HEALTH CARE AND HUMAN SERVICES POLICY, RESEARCH, AND CONSULTING - **WITH REAL-WORLD PERSPECTIVE**.

MO HealthNet Comprehensive Review Final Report

February 28, 2010

Final Version - 4/30/2010

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Project Overview

- MO HealthNet retained The Lewin Group to conduct a comprehensive review of Missouri's Medicaid program
- This review included numerous interviews with Missouri officials, documentation review, and intensive data analysis
- Specific areas of analysis included the pharmacy program, clinical services, long-term care, high volume providers, high cost participants, and non-emergency medical transport
- Lewin also provided a prioritized list of short-term cost containment opportunities that are being used as part of the SFY11 budget development process
- This report includes our "big-picture" assessment of the Missouri Medicaid program and potential opportunities for organizational improvement

Program Organization & Management

MO HealthNet Operations: Current State Observations

- Siloed structure and divided accountability
  - Administration is organized by type of service divided across agencies
- Low staffing levels in some areas limit effectiveness
  - Lack of sufficient staff dedicated to providing needed program-wide policy perspectives
  - Numerous vacancies, including several key management positions
- Contractor reliance can lead to redundancy across contractors and limited (or highly concentrated) institutional knowledge
  - Repeated learning curve for new contractors
  - Sharing of information among contractors difficult
- Limited current use of performance measurement and reporting capabilities
  - Many lengthy reports are generated routinely, but their use appears to be limited

Finding #1: Siloed structure inhibits coordination

- MO HealthNet's senior leadership works collaboratively on Medicaid policy development; however, with multiple cabinet-level agencies and divisions involved in administration, silos persist
  - Agencies with Medicaid administration responsibilities include the Departments of Social Services (DSS), Health and Senior Services (DHSS), Mental Health (DMH), and Education
- DSS has ultimate responsibility for Medicaid, but lacks authority over several components of the program including long-term care services administered by DHSS and mental health services administered by DMH
- Further, while the MO HealthNet Division of DSS is responsible for Medicaid operations, eligibility services are administered by the Family Support Division
- Division of authority can lead to knowledge gaps, accountability gaps, and low levels of coordination

A Coordinating Authority Could Improve Operational Efficiency and Coordination

- Overview of revised structure:
  - Overall responsibility for Medicaid oversight would ideally be a cabinet-level position with authority over all aspects of the program
  - A unified Medicaid department is an option, but most states have opted to coordinate Medicaid functions across different agencies
  - DSS may want to consider integrating eligibility policy and oversight functions with MO HealthNet
  - Ongoing systems integration efforts are critical to enhancing program coordination
  - Several examples of other states' efforts are included in Appendix A
- Rationale for change:
  - Currently, budget and policy decisions are coordinated by the State Budget Office, as that is the first place all Medicaid information comes together
  - Each agency with Medicaid oversight and operational responsibilities has its own circle of stakeholders
  - Effective management of the Medicaid program requires the balancing of program and financial priorities for a diverse and vulnerable set of populations
    - A coordinating authority would have the broader perspective and ability to balance interests necessary to achieve most efficacious use of limited State resources

A Coordinating Authority Must Be Given the Resources and Authority to Succeed

- Such an approach will require legislation, appropriations and a process by which the structure and specific authority designations are defined and implemented
  - Responsibility and authority of existing agencies will need to be realigned
  - This process will require a dedicated project team to work with State leaders to refine objectives, clarify mission, and establish work plan for accomplishing realignment
- Sufficient funding must be appropriated for staff levels that allow for work to be driven by the coordinating body, rather than relying on the individual departments
- If undertaken, must be willing to commit significant time and energy to communicating with staff and resolving countless (often minor) operational challenges that will arise

Insufficient authority to compel coordination relegates these bodies to "facilitators" with little ability to effect real change

Regardless of Decision on Coordinating Authority, Responsibility for Institutional LTC and HCBS for the Aged Should be Realigned within the Same Agency

- Currently, MHN budgets for and oversees nursing facility services and DHSS budgets for and oversees HCBS for older adults and people with disabilities
- LTC and HCBS services for older adults are part of the same care continuum and should be planned for and budgeted in a unified manner
- Current arrangement fragments accountability and impedes planning and coordination
- If realignment is not done, the level of interagency collaboration and coordination needs to increase significantly beyond where it is today
  - At a minimum, there needs to be cross-agency budget planning/collaboration, policy development, and spending authority
- Development of a Medicaid coordinating authority would also have to consider alignment of Medicaid-funded services currently administered by DMH

Finding #2: Low Staffing Levels in Some Areas Limit Effectiveness

- Two senior management positions under MO HealthNet Operations are vacant (Directors of Program Management/Quality and Information Services)
  - These vacancies result in senior leaders devoting significant time to day-to-day operations rather than policy development and other "big picture" goals
- There is a lack of sufficient staff dedicated to providing needed program-wide policy perspectives
- Staff responsible for project implementation do not have sufficient time to truly manage, measure results of, and refine project activities
- Limited number of Program Integrity staff constrains depth and breadth of activities; for example:
  - Staff struggle to keep up with potential cases and do not have time to take advantage of data-mining technology through Thomson Medstat
  - Several program "dashboards" have been created, but are not run repeatedly because staff do not have capacity to act on data
- Decline in staffing at DHSS to manage community-based LTC programs has contributed to insufficient oversight
  - The changes we have recommended to the intake and assessment system for LTC are designed to resolve problems that appear to be a result of reductions in DHSS staffing levels

Designate Policy and Project Management Personnel

- Consider adding Policy and Program Management Unit to the Medicaid Director's office to guide policy decisions, oversee project implementation, and evaluate program effectiveness
- Policy analysis and development efforts are currently spread over Operations, Clinical Services, and Finance
  - While each of these areas needs to retain these capabilities and involvement, MO HealthNet will benefit from an increase in Division-wide policy perspective
- With multiple program changes anticipated in a short time frame, a focus on project management is strongly recommended
- Staff would consist of a Director, 1-2 policy analysts and 1-2 project managers
  - High-level project management training is commercially available for existing staff
  - These functions could be outsourced during a transition period

Hire a Full-Time Medical Director for the MO HealthNet Program

- Federal regulations require each Medicaid program to have a Medical Director
  - In Missouri, the Medicaid Director is also a physician and also functions as the Medical Director
  - Full-time demands of Medicaid Director position limit ability to pursue full range of needed Medical Director responsibilities
- A Medical Director should have the ability to relate directly to the provider community, coupled with strong policy capability and vision
- Increasing national emphasis on quality of care, electronic health records, health information exchanges, and coordinated care strategies increases the need for a full-time Medical Director
  - A full-time Medical Director would be able to lead comprehensive quality initiatives as well as work with Clinical Services leadership to maximize effectiveness of tools such as CyberAccess and SmartPA
- Without ongoing clinical responsibilities, the Medicaid Director would be able to focus exclusively on strategic planning and day-to-day program administration

Finding #3: MO HealthNet's Reliance on Contractors Necessitates Stronger Coordination and Oversight

- MO HealthNet relies heavily on various contractors for such functions as IT development and operations, call-center operations, program evaluation, service delivery, and consulting services
  - Contractors lend a depth and breadth of specialized expertise
  - Contractors can also fill staffing gaps and address short-term needs without long-term budget commitment
- With such a range of vendors and contracted services, oversight, coordination, and performance evaluation are critical to maximizing ROI
  - MO HealthNet's current oversight of contracted activities appears limited and may be the result of staffing levels, skill sets or historical lack of institutional emphasis

Recommendations for Contractor Utilization & Oversight

- Each contractor should be overseen by a contract manager, responsible for ensuring adherence to the contract terms
- Contractor performance should be measured using performance metrics that are incorporated into each contract
  - Consider opportunities to tie contractor profitability to MO HealthNet savings, where appropriate, and other performance metrics
- Develop work plans for implementation and monitoring purposes and to establish key performance dates and activities against which to measure performance
  - Require periodic reporting and performance reviews
- In the case of consultants, multiple points of view can be valuable, but care should be taken to avoid duplication of efforts
  - Areas of consensus should be emphasized for implementation
- Some contractors are direct competitors, enhancing the silo effect
  - Contractor coordination is significantly hindered by competitive relationships and must be facilitated by State staff

Finding #4: In-house Reporting Capacity is Limited

- User-defined reports can be produced using Medstat tools (Decision Analyst / Net Effect)
  - However, limited number of staff have ability to use these tools (estimate about a dozen users with varying levels of ability)
- MMIS staff are often relied upon to produce ad hoc reports
  - Requests to MMIS staff are prioritized along with other tasks
  - Time spent generating reports detracts from MMIS development and operations
- Ad hoc requests tend to be for specialized purposes rather than general distribution for ongoing program management
- Contractors produce performance reports, but these are very specific to certain program areas and not widely distributed

Focus on In-house Ability to Produce Ad Hoc Reports

- In 2002, Idaho Medicaid reported savings of nearly $200K, simply by developing the ability to access reports internally without relying on a contractor[1]
  - More than 500 reports are available through the Idaho Data Engine Acquisition, with 160 available instantly
- Medstat (now Thomson Reuters) products are designed to facilitate user-defined reporting and should be leveraged to increase staff ability to generate reports
  - Staff training is required to ensure that sufficient staff across the Division can generate reports
    - Training can be provided by Thomson Reuters, or by proficient staff
    - Regular user group meetings can help disseminate expertise
- If new policy analysts are added, skills and/or willingness to be trained in query development and data analysis should be a top priority

Sources:[1] http://www.legislature.idaho.gov/ope/publications/reports/r0405f.pdf

Finding #5: Limited Current Use of Performance Measures

- Various reports are produced, but few are routinely used by senior management, and those that are used focus on program expenditures
  - A DSS Monthly Management Report includes 20 separate tables for MO HealthNet spanning more than 100 pages
    - The most commonly used include Figure 5 (60-mo payment trend) and Table 23 (recipient and payment amounts by eligibility category)
    - Table 23, including monthly expenditures by provider type and eligibility category, is what "everyone is judged by"
  - Management Reports such as Table 23 have data issues that limit their usefulness
    - Spending totals only include amounts paid through claims and do not include supplemental payments such as those made to hospitals
    - Units of service are not reliably counted and, therefore, several columns of data are disregarded
  - Program areas produce various performance reports with varying levels of detail and regularity (e.g. pharmacy, program integrity, call center)
- A March 2009 memo from Health Management Associates (HMA) also indicated that "Individual staff and organizational unit performance standards appear to be nonexistent in the Division"

Implement Series of Metrics & Management Dashboards

- Ultimate goal should be instant electronic access to current metrics
  - Managers and staff at different levels would have specific access permissions
  - Automated electronic dashboards would allow users to “drill-down” to underlying data
  - Data would be compiled from a variety of sources including the data warehouse, eligibility system, and financial management system
- Interim goal is the establishment of a concise set of metrics for senior leaders
  - We recommend that key metrics be compiled monthly and displayed graphically in an executive dashboard
  - Initial set of recommended metrics (included in the following slides) should be reviewed by MO HealthNet leadership and refined as needed
  - Format and comprehensiveness of dashboard metrics should be reviewed annually
- Additional program-specific metrics should be used by program managers responsible for day-to-day operations
- There are a limited number of publically available Medicaid metrics
  - Several examples from other states are included in Appendix B

Implementing Metric Reporting

- The level of effort required to report metrics will depend on the frequency of reporting as well as the number of metrics; however, most of the data required in our examples already exists
  - We recommend that the executive dashboard report be produced monthly with the most current data available
- MO HealthNet should also work with Thomson Reuters and Infocrossing to automate production of charts based on claims and eligibility data contained in the data warehouse
  - Establish a metric development committee including program and MMIS staff to help identify appropriate data elements
  - This recommendation is consistent with the March 2009 HMA memo that suggested full utilization of the Thomson Reuters data warehouse and capabilities
- Identify metrics that apply to senior leaders such as the Secretary and Medicaid Director and those that apply to program managers

Metric Examples for MO HealthNet

- The following slides contain recommended metrics by program area
  - Generally, the data used to compile these charts already exists in program reports
  - Upon review, MO HealthNet and DSS may decide that some of these examples do not fit current priorities or that others are preferred
    - Metrics ultimately selected for dashboard inclusion should align with Agency and Division objectives which can change
- In some cases, suggested variables are not currently calculated (e.g. PMPM) and would require some additional in-house or contractor resources to implement
  - Potentially challenging is the inclusion of payments such as Direct Medicaid and GME add-ons that are not associated with claims; however, such payments represent a significant amount of hospital expenditures and should be accounted for in a true "dashboard" metric

Note: Dashboard mock-ups do not contain actual data and are intended as illustrative examples only

We Propose Performance Metrics in the Following Seven Categories

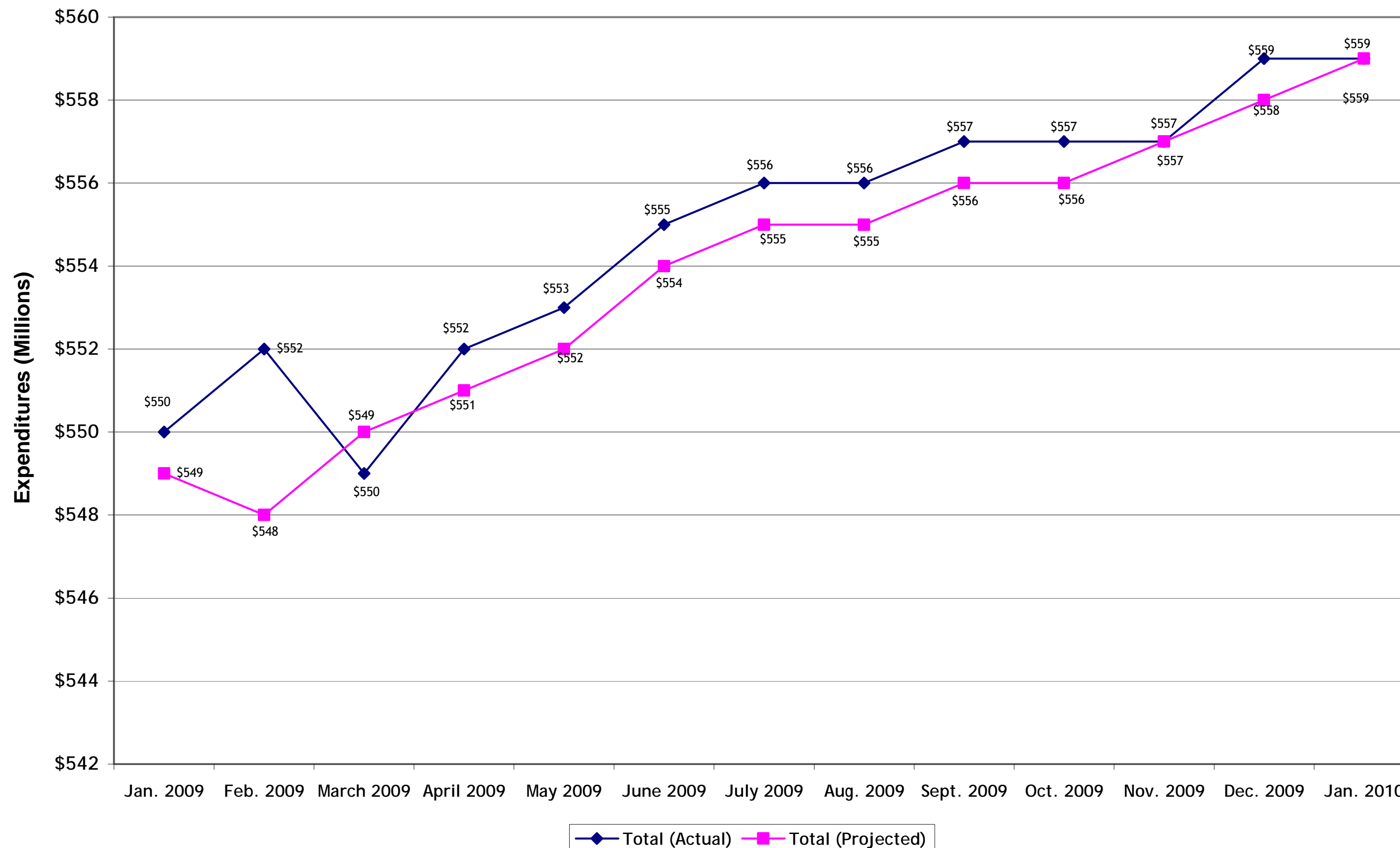
- Expenditures
- Enrollment
- Program Integrity
- Long-Term Care
- Care Management
- Contractor Performance
- Special Projects

Expenditure Metrics

- Expenditure dashboard charts are intended to provide a snapshot of expenditures versus projections
  - Expenditures are broken out by both eligibility category and type of service (note: we only present a couple of examples by service type, but at a minimum, the top five programs should be included)
  - Periodic supplemental payments should be included in expenditures and projections displayed (i.e. all payments to providers, regardless of whether they are paid via claims or through lump sums)
  - Rolling 12-month trend information is also included
  - Top service categories are included; however, budget staff should be monitoring smaller categories for fluctuations
  - Budget staff compile this data monthly in a series of spreadsheets
    - As we discuss further in the Finance and Budget section, we recommend that this manual process be automated

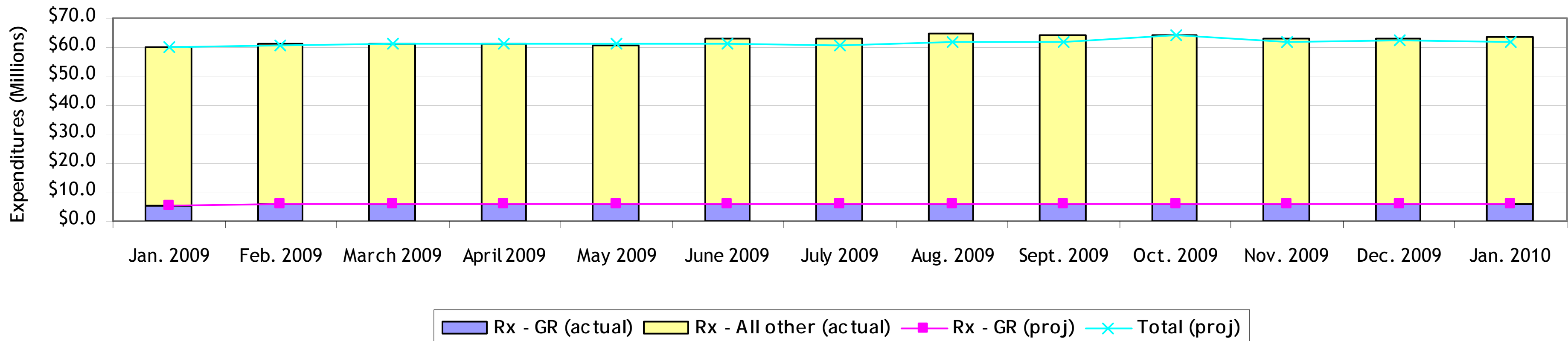
Expenditures – Total Program (excluding administrative costs)

Illustrative data only



Expenditures - Pharmacy Costs

Illustrative data only



Fiscal Year To Date (Millions)			
	Actual	Projected	% Difference
GR	$41.4	$40.4	2.5%
Total	$445.7	$434.9	2.5%

