



Managed Care Update

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MO HealthNet Oversight Committee

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December 2016 Enrollment Market Share

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	EASTERN		CENTRAL		WESTERN			
MANAGED CARE HEALTH PLANS	Eastern enrollment	% of total (Eastern)	Central enrollment	% of total (Central)	Western enrollment	% of total (Western)	Total	% of Total
Aetna Better Health of Missouri	142,518	58.93%	46,416	47.12%	90,583	54.43%	279,517	55.15%
Home State (Centene)	51,226	21.18%	20,063	20.37%	34,526	20.74%	105,815	20.88%
Missouri Care (Wellcare)	<u>48,116</u>	19.89%	<u>32,033</u>	32.52%	<u>41,323</u>	24.83%	<u>121,472</u>	23.97%
	241,860		98,512		166,432		506,804	

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May 2017 Managed Care Award

Statewide Managed Care Timeline

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Date	Activity
October 14, 2016	Award to three health plans
Beginning December 6, 2016	Open enrollment packets mailed
January 20, 2017 to April 3, 2017	Open enrollment period
April 3, 2017	Begin auto assignment
In April 2017	Share new participant history and active prior authorization files with health plans
May 1, 2017	Geographic expansion services begin

Managed Care Evaluation

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- ❖ Organizational Experience & Method of Performance
- ❖ Quality
- ❖ Access to Care & Care Management
- ❖ Medicaid Reform & Transformation
- ❖ Accountable Care Organization
- ❖ MBE/WBE Participation
- ❖ Organization for the Blind/Sheltered Workshop Preference
- ❖ Missouri Service Disabled Veteran Business Preference

Evaluations/Contract Awards

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Health Plan	Awarded Points
Missouri Care	199
United Healthcare of the Midwest	194
Home State Health Plan	174
Aetna Better Health of Missouri	166

October 28, 2016 Aetna Better Health of Missouri submitted a protest to the Office of Administration regarding the contract.

Key Changes in May 1, 2017 Contract

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- Geographic Expansion Statewide
- Contract Period
- Medical Loss Ratio (MLR)
- Provider Credentialing Provisions
- Mental Health Parity
- Performance Withhold Program Changes
- Min/Max Enrollment Percentages
- Care Management Integration
- Accountable Care Organization (ACO) Encouragement

Managed Care Unit Structure

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Policy, Contracts & Compliance

Operations

Stakeholder Services

Communications

Statewide MC Communications

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- Contract Award Notification
 - ▣ Stakeholders
 - ▣ Bulletin
- Pre-Enrollment Flyer sent to 119,668 households that are currently in FFS program and will transition to Managed Care effective May 1, 2017.
- Website Redesign
- Provider Tool Kit
 - ▣ What is Managed Care
 - ▣ State Contract with the Managed Care Organizations
 - ▣ Contracting with a Managed Care Organization

Pre- Enrollment Flyer



Important Updates



Sign up to receive important MO HealthNet Managed Care information by email at: dss.mo.gov/mhd/participants/mc

The way your MO HealthNet (Medicaid) coverage is provided to you and/or members of your household will change beginning Spring 2017



Why is this change happening?

Your MO HealthNet coverage will be provided by a MO HealthNet Managed Care health plan beginning Spring 2017 due to a change in law.



What do I need to do?

You will choose a Managed Care health plan and Primary Care Provider (PCP). A PCP is your doctor, nurse practitioner, or clinic. If you don't choose a health plan and a PCP (doctor), one will be chosen for you.



When will I need to choose a MO HealthNet Managed Care health plan and PCP (doctor)?

The enrollment period is January - April 2017. You will soon receive your enrollment packet in the mail. Your Packet will have information about your Managed Care health plan choices, how to choose a health plan and PCP (doctor) and how to enroll.



Can I keep my current doctor?

You may be able to keep your doctor if they are a Managed Care provider with one of the MO HealthNet Managed Care health plans. You can ask your doctor if they are a MO HealthNet Managed Care provider or you call our Enrollment Helpline at 1-800-348-6627 and they can check for you.



