and coordinate care for Medicare fee-for-service beneficiaries…established a mechanism of shared governance that provides all ACO participants with an appropriate proportionate control over the ACOs decision-making process

ACO ENVISIONS INTEGRATED CARE



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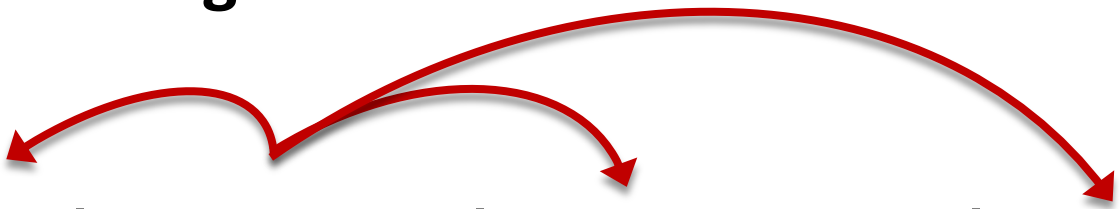
…FROM ENCOUNTERS…TO ONGOING MGMT

Fee-For-Service

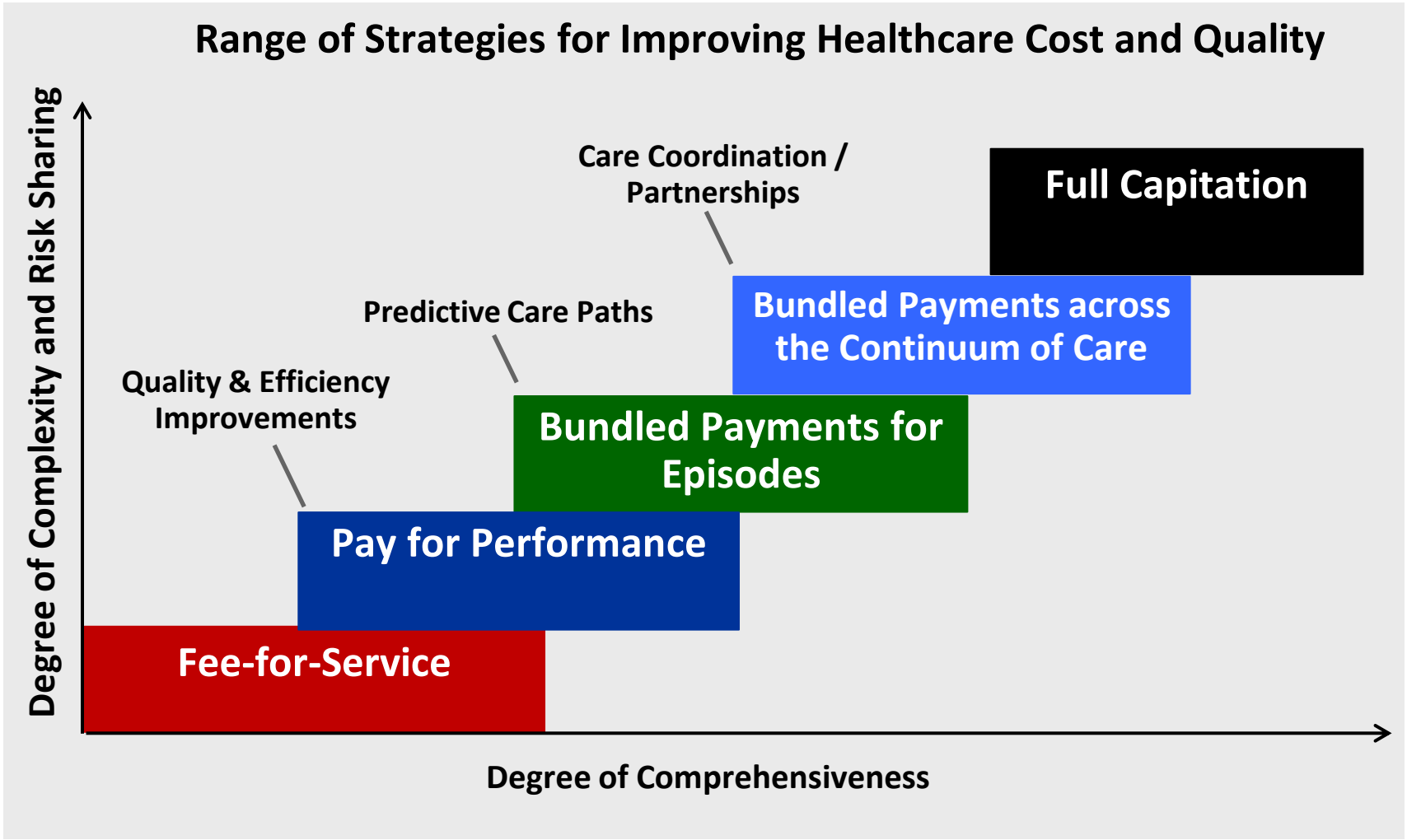
Pre-Encounter	Encounter	Post-Encounter	Disengaged
X	$$$$$	X	X