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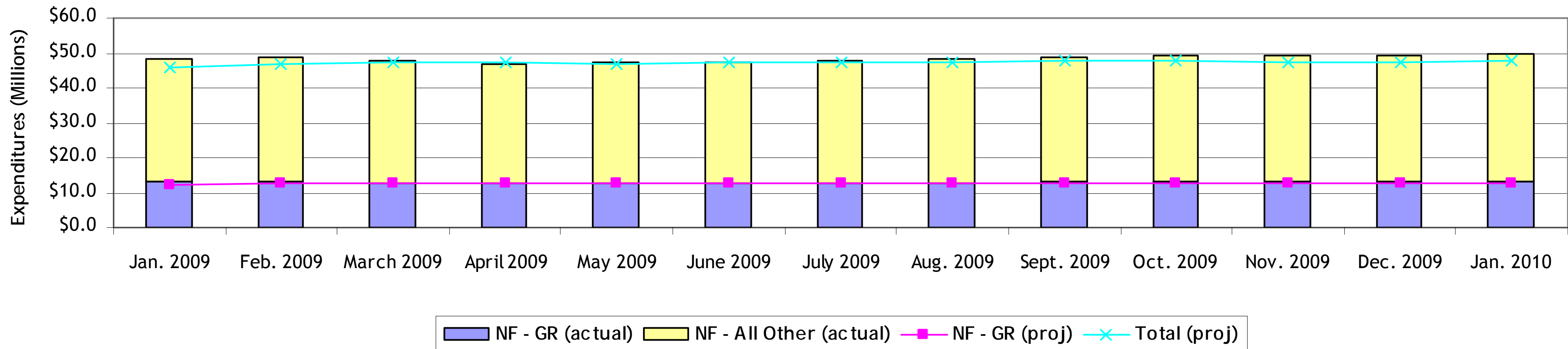
Expenditures - Nursing Facility Costs

Illustrative data only



Fiscal Year To Date (Millions)			
	Actual	Projected	% Difference
GR	$91.5	$88.9	3.0%
Total	$342.8	$332.9	3.0%

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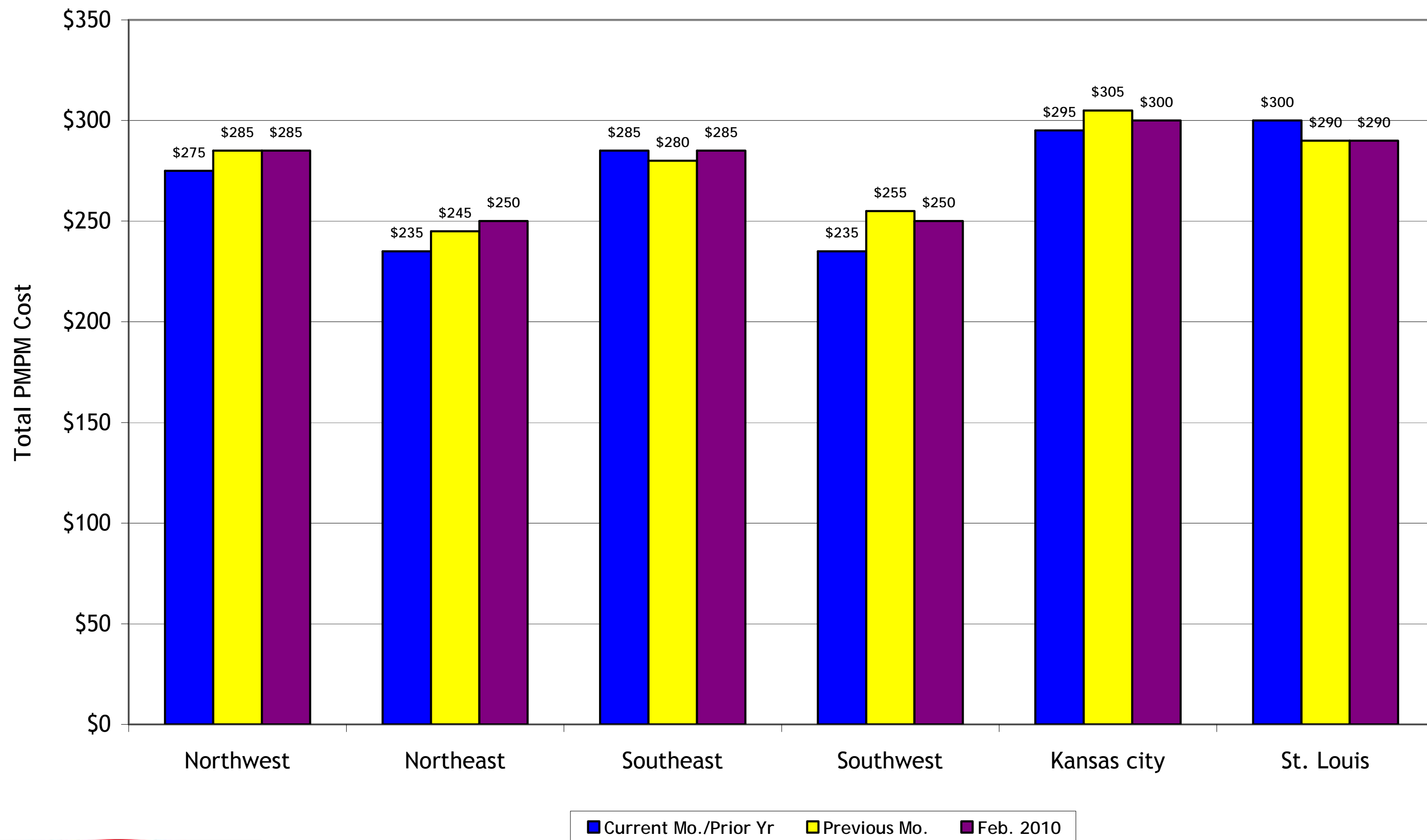
Expenditures – Per Member Per Month Spending

- Total spending per member per month (PMPM)
  - High level aggregate spending metric that allows senior leaders to monitor overall spending while accounting for caseload growth
  - PMPM view allows tracking by population so that shift in services can be reflected in one metric
  - Significant changes would require drill-down to program area to identify cause
  - Metric would divide total incurred costs by same month's membership
  - Due to claims lag, most current PMPM could be presented for fourth month prior and compared to fifth month prior and the same month from the previous year
    - Completion factors must be applied to account for claims lag

Expenditures – PMPM by Region

Illustrative data only



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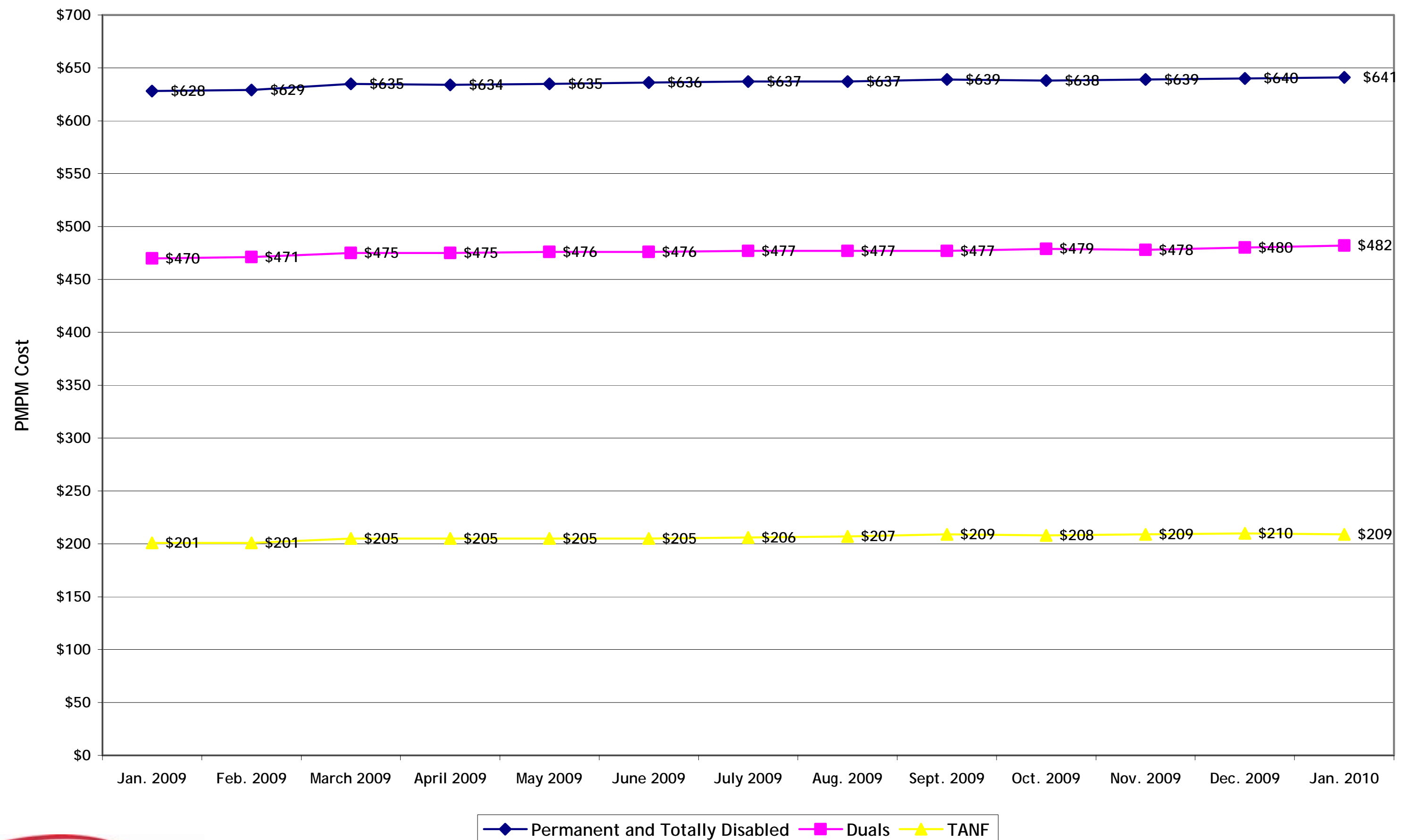
Expenditures - PMPM by Eligibility Category

Illustrative data only



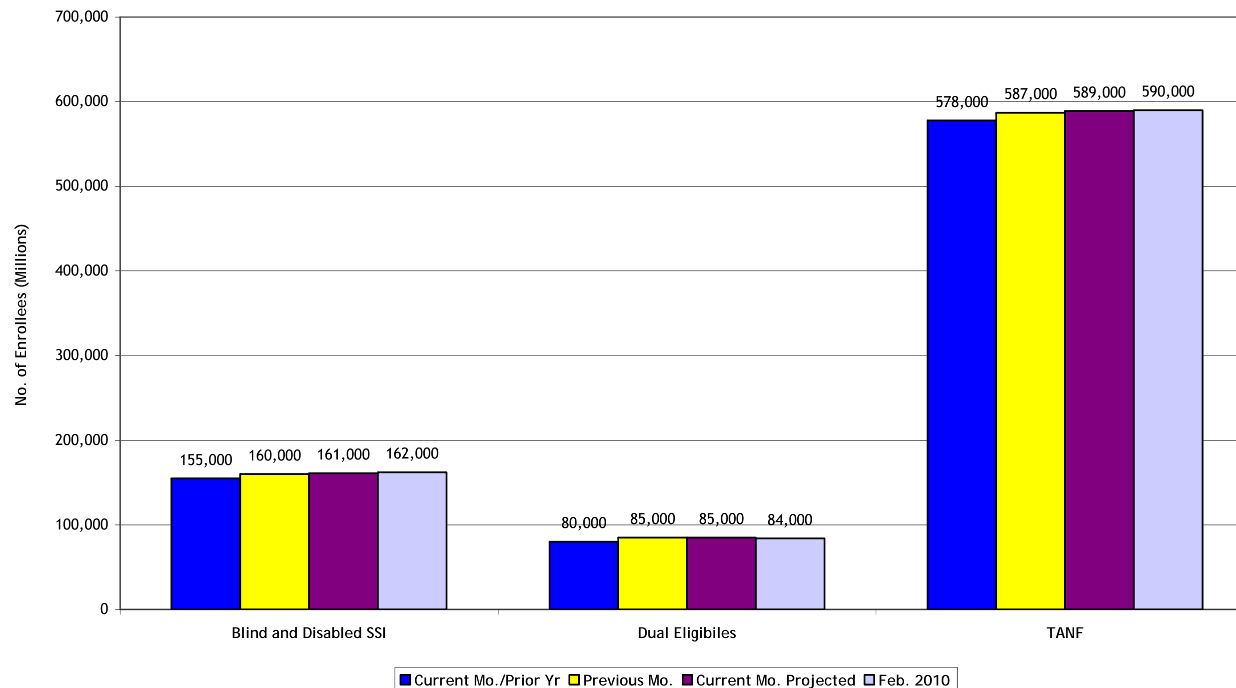
Enrollment Metrics

- A key driver of Medicaid program costs, enrollment, is presented by region for the current month, previous month, and same month from the previous year
- A separate chart is provided for eligibility categories
  - Existing eligibility reports include many more eligibility categories
  - These have been condensed into just three categories (TANF, Persons with Disabilities (non-dual), and Dual Eligible Participants)
- Data table shows percent change in enrollment
- All data are currently maintained by the Family Support Division and should be readily available for summarizing

Enrollment by Category

Illustrative data only

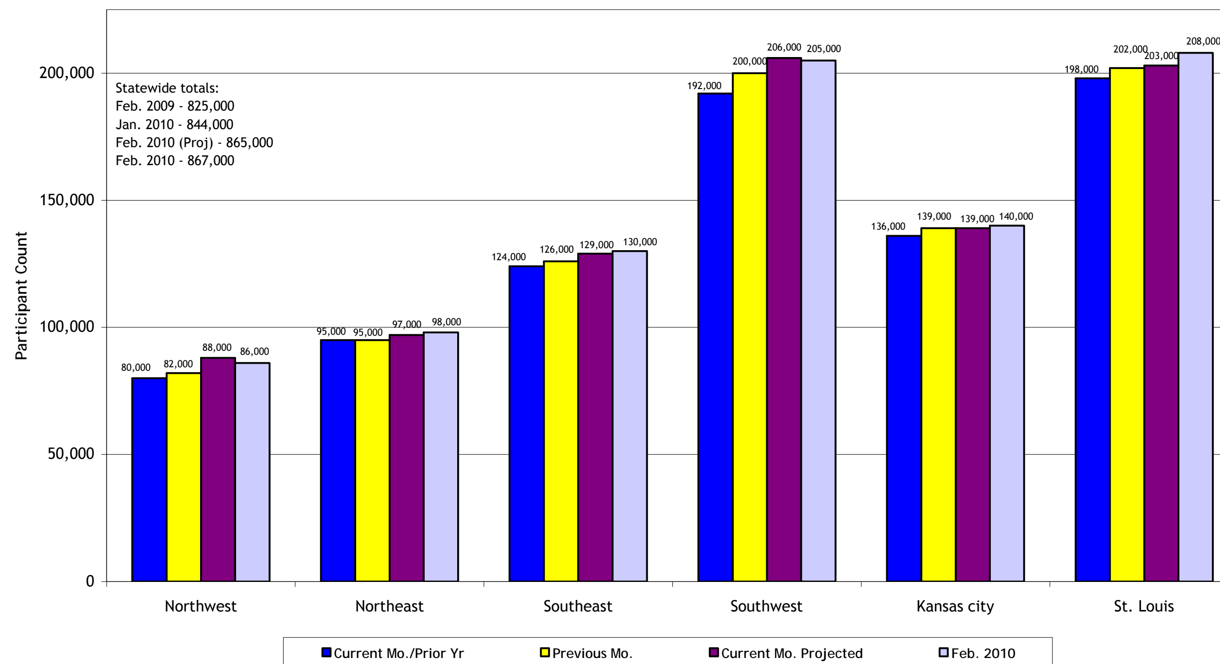
Enrollee Count by Eligibility Category
February 2010, Previous Month, Current Month/Prior Yr., and Current Month (Projected) Comparison



Percent Change in Enrollment			
Change from :	BD SSI	Duals	TANF
Projected	0.6%	-1.2%	0.2%
Prior Month	1.2%	-1.2%	0.5%
Same Month Prior Yr	4.3%	4.8%	2.0%

Enrollment by Region

Illustrative data only



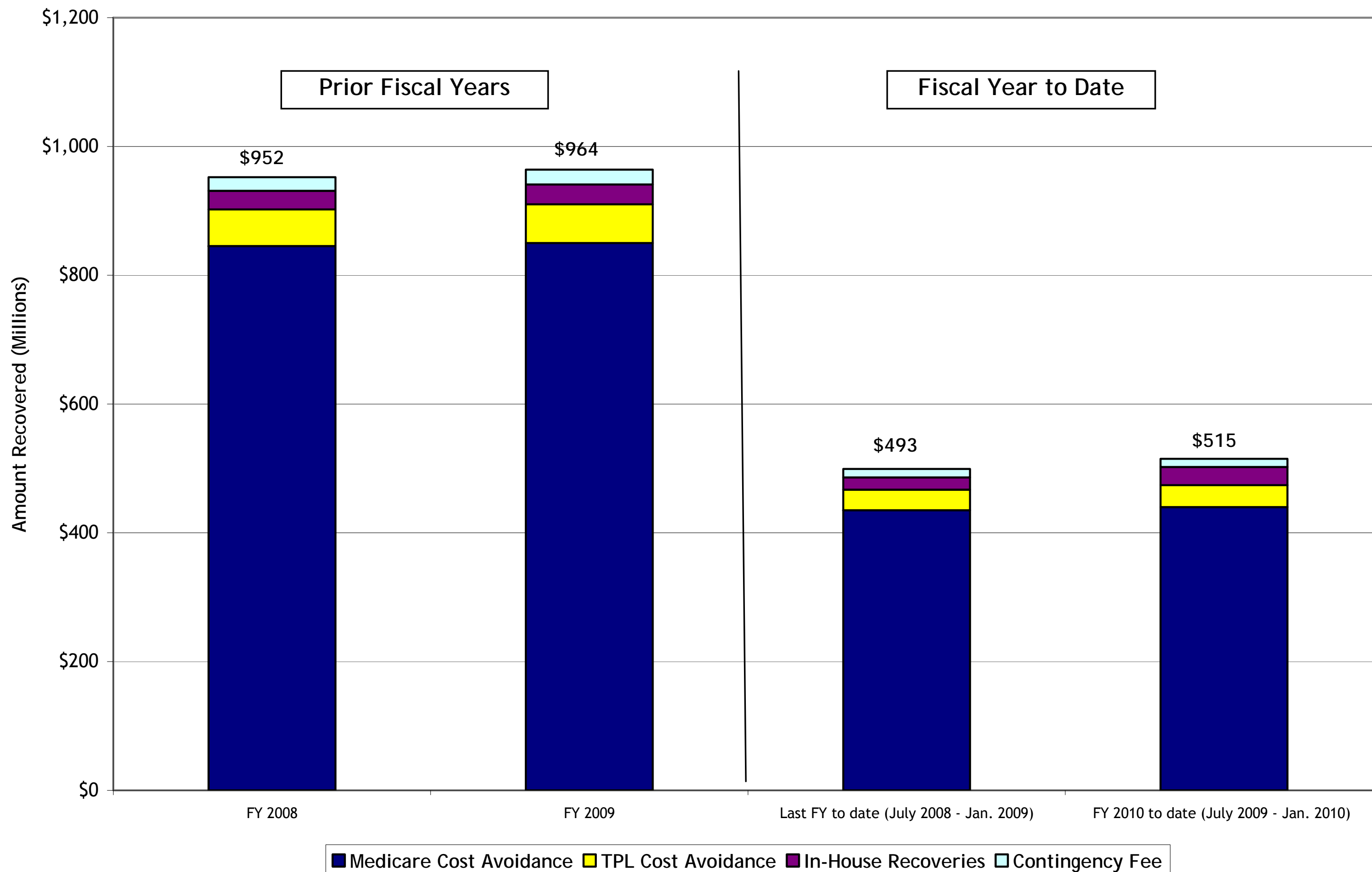
Change from :	Northwest	Northeast	Southeast	Southwest	Kansas City	St. Louis
Projected	-2.3%	1.0%	0.8%	-0.5%	0.7%	2.5%
Prior Month	4.7%	3.1%	3.1%	2.4%	0.7%	2.9%
Same Month Prior Yr:	7.0%	3.1%	4.6%	6.3%	2.9%	4.8%