Will my benefits change?

Your health care benefits will stay the same.



Important Dates

January 2017
Enrollment begins

April 2017
Enrollment ends

Spring 2017
New MO HealthNet Managed Care coverage begins

Questions?

Enrollment Helpline
1-800-348-6627
Open 7 a.m. to 6 p.m.
Monday-Friday

¿Necesita información en Español?
Lláme al 1-800-348-6627

Hearing or Speech Impaired
Relay Missouri
1-800-735-2466 Voice, or
1-800-735-2966 Text Phone

Translator Services
1-800-348-6627

Member Options

- Potential Enrollees will be provided the three health plan options available to them.
- Members in expansion counties received letter in mid-November explaining the change from FFS.
- Members currently enrolled with Aetna Better Health of Missouri will receive a notice from MHD regarding the expiration of Aetna Better Health of Missouri's health plan with MO HealthNet Managed Care and the three health plan options available to them.

Network Adequacy & COA

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- The three awarded health plans have been approved or have applied for a certificate of authority from the Department of Insurance, Financial Institutions & Professional Registration to establish and operate a health maintenance organization (HMO) in all counties.

Readiness Reviews

- Transition of Care (September 2016)
 - Preliminary findings demonstrate the health plans are not doing or not consistently doing transition of care
 - MHD will continue to focus on this issue and work with the health plans to mitigate the risks to participants

- Enrollment Broker (November 2016)
 - Reviewing call center & printing capacity
 - MHD will permit vendor to use an over-flow call center during open enrollment period

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Managed Care Rule

Planned Readiness Reviews

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- ❑ Ownership and Disclosure, and Business Transactions
- ❑ Credentialing & Provider Contracting
- ❑ Provider Network
- ❑ Prior Authorization Transitions
- ❑ Provider Reimbursement & Financial Reporting
- ❑ Non-Emergency Medical Transportation (NEMT)
- ❑ Participant Call Center/ Authorized Representatives
- ❑ Certified Community Behavioral Health Clinic (CCHBC)
- ❑ Case Management & Disease Management
- ❑ Grievance & Appeals
- ❑ Third Party Liability
- ❑ Local Community Care Coordination Program (LCCCP)

Managed Care Final Rule Overview

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- Published in the Federal Register on May 6, 2016
- Rule Effective Date - July 5, 2016
- This final rule advances the CMS's mission of better care, smarter spending, and healthier people
- Key Goals
 - To support State efforts to advance delivery system reform and improve the quality of care
 - To strengthen the beneficiary experience of care and key beneficiary protections
 - To strengthen program integrity by improving accountability and transparency
 - To align key Medicaid and CHIP managed care requirements with other health coverage programs

Managed Care Final Rule Key Dates

Effective Dates						
Federal Register	Effective Date of Rule	Phased Implementation of New Provisions				
May 6, 2016	July 5, 2016	July 5, 2016	July 1, 2017	July 1, 2018	July 1, 2019	TBD Additional Guidance

In some instances the implementation date is dependent upon release of additional CMS guidance or protocols that could further delay implementation of the provision. We are aware that CMS will be issuing a Frequently Asked Questions document and additional guidance on, among other things, IMD services, the quality rating system, and the annual report on the managed care program.

Managed Care Final Rule IMD

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- Permits state to make a monthly capitation payment to the managed care plan for an enrollee, aged 21-64, that has a short term stay in an Institution of Mental Disease (IMD)
 - ▣ Short term stay: no more than 15 days within the month
 - ▣ Establishes rate setting requirements for utilization and price of covered services rendered in alternative setting of the IMD
- “In lieu of services” (ILOS) are medically appropriate and cost effective alternatives to state plan services or settings
 - ▣ Establishes contractual requirements for ILOS
 - ▣ Establishes rate setting requirements for ILOS
- Effective July 5, 2016
- Additional CMS Guidance Expected