Population Management



Pre-Encounter	Encounter	Post-Encounter	Disengaged
$	$$	$	$

GETTING TO THE GOAL:
BETTER OUTCOMES AT LOWER COST

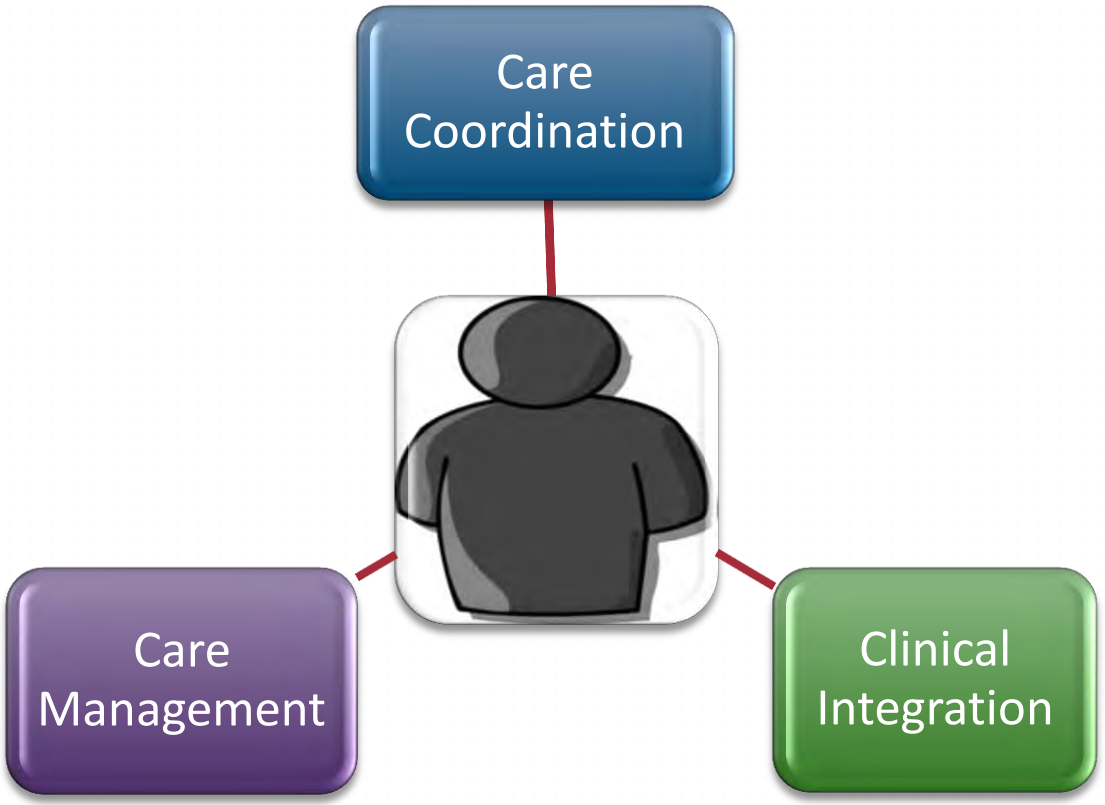


Alternate payment models require quality improvements

IMPORTANT PROVIDER COMPETENCIES

Characteristics:

- ✓ Outcomes-oriented
- ✓ Enabled by technology
- ✓ Patient-centered
- ✓ Use of data and analytics
- ✓ Performance transparency
- ✓ Ability to partner across organizations



ACOs VS. EARLIER DELIVERY MODELS

- **ACOs and Managed Care**
  - In Managed Care an insurance company bears the risk for profit or loss
  - In ACOs healthcare providers bear the risk for profit or loss
  - ACOs give providers more flexibility to decide how they use resources to care for patients
- **ACOs and Health Homes (HHs)**
  - Both models promote the use of enhanced resources (e.g., EHRs, patient registries)
  - Both models require providers to measure and report quality of care and outcomes
  - HHs do not offer explicit incentives for providers to work collaboratively to reduce costs/improve quality
  - HH models calls for providers to take responsibility for coordinating care

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WHAT ACOs ARE OUT THERE?