Program Integrity Metrics

- The Program Integrity Unit tracks a variety of metrics in program-level reports
  - Some of the dashboard metric examples include an additional level of detail (e.g., MFCU cases are reported by status rather than as simple totals)
  - Metrics help demonstrate ROI for Program Integrity activities

Program Integrity - Dollars Recovered

Illustrative data only



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Program Integrity - Referrals to Medicaid Fraud Control Unit

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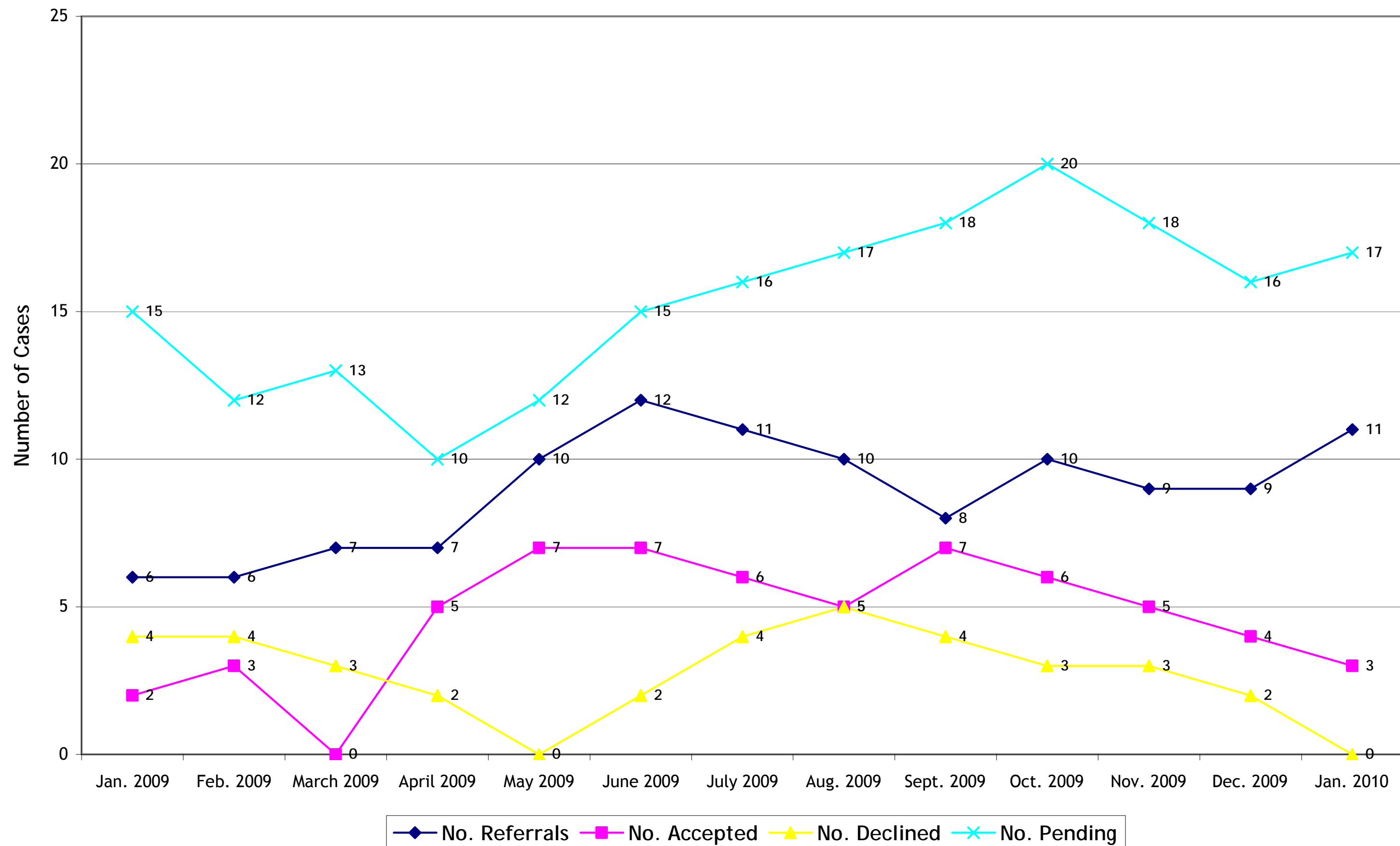

Program Integrity - Lock-In Participants

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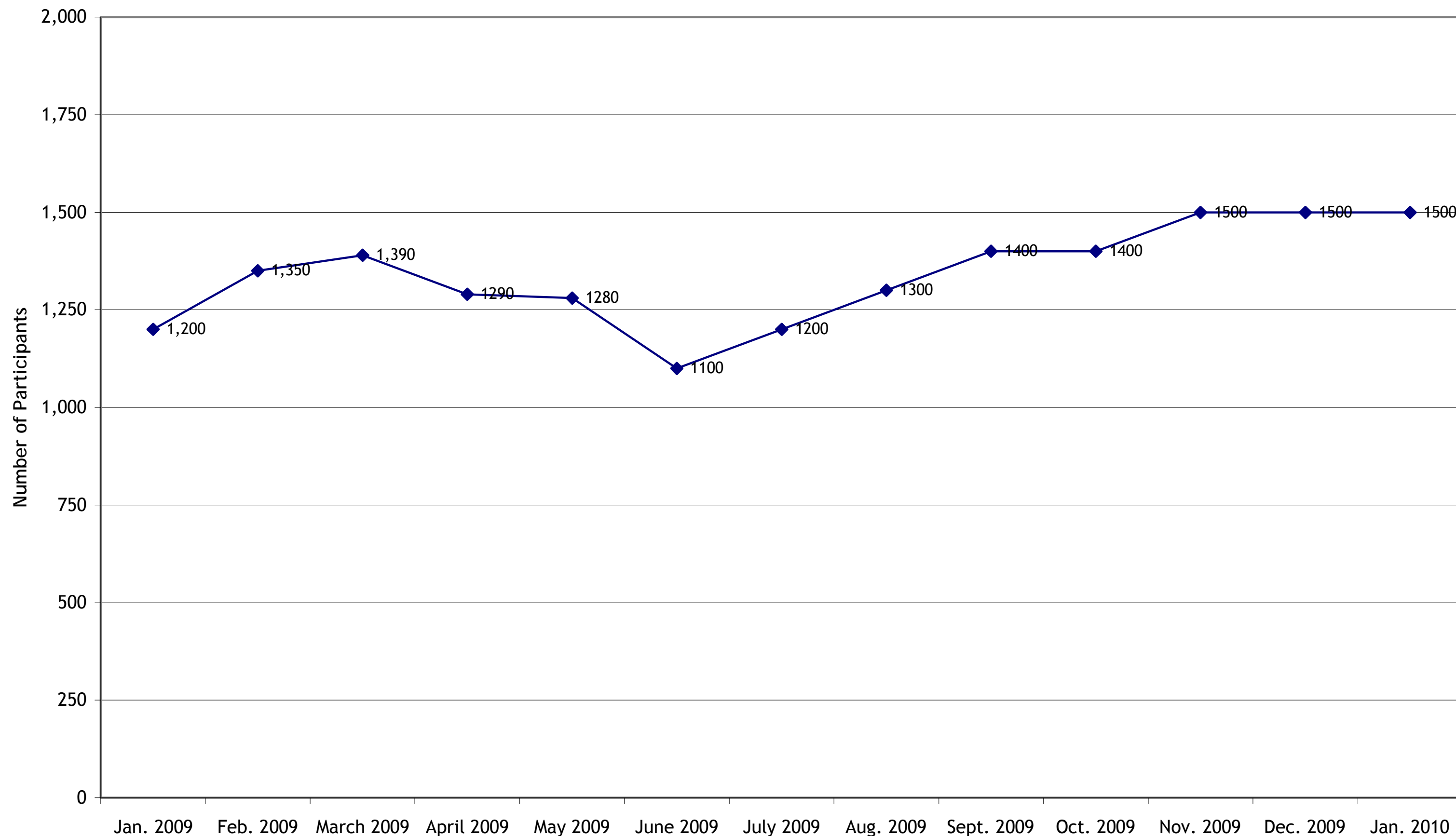
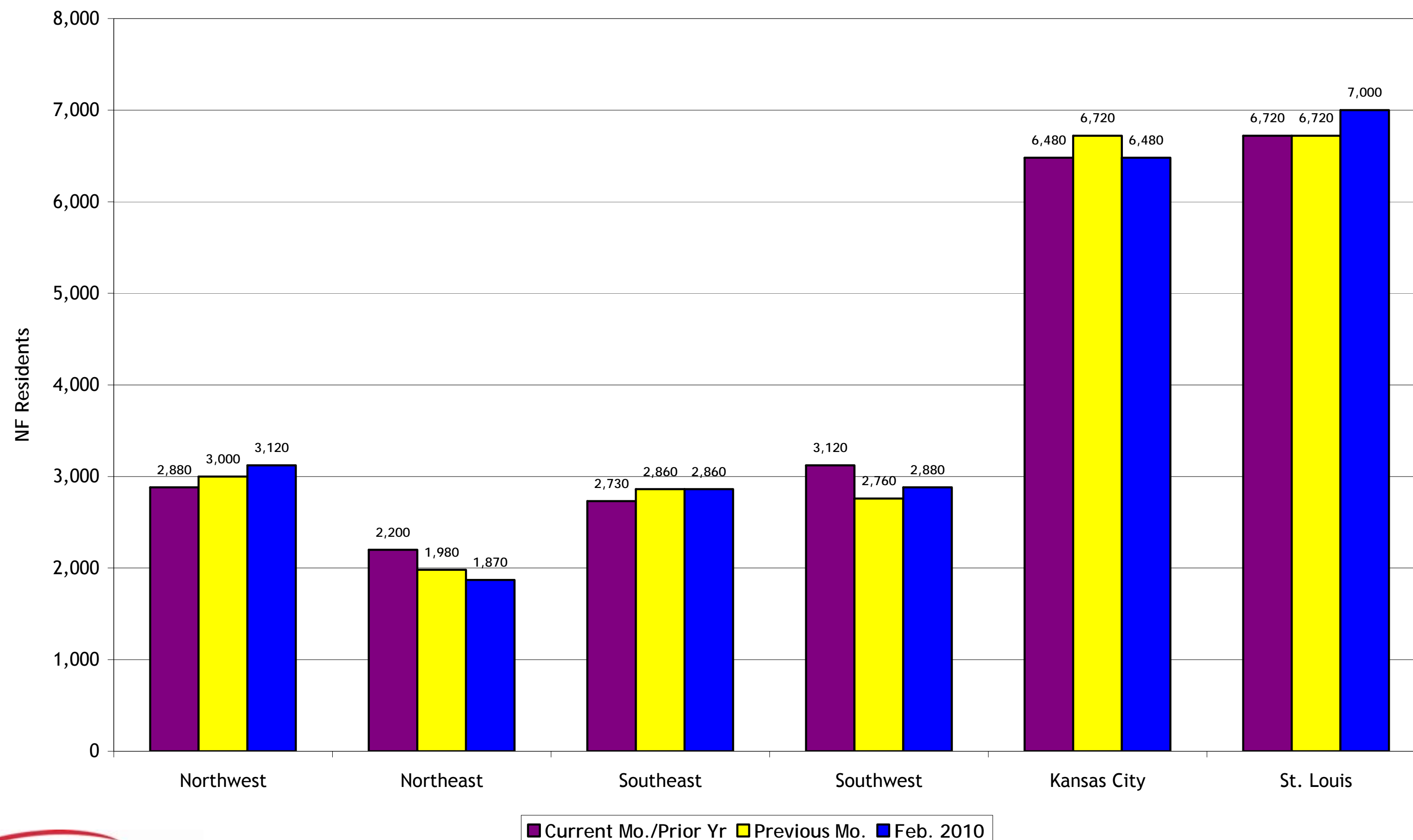


Long-Term Care Metrics

- LTC Medicaid Census
  - Primary LTC metric that is clear and unambiguous
    - -- For example, want NF census to go down every single month
  - Recommend a county-level report or an alignment to the four DHSS regional offices or the 10 AAAs to help identify trends that require intervention at the local level
  - There are several potential data sources including eligibility data, MDS data, or possibly claims
  - DHSS is accustomed to reporting the number of Medicaid clients
- Days to Complete LOC
  - LOC assessments are currently conducted by a mix of DHSS staff and "community partners"
  - Timeliness of LOC determinations is a critical part of the Medicaid agency's responsibilities for eligibility determinations
  - It is also a critical aspect of rapidly authorizing services for people who may be ready for discharge from a hospital or struggling to stay in the community instead of an institution
  - When MHD reforms the intake and assessment process for LTC, tracking turnaround times for LOC assessments will help monitor successes or failures during the transition
  - DHSS should have this data available currently, and should require this metric as part of any future contract

Long-Term Care – Nursing Facility Medicaid Census

Illustrative data only



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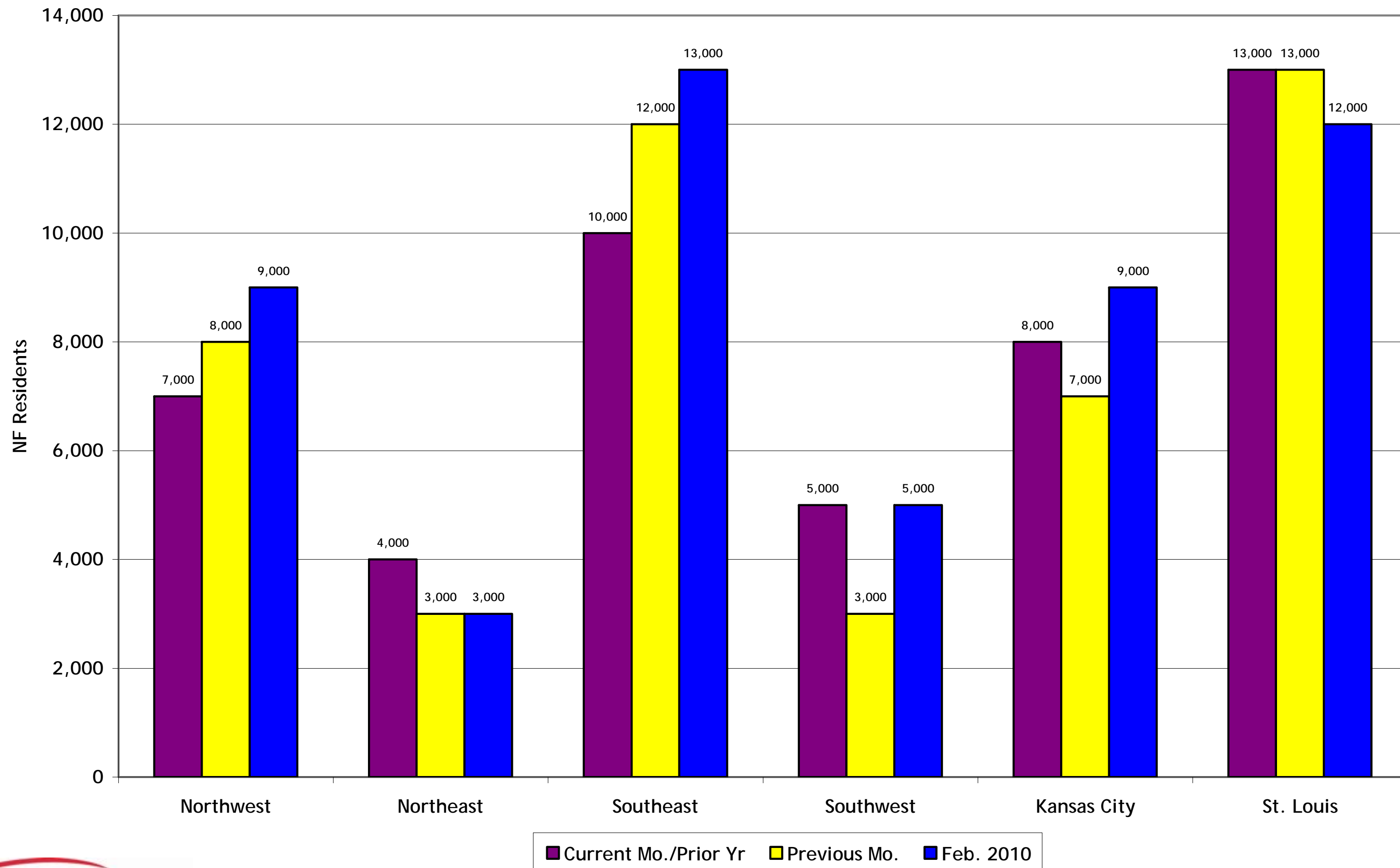
Long-Term Care - HCBS Census

Illustrative data only



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Long-Term Care - Level of Care Decision Time