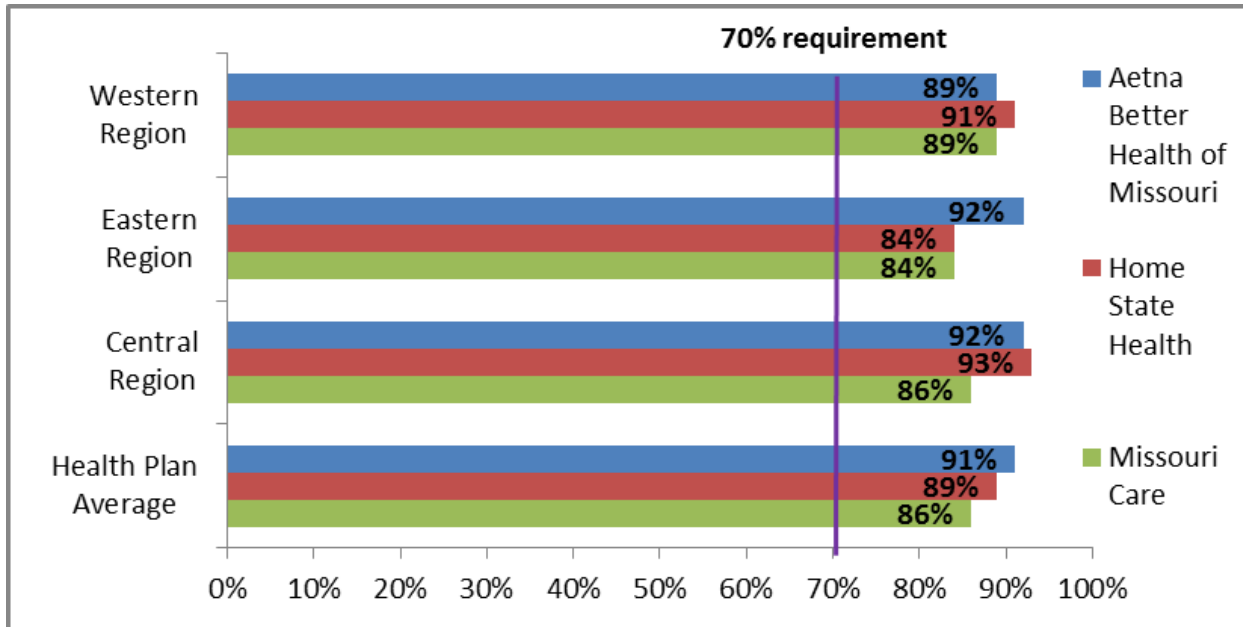
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Withhold Program & Other Issues