- Medicare Pioneer
  - 32 nationally – none in Missouri
- Medicare Shared Savings Program (MSSP)
  - BJC, Mercy, Mosaic, St Louis Physician Alliance
- Center for Medicare and Medicaid Innovation
- Medicaid waivers and state plan amendments
- Medicaid
  - Children's Mercy under HealthCare USA and Missouri Care

Total ACOs in U.S. 2010-2013

Source: Leavitt Partners Center for Accountable Care Intelligence

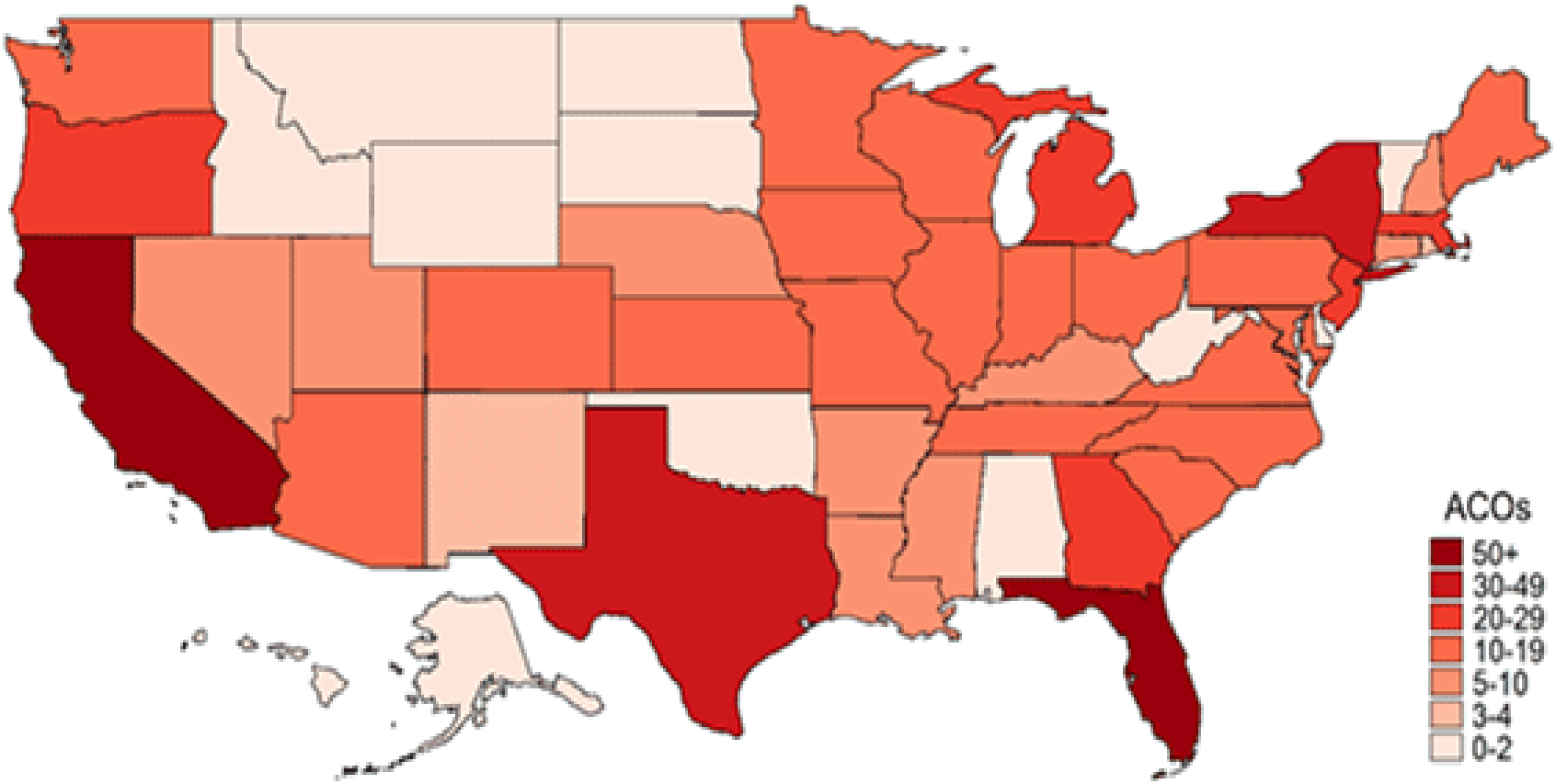
Total ACOs by Sponsoring Entity 2011-2013