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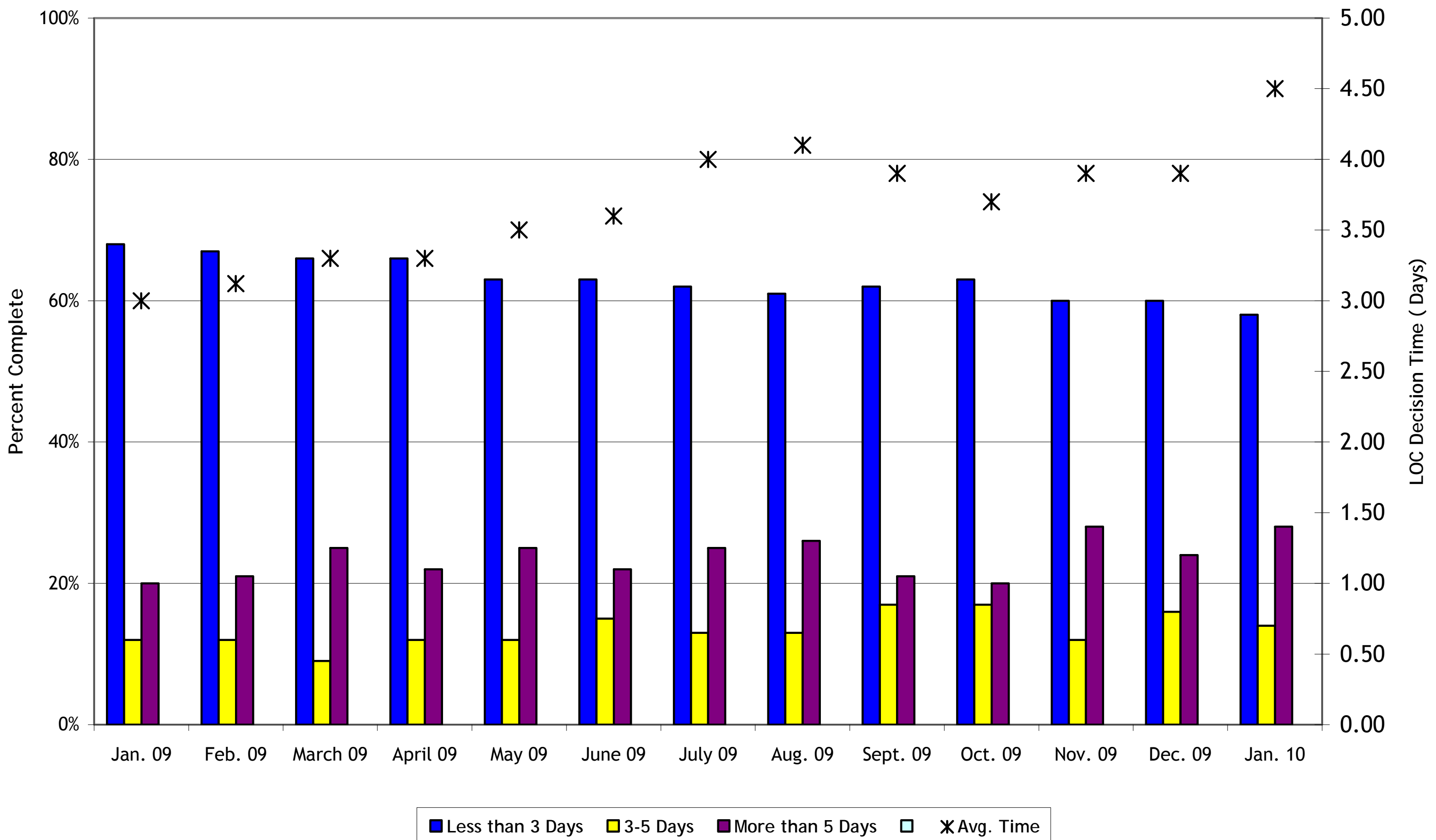
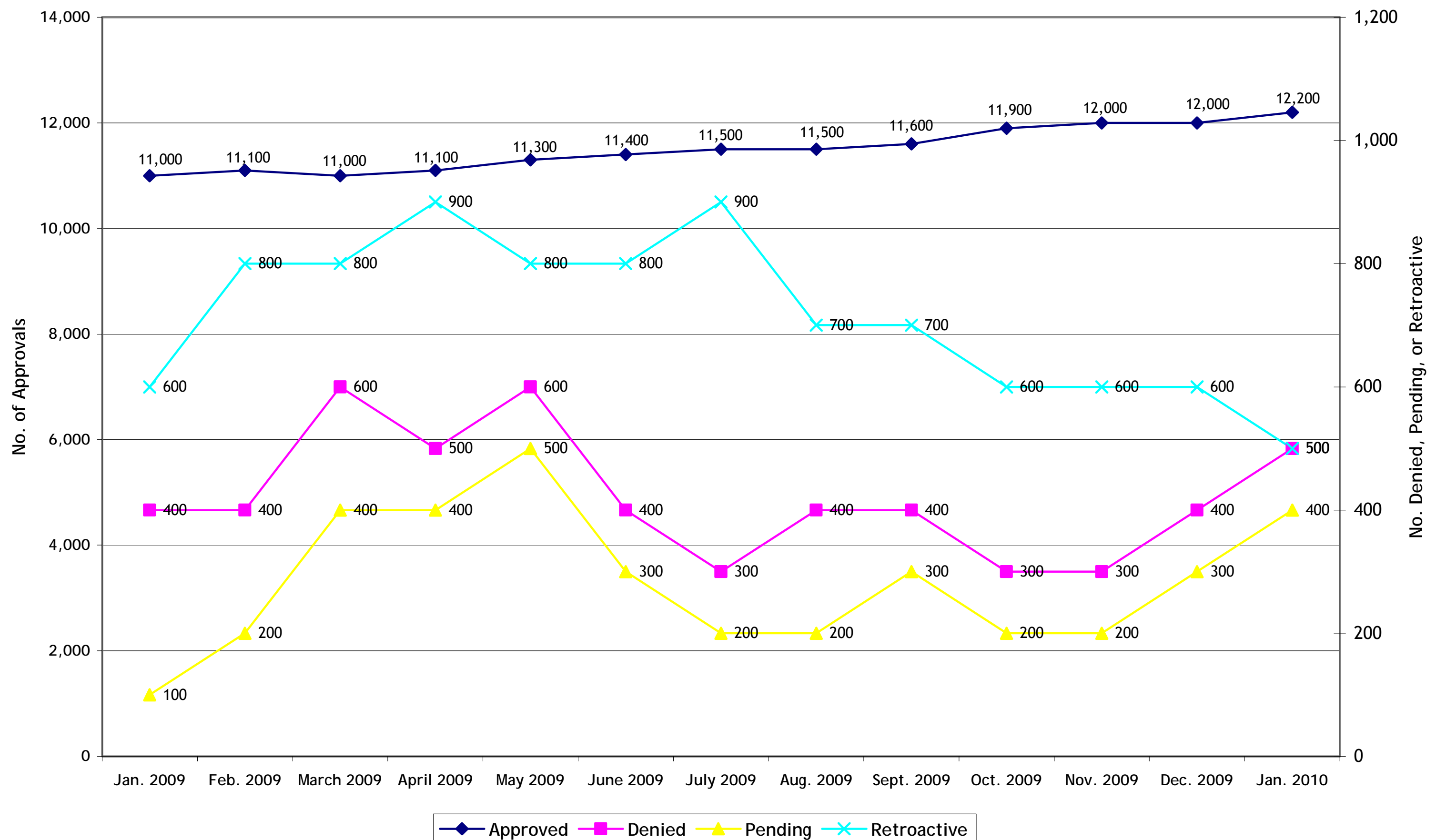


Care Management Metrics

- Care management metrics can include both enrollment in care management programs as well as operational metrics such as prior authorizations
  - Pharmacy prior authorizations are currently reported in ACS' monthly Drug Helpdesk Status Report
  - Inpatient prior authorization data should also be reported as part of the new ACS contract
  - Total transactions completed may also be included as one of the components of the contractor's monthly performance score
  - MHD emphasis on care management makes these metrics especially important to monitor

Care Management - Inpatient Prior Authorizations

Illustrative data only



Care Management - Pharmacy Prior Authorizations

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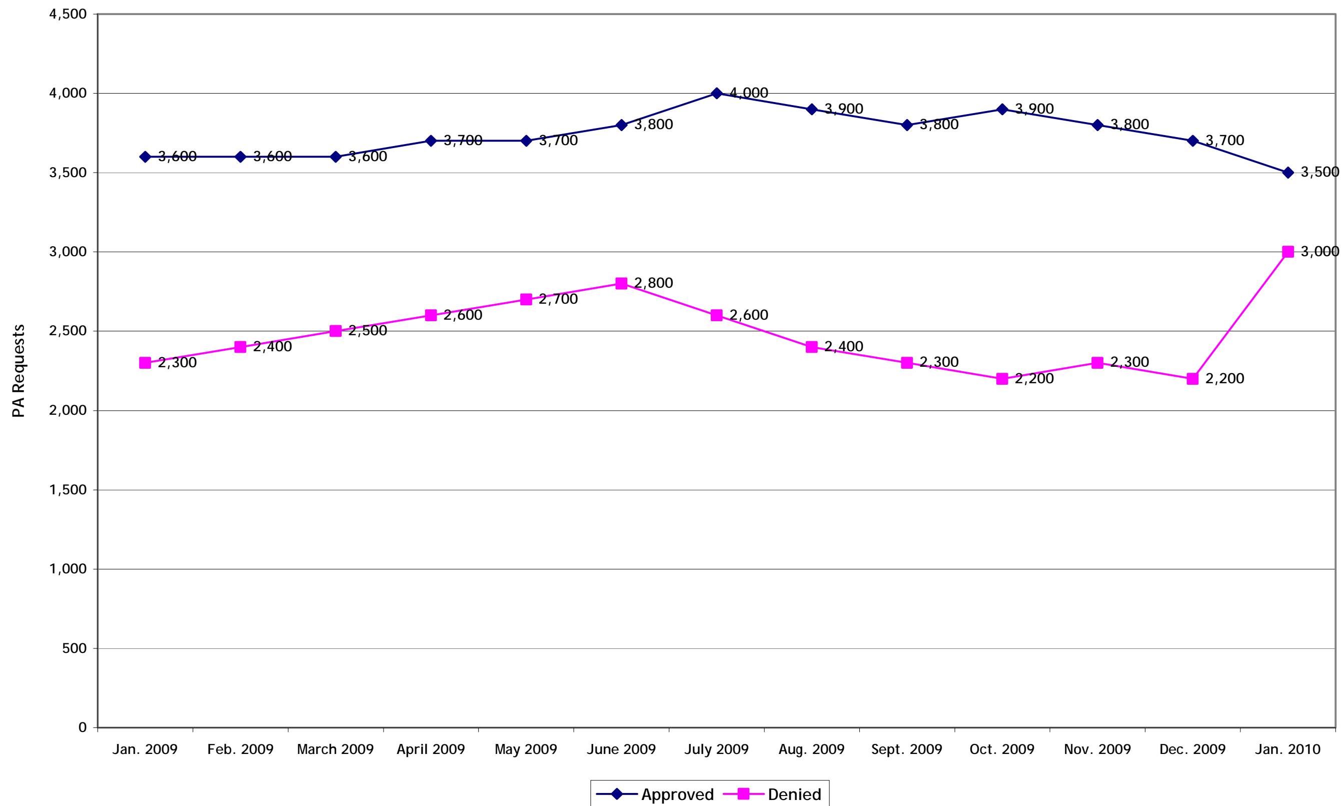


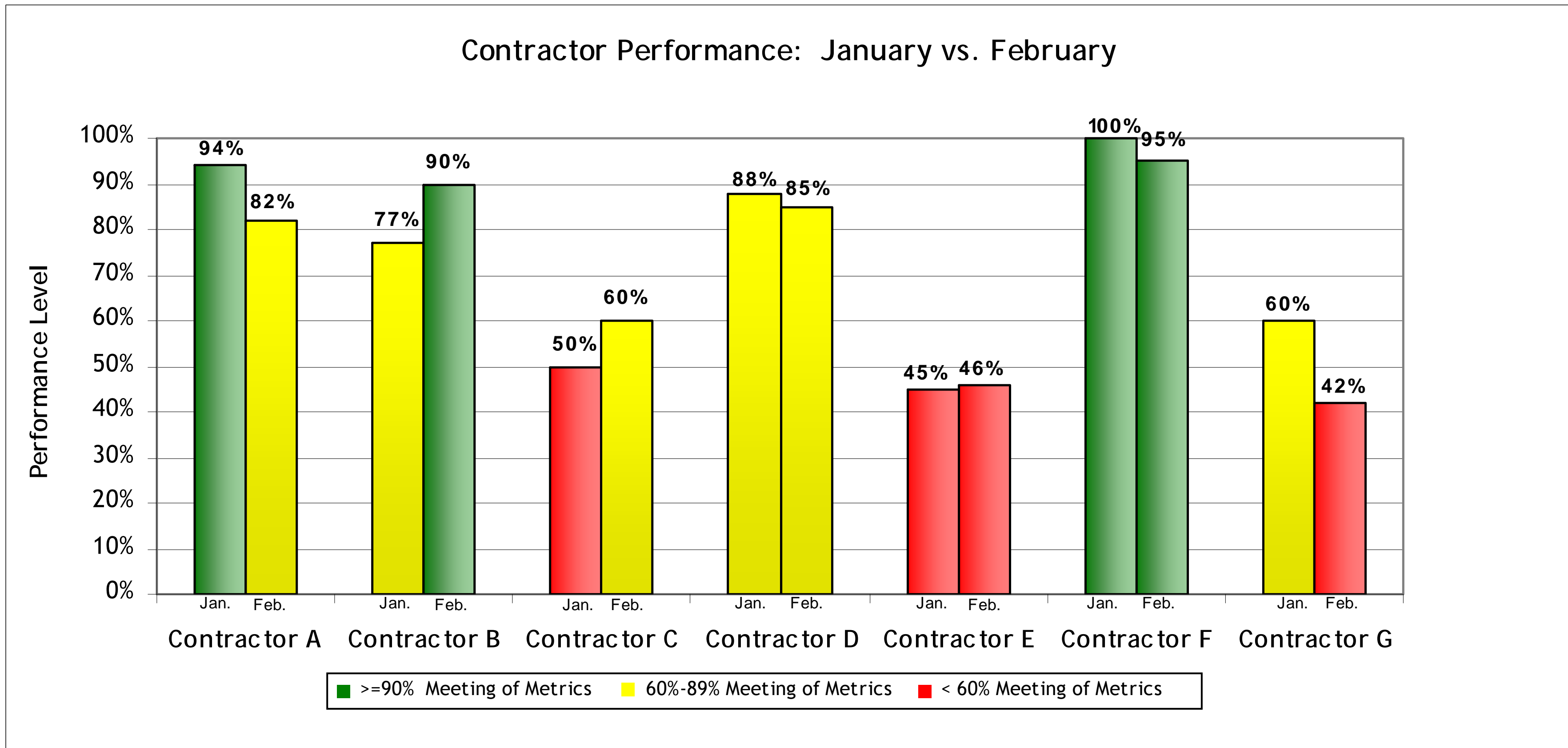
- Note: If psychotropics are added as a class, we recommend adding separate approval/denial lines

Contractor Performance Metrics

- Each contract should include several metrics that measure a contractor's performance
  - For example, the APS Status Report includes several metrics, though it is not clear how the results relate to expectations
  - HMA's March 2009 memo also indicated that "interventions such as CCIP and the ASO should be managed by the Division against clear contractual quality standards"
- Metrics should be weighted by importance to determine a monthly performance rating from 0-100
  - For example, the most critical measure of an MMIS vendor's performance might be timely claims processing, which would be weighted higher than other metrics
- Colors indicate performance relative to thresholds (e.g., green for ≥90 percent and red for ≤ 60 percent)
- Metric development and weighting will require significant effort, as they do not currently exist

Contractor Performance

Illustrative data only



- Upon gaining drill-down capability, user could view historical performance for each contractor

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Special Project Metrics

- In addition to routine operating metrics, we suggest including a section to report on the status of special projects
  - For example, if MO HealthNet is implementing a new program, a chart could be added to show progress relative to a project plan
    - If specific project management personnel can be designated, they would be responsible for collecting and reporting this information
    - Otherwise, program managers responsible for the project should be tracking progress against a project plan
- Different types of special projects could be included such as program development activities or projects to complete a certain number of activities (processing claims, eliminating backlogs, obtaining reimbursement)
- While all special projects should be monitored at the project manager/director level, we would recommend that no more than two-to-three high-profile projects be identified for the Director's Dashboard. For example:
  - MMIS redesign
  - Nursing Facility Part A Repricing
  - Health Reform Eligibility Expansions

Special Project - New Program Development

Illustrative data only

PROJECT STATUS	Planned Start Date	Actual Start Date	Planned Complete Date	Actual Complete Date	Percent complete	Status or Comments
Obtain SPA approval	12/1/09	12/1/09	4/1/10	4/15/10	100%	Approval granted retroactive to 1/1/10
Draft provider billing rules	1/15/10	1/20/10	3/15/10	4/1/10	100%	Complete
Establish new MMIS billing codes	1/15/10	1/15/10	3/31/10		75%	Programming delays have led to a delay in testing
Establish Rules	1/15/10	1/15/10	2/15/10	2/20/10	100%	Complete
Program Changes	2/15/10	3/1/10	3/15/10		90%	In progress - Delayed
Test Changes	3/15/10				0%	Delayed - Pending programming completion
Initiate Claims Payment	4/1/10				0%	Delayed

Note: In earlier stages of the project, project components that are now marked "complete" would have detailed rows on major aspects included in the dashboard. Once completed, the stages will be shown as above.

Over Time Create a Consistent Culture of Accountability for Senior and Mid-level Staff

- In addition to the executive dashboard metrics, program managers should develop program specific performance metrics
  - Several program areas including pharmacy, call center, program integrity, budget, and MMIS already collect a variety of metrics and produce reports
  - Metrics should be shared with program staff to develop an understanding of how performance is being measured
  - Managers should use metrics to monitor performance and intervene when necessary
- Significant shifts that merit executive involvement could be added to the monthly executive dashboard, or shared separately
- The following slide includes a number of sample metrics for managers
  - In addition to the examples here, a number of important metrics for monitoring enrollment activities were suggested in an August 2009 memo from HMA

Examples of Metrics for Individual Program Managers

Metric	Description	Data Source
Average and median LOC scores for the current caseload, by program	Scores provide a proxy for average acuity of individuals; higher average scores indicate that services are more likely substituting for higher, more expensive services	DHSS and/or future vendor
LOC denial rates, by program	For monitoring the impact of proposed intake and assessment changes, and any future changes to the LOC criteria	DHSS and/or future vendor
Average and median cost of HCBS care plans, by program, by county/region	Will help expose regional variations in care plans and longitudinal trends; also part of the process for monitoring the proposed new intake and assessment system	Care plans, potentially through CyberAccess
Electronic care management tool utilization	Used to track provider utilization of tools such as CyberAccess and SmartPA	Clinical Services / Contractor
Percent change in prescriptions by therapeutic class	Metric for monitoring physician prescribing patterns and market shifts	Pharmacy unit
DME units of service and total billed	Allows monitoring of DME subcategories for significant changes in utilization	Claims data
Call center calls received, abandoned, call duration	Performance metrics related to customer service	Call center operations

Care Management

Finding #6: MO HealthNet has Cultivated a Philosophical Commitment to Care Management and HIT

- Commitment to care management and coordination
  - Chronic Care Improvement Program has established a strong foundation for providing much-needed care coordination services to MO HealthNet's non-capitated high-need beneficiaries
  - Enhanced Inpatient Review Services program is being implemented to provide pre-certification and continued stay reviews
- Focus on HIT to enhance quality and efficiency
  - CyberAccess continues to be enhanced and is increasingly used by Missouri providers to expand their knowledge base and facilitate efficient interaction with MO HealthNet
  - CCIP has innovative care management components, for example, connectivity between CyberAccess and CareConnection and health coaches in selected federally-qualified health centers and Truman Medical Center
  - SmartPA has extensive algorithm-based rules to maximize pre-certification in clinically-related areas, including durable medical equipment

Finding #7: Existing care management/service coordination approaches are not optimized

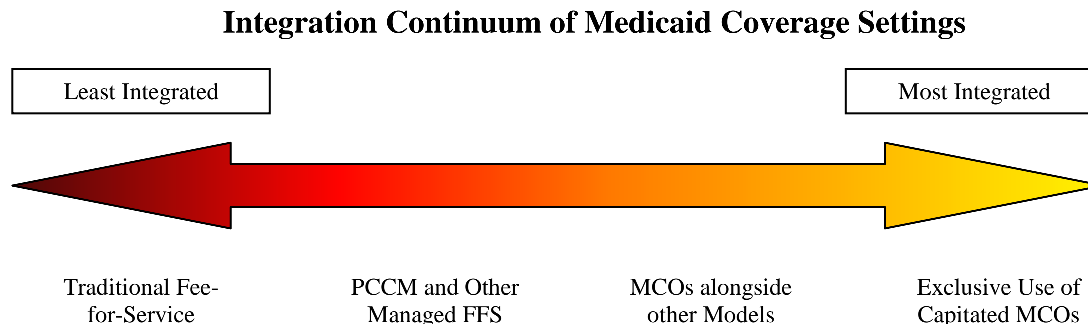
- Ultimately, the current resource commitment required to build and monitor an effective care management program is insufficient
  - Adding a full-time Medicaid Medical Director can help increase this commitment
- The CCIP program has not been effective in reducing Medicaid costs for the dual-eligible population and opportunities may exist to enhance program effectiveness for other participants
- Case management/services coordination for community-based long-term care programs is virtually non-existent
  - There does not appear to be any robust assistance available to Medicaid beneficiaries transitioning out of hospitals or nursing facilities

A Significant Number of MO HealthNet Participants Would Benefit from More Robust Care Management

- Similar to other states nationwide, the Aged, Blind, and Disabled (ABD) population accounts for less than 30 percent of Missouri's Medicaid enrollees yet accounts for more than 60 percent of spending
- While much of this spending is for long-term care, through claims analysis we identified more than 10,000 participants with extremely high use of pharmacy services (more than $5,000), emergency room visits (ten or more), and/or inpatient admissions (three or more) in one year
- In a separate analysis, we identified over 6,000 participants that incurred more than $100,000 of Medicaid expenses in 2008
- Many participants don't reach these thresholds, but have chronic conditions, disabilities, and/or serious mental illness and could benefit from a coordinated care management approach

How Far Towards MCO Capitation Contracting Should MO HealthNet Move for its High-Cost Groups?