Performance Withhold Program

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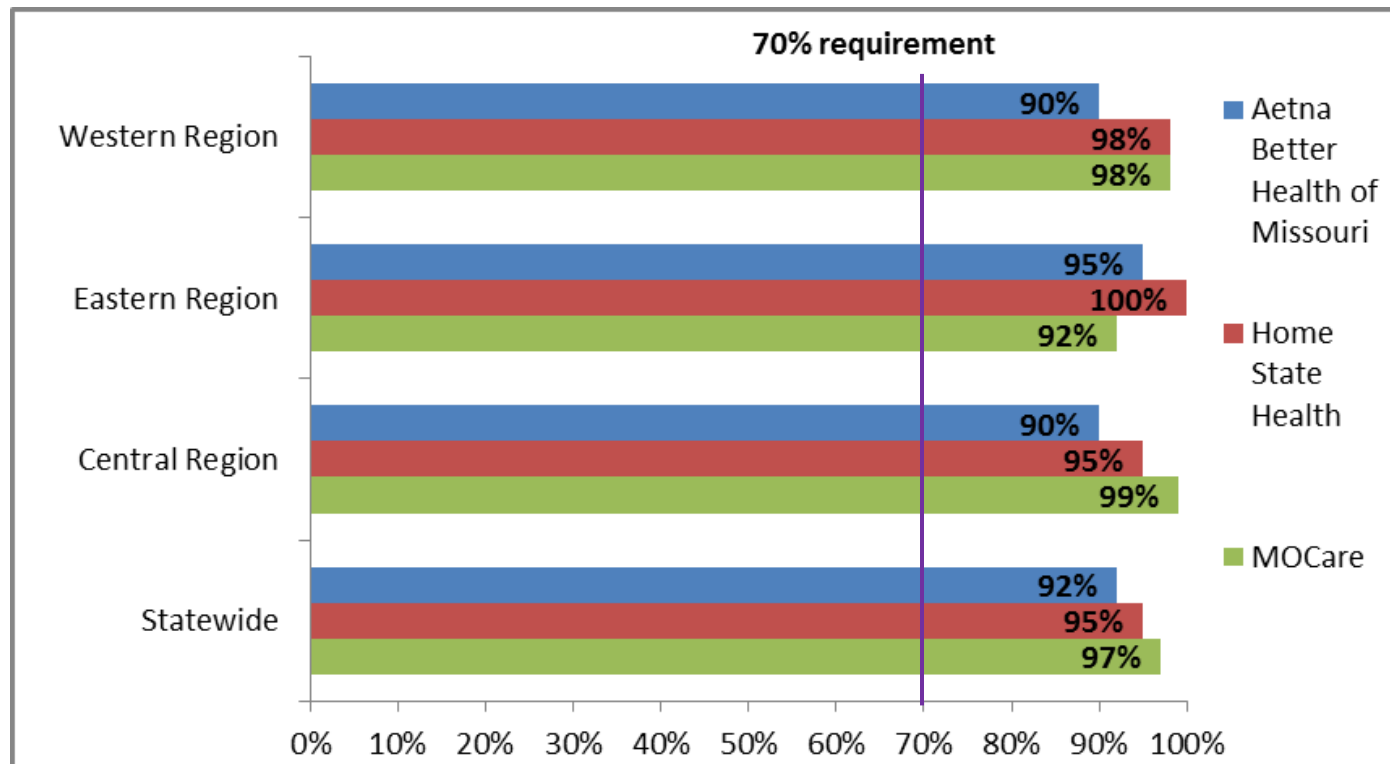
- 2016 Appointment Standards Performance “Secret Shopper” Survey
 - ▣ Percentage of PCP Offices Offering Available Appointments for Routine Care (30 days)



Performance Withhold Program (Continued)