Source: Leavitt Partners Center for Accountable Care Intelligence

Estimated ACO Covered Lives

Source: Leavitt Partners Center for Accountable Care Intelligence

ACOs by State



Source: Leavitt Partners Center for Accountable Care Intelligence

COLORADO MEDICAID ACO

- **First Medicaid ACO in the nation began May 2011 following discontinuation of traditional managed care**
- **Model (Primary Care Case Management State Plan Option)**
  - Services continue to be paid fee-for-service
  - PCPs receive $4 PMPM
  - Seven Regional Care Collaborative Organizations (RCCO) get $8-$10 PMPM
  - $1 PMPMIs withhold from the PCPs and RCCOs and later paid out on a performance incentive basis
  - Independent data and analytics contractor reports on performance to state
- **Outcomes from 2014 Annual Report**
  - 58% of Medicaid clients enrolled at 70% of those in a medical home
  - Decreased: ER visits, hospital readmissions, and high-cost imaging
  - Savings: $100 M gross, $69 M program cost, $31 M net savings to the state

UTAH MEDICAID ACO

- **Medicaid ACO began January 2013 delivered through 4 MCOs**
- **Model (Managed Care 1915b Waiver)**
  - Operates I 4 urban counties with 70% of state population
  - Modified existing MCO contracts
  - ACOs receive monthly risk adjusted full risk capitation payments
  - Pharmacy carved in except for hemophilia and psychiatric medications
  - Mental health in separate pre-paid plans
- **Outcomes – none yet**

OREGON MEDICAID ACO

- **Began 2013 delivered through 16 Coordinated Care Organizations (CCO) statewide**
- **Model (1115 Waiver)**
  - 90% of Medicaid enrollees are in a CCO including dual eligibles and CHIP, considering adding state employees
  - 1% of capitation withheld for quality reporting and bonus pool
  - CMS waiver provides $1.9 billion over five years with potential for reduction if one to 2% cost reductions not met
  - CCOs are a mixture of not-for-profit and for-profit organizations
- **Outcomes**
  - 85% of Medicaid population enrolled
  - Decreased ER use, hospital admissions, and hospital readmissions
  - Reduced cost of care for 19 out of 21 financial measures monitored

COMPARISON OF MEDICAID ACOs

	Colorado	Utah	Oregon
Delivery System	FFS plus PMPMs for networks and providers	Capitated payments	Capitated payments
Payment at risk based on quality?	Yes, small amount of PMPM at risk based on quality/utilization targets	No, but contract requires quality performance	Yes, additional bonus pool for quality performance
Services included	Help beneficiaries access behavioral health, long-term care (but those services not part of payment)	Physical health	Physical health, Behavioral health, Dental health
Populations excluded	Excludes beneficiaries residing in an institution	Excludes beneficiaries residing in an institution	Excludes program for all-inclusive care for the elderly (PACE)
Mandatory enrollment?	Passive enrollment with opt-out	Yes, for four most populous counties	Yes
% of Medicaid enrollees	47%	70%	90%

Rice, D. (2014). *Medicaid accountable care organizations in other states*. Fiscal Research Division. North Carolina General Assembly.

IOWA MEDICAID ACO

- **Began July 2012**
- **Model (1115 Waiver)**
  - Implemented as part of an Innovations Grant
  - Services are paid fee for service with each ACO allocated a global budget
  - Five Regional ACOs with 30,000 attributed patients
- **Payments**
  - $4 PMPM PC Case Manager fee
  - $25 per patient per year for a Health Risk Assessment
  - $10 per patient if over 50% get an annual physical
  - $4 PMPM for after hours access and supporting healthy behaviors
  - Up to $4 PMPM for meeting quality measures
- **Outcomes**
  - 83% of providers qualify to participate
  - Third Quarter 2014 performance payments totaled $126,368 statewide

MINNESOTA MEDICAID ACO

- **Developed and issued RFP in 2011, Implemented January 2013**
- **Model (1115 Waiver)**
  - Similar to Medicare MSSP - services paid FFS with performance bonus based on quality and shared savings
  - All Medicaid except Dual Eligibles
  - Patient attribution based on Health Care Homes and PCPs
  - Seven Clinical and 2 patient experience measures
- **Outcomes**
  - $10.5 M savings across 6 ACOs serving 100,000 patient
  - Three of the six ACOs saved enough to get a shared savings payment
  - Three additional ACOs added in 2014

NEW JERSEY MEDICAID ACO

- **Law enacted August 2011, Draft regulations released May 2013, planned to launch in 2015**
- **Model (1115 Waiver)**
  - ACO responsible for all Medicaid enrollees in a set geographic area
  - ACOs must be non-profit provider collaborations that include Hospitals, PCPs, BH providers, and Community members
  - Medicaid MCOs (4 total) permitted but not required to participate