- In the past, Medicaid programs simply paid claims; however, this traditional fee-for-service is clearly insufficient – it is a non-system that preserves a "just pay claims" approach
- Increasing emphasis is on improving quality and containing costs through care management techniques
- Capitation contracting with managed care organizations (MCOs) most fully deploys care integration principles and cost management techniques
  - Many states have expanded managed care to Medicaid participants with disabilities and chronic conditions
- Vast middle ground exists between these two ends of the continuum



Note: Our scope of work excluded in-depth analyses of managed care in Missouri Medicaid

Initiating MCO-based Managed Care for the ABD Population Involves Careful Consideration

- Missouri may consider expanding the current Medicaid MCOs' role or can initiate a full procurement. For either option, it will be important to consider:

1. How to engage beneficiary stakeholders and secure their support
2. How other stakeholders (e.g. agencies, providers, contractors) will be impacted
3. Whether to enroll the SSI population on a voluntary or mandatory basis
4. What regions to include in a managed care expansion
5. Whether to include both dually-eligible and non-Medicare-eligible participants
6. What services to provide through the MCO
7. What financial arrangement is appropriate for the MCOs (e.g., capitation rate, stop loss)
8. Whether the provider networks are adequate for this new, more complicated population
9. What resources are needed within MO Medicaid
10. How to ensure sufficient managed care quality oversight
11. How MO HealthNet financing arrangement will be impacted

1. Engage Beneficiary Stakeholders and Gain Their Support

- Beneficiary and advocate support is critical to ensuring a smooth program implementation and linkages outside of the traditional medical community important for this population
- Strategies to gain stakeholder support include:
  - Public Meetings: Prior to implementation and throughout the program implementation process, public meetings can be a valuable strategy for gathering opinions from individual consumers. Pennsylvania held public meetings before and after implementation to discuss concerns from advocates and consumers regarding expansion of mandatory SSI managed care into additional areas of the State.
  - Focus Groups: Focus groups are an effective way to obtain specific consumer and provider concerns and recommendations regarding implementation of an SSI program. For example, Oregon convened a wide group of stakeholders to provide feedback throughout implementation, often emphasizing that "everyone would get something and not everyone would get everything."
  - Advisory Committees: Several states have used advisory committees comprised of various stakeholders to provide input on initial program design and implementation, as well as ongoing feedback. For example, Pennsylvania assembled Regional Advisory Committees (RACs) in which beneficiaries and physicians meet regularly to provide feedback on disease management activities targeting the SSI population. New York also created an SSI Task Force comprised of multiple stakeholders.

2. Involve Other Stakeholders

- Agencies that administer programs that are used substantially by the ABD population will need to be involved in planning and implementation activities, in particular:
  - Department of Mental Health
  - Department of Health and Senior Services
- Providers will need to be consulted and involved in planning activities, particularly those that will be most impacted, including:
  - Physicians
  - Hospitals
  - Community-based providers
- Several existing contracts would need to be expanded or re-procured:
  - Enrollment Broker
  - External Quality Review Organization
  - Actuarial

3. Decide on Mandatory vs. Voluntary Enrollment

- Beneficiaries and advocates may be more comfortable with voluntary enrollment due to increased choice, while MCOs are likely to support mandatory enrollment to reduce risk
  - Historically, mandatory enrollment has proven far more effective at controlling cost and minimizing administrative expenses
- Most significant cost savings are associated with mandatory enrollment to ensure highest enrollment levels
  - However, continuity of care may be jeopardized without sufficient access to specialists and the fact that long-time providers may withdraw based on managed care
- Voluntary enrollment requires more complicated risk methodology, given the issue of beneficiaries who may “opt out” of the program
  - However, voluntary enrollment allows for a gradual phase-in of the program while learning about the population and its unique needs

4. Determine Which Counties or Regions Will Be Included in ABD Managed Care

- Currently, Medicaid managed care for the TANF population is limited to the I-70 corridor
  - Efforts to expand beyond this area have had limited success
- Enrolling the ABD population into managed care will raise similar questions regarding appropriate regions and access to care in more rural parts of the State
- The State may want to consider initiating a pilot program or a phased approach to implementation
  - Piloting or phasing-in allows the State to adjust the program based on Missouri-specific experience and outcomes

5. Dually Eligible Participants Present an Additional Challenge

- Much of the ABD population is dually-eligible for both Medicaid and Medicare
- Participants that are eligible for both Medicare and Medicaid are among the most expensive and most likely to need care management
- While additional care management opportunities may exist, dual eligible participants present a unique challenge since most of their acute care costs are covered by Medicare
  - Therefore, savings associated with care management are most likely to accrue to Medicare, unless there is a shared-savings agreement with CMS
- The most common option that states have pursued is the use of Special Needs Plans (SNPs)
  - Current SNP program authorization expires in December 2010
- Other states have relied on waiver authority under Sections 1115, 1915(a), or 1915(b)/(c) of the Social Security Act to address cross-program financing and operational issues
- North Carolina's demonstration program, including shared-savings, was authorized by Section 646 of the Medicare Modernization Act
  - Window of opportunity under this Section is likely closed

For a detailed analysis of legal options see: http://www.chcs.org/usr_doc/Supporting_Alternative_Integrated_Models_for_Dual_Eligibles.pdf

6. Determine Services to be Provided through the MCO

- There will likely be considerable pressure to exclude particular services from managed care for the ABD population
  - Services that are most often "carved out" include pharmacy, mental health, and substance abuse services
  - Pharmacy and mental health services account for a very significant proportion of health care spending for this population and should be included for managed care to fully succeed
- To receive the greatest benefit of care coordination provided through managed care MCOs must be permitted to manage all services
  - Our experience is that, when services are carved out of the managed care benefit, MCOs are far less likely to consider the carved-out services in their overall care management approach
  - This leads to both less-effective overall care management and limits cost containment that can be affected by the MCOs

7. Analyze Financial Arrangements

- Rate setting for a population with diverse and extensive health care needs is more complicated than for the TANF population
  - MO HealthNet may want to consider MCO risk corridors (a financial arrangement where the State would share a portion of unanticipated gains and losses) or stop-loss provisions (a financial arrangement to cap an MCO's loss for any individual), particularly in the early years of the program
  - In some early state experiences, costs were significantly higher than expected due to the fact that there had been significant unmet need in the fee-for-service program, particularly related to behavioral health
- Significant start-up costs will likely limit the opportunity for short-term savings

8. Ensure Sufficient Provider Networks

- Networks to provide services to the ABD population differ from TANF networks
  - States are required to allow specialists to serve as primary care providers (PCPs)
  - PCP visits may take longer for beneficiaries with multiple or complicated conditions
  - Additional types of specialists may be needed to serve this population
- MCOs must demonstrate adequate networks of providers (including specialists) and provide access within specified distance and timeframes
  - State effort to evaluate MCO readiness may be significant
  - Identifying sufficient numbers of providers who are able and willing to participate may be challenging, particularly in more rural areas

9. Ensure Sufficient Internal Resources

- Expanding managed care to the ABD population would require significant resources within MO HealthNet
  - With many potential stakeholders, numerous discussions are likely prior to actually issuing an RFP
    - Discussions may include access concerns, quality concerns, and carve-in/out dynamics
    - Preparing for these discussions and addressing stakeholder concerns will likely include a variety of analytics and public communications
  - Impact on other aspects of MO HealthNet financing will require dedicated effort by policy development staff, possibly in conjunction with provider associations and CMS
  - Significant time and effort would be required to issue an RFP, oversee rate range determination, and establish contracts with MCOs
    - This process could easily take 18 months or more
  - MMIS updates will be required to account for the expanded population in the managed care program
- Sufficient time and resources will need to be devoted to submitting a waiver modification to CMS and obtaining approval

10. Strong Quality Oversight is Essential for Particularly Vulnerable Populations

- Managed care quality assessment and improvement is currently overseen by a small staff within MO HealthNet Operations
- Any expansion of managed care beyond the existing I-70 TANF population would require a far more robust and higher-profile oversight unit
  - Expansion would require a larger EQRO, as described earlier
- Managed Care Operations, including plan operations as well as quality assessment and improvement, should be elevated to a Director-level position within MO HealthNet

Quality assessment and improvement activities should be emphasized by MO HealthNet and include both managed care and fee-for-service programs, regardless of the decision on expanding managed care

11. Determine Potential Impact on Existing Financing Mechanisms

- As in other states, managed care is expected to reduce inpatient hospital utilization and, therefore, result in reduced payments to hospitals
  - This shift would have a relatively minor impact on the FRA tax assessment because Medicaid represents a relatively small proportion of hospital revenues
  - Tax revenues could be more impacted if MCOs reimburse hospitals at rates substantially lower than total Medicaid payments
- We expect, however, that supplemental upper payment limit (UPL) payments will be significantly impacted
  - Federal policies currently permit these significant supplemental payments to hospitals, which in Missouri are financed by the FRA
  - However, these policies do not allow states to count inpatient days for MCO enrollees in determining the UPL
  - Shifting a significant proportion of the population into managed care would lower the UPL, sharply reducing the total amount of revenue that could be paid to hospitals
  - While these funds could potentially be used in other parts of the program, such a decision requires careful and detailed policy analysis
  - If the UPL were lowered too far, total payments to hospitals may fall short of the amount required by RSMo §208.471, forcing a reduction in the tax assessment or expiration of the tax

Managed Care Expansion Could Ultimately Be a Viable Option if Key Challenges are Overcome

- Moving high-cost subgroups into capitation may be advisable under the following circumstances:
  - Sufficient time and State resources are provided to ensure a successful implementation
  - Sufficient provider capacity is identified and providers are prepared for the expansion
  - High cost services are included within the managed care scope to maximize ROI
  - The State is able to preserve or replace existing Federal UPL revenue, possibly through an 1115 waiver, negotiated with CMS, such as the one that created Florida's Low Income Pool (LIP)
  - For dual eligibles to be included, Medicare and Medicaid spending would need to be combined in a manner that permits the State to share in the savings that occur on this entire pool of funds (this would also require a special arrangement with CMS)

Enhanced Care Management May be a More Viable Short-Term Approach for Non-Dual-Eligible ABD Participants

- Managed care expansion would require significant staff attention and resources at the same time that national health reform is already stretching limited Medicaid resources nationwide
- Existing hospital financing mechanisms tied to fee-for-service patients would be significantly affected by a shift to managed care
  - Mitigating these impacts would most likely involve negotiations with CMS which could take a substantial amount of time to complete, further limiting any short-term savings
- A targeted care management approach for the costliest participants could achieve similar reductions in inpatient utilization without significantly impacting the UPL
  - Such a program could potentially be funded with FRA tax revenue while mitigating the impact on total hospital revenues under the UPL

Medicaid Care Management Terminology

- **Patient Centered Medical Homes** - Each patient has an ongoing relationship with a personal physician who leads a team of individuals that collectively takes responsibility for the ongoing care of patients. Care is coordinated across all elements of the health care system and the patient's community. Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it.[1]
- **Primary Care Case Management (PCCM)** – Basic PCCM program have long been used by Medicaid programs to link patients with providers that perform basic care management functions for a small monthly fee. Increasingly, states are using *enhanced* PCCM programs to provide more intensive case management and care coordination (such as through medical homes)

Sources: [1]Joint Principles of the Patient-Centered Medical Home, March, 2007; accessed at: http://www.medicalhomeinfo.org/Joint%20Statement.pdf

Patient Centered Medical Homes Could Meet the State's Care Management Objectives

- Nationally, there is an increasing use of "Patient Centered Medical Homes," a coordinated approach that relies on primary care teams to address all of a patient's health care needs
- North Carolina has been a leader in this area through their Community Care of North Carolina (CCNC) program, an enhanced PCCM program
- Vermont's multi-payer Blueprint for Health has been touted as a model for a National Medical Home Initiative
- Many other states have programs in various stages of implementation and several examples are include in Appendix C
- Senate Bill 577 requires that participants "shall be enrolled in a health improvement plan and be provided a health care home" by 2011
  - Health improvement plans include coordinated fee-for-service plans and are required to use evidence-based best practices
- National health reform legislation signaled a federal emphasis on the concept and the potential for additional funding opportunities in the future
- Program development ties neatly together with HIT tools such as CyberAccess that MO HealthNet has worked hard to implement

Federal Health Reform Bill Includes State Plan Option for "Health Homes" with 90/10 Funding

- Section 2703 of H.R. 3590 provides for a state plan option to designate "health homes" for individuals with chronic conditions beginning January 1, 2011
- During the first two years that the SPA is in effect, states will receive an FMAP of 90 percent for "payments for the provision of health home services"
  - Payment methodology not limited to PMPM
- Planning grants are also available beginning January 1, 2011 to develop a SPA under this section
- Eligible individuals include those with two chronic conditions, one chronic condition and at risk for a second, or one serious and persistent mental health condition

Key Considerations for Medical Home Success

- Medical homes require a sufficient supply of primary care practitioners
  - Missouri may want to evaluate their current method of GME reimbursement and consider incentives for training and retaining primary care practitioners in underserved areas
- A critical factor in making the medical home work for beneficiaries with chronic illnesses and disabilities is to provide various forms of external support to physician practices including:[1]
  - Risk stratification through predictive modeling and targeting of the intensity of the intervention (i.e., high- or low-touch)
  - Current information about their patients' conditions, care needs, and service use
  - Resources for care management and care coordination that are often not available in physician offices
  - Performance measurement and incentives for medical homes that improve care for beneficiaries, likely starting with "paying for participation"

Sources:[1]http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/Enhanced%20Medical%20Home%20For%20Medi-Cal%27s%20SPD%20Population.PDF

Existing Care Management Program (CCIP) Provides a Foundation for Care Management, Including Medical Homes, But Needs Strengthening

- Approximately 2,000 physicians participate in the current care coordination initiative
  - However, provider engagement is inconsistent
- Interconnectivity between CyberAccess and CareConnection allows providers and health coaches to share patient information on a real time basis
  - Health information technology is an important part of the program and tools are continually being enhanced (e.g. hospital case management tool under development)
- The presence of health coaches in FQHCs and the Truman Medical Center offers in-person care management to members at a "teachable" moment, immediately following the provision of care
  - However, the vast majority of patient contact is telephonic
- Gateway conditions do not target those individuals who are most likely to benefit from care coordination

The Existing Care Coordination Program Can Be Improved

- Future contract enhancements can further improve the program
  - Incorporate shared risk component to further incentivize cost containment
  - Stratify program so that higher intensity interventions are targeted at the participants deemed to be most impactable and for whom lower intensity outreach efforts have not succeeded
  - Consider a pay-for-performance component based on outcomes
  - Continue to integrate HIT tools
- A full evaluation of CyberAccess is recommended to:
  - Evaluate the utility and ease of use of the existing system
  - Identify enhancement opportunities
  - Consider ways that CyberAccess use can be further encouraged
    - For example, could it be extended to State and local government employees to make it more worthwhile for providers to use it?
    - Consider linking CyberAccess to billing/claims system to simplify provider workload

MO HealthNet Should Target Individuals for Outreach Based on the Ability to Effect Change

- Claims cost levels alone should *not* drive who is targeted
  - Many persons with high-costs are not amenable to being helped by outreach in a way that will yield sufficient Medicaid savings
- Eligibility category should also *not* drive who is targeted
  - Many persons in ABD, for example, are using the health care system appropriately (and many have only minor health issues)
- "Disease management" model is not suggested either
  - Focusing on pre-selected diagnoses can include many people who are not amenable to impacts and exclude many persons who are amenable
- Our suggested target groups, based on claims analysis, include approximately 10,000 non-dual eligible high utilizers
- Other groups could also be targeted, but the size of this target population is large enough to exhaust existing outreach resources
  - For example, we also looked at high cost individuals (>$100K) and identified about 6,000 that warrant additional analysis to determine impactability

Targeting Could Potentially be Improved Using Predictive Modeling Principles

- Predictive modeling identifies individuals and subgroups that are most likely to be impactable through outreach and care coordination
- Predictive models are data-driven, decision-support tools that estimate an individual's future potential health care costs and/or opportunities for care management
- Predictive variables can include diagnosis, prescriptions, functional status, and prior cost
- Building or purchasing a predictive modeling tool can be a costly and time consuming endeavor
  - MO HealthNet should evaluate the ROI associated with a fully capable system versus incorporation of basic predictive modeling principles into the care management selection process

Source: Center for Health Care Strategies, "Predictive Modeling: A Guide for State Medicaid Purchasers" accessed at: http://www.chcs.org/usr_doc/Predictive_Modeling_Guide.pdf

A Stepwise Approach to Care Management Would Target Levels of Intervention Depending on Need

- Lowest levels would involve phone calls and mailings
- Highest levels could involve extensive face-to-face interaction by multiple persons
- Impacts on individuals' health status and costs will vary – even when same outreach approach is taken with people with similar-looking circumstances
  - Some beneficiaries will improve substantially with even modest outreach
  - Others will be unable or unwilling to improve despite extensive outreach efforts
- This stepwise approach, combined with targeting potential participants, allows MO HealthNet to match the extent of intervention to available resources

Evidence is Spotty as to Which Outreach Approaches Work Optimally for Which Persons

- Existing Medicaid outreach programs have been difficult and controversial to measure
  - Outreach programs have not typically been designed up-front in a manner conducive to an accurate assessment of savings
  - Contractors tend to share only those analyses and methodologies that show savings and validate the services they are providing (or seeking to sell)
  - States are also often reluctant to disclose findings that their initiatives have not been cost-effective
  - Seemingly minor methodological changes to how the impacts are quantified often yield dramatically different results
- Assessing the impacts of Missouri's CCIP initiative has been a good case example of the challenges involved in quantifying savings (or lack thereof)

Our Recommended Approach is Designed to *Create* an Ongoing Evidence-Based Structure

- Electronically track all outreach attempts and interactions for each targeted individual
  - Support tracking the level of effort needed to make contact with each targeted person & degree of engagement achieved with the beneficiary, family members or other key day-to-day caregivers, key providers, etc.
    - Outreach often needs to occur with persons other than the beneficiary due to mental health issues, home environment issues, strong degree to which significant others can “either be part of solution or part of the problem,” etc.
  - Allow for comparisons between cost/usage impacts and level/nature of outreach efforts and actual interactions

Actively promote provider engagement

- Create a Physician Advisory Board, with engagement by incoming Medicaid Medical Director, to engage physicians in MO HealthNet
  - Possible topics for discussion would include the promotion/enhancement of CyberAccess, evaluation goals, ongoing measurement strategies, care management tools for providers, future pilot or demonstration projects
- Identify program champions
  - "Providers are critical to any care management program; interested providers will endorse the concepts of the interventions with patients, identify interventions needed for patients, and provide valuable program input."[1]

Source: [1]The Lewin Group, "Designing and Implementing Medicaid Disease and Care Management Programs: A User's Guide," March, 2008. Accessed at: http://www.ahrq.gov/qual/medicaidmgmt/medicaidmgmt.pdf

State Has Several Options as to Who Conducts the Recommended Care Management Programs

- Direct performance by State
  - Entails creating a care management group whose sole function is to interact with targeted beneficiaries and catalogue all outreach activities
  - Would require redeploying some existing personnel and likely some new hiring as well. States often have difficulty hiring and retaining qualified clinical staff.
  - Would require substantial time to, for example, identify, develop and install a care management system
- Contracting with the existing care management vendor or procuring a new vendor are other options for implementing the enhanced program
  - Contracting out can likely be accomplished more quickly than direct performance approach
  - Unclear how a vendor approach would operate in a “health home” environment
  - Strong performance incentives would be needed to incent these organizations to maximize net Medicaid savings
- Suggested outreach approach also requires strong analytic component
  - Provide initial and ongoing beneficiary-specific data to outreach team to support their efforts as well as extensive reporting to track outreach efforts and impacts
  - These analytics could be performed directly by the State or contracted out

Evaluation Must Be a Strong Component of the Care Management Program

- Establish clear evaluation goals (e.g., cost containment, access to preventive care and screenings, quality outcomes) and manage expectations of key stakeholders
- Continue to develop electronic tools to track providers and participants, measure outcomes, and determine ROI
  - Institute ongoing or periodic program monitoring activities to generate "real-time" results
  - Evaluate the appropriateness of these results for inclusion in the Executive Dashboard
- Leverage incoming Medicaid Medical Director and enhanced Quality Unit to lead evaluation component and spearhead resulting continuous quality improvement strategy
  - An enhanced Quality Unit should be established regardless of the care management approach adopted
- Identify appropriate opportunities to compare performance and outcomes across programs

Program Structure & Financing

MO HealthNet: The Current State

- Outdated reimbursement systems
- Line item budgeting hinders policy making and program assessment
- Budget process requires significant manual effort
- Heavy reliance on provider taxes to the detriment of policy making and program management

Finding #8: Institutional Reimbursement Systems Do Not Incentivize Efficiency

- Current reimbursement systems are not value-based and reward utilization over efficiency
- Per-diem inpatient reimbursement incentivizes high utilization for low-acuity patients
- Cost-to-charge reimbursement for outpatient care incentivizes volume over efficiency
- Outdated nursing facility cost base negates intent to reimburse providers based on cost experience
- Nursing facilities also have financial incentive to seek low-acuity Medicaid residents over high-need ones that might otherwise be kept out of a hospital

Note: Our scope of work excluded in-depth analyses of Missouri Medicaid hospital reimbursement

Missouri Should Align Reimbursement with Policy Goals of Promoting Efficiency, Effectiveness, and Quality of Care

- Institutional reimbursement systems should account for patient acuity
  - Providers are accustomed to acuity-based reimbursement from other payers
  - Higher acuity hospital patients should result in higher reimbursement using a Diagnosis Related Group (DRG)-type methodology
    - Some states base their hospital reimbursement on Medicare DRGs modified for state-specific attributes
  - CMS and other payers have also moved to an outpatient prospective payment system that pays a fixed rate for groups of clinically similar services called Ambulatory Patient Classifications (APCs)
  - Nursing facility rates should include adjustment based on Resource Utilization Group (RUGs)
    - RUGs are based on MDS data that is already collected by the State
    - Would not require an overall rate increase

Missouri Should Align Reimbursement with Policy Goals of Promoting Efficiency, Effectiveness, and Quality of Care (continued)

- Reimbursing facilities on a reasonable price, rather than provider-specific cost, basis promotes efficiency
  - DRGs and APCs are structured so that payors can reimburse facilities a price for services that does not depend on an individual provider's cost experience
  - Nursing facilities can be paid a price per day, with acuity adjustment, based on the overall cost experience of the industry
  - The most efficient providers have an opportunity to realize a profit by holding costs below the established rate of payment
  - By rebasing industry costs periodically, efficiency gains can help hold down rates
- In other deliverables, we have noted multiple places where Medicaid rates appear to be only loosely based on value-based purchasing concepts (e.g., $400m in payments for personal care services)
  - Additional analysis of reimbursement policies is warranted for certain non-institutional services in addition to those for hospitals and nursing facilities

Missouri Should Align Reimbursement with Policy Goals of Promoting Efficiency, Effectiveness, and Quality of Care (continued)

- Reimbursement systems that promote efficiency should incorporate components to incentivize high quality care
  - Helps mitigate the incentive to simply provide the minimum level of service for the lowest cost
  - CMS/Premier Hospital Quality Incentive Demonstration provided 1% – 2% bonus payments to high performing hospitals and 1% – 2% penalties to the lowest performers
    - Participating hospitals have improved quality scores by an average of 17.2% over four years in the five clinical areas measured[1]
    - Additional research showed that HQID participants scored on average 6.9 percentage points higher (94.64 percent to 87.36 percent) than non-participants[1]
  - The Arkansas Medicaid Inpatient Quality Incentive program provides bonus payments to hospitals that improve care for pneumonia, heart failure and prevention of surgical infection
    - During the most recent round, 27 Arkansas hospitals improved care sufficiently to qualify for recognition[2]
  - Other potential approaches include not paying for "never events" and bundling payments to encompass a complete episode of care
  - Several states provide add-on payments to nursing facility rates based on performance indicators, although many are in early stages
    - Including IA, GA, KS, MN, OH, OK among others

Sources:[1] www.qualitydemo.com; [2]http://www.afmc.org/HTML/programs/quality_improve/hospital/iqi.aspx

Finding #9: Line Item Budgeting Hinders Coordinated Policy Making

- Other states allow considerably more budget flexibility by appropriating a lump sum of Medicaid funds
  - Departments then allocate funding to program areas
  - Legislative influence over program direction is maintained through statute and oversight
- In addition, appropriating funds for individual program lines inhibits coordinated care
- For example, reductions in nursing facility spending should lead to increases in HCBS spending
  - Separate budget lines in different agencies does not allow this to occur without legislative involvement
  - Similar examples exist across the care continuum (e.g. shifting costs from ERs to clinics)
- This problem is not unique to Missouri
  - For example, a 2009 report from the Illinois Taxpayer Action Board states that "In Illinois, department heads are too often focused on particular line items within a department, or even a division, budget. In this situation, decisions are made based on available funding in a given line item, instead of available funding in the entire system."[1]

Sources:[1] http://www.illinois.gov/PressReleases/Documents/TAB%20Report%20FINAL.pdf

Unify Budgeting to Support Program-Wide Policymaking

- Consider budgeting by population rather than service
- Many states have been exploring opportunities for coordinated Medicaid budgeting
- For example, create a global budget for long-term care
  - Current appropriations are service- or program-specific, and this does not allow executive authority to reallocate funds within the LTC system or leverage investments in one place to achieve savings in another
  - Several states have used budget flexibility and administrative consolidation as essential components to improving their LTC systems (e.g., OR, NJ, VT, WA, WI; OH is also beginning the process)

Framework for PMPM budget

- A budget based on per-member-per-month spending would allow the program to align spending with program needs on an ongoing basis
- Assessing overall cost of care by population group allows focus to be on the cost of care per participant rather than changes in provider category spending
  - For example, budgeting and monitoring on a PMPM basis could inform a discussion on the relationship between increased pharmacy spending and decreased inpatient spending
- Opportunities may exist to use existing Thomson contract to monitor spending on a PMPM basis

Finding #10: Current Budget Process Requires Significant Manual Effort

- Budget projections require manual update of dozens of worksheets each month
  - Process requires a significant amount of ongoing staff time
- Data systems are not integrated
  - Information that is input into worksheets is all captured through financial transaction systems
  - MMIS and other systems development and integration should include mechanisms to automatically generate budget status and projection reports based on paid claims, provider tax revenue, enrollment trends, etc.
- Automating reports would free up staff time that could be redirected toward policy development and project management

Finding #11: Heavy Reliance on Provider Taxes To the Detriment of Policy Making

- Provider taxes help generate significant financial advantages for Missouri; however, they also lead to:
  - Significant amount of administrative effort from MO HealthNet leadership, diminishing focus on other policy issues
  - Policy distortions and skewed cost-benefit calculations for otherwise good policy actions (e.g., MCO carve-outs; actions to reduce ICF/MR, nursing facility, and hospital utilization)
- Statutory "poison pills" require funds generated to enhance payments to the taxed providers, rather than being used to promote policy objectives
- There is risk that the 5.5 percent maximum tax rate might decrease in future years, which would jeopardize Medicaid program funding

1115 Waiver Reform Opportunity

1115 Waiver Basics

- Section 1115 of the Social Security Act provides broad authority to authorize experimental, pilot, or demonstration projects promoting the objectives of the Medicaid statute
- Flexibility is sufficiently broad to allow states to test substantially new policy ideas
- There are two types of Medicaid authority that may be requested under Section 1115:
  - Section 1115(a)(1) – allows the Secretary to waive provisions of section 1902 to operate demonstration programs, and
  - Section 1115(a)(2) – allows the Secretary to provide federal financial participation for costs that otherwise cannot be matched under Section 1903.
- Projects are generally approved to operate for a five-year period, and states may submit renewal requests to continue the project for additional periods of time
- Demonstrations must be "budget neutral"

[1]Source: http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/03_Research&DemonstrationProjects-Section1115.asp

1115 Waiver Opportunity

- The only mechanism we can envision for breaking the reliance on provider taxes is negotiating an 1115 waiver demonstration
- Under this demo, Missouri would terminate provider taxes in exchange for federal financial contribution to a new fund
- Benefits to MO: This demo would remove many of the policy distortions attributable to provider taxes
- This demo would be a structural change that might not lead to immediate savings, but it is necessary to allow future initiatives that reduce use of institutional services to proceed and to maximize the financial gain from these initiatives
- Benefits to CMS: CMS has clearly grown uneasy with the widespread use of provider taxes as evidenced by recent efforts to restrict the allowable amount of taxes
- Recent demonstrations have allowed states to redirect disproportionate share hospital (DSH) funds and supplemental upper payment limit (UPL) payments to provide care for the un- and under-insured

1115 Waiver Opportunity

- Replacing the more than $1 billion in non-federal share that provider taxes generate would be a significant hurdle and a detailed analysis would be required to determine whether current reimbursement levels could at least be maintained under the demo
- Several options could be considered/negotiated:

1. More than 40 public hospitals could use certified public expenditures (CPEs) for both Medicaid and DSH-eligible costs to draw down FFP
   - DSH, currently funded through a provider tax, would be rolled into a fund to provide care to the un- and under-insured
   - MO HealthNet has previously attempted to move to CPE-based reimbursement but encountered difficulties with CMS approval
2. Services currently not matchable, such as behavioral health services for people above Medicaid eligibility, the state-only funds that DHSS and DMH use for people in spend-down cycles, and health care for the uninsured could become eligible for FFP
3. Additional funds may have to be generated through a tax, ideally on tobacco, alcohol, or sugary beverages; or,
4. Scope of waiver could be limited to eliminate only a portion of provider taxes (e.g., nursing facilities and pharmacy)

Next Steps & First Priorities

Next Steps

- Initiate process to refine objectives, clarify mission, and establish work plan for accomplishing Medicaid program coordination
- Begin discussions with stakeholders on efforts to modify reimbursement systems to align with policy principles
- Determine whether or not to pursue a managed care expansion for high cost participants, weighing financial impact, resource requirements, and provider readiness
- Identify metrics and implement a performance measurement program
- Initiate realignment of LTC administration and budgeting
- Work with Legislature to relax restrictions on provider tax use
- Begin process to refine potential approaches to a comprehensive 1115 waiver

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Appendix A – State Reorganization Examples

Examples of Other States: Program Restructuring & Coordination - Massachusetts[1]

- In 2004, Massachusetts began reorganizing its Executive Office of Health and Human Services (EOHHS) agencies
  - The Medicaid office was elevated to the EOHHS level
  - As a unit, Medicaid shrank/decentralized
  - Many Medicaid staff moved into the EOHHS operating agencies (e.g., the LTC team moved to Elder Affairs)
- It created many more “dotted line” relationships between Medicaid and the other agencies, more of a matrix management model
  - Spawned greater interagency collaboration
- Transition required a major investment of staff time, even for routine activities, when they moved into different agencies
  - Strong executive leadership was essential to keep re-org moving
- Now “re-centralizing” some functions to Medicaid to maximize coordination
  - Organization is still evolving today as MA works toward optimal balance

[1] Rhode Island created a similar EOHHS in 2004

Examples of Other States: Program Restructuring & Coordination - District of Columbia

- Established the Department of Health Care Finance (DHCF) in October, 2008 as the Medicaid agency, replacing the Department of Health's (DOH) Medical Assistance Administration (MMA).[1]
  - Previously, both MAA and DOH were responsible for Medicaid and the DC Healthcare Alliance, a health care program for the uninsured
  - The Health Care Finance Agency Director was created as a Cabinet-level position
  - The claims processing and payment functions for all publicly funded health care programs were consolidated into DHCF
- DHCF primary objectives include:[2]
  - Increase Accountability
    - By consolidating the $1.6 billion in health care functions for Medicaid and the DC HealthCare Alliance into a stand-alone agency, D.C looked to improve the effectiveness and accountability within the Medicaid and Alliance programs
  - Address Operational Inefficiencies
    - The previous model had resulted in significant loss in federal reimbursement and fragmented communications with community providers
    - The consolidation and standardization of all claims processing into a centralized health care agency looked to remedy this problem
  - Enable the DOH to focus on its traditional public health activities
    - Previously overshadowed by Medicaid and DC Healthcare Alliance spending

Sources:[1] Department of Health Care Finance Establishment Act of 2007, Codification District of Columbia Official Code; [2]Dollars and Sense: A Proposal to Maximize the Efficiency of DC's Health Care Dollars to Improve Quality and Access for District Residents, May 2007. District of Columbia Primary Care Association

Examples of Other States: Program Restructuring & Coordination - Ohio

- The Executive Medicaid Management Administration (EMMA), established by Executive Order in 2007, aims to coordinate Medicaid policies and functions across agencies and maximize the efficient and effective delivery of health care
  - Administrative Structure:
    - Executive Director, Chief Legal Counsel, Policy Analyst, Project Manager and Executive Assistant
    - Council of cabinet agency partners, consisting of the directors of the eight state agencies responsible for Medicaid-funded programs, services or budget development
    - Staff in partner agencies designated to participate on workgroups commissioned by the EMMA Council.
  - Utilizes interagency workgroups organized around specific, time-limited projects
  - Exists as a “virtual” agency, in order to not duplicate existing administrative infrastructure and support services such as Information Technology, Human Resources and Fiscal Operations
    - Instead utilizes resources from partner agencies as needed.

Source: Ohio Executive Medicaid Management Administration, Annual Report, 2009. http://emma.ohio.gov/reports/EMMAnew.pdf;

Examples of Other States: Program Restructuring & Coordination – Kansas[1]

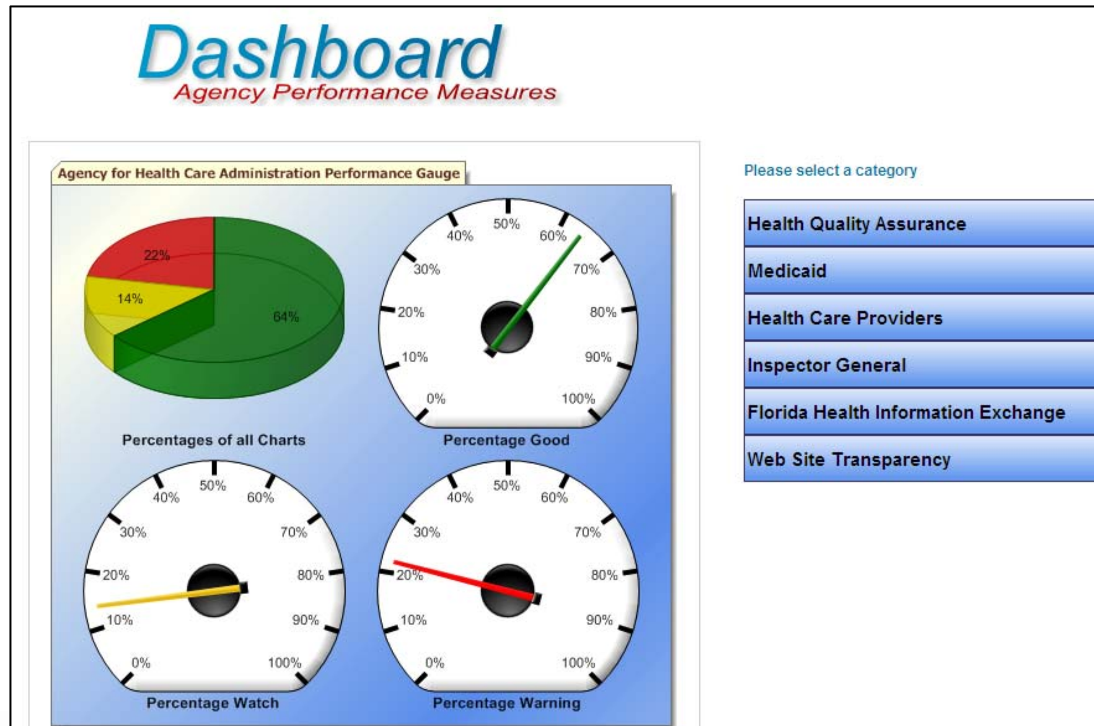
- Established the Kansas Health Policy Authority (KHPA) in July 2005 as a state agency to develop and maintain a coordinated health policy agenda, combining the effective purchasing and administration of health care with health promotion oriented public health strategies
- Resulted in a transfer of responsibilities from the Departments of Social and Rehabilitation Services and Health and Environment Authority.
- The Department of Social and Rehabilitation Services and the Department on Aging remain separate agencies
- Combined health insurance programs, including Medicaid, State Children's Health Insurance Program and MediKan and the State Employee Health Benefits Plan (SEHBP) under the KHPA to leverage purchasing power[2]

Source:[1]Kansas Legislative Research Department. http://skyways.lib.ks.us/ksleg/KLRD/Publications/HealthPolicyAuthority_sum.pdf; [2] KHPA Medicaid Transformation Fact Sheet;

Appendix B – Dashboard Examples

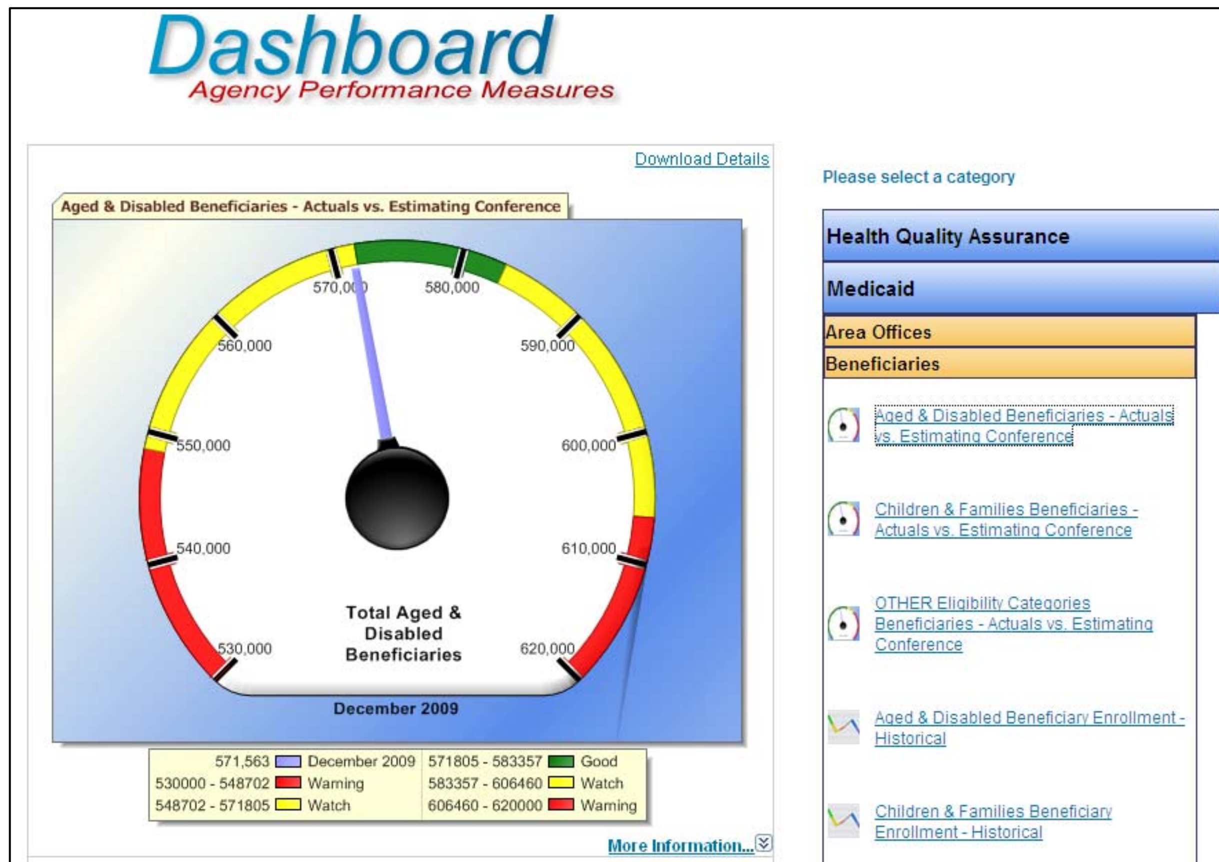
Florida AHCA Publishes Operating Metrics Online

- Florida's Agency for Health Care Administration publishes high-level metrics each month at http://ahcaxnet.fdhc.state.fl.us/dashboard/
- Site allows users to download details that make up each metric



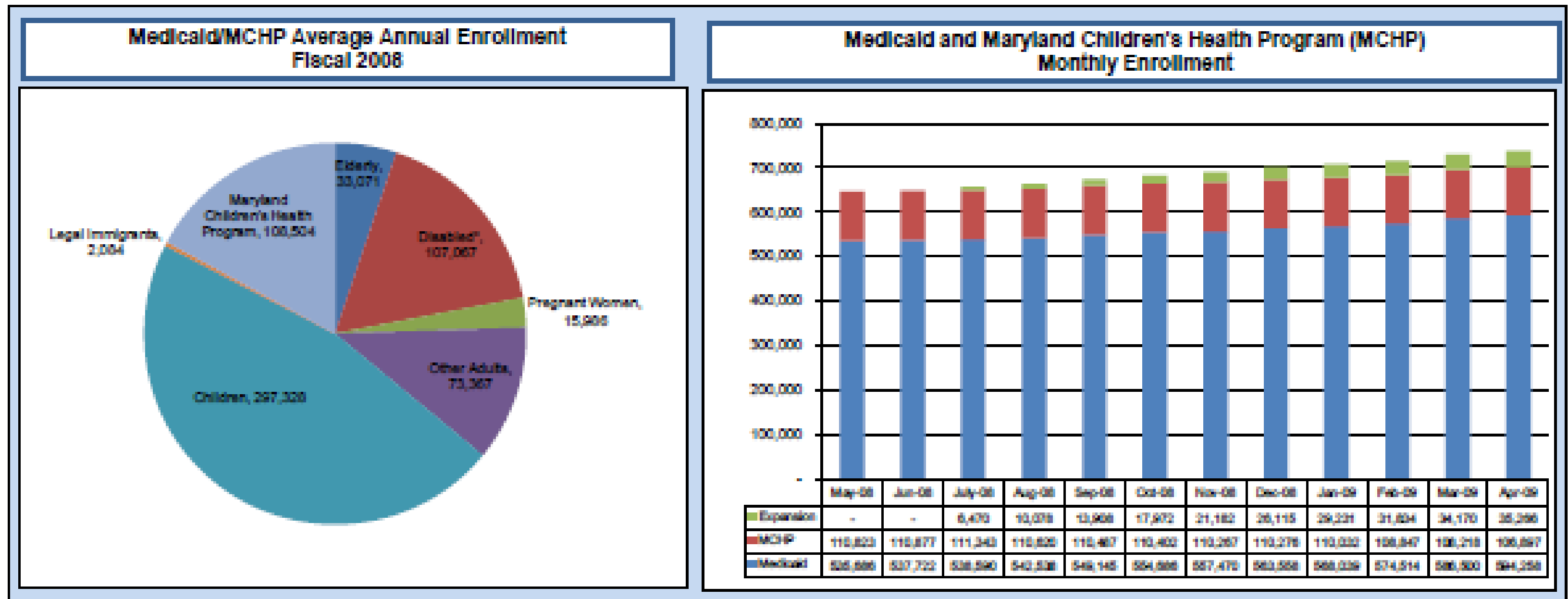
Florida Metric Example

- Dials measure actual values versus projections



Maryland's General Assembly Also Publishes Dashboard Metrics

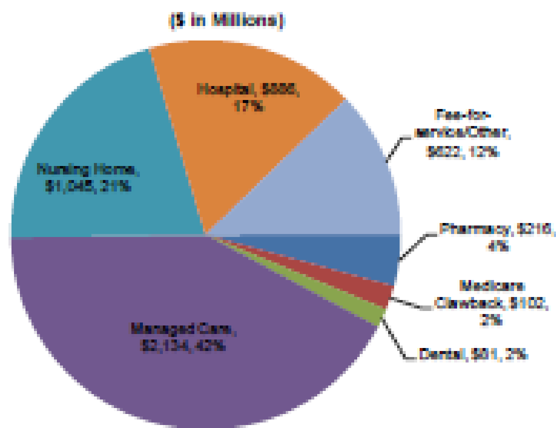
- Limited set of metrics for Maryland public health insurance programs is published by the General Assembly at http://mlis.state.md.us/other/opa/internet_Medicaid_Data_Dashboard.pdf



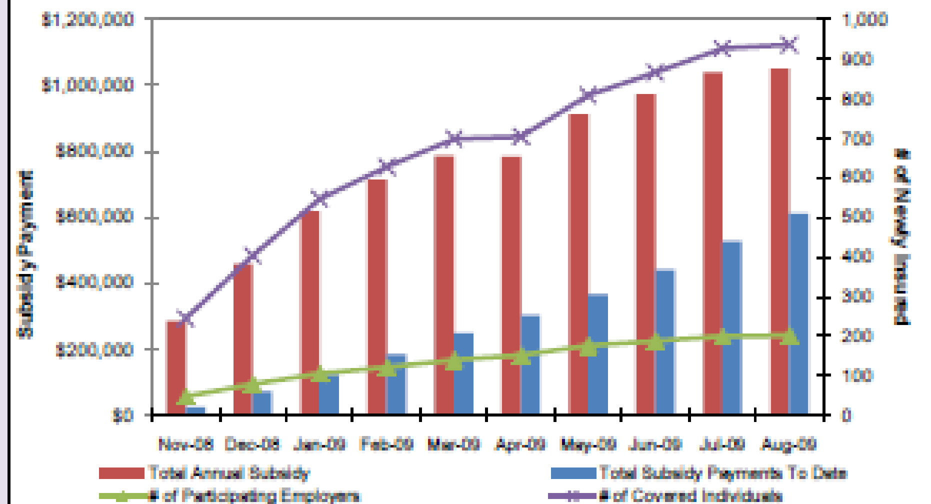
	May-08	Jun-08	July-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09	Apr-09
Expansion	-	-	6,470	10,076	13,908	17,972	21,182	26,115	29,231	31,834	34,170	35,266
MCHP	110,823	110,877	111,343	110,828	110,467	110,402	110,267	110,276	110,032	109,847	108,218	106,897
Medicaid	535,886	537,722	538,590	540,538	546,145	554,888	557,479	563,558	568,036	574,514	586,500	594,256

Maryland Metric Example

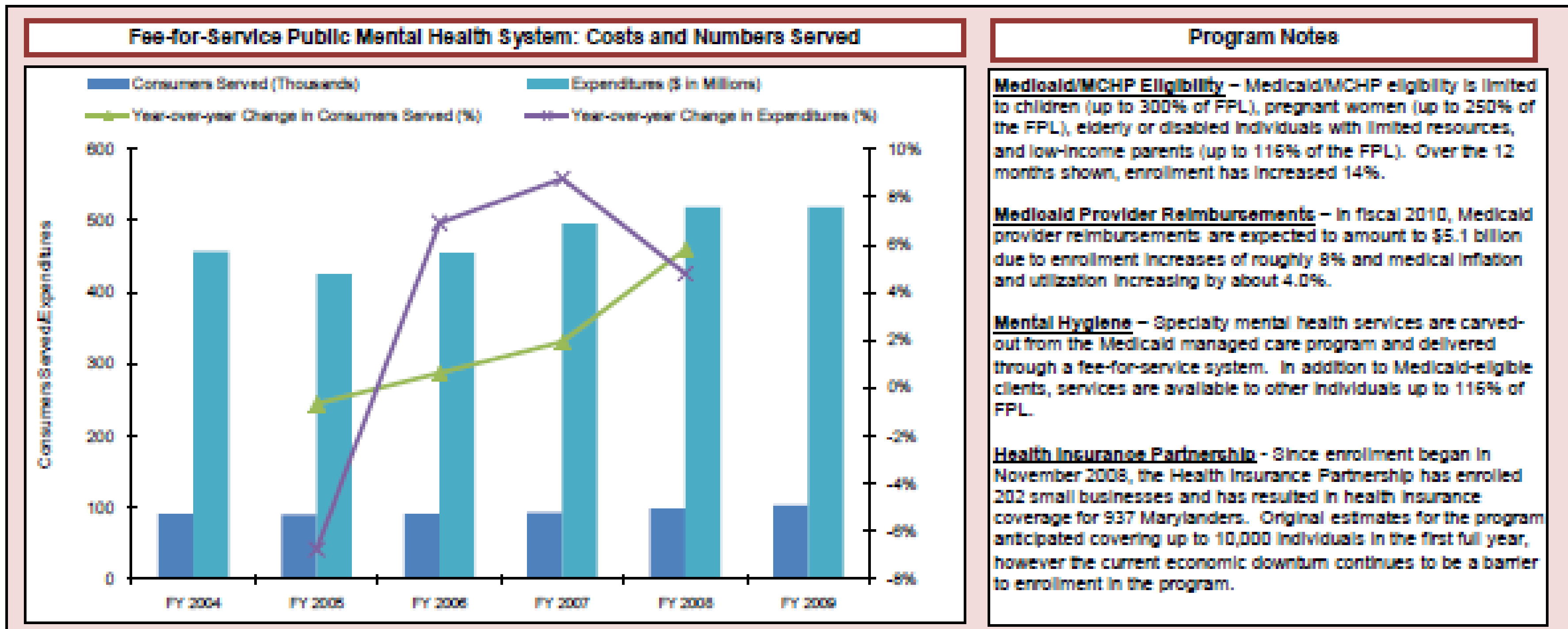
Medicaid/MCHP Provider Reimbursements by Services – Type Fiscal 2010



Cost and Enrollment of Health Insurance Partnership

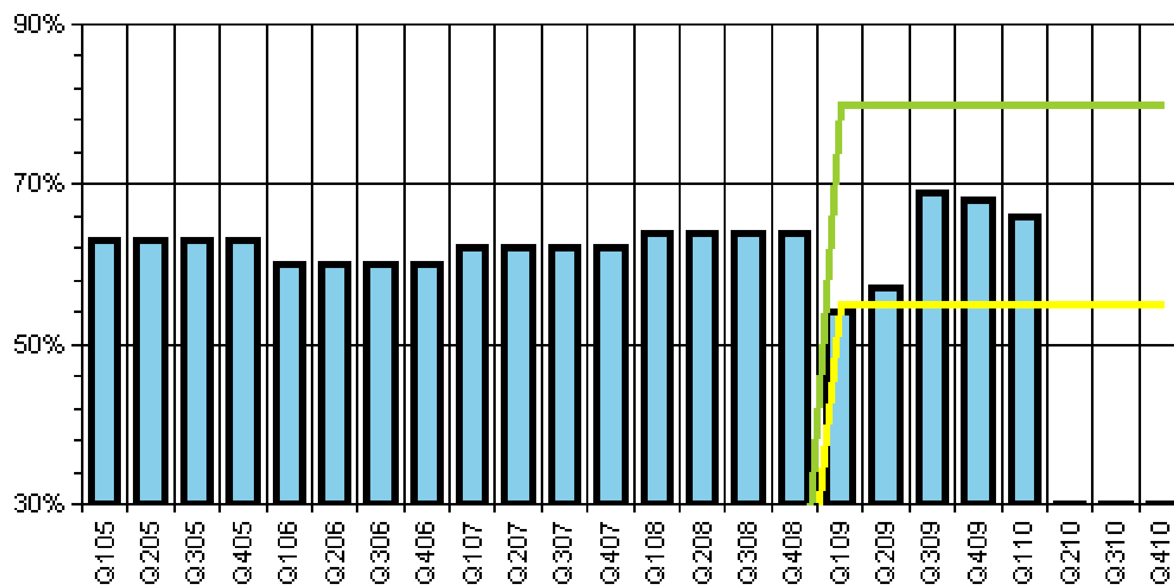


Maryland Metric Example

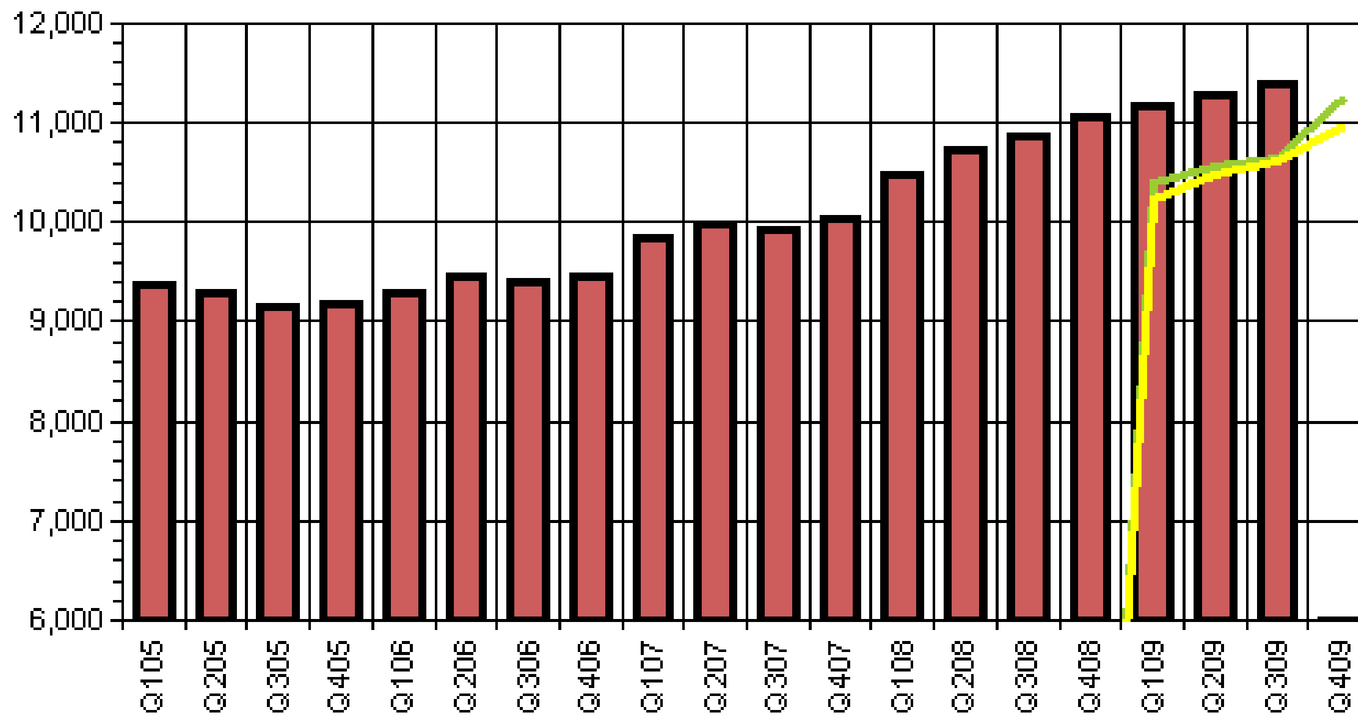


Indiana OMB Maintains a Limited Set of Metrics for Each Agency

- Indiana OMB maintains performance metrics for state agencies, including FSSA at: http://www.in.gov/omb/2379.htm
- Green lines represent optimal performance targets while yellow represents performance in need of improvement



Indiana Metric Example



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Appendix C – State Care Management Programs

North Carolina: Community Care of North Carolina, Enhanced Primary Care Case Management

- Community Care of North Carolina (CCNC)
  - Statewide enhanced primary care case management, providing medical home to enrollees
  - First started in 1990's, expanded to include people with disabilities in 2007
  - Public–private partnership between the State and 14 nonprofit community care networks
- Demonstration Design:
  - Targets majority of Medicaid enrollees, with few exceptions
  - Fee-for-service reimbursement supplemented by a per-member per-month (PMPM) fee for case management
    - Local networks receive $3 per member per month (PMPM) fee to implement population management strategies
    - Physicians receive an additional $2.50 PMPM for medical home and population-management activities
  - Clinical initiatives:
    - Disease management programs, emergency room initiatives, case management of high risk/high cost patients, and pharmacy management
  - Program interventions:
    - Medical home, call centers, telephonic & in-person care management, provider reporting, & evidence based guidelines
- Costs/Funding:
  - Funded through grants and the Department of Health and Human Services
  - Program data confirms both cost savings and quality improvement
    - An actuarial analysis by Mercer Human Resources Consulting estimated savings of $154-170 million in FY 2006 as a result of CCNC's care management and quality improvement activities (compared with historical FFS costs)[1]

Sources: [1]Community Care of North Carolina: Building Community Systems of Care Through State and Local Partnerships. The Commonwealth Fund Case Study, June 2009

Integrated Care for Dual Eligibles: North Carolina Community Care Networks (NC-CCN)

- Demonstration under the Medicare Health Care Quality Demonstration Program (section 646 of MMA)
- Built upon existing Community Care Program
  - Extends medical home and community-based care management system to dual eligible and Medicare-only population
- Combines a physician-directed care management approach with the use of HIT to connect providers, support care management and delivery, measure performance, and implement pay-for-performance financial incentives
- Operates under a shared-savings agreement with the federal government
- Demonstration go-live date: January 2010

Source: http://www.ncmedicaljournal.com/May-Jun-09/Wade.pdf

Integrated Care for Dual Eligibles: North Carolina Community Care Networks (NC-CCN), cont'd.

- Demonstration design
  - Years 1 and 2: Community Care will manage approximately 44,000 dual eligible beneficiaries who receive care from 165 Community Care practices in 26 counties
  - Beginning of Year 3: an estimated 170,000 Medicare-only beneficiaries, who receive care from those 165 practices, will be added to the demonstration
  - Years 3-5: Community Care will manage estimated 214,000 Medicare-only and dual-eligible beneficiaries
  - Multi-disease focus where medical homes and care managers must take a more patient-centered and holistic approach

Sources: http://www.ncmedicaljournal.com/May-Jun-09/Wade.pdf; http://www.medicalnewstoday.com/articles/177365.php

Integrated Care for Dual Eligibles: North Carolina Community Care Networks (NC-CCN), cont'd.