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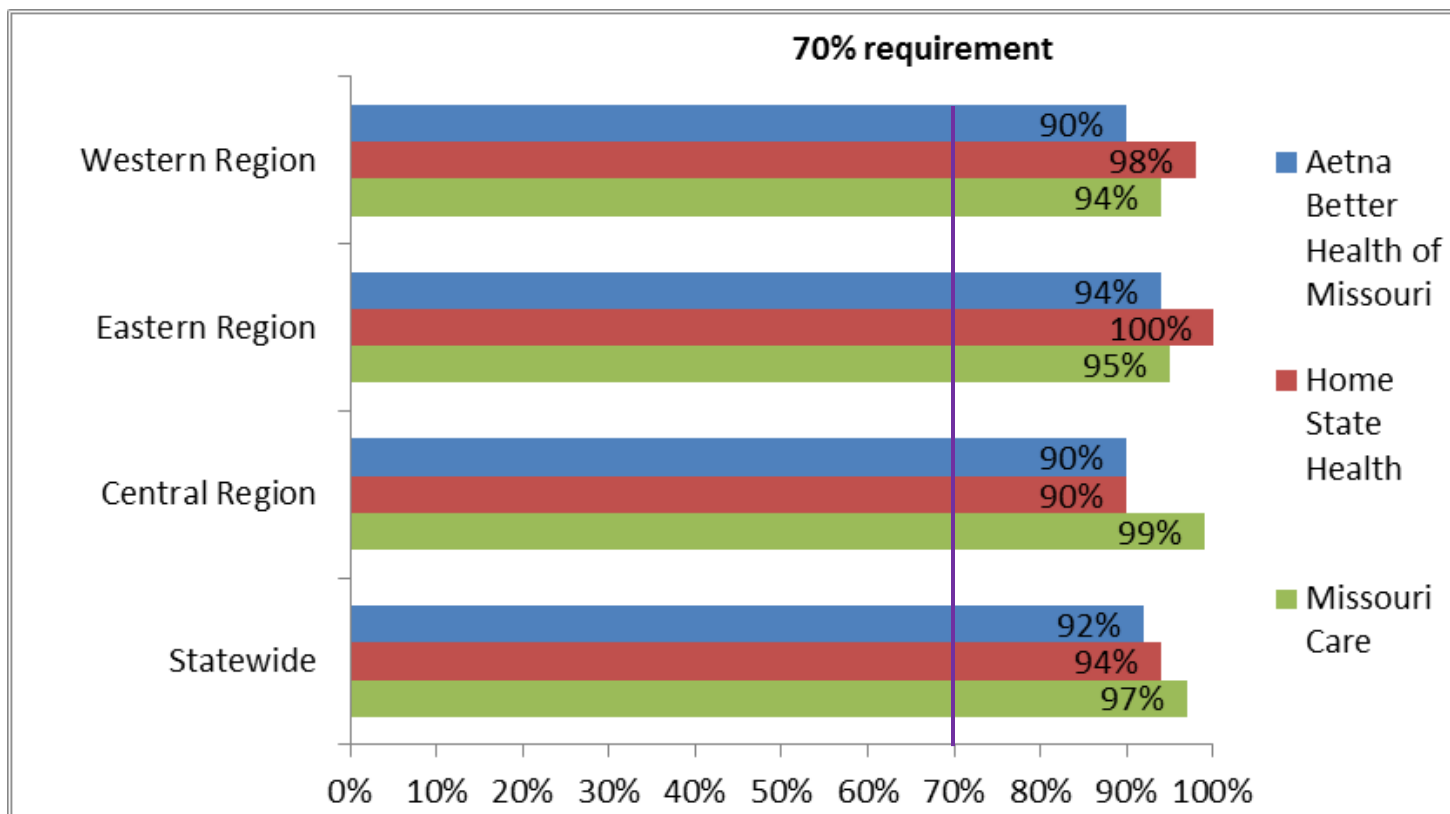
- Percentage of PCP Offices Offering Available Appointments for Sick Care (1 week or 5 business days)



Performance Withhold Program (Continued)

