MO HEALTHNET OVERSIGHT COMMITTEE
OCTOBER 27, 2009

This packet contains the following information:

1. 2010 Tentative Meeting Schedule

2. MO HealthNet participation by eligibility category

3. MO HealthNet Comprehensive Review

4. Biography of guest speaker Marcia Morgan, Alicia Smith & Associates

5. Biography of guest speaker David Parrella, Alicia Smith & Associates

6. Presentation of Alicia Smith & Associates entitled "Comparative Analysis of Quality of Care and Access to Services in MO HealthNet"

7. Biography of guest speaker Angie WasDyke, Mercer Government Human Services Consulting

8. Presentation of Mercer entitled "MO HealthNet Managed Care Cost Avoidance Model"

9. "Chronic Care Improvement Program Overview" presented by George Oestreich, PharmD, MPA, MO HealthNet Division

10. Presentation of Mercer entitled "MO HealthNet Chronic Care Improvement Program (CCIP) Financial Evaluation"

11. "National Health Reform" presentation of Ian McCaslin, M.D., M.P.H., MO HealthNet Division

MO HEALTHNET COMMITTEE
2010 TENTATIVE MEETING SCHEDULE

February 2, 2010

May 4, 2010

August 3, 2010

November 9, 2010

All meetings will convene at 12:00 Noon and adjourn no later than 4:00 p.m.

205 Jefferson, 10th Floor, Conference Room B
Jefferson City, MO

CALL 573-751-6961 FOR ADDITIONAL INFORMATION

DRAFT

MoHealthNet Participation

	Participants as of March 2008	Participants as of September 2009	Change Since March 2008	Percentage of September 2009 Participants	Current Income Eligibility Maximums (Shown as a Percentage of Federal Poverty Level)	Projected Participants by June 2010
Children	484,750	521,883	+37,133	60.3%	300%	553,464(1)
Persons with Disabilities	147,208	157,596	+10,388	18.2%	85%	166,096(2)
Custodial Parents	74,561	78,701	+4,140	9.1%	TANF level (approximately 19%)	85,188(1)
Seniors	76,808	77,418	+610	8.9%	85%	78,133(2)
Pregnant Women	28,301	29,879	+1,578	3.5%	185%	31,291(1)
Total	811,628	865,477	+53,749			914,172
Women's Health Services	19,831	29,895	+10,064		185%	59,760(3)

Clarifications and Assumptions:

(1) Growth in custodial parent, pregnant women and child enrollment is based on a six-month average caseload growth through June 2010.

(2) Projected enrollment is based on a six-month average caseload growth through the end of SFY-2009 and SFY-2010 budgeted caseload growth. (Total growth for SFY-2010 was budgeted at 6,317 persons with disabilities and 1,248 seniors.)

(3) Growth is due to the addition of Uninsured Women's Health Services eligibility category that began enrolling in January 2009. Based on preliminary trend data, enrollment is expected to grow by approximately 90% through June 2010.

Source: Missouri Department of Social Services, Family Support Division/MO HealthNet Division, Monthly Management Report

MISSOURI MEDICAID COMPREHENSIVE ASSESSMENT

The MO HealthNet Division has contracted with The Lewin Group to:

- Perform a comprehensive review of Missouri's Medicaid program
- Identify short-term solutions and provide recommendations for improved operations into the future

In conducting this review The Lewin Group will:

1. Conduct meetings with state agencies and Budget staff. Meetings will focus on short-term cost savings opportunities, including but not limited to assessments of the following areas:
    - Clinical Services;
    - Pharmacy services;
    - Long-term care and home and community based services;
    - Provider reimbursement;
    - Services evaluations;
    - Hospital services, including ED utilization; and
    - Revenue maximization opportunities

2. Review specific components relating to Medicaid within the Department of Mental Health and Department of Health and Senior Services, in light of cost containment deliberations

3. Assess selected tools and systems supporting the programs under review, including selected electronic tools utilized for claims edits, as well as applicable provider web portal utilization.

4. Review both state and vendor provided call centers.

5. Request and begin review of at least three years of claims, eligibility, and encounter data files. Upon obtaining the data, will conduct analyses focused on identifying cost savings opportunities with supporting estimates of the cost savings of various cost containment options.

6. Measure the impact of divisional programs designed to produce program savings in order to calculate an ROI for each individual program.

7. Conduct analyses on high-cost beneficiaries and high-volume providers in various counties/regions of the state.

8. Conduct a review of Clinical Services Programs, with priority given to early review of the Pharmacy program. Clinical Services encompasses a number of additional programs, including but not limited to: Psychology, Dental, Medical Pre-certification, DME, Optical Pre-certification, Hospice, Chronic Care Improvement Program, and Missouri Rx Plan.
    a. Based upon the comprehensive analysis of state claims data and program materials/reports, existing programs will be rank-ordered for potential for short-term return on investment (ROI), after which the State and the contractor will jointly determine which programs are most appropriate for in-depth reviews.
    b. The following are goals for the review of the selected Clinical Services:
        i. Assess the effectiveness and efficiency of the program, particularly with respect to management of the benefit provided to Medicaid participants, in order to make specific recommendations for improvement.
        ii. Identify areas within each program element with potential to produce short-term ROI in the form of actual claims reductions and/or administrative cost savings, or demonstrating enhanced value in improving access to care or quality of care.
        iii. Identify specific program elements that may produce improved ROI within 12 months, 12-36 months, or longer term.

9. Conduct a two-staged focused assessment of the Long-Term Care program including home and community based options. The review will include gathering information from discussions with State staff, providers, consumers and their representatives, and document review and data analysis. Specific components of the review will include: finance/budgeting/accounting, rate setting, utilization review/prior authorization, eligibility and service delivery, claims and encounter data processing, and evaluation of service delivery to consumer demand. Evaluation of policy and framework for achieving cost containment will be provided by the contractor.

10. Work with staff to develop a high-level set of metrics appropriate for the Medicaid Director and the Director of the Department of Social Services. The metrics will be designed to meet the end-user needs of the program's high-level managers. The contractor will develop mock-ups of the dashboards and assess the level of effort (e.g., additional or different data collection, systems programming) that is needed to produce the metrics and dashboards on a regular basis. The contractor will review up to 10 existing metrics and reports, including those produced by Infocrossing as part of its MMIS responsibilities, to determine what is currently available to program managers and the appropriateness of including data from these sources in the high-level metrics.

Summary of Deliverables and Due Dates

Deliverable	Due Date
1. Project Management Work Plan	Within 2 weeks of Task Order execution
2. Pharmacy Review	November 1, 2009
3. Prioritized List of Short-Term Cost Containment Savings	November 30, 2009
4. Other Clinical Service Area Review	December 1, 2009
5. Long-Term Care Short-Term Cost Savings	December 15, 2009
6. Provider Assessment	January 31, 2010
7. Long-Term Care Longer-Term Cost Savings	February 28, 2010
8. High-Cost Beneficiaries and High-Volume Providers Analysis	February 28, 2010
9. Metrics and Dashboards	February 28, 2010
10. Finance and Budget Assessment	February 28, 2010
11. Final Medicaid Program Assessment	February 28, 2010

Reporting Requirements:

1. Upon completion of each task prepare a report summarizing findings and recommendations
2. Prepare a detailed report describing and ranking a list of state Medicaid budget reduction options focused on savings opportunities, to include executive summary materials and slide presentations for stakeholders and policymakers
3. Prepare a final detailed report on how the Medicaid program can be restructured and managed to perform optimally over the long term, to include executive summary materials and slide presentations for stakeholders and policymakers

Marcia R. Morgan
Partner
Alicia Smith & Associates, LLC

Marcia Morgan. Has a public sector background with a career history of being appointed to organizations experiencing dynamic change due to legislation or policy shifts at the state and federal government levels. She has worked for the Commonwealth of Kentucky serving in a number of management and policy positions with increasing decision making authority and visibility over a 24-year period.

During her employment tenure she demonstrated commitment and professional competence in the administration and management of complex government programs in 5 executive cabinets and 2 constitutional offices. Ms. Morgan's appointment as Secretary and Chief Executive Officer of the Cabinet for Health Services makes her uniquely qualified to assist clients in meeting policy objectives while providing operational expertise and sound analysis to support Medicaid policy and program changes in evolving and challenging state and federal government venues.

She joined AS&A on April 16, 2005 and became a partner in the firm on January 1, 2006. Since joining the firm, Ms. Morgan has worked with Hawaii, Missouri, Georgia, Tennessee and other states to improve Medicaid and mental health programs in operationalizing complex policy decisions.

Representative Accomplishments

- Worked with Medicaid agencies on readiness and implementation activities to support the service delivery system when transitioning from a fee for service environment to managed care. Activities included: reviewing contract deliverables, conducting on-site readiness review of managed care organizations, monitored transition activities performed by managed care organizations.
- On behalf of state Medicaid agencies, she has worked extensively "on-site" to implement managed care. She has worked extensively in managing organizational change and building staff capacity to administer and monitor managed care organizations. Worked on operationalizing various reorganization efforts and process re-design efforts to meet management objectives, i.e. process mapping, re-engineering development of service level agreements, memoranda of agreements.
- Worked with State Medicaid agencies on system re-design efforts including service delivery strategies, e.g. managed care, fee-for-service, PCCMs. Examined and analyzed delivery strategies within the agencies budget context to select service delivery strategies which maximized available funding.
- Worked with a state agency on re-designing their MR/DD system to comply with federal law and regulations. This project required a comprehensive analysis of the existing service delivery system including rates, cost reports, program governance and other germane components necessary to support a comprehensive waiver program offering services to the MR/DD population. In conjunction with the administering agency she helped develop strategies to minimize impacts on system stakeholders as a result of the program re-design effort.
- Worked on a research project for a State Mental Health Agency, to identify multiple funding streams and barriers, which limit the State's ability to build a comprehensive system of services for individuals with mental health problems. The project proposed solutions to build an integrated seamless system of care.
- Prepared an 1115 Demonstration Waiver renewal for a State's Medicaid Agency to manage the Medicaid population including the Aged, Blind and Disabled population.
- Prepared Request for Proposals for State Medicaid agencies to procure managed care organizations.
- Assisted in developing the scope of work for a State Medicaid Agency to procure an Administrative Services Organization.

- Worked with a State mental health agency on a Disproportionate Share Hospital Funds Project, which when implemented will help expand community based services for persons with serious mental illness.

As the Secretary, Cabinet for Health Services

- Provided executive leadership for healthcare programs and initiatives operated and undertaken by Kentucky during her tenure as Secretary. Responsible for the day to day operations of a multi-faceted health care agency which included: Medicaid, Public Health Departments, Mental Health & Mental Retardation Services, including state operated hospitals and residential facilities, Certificate of Need, Aging Services, Office of Inspector General and The Commission for Women's Mental and Physical Health.
- Negotiated with provider and advocacy communities on a multitude of issues and programs including: Medicaid cost containment initiatives, CMS waiver requests, provider taxes, regulation and policy changes, implementation of new programs, i.e. the development of the state's Olmstead Plan and redesign of the state's Supports for Community Living Program for the MR/DD population.
- Provided executive level supervision in developing rate setting methodologies for hospitals, nursing facilities, behavioral health services and home health services. Transitioned all cost based private providers to fee based structures.
- Served as the Governor's Healthcare Advisor to the National Governors Association.
- Prepared and presented briefings for various audiences including the Press, Governor, Legislature and other public/private stakeholders in the health care delivery system.
- Managed contract negotiations with managed care organizations, claims processing entities, pharmacy benefit managers and other players necessary to support Medicaid and Mental Health & Mental Retardation Services.
- Managed ICF/MR facilities and aggressively pursued "new" active treatment processes/policies to help transition residents to the community.

While Interim Secretary, Cabinet for Health Services

- Established an Olmstead Compliance Plan for the Commonwealth of Kentucky, which incorporated an integrated network approach for the maintenance and establishment of a full array of services providing viable choice for Kentuckians.
- Implemented Medicaid revenue maximization strategies including intergovernmental transfers, targeted case management services for children, administrative claiming for education services.
- Provided leadership and policy direction for the Cabinets legislative efforts. Established monitoring system to analyze legislation and develop strategies to minimize or maximize program impact.

As the Deputy Secretary, Cabinet for Health Services

- Served as Chief Financial Officer for the Cabinet and was responsible for the development and management of the Cabinet's Biennial budget. Supervised budget and policy analysts performing financial analysis necessary to support budget forecasts and determining fiscal impact of programming changes for major health care programs.

As the Executive Director, Office of Program Support, Cabinet for Health Services

- Served as Budget Director for the Cabinet and implemented a consensus forecast approach to the Medicaid budget utilizing linear progression analysis and econometric models to support budget construct in conjunction with traditional utilization, expenditure and eligible population data.
- Member of the Cabinet's Managed Care Development Team to implement regional not-for-profit partnerships under a 1115 demonstration waiver. The team's duties included: RFP development, evaluation of proposals, contract negotiations and strategic leadership to activate partnerships with an aggressive public communications component which incorporated member/provider education. Tools developed: readiness review instruments, checklists for provider capacity, education forums, regulation development and other action steps necessary to support a transition from a fee for service system to a managed care environment.
- Helped develop and implement Kentucky's Children Insurance Program pursuant to Title XXI. Kentucky's SCHIP program participated in the redistribution of SCHIP funding beginning in year 1 of the authorization. Managed and developed all program activities including the design of the program and the outreach campaign.
- Responsible for managing all contracts and procurements for the Cabinet to ensure compliance with contract and procurement requirements. Participated in a complete re-engineering effort to streamline contract management.

EDUCATION

University of Kentucky, Lexington, KY
B.A. in General Studies (Political Science with a minor in History) - 1976

David Parrella
Consultant
Alicia Smith & Associates, LLC

Mr. Parrella joined Alicia Smith & Associates, LLC August 3, 2009. Mr. Parrella brings more than 20 years of experience in the health care sector highlighted by a focus on program development and implementation. Before retiring in June of 2009, Mr. Parrella was employed by the Connecticut Department of Social Services (DSS) for twenty-two years. During his tenure with the Department of Social Service he held various positions, including twelve years as the Director of Medical Care Administration (the Medicaid director). As Medicaid director he was twice elected to be Chairman of the National Association of State Medicaid Directors (NASMD). In that capacity he served on numerous national health policy forums and recently led the successful effort to impose a moratorium on several Medicaid regulatory changes proposed by the Centers for Medicare and Medicaid Services (CMS).

Representative Accomplishments

As the Director of Medical Care Administration, Connecticut Department of Social Services

- Supervised 3 Directors, 7 Managers, and 105 other staff in the administration of the State Medicaid Program and state funded health care programs (General Assistance, Homecare, HIV, Elderly, Pharmacy Assistance, Hospital Disproportionate Share, etc.).
- Provided executive leadership in the administration of the State Medicaid Program and state funded healthcare programs.
- Designed and implemented a Title XXI expansion for children (HUSKY B), including program for children with special health care needs (HUSKY Plus).
- Designed and implemented the Charter Oak program for the uninsured in Connecticut

As the Director of Administration Policy, Connecticut Department of Social Services

- Designed and implemented a managed care program for 240,999 recipients in TANF and related coverage groups (HUSKY A).

As the Acting Deputy Commissioner, Health Care Financing, Connecticut Department of Social Services

- Supervised state medical assistance program listed under Director of Medical Care Administration.
- Designed and implemented the original Medicaid managed care program.

As the Chief of Medicaid Policy and Program Implementation, Department of Income Maintenance

- Supervised the Medicaid Management Information System (MMIS), Third Party Liability, and Medicaid Policy Units.

As the Program Manager, Medical Care Administration, Department of Income Maintenance

- Supervised a staff of seven in the development of special projects for the Connecticut Medicaid Program including federal waivers, the preparation of requests for proposals,

and the development of policy and systems for the reimbursement of new Medicaid services.
- Performed trend analysis and evaluation of existing programs.
- Prepared budget options and reports.

As the Medicaid Policy Consultant, Department of Income Maintenance

- Evaluated and develop state policy on services provided by physicians and other community health care providers.
- Researched and develop a charge-based provider reimbursement methodology.
- Designed and implement prevailing and customary charge screens for the Medicaid Management Information System.
- Developed alternative programs for the delivery and reimbursement of AIDS related health care including the Connecticut AZT program.
- Developed and wrote the formal application for a federal home and community based services waiver for persons with a diagnosis of AIDS or ARC.
- Liaison with the Connecticut Medical Society and other provider organizations.

As the Assistant Director/Planner, Mashantucket Pequot Indian Health Department

- Developed community health assessment instrument and managed the research project to assess tribal health needs.
- Developed and wrote the formal tribal health plan for the Indian Health Service.
- Supervised community health staff in health needs assessment, client intake, and health service delivery.
- Prepared annual contract proposal to the federal government for a tribal health system including program descriptions, job classifications, work plans and line item budgets.
- Managed the department's overall health planning and federal compliance function.
- Developed tribal health service polices and procedures.
- Implemented and monitored contracts with health care providers including physicians, dentists, pharmacies and hospitals.

EDUCATION

University of Connecticut, Greater Hartford, CT
A.B.D. in Primary Healthcare, Community Participation - 1983

University of Oregon, Eugene, OR
M.A. in Anthropology – 1978

Yale University, New Haven, CT
B.A. in History - 1972

MISSOURI DEPARTMENT OF SOCIAL SERVICES

MO HealthNet DIVISION

Comparative Analysis of Quality of Care and Access to Services in MO HealthNet

MoHealthNet

October 27, 2009

Presented By:

ALICIA SMITH & ASSOCIATES, LLC

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MO HealthNet GOALS

- The system must pay attention to the wellness of the individual, including health education.
- Participants must have access to chronic care management.
- MO HealthNet should provide services in the appropriate setting at the right cost.
- Care plans should emphasize the needs of the individual.
- Care should be based on evidence-based guidelines to improve quality.
- Participants should be responsible for their own health.

MANAGED CARE

- **Managed Care** – a system of health care delivery where some portion of the activities in the delivery of health care is contracted out. These contracts can be:
  - Comprehensive Risk : Managed Care Organization (MCO);
  - Partial Risk : Prepaid Inpatient Health Plan (PIHP) or Prepaid Ambulatory Health Plan (PAHP);
  - Non-Risk : Administrative Services Organization (ASO), as in the Chronic Care Improvement Program (CCIP); or
  - Primary Care Case Management (PCCM)

TOOLS TO MANAGE CARE WAIVERS/BBA

- 1915(b) – Medicaid waiver that allows the state to waive State Plan requirements for Freedom of Choice, Statewidedness, and Comparability.

- 1115 – A research and demonstration waiver that allows greater flexibility for the state to modify other requirements in the State Plan, including eligibility.

- The Balanced Budget Act of 1997 allows states to have managed care under a state plan amendment.

NATIONAL TRENDS

YEAR	MEDICAID POPULATION	MANAGED CARE	% MANAGED CARE
2008	47,142,791	33,427,582	70.91%
2007	45,962,271	29,463,098	64.10%
2006	45,652,642	29,830,406	65.34%
2005	45,392,325	28,575,585	62.95%
2004	44,355,955	26,913,570	60.68%
2003	42,740,719	25,262,873	59.11%
2002	40,147,539	23,117,668	57.58%
2001	36,562,567	20,773,813	56.82%
2000	33,690,364	18,786,137	55.76%
1999	31,940,188	17,756,603	55.59%

NATIONAL TRENDS (cont.)

- All but two states (Alaska and Wyoming) have some form of managed care.

- 70% enrollment figure can be deceiving. Not all of those participants are enrolled in full-risk managed care. Many states offer PCCM, ASO, or partial-risk options.

FEE-FOR-SERVICE

- Traditional method of administering the Medicaid State Plan where the state staff of the Single State Agency is responsible for provider enrollment, determining the scope of coverage and the rates of reimbursement. States may contract out certain activities such as disease management or claims processing.

- Even in instances when the state has contracted all or part of these duties under managed care, the ultimate authority for decisions and responsibility to the federal government still resides with the Single State Agency.

ADVANTAGES OF FEE-FOR-SERVICE

- Open provider network for those providers who meet state standards.
- Maximum state control over rates, services, medical necessity determinations.
- Claims data is maintained within the state MMIS system.

ADVANTAGES OF MANAGED CARE

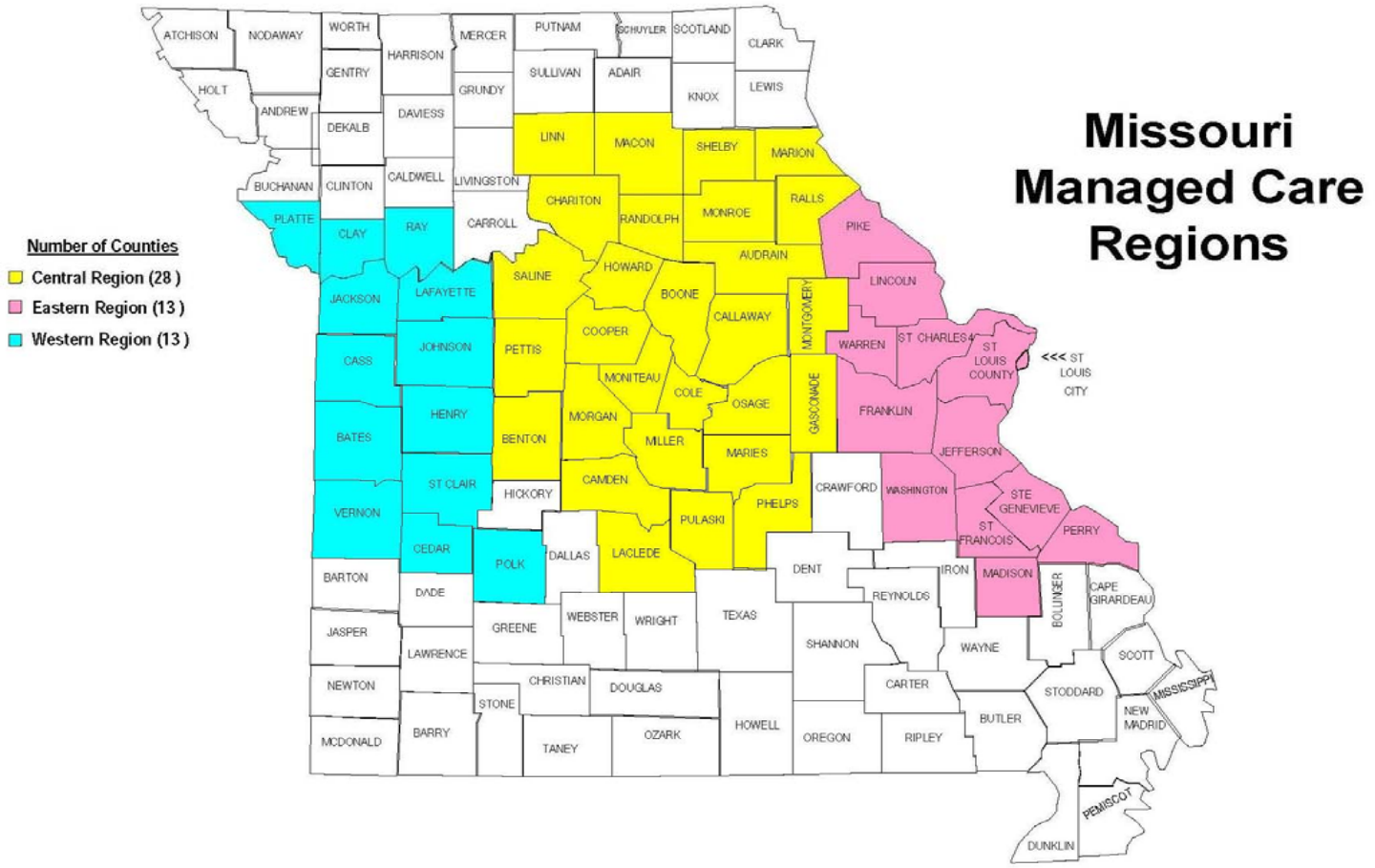
- Budget predictability.
- Provider network is contractually obligated to meet state standards.
- Quality reporting to the state is enhanced with supplemental data (chart reviews, client satisfaction surveys) that goes beyond administrative claims data.

MEDICAID IN MISSOURI

- Single State Agency – the Department of Social Services

- Medicaid Division – MO HealthNet (fee-for-service and managed care)

MANAGED CARE AND FEE-FOR-SERVICE REGIONS



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ENROLLMENT AS OF SEPTEMBER, 2009

- **Managed Care**

	Adults	Pregnant Women	MO HealthNet Kids	CHIP Kids	Total
East	27,990	7,479	150,465	19,500	205,434
West	16,493	5,427	98,333	13,759	134,012
Central	9,671	3,595	58,323	9,883	81,472
Total	54,154	16,501	307,121	43,142	420,918

- **Fee-For-Service**

FFS	25,677	10,291	153,720	27,890	217,578

TIMELINE

- September 1, 1995 – Missouri introduces MC+ in the Eastern Region.
- March 1, 1996 - Missouri introduces MC+ in the Central Region.
- November 8, 1997 - Missouri introduces MC+ in the Western Region.

MANAGED CARE QUALITY MEASURES

- Performance measurement – HEDIS (Healthcare Effectiveness Data and Information Set)
- EQRO (External Quality Review Organization)
- Accreditation by NCQA (National Committee for Quality Assurance)
- Provider Access Standards

VIEW FROM SURROUNDING STATES

STATE	Population	Median Annual Income 2006-2008	Urban/Rural Distribution 2008	% of Individuals Under 133% of FPL 2008	Unemployment Rate Sept. 2009	Medicaid Enrollment 2006	Match Rate June 2009
INDIANA	6.2M	$48,095	72% - U 28% - R	22.7%	9.6%	1M 16% of the population	64.26% vs. ARRA Rate 74.21%
ARKANSAS	2.8M	$40,507	64% - U 36% - R	26.6%	7.1%	754,700 27% of the population	72.81% vs. ARRA Rate 80.46%
OKLAHOMA	3.5M	$44,154	68% - U 32% - R	25.9%	6.7%	701,300 20% of the population	65.90% vs. ARRA Rate 75.83%
MISSOURI	5.8M	$47,139	77% - U 23% - R	23.3%	9.5%	1M 18% of the population	63.19% vs. ARRA Rate 73.27%

SOURCES:

1. KAISER FAMILY FOUNDATION STATE HEALTH FACTS.ORG
2. BUREAU OF LABOR STATISTICS
3. DEPT. OF HEALTH & HUMAN SERVICES WEBSITE

VIEW FROM SURROUNDING STATES (cont.)

- Indiana - Moved from a mixed model of PCCM and at-risk MCOs to statewide MCOs
- Arkansas - Moved from Fee-