- Costs/Funding
  - Networks will receive a per member per month fee for benefits
  - Any Medicare savings beyond a set threshold (using comparison counties) will be reinvested in the project for services for non-duals, home-based services, health information technology (HIT), and/or potential coverage expansions
  - NC and CMS will share in a portion of Medicare savings achieved once quality of care and cost objectives are met
  - The earliest Community Care will receive any savings is at the end of year 2

Sources: http://www.ncmedicaljournal.com/May-Jun-09/Wade.pdf; http://www.medicalnewstoday.com/articles/177365.php; http://www.chcs.org/usr_doc/Integrated_Care_Resource_Paper.pdf

Vermont: The Blueprint Medical Home Model

- Blueprint Medical Home Model
  - Focus on people with, or at risk for, chronic conditions
  - Part of the current 'Blueprint for Health, Chronic Care' initiative to enable Vermonters with, and at risk for, chronic disease lead healthier lives.
  - Launched in '08, includes 60,000 Medicaid beneficiaries[1]
- Demonstration Design:
  - Creates medical homes for the chronically ill, with primary care physicians (PCPs) receiving an extra $1.20 to $2.39 per patient a month to coordinate care[1]
  - PCPs use funds to create Community Care Teams to treat patients requiring additional attention – such as patients who need help losing weight, lowering their blood pressure or making other health changes
    - The doctors' practices receive bonuses if a patient's health improves based on certain measurements.
  - Medicaid and private insurer participation
- Costs/Funding[2]
  - State has appropriated general funds for the program
  - As of June '08, insurers in Vermont will pay a tax of .19 percent to establish HIT systems that will enable providers to more effectively coordinate care

Sources: [1] State Involvement in Multi-Payer Medical Home Initiatives. National Academy for State Health Policy, November 2009; [2]Vermont Pilots Medical Homes for the Chronically Ill. National Conference of State Legislatures, July 2008; Medical Home Scan November 2008, National Academy for State Health Policy, Medical Home & Patient Centered Care

Illinois: Illinois Health Connect Medical Home Model

- Health Connect: Illinois' Primary Care Case Management (PCCM) Program
  - Provides medical homes to all children under the age of 19, parents living with children 18 years and younger, and adults with disabilities
  - First implemented July 2006
- Demonstration Design[1]
  - Focus on patient outcomes and preventive care
  - Rolled out in two phases, with voluntary and mandatory beneficiary participation
  - PCPs receive a PMPM fee for PCCM activities that varies based on the member's eligibility category
    - Providers given utilization feedback tied to a pay for performance program.
    - PCCM providers are supported in serving as medical homes by a disease management program.
- Costs/Funding
  - Part of efforts to more efficiently manage State medical programs
  - State claims the Medical Home model, in conjunction with a Disease Management program, has achieved $34 million in net savings during FY 2007[2]
  - $2 million ER diversion federal grant, received April ’08, will also work to improve care coordination within the Health Connect program[3]

Sources: [1] IL Health Connect Fact Sheet, February 2007; [2] Gov. Blagojevich announces major cost savings from more efficient care management in Medicaid program, Illinois Government News Network April 29 ’08; [3] Gov. Blagojevich announces $2 million federal grant to promote primary care, prevent use of emergency rooms, Illinois Government News Network April 24 ‘08

Oklahoma: SoonerCare Choice Primary Care Case Management Program

- SoonerCare Choice primary care case management (PCCM) program:
  - Implemented January 2009
  - Stemmed from Medical Advisory Task force recommendations in February 2007[1]
  - 65 percent of the State's Medicaid beneficiaries are enrolled[2]
- Demonstration Design
  - Patterned after the North Carolina and Alabama medical home model
  - New reimbursement methodology based on:
    - Monthly care coordination payments
    - Visit based FFS component
    - Performance based component
    - Additional payments also made to provider networks
  - Three tiers of medical homes: Entry, Advanced, and Optimal levels (with Optimal being the most care intensive)
    - Care coordination payments vary depending on eligibility category and tier of medical home
- Costs/Funding
  - No new funding source

Sources: [1] An Improved Medical Home for Every SoonerCare Choice Member, Oklahoma Healthcare Authority, February 2010 [2] SoonerCare 1115 Waiver Evaluation: Final Report; Mathematica Policy Research January 2009

Washington: State to implement two coordinated medical home pilot projects

- State leads two coordinated medical home pilot projects
  1. Patient Centered Medical Home Multipayer Reimbursement Model
     - Operational in fall of 2010
     - Project to develop, implement and evaluate a pilot of one or more medical home provider reimbursement models
     - Public-private partnership, led by the State Health Care Authority and the Department of Social and Health Services, in conjunction with the Puget Sound Health Alliance (a regional partnership including employers, physicians, hospitals, patients, health plans)
     - To date, at least eight health insurers have committed to help the state test the medical home model.
  2. Patient-Centered Medical Home Collaborative, two year test pilot
     - Implemented in 2008
     - Includes includes 33 participating primary care providers with program goal of increasing access to primary care providers and medical homes.
     - Featured learning sessions for providers focused on medical homes for patients with chronic diseases and children with special health care needs.
     - Public-private partnership with the Washington State Medical Association (WSMA) and Washington Academy of Family Practice (WAFP)

Sources: [1] Washington State Medical Home Activities, Public Sector Initiatives http://www.medicalhome.org/about/medhomeplan.cfm#activities[2] Washington State Health Care Authority Medical Homes Project Overview, http://www.hca.wa.gov/medical_homes.html; [3] Medical Home State Map, National Academy for State Health Policy, http://www.nashp.org/node/1282

Appendix D – Capitated Programs for Duals

Integrated Care for Dual Eligibles: Minnesota Senior Health Options (MSHO)

- Demonstration facilitates the integration of primary, acute and long-term care services for persons over age 65 who are dually eligible for both Medicare and Medicaid
  - Approximately 46,000 people
  - Project became operational in 1997
  - Originally authorized under 1115 waiver
- MN has received approval to switch from its 1115 waiver to a combination of section 1915(a) and section 1915(c) waiver authority
  - 1915(c) waiver allows states to provide home-and community-based services to individuals at risk of nursing home placement and permits MN to access some special eligibility provisions such as protection against spousal impoverishment
  - 1915(a) authority is not subject to OMB's budget-neutrality policy
- Federal waivers granted Minnesota a Medicare risk adjustment payment for frail elderly dual eligibles in the community as an incentive to prevent unnecessary institutionalization

Source: http://www.oregon.gov/OHPPR/RSCH/docs/HRSAB.DualElig.BP.pdf

Integrated Care for Dual Eligibles: Minnesota Senior Health Options (MSHO), cont'd.

- Demonstration design
  - Enrollees are entitled to receive all Medicaid services provided, plus all Medicare services under Parts A and B
  - Health plans will provide services available under the current home-and community-based waiver, which consists mainly of extended home care benefits to frail elderly eligible for nursing home care
  - Health plans are responsible for the first 180 days of care in a nursing facility for those who enroll in Minnesota Senior Health Options while living in the community
  - Single enrollment process for both Medicare and Medicaid
  - Currently serving approximately 35,000 enrollees
- Costs/Funding
  - Robert Wood Johnson Foundation supported this project through three unsolicited grants totaling $1,486,528
  - CMS provided matching funds

Sources: http://www.oregon.gov/OHPPR/RSCH/docs/HRSAB.DualElig.BP.pdf; http://www.dhs.state.mn.us/main/groups/county_access/documents/pub/dhs16_147781.pdf http://www.rwjf.org/pr/product.jsp?id=37555

Integrated Care for Dual Eligibles: New Mexico Coordination of Long-Term Services (CoLTS)

- Joint initiative of the New Mexico Aging and Long-Term Services Department and the New Mexico Human Services Department
  - Aging and Long-Term Services Department (ALTSD) manages the program
- CoLTS is a managed long-term services and acute care program that serves:
  - Dual eligibles
  - Nursing home residents
  - Disabled & Elderly waiver individuals
  - Adults receiving Personal Care Option services
  - Certain individuals with brain injury who meet medical and financial eligibility
- Health Plans coordinate care - AMERIGROUP and Evercare
- Waiver applications submitted in early July 2007; Waivers approved by the CMS in July 2008

Sources: http://www.chcs.org/usr_doc/Heyeck,_NM.pdf; http://www.nmaging.state.nm.us/COLTS_overview.html

Integrated Care for Dual Eligibles: New Mexico Coordination of Long-Term Services (CoLTS), cont'd.

- Demonstration design
  - Estimated number of eligible individuals: 38,000
  - Covered services:
    - Nursing facility services, primary and acute care, dental and vision care, transportation, service coordination, adult day health, respite, assisted living, community transition services, relocation specialists, environmental modifications, private duty nursing for adults, skilled maintenance therapy
  - Risk-bearing contracts to provide Medicaid benefits
  - Statewide provider networks capable of providing all covered services
- Costs/Funding
  - FY09 CoLTS MCO Contracts - $390 million (phase-in year)
  - MCO administration fee is limited - 5 – 7% depending on cohort
  - Average per member per month (pmpm) capitation rate = $1,530.00

Sources: http://www.chcs.org/usr_doc/Heyeck,_NM.pdf; http://www.nmaging.state.nm.us/COLTS_overview.html

Integrated Care for Dual Eligibles: Texas STAR+PLUS

- Combined 1915(b)/(c) Waiver - Texas STAR+PLUS program
- The objective of the waiver is to improve access to health care, improve quality and outcomes of health care, ensure that clients receive appropriate level of care in the least restrictive setting consistent with their personal safety, and to create accountability and controls on costs.
  - Serves disabled and elderly beneficiaries and integrates acute and long-term care services through a managed care delivery system, consisting of three managed care organizations (MCOs) and a primary care case management system (PCCM.)
  - Approximately 51% of the eligible population are dually eligible
  - Although STAR+PLUS does not restrict Medicare freedom of choice, an enhanced drug benefit is provided as an incentive to dual eligibles that elect to enroll in the same MCO for their Medicaid and Medicare services
- Capitated payments to health plans control costs and provide for continuity of care for high-risk dually eligible population

Sources:http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/06_Combined1915bc.asp
http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/MWDL/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=4&sortOrder=descending&itemID=CMS047949&intNumPerPage=10
http://www.hhsc.state.tx.us/starplus/general_descrp.htm

Appendix E – 1115 Waiver Examples

Massachusetts: MassHealth 1115 Waiver

- Aims for universal health coverage of state residents
  - Waiver originally implemented in 1997. Major reform plans first approved in 2005, expanding coverage while restructuring how private insurance is purchased, sold, and administered, and how public subsidies are delivered
  - As of 2009, less than 3% of the population uninsured[1]
- Demonstration Design
  - Creation of Safety Net Care Pool (SNCP) & Funding Stream
    - Offsets uncompensated hospital costs, pays for designated healthcare programs, and subsidizes private insurance premiums for eligible populations
  - Commonwealth Choice, Commonwealth Care, and MassHealth Health Plans
    - Commonwealth Choice, comprised of six nonprofit health plans. Consumers not eligible for government subsidized programs choose private plans using the Health Connector, the state-wide health insurance exchange
    - Commonwealth Care premium assistance program to help low-income adults without employer-sponsored insurance who are not eligible for MassHealth (up to 300% FPL)
    - MassHealth, covering most individuals below 300% FPL

Sources: [1]Medicaid Section 1115 Demonstration Waivers: Comparing California, Massachusetts, and New York. Health Management Associates, Oct. 2009 and The MassHealth Waiver: 2009-2011 and Beyond. Center for Health, Law, and Economics, University of Massachusetts Medical School. Massachusetts Statewide Health Reform Section 1115 Demonstration Fact Sheet, CMS Summary Sheet

Massachusetts: MassHealth Waiver, cont'd

- Demonstration Design
  - Individual health insurance mandate[1]
    - If individual does not qualify for affordability exemption, faces penalty of half the cost of the lowest-price Health Connector plan available for each uninsured month.
  - Employer participation requirements[2]
    - Employers with 11+ FTEs must make a State-determined 'fair and reasonable' premium contribution toward health insurance for their employees, or pay up to $295 per employee, per year into the State's Safety Net Trust Fund.
- Costs/Funding
  - Safety Net Care Pool financed by federal and state expenditures previously used for DSH payments and for supplemental payments to managed care organizations.
    - Three-year aggregate spending limit
    - Directs more federal and state health dollars to individuals and less to institutions
  - Employer contributions

Sources:[1] Health Connector, Individuals https://www.mahealthconnector.org/portal/site/connector/menuitem.afc6a36a62ec1a50dbef6f47d7468a0c/?fiShown=default; [2] Health Connector, Employers https://www.mahealthconnector.org/portal/site/connector/menuitem.d6907c916713afde505da95c0ce08041/?fiShown=default

Vermont: Global Commitment 1115 Waiver

- Encompasses majority of State Medicaid programs
- Demonstration approved by CMS and State legislature in ‘05, expires Sept. ’10
- Demonstration Design:
  - Managed Care Delivery System
    - Agency of Human Services contracts with the Office of Vermont Health Access to serve as a publicly sponsored managed care organization, paying a lump sum premium per month
  - Premium assistance to purchase private coverage
    - Offered to State residents who have been without health insurance coverage for a year or more, have income at or below 200 percent of the FPL, and who do not have access to ‘cost effective’ employer-sponsored insurance as determined by the State.
  - Program Flexibility
    - Allows benefit change of up to 5% of comparison year expenditures for non-mandatory populations
  - Coverage expansions for specific populations
- Costs/Funding
  - Aggregate Budget Neutrality Cap
    - Operates under five-year budget neutrality ceiling, with annual ceiling increases based on 9% inflation rate. Places State at risk for caseload, inflation, utilization

Sources:[1] Vermont Global Commitment to Health Section 1115 Demonstration Fact Sheet, CMS Summary Sheet; State of Vermont, Agency of Human Services. Global Commitment to Health Revised Evaluation Plan, March 2008

Rhode Island: Global Consumer Choice Compact Waiver

- RI to operate entire Medicaid program under a single Section 1115 Waiver as of Jan. '09.[1]
- Demonstration Design:
  - Managed care expansion
  - Link reimbursement to performance and quality-of-care improvements
  - Enhance the availability of home- and community-based programs
- Costs/Funding
  - Defined five-year state and federal commitment
  - State at risk for unanticipated caseload increases
  - In exchange for the spending cap, State gains significant flexibility to change eligibility levels, services, and cost sharing.
- Global waiver remains controversial[2]
  - State has moved forward with the global waiver reform goals
    - Implemented a new 'level of care' determination to assess community or institutional placement for long term care services
    - Mandatory managed care or PCCM for non-dual adults with disabilities
  - First year savings ($67 million) originally predicted, yet to be realized

Sources:[1] Rhode Island Pursues Health Reforms in Public and Private Sector. Robert Wood Johnson Foundation State Initiatives http://www.statecoverage.org/node/1343; [2] Rhode Island's Global Consumer Choice Section 1115 Demonstration Waiver, Quarterly Progress Report July 1, 2009 – September 30, 2009; 3 *Medicaid Global Waiver Savings Questioned,* AARP Jan 2010.

Florida: Medicaid Reform Demonstration

- Five-year restructuring of Medicaid from a defined benefit to a defined contribution program[1]
  - Implemented July 2006 in two counties, expanded following year to three additional counties
  - 9% of state population participating
- Demonstration Design
  - Mandated managed care for designated populations
  - Managed care plans given flexibility in designing benefit packages and cost sharing
  - Beneficiaries receive risk-adjusted premiums to choose among different plans with different benefit packages.
    - Voluntary opt out program, allowing beneficiaries to use their Medicaid premiums to purchase employer sponsored insurance
  - Annual benefit limit for non-pregnant adults
  - Wellness Incentive program, providing 'enhanced benefit credits' for health related purchases to participating enrollees

Sources:[1] [1] Summary of Florida Medicaid Reform Waiver: Early Findings and Current Status, Kaiser Family Foundation. October, 2008 Florida Medicaid Reform Section 1115 Demonstration Fact Sheet, CMS Summary Sheet http://www.ncsl.org/default.aspx?tabid=14347

Florida: Medicaid Reform Demonstration, cont'd

- Costs/Funding
  - Low Income Pool, provides payments to safety net providers
    - Capped at $1 billion per year, financed with state and matching federal funds
    - Replaces some hospital financing arrangements
  - Establishes per capita caps that limit the amount of federal funds the state can receive per beneficiary for the eligibility groups covered by the waiver
- In December 2007, the State Agency for Health Care Administration did not recommend expansion of reform during the 2008 legislative session, stating the reform plan required further study.

Sources:1 1 Summary of Florida Medicaid Reform Waiver: Early Findings and Current Status, Kaiser Family Foundation. October, 2008 Florida Medicaid Reform Section 1115 Demonstration Fact Sheet, CMS Summary Sheet http://www.ncsl.org/default.aspx?tabid=14347

New York: Federal State Health Reform Partnership Waiver (F-SHRP)

- Partnership Plan looks to streamline State healthcare system operations over five-year demonstration period (Oct. 2006 – Sept. 2011)
- Demonstration design Includes:
  - Expand managed care requirements to additional fourteen counties
  - Increase fraud and abuse recoveries to at least 1.5% of its total Medicaid expenditures for FY 2005 by end of demonstration
  - Create program to increase rate of private insurance coverage for currently uninsured, but employed, state residents
  - Implement designated program cost containment initiatives such as expansion of managed care long term care and pay for performance demonstrations
  - Establish single point of entry for Medicaid recipients needing long-term care
  - Required to meet series of established performance milestones

Sources:[1] New York Federal-State Health Reform Partnership Section 1115 Demonstration CMS Fact Sheet, Oct. 2006; [2] New York State Department of Health, Federal-State Health Reform Partnership (F-SHRP), June 2007.

New York: Federal State Health Reform Partnership Waiver (F-SHRP), cont'd

- Cost/Funding
  - Federal government to provide funding up to $1.5 billion (up to $300 million per year) to the State for specific designated expenditures.
    - In turn, NY is required to generate $3 billion in total Medicaid savings
    - If savings are not achieved by the end of the demonstration, it will be required to refund to the Federal government the difference between the Federal investment in the F-SHRP reforms and the Federal savings generated.
    - The demonstration must generate Federal savings sufficient to offset the Federal investment.
- As of 2009, waiver budget neutrality requirements on track[3]

Sources:[1] New York Federal-State Health Reform Partnership Section 1115 Demonstration CMS Fact Sheet, Oct. 2006; [2] New York State Department of Health, Federal-State Health Reform Partnership (F-SHRP), June 2007. [3]California MediCal Waiver Options Supplemental Chart Pack: State Waiver Comparison Draft. Health Management Associates/Harbage Consulting Page, July 2009

California: Medi-Cal Hospital Uninsured Care 1115 Waiver

- Demonstration in effect from Sept. 2005 - August. 2010
  - Fundamentally alters the way Medi-Cal pays hospitals
  - Coverage expansion initiatives
- Demonstration Design
  - Selective Provider Contracting Program, allowing for selective contracts with private and certain public hospitals to provide inpatient services to Medi-Cal beneficiaries on a negotiated rate basis.
  - Creates a Safety Net Care Pool, utilizing State and new federal matching funds for the reimbursement of costs of providing medical care services to the uninsured or creating an insurance product targeted to the uninsured.
  - The Coverage Initiative, created through a waiver amendment in 2007, expands healthcare coverage for eligible low-income, uninsured individuals up to 200% FPL.
    - Will affect up to 180,000 low-income, uninsured persons
  - Expansion of managed care to the Aged, Blind, and Disabled (ABD) population.

Sources:[1] California Demonstration CMS Fact Sheet, March 2009. [2] MediCal Health Care Coverage Initiative – Questions and Answers. http://www.dhcs.ca.gov/services/Documents/CoverageInitiativeQA.doc; [3] Medeicaid Section 1115 Demonstrations: Comparing California, Massachusetts, and New York. California Health Foundation, Oct. 2009

California: Medi-Cal Hospital Uninsured Care 1115 Waiver, cont'd

- Costs/Funding
  - With the Safety Net Care Pool, CA receives $766 million per year for five years (total of $3.83 billion) in federal matching dollars for the costs of caring for uninsured, or for the creation of an insurance product targeted to the uninsured.
    - First two years of demonstration, $360 million in federal matching funds conditioned on mandated enrollment of managed care for the ABD population (CA failed to accomplish this on large scale and lost funds)
    - Last three years of waiver $540 million must be used in support of the Coverage Initiative
  - State is not allowed to create new inpatient, outpatient, and physician services taxes as source of federal matching funds

Sources:[1] California Demonstration CMS Fact Sheet, March 2009. [2] MediCal Health Care Coverage Initiative – Questions and Answers. http://www.dhcs.ca.gov/services/Documents/CoverageInitiativeQA.doc; [3] Medeicaid Section 1115 Demonstrations: Comparing California, Massachusetts, and New York. California Health Foundation, Oct. 2009