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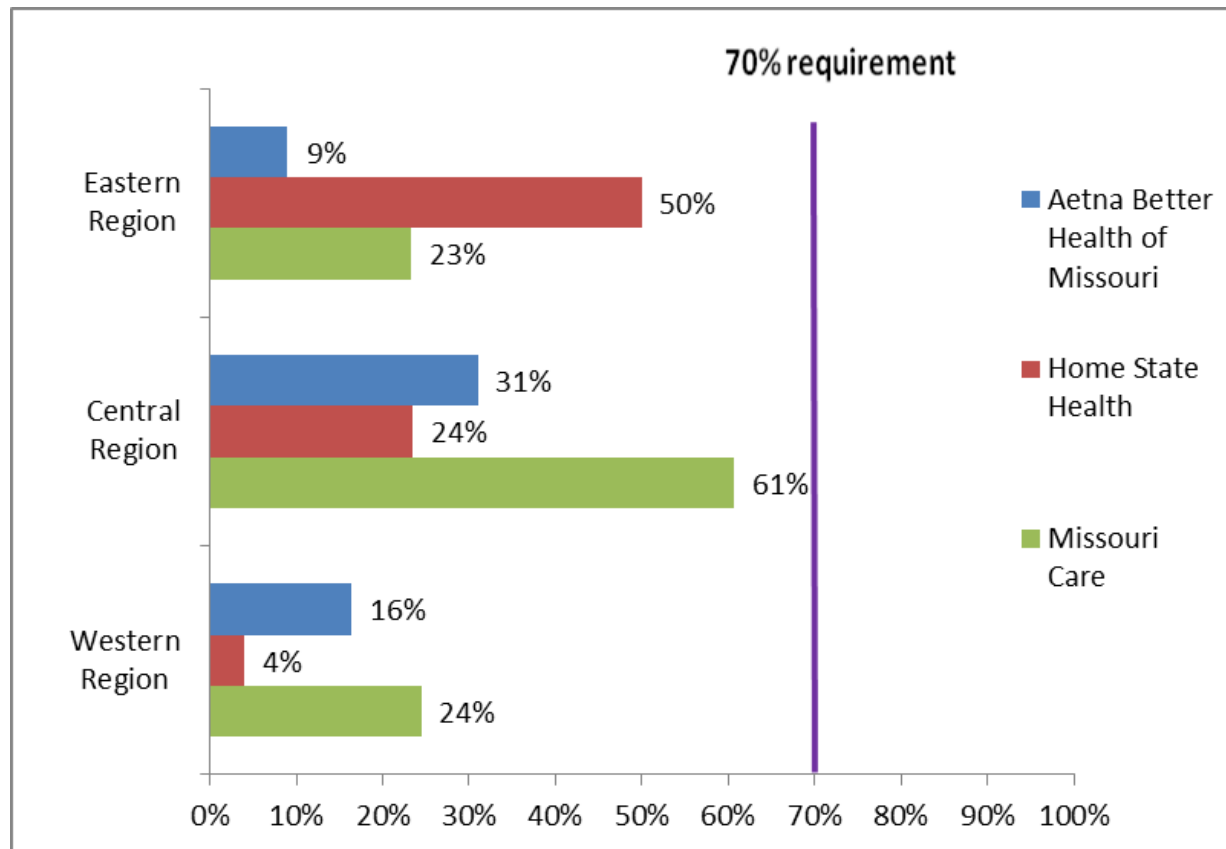
- Percentage of PCP Offices Offering Available Appointments for Urgent Care (24 hours)



Performance Withhold Program (Continued)

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- Percentage of Psychiatrists that offered an appointment within two weeks



Performance Withhold Program (Continued)

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- The average wait time for an appointment with a psychiatrist by health plan was well above the two (2) week standard. In fact, the average wait time between a call to a psychiatrist's office and their next available appointment was more than double the standard for each health plan:
 - Aetna Better Health of Missouri: 46 days
 - Home State Health: 36 days
 - Missouri Care: 39 days

Sanctions Issued In CY 2016

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- March 2016 – The MC contract requires health plans to obtain approval from the State prior to establishing any new subcontracting arrangements and before changing any subcontractors.
 - Aetna Better Health of Missouri

- November 2016 – The MC contract includes provisions regarding the credentialing of providers, specifically “ the credentialing and re-credentialing process shall not take longer than sixty (60) business days pursuant to RSMo 376.158. The health plan shall ensure providers are included in the network and eligible to receive payment immediately upon completion of the credentialing and re-credentialing process.”
 - Aetna Better Health of Missouri

Certified Community Behavioral Health Center (CCBHC)

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- The State of Missouri applied for a CMS demonstration grant to pilot a Medicaid Prospective Payment System (PPS) for community behavioral health services provided by organizations that meet new federal Certified Community Behavioral Health Center (CCBHC) standards.
- Missouri is applying to be one of eight states selected to participate in the two year demonstration, beginning July 1, 2017.
- CCBHCs are required to provide a comprehensive array of community behavioral health services including 24-hour-a-day behavioral health mobile crisis response teams; screening, assessment and diagnosis; person-centered and family-centered treatment planning; outpatient substance use disorder and mental health treatment services; primary care screening and monitoring; targeted case management; psychiatric rehabilitation; and peer and family support services for children, adolescents, and adults, including members of the armed forces and veterans.
- The goal of the demonstration project is to expand the availability, accessibility and quality of a comprehensive array of community based behavioral health services, while testing a cost-based approach to reimbursement for community behavioral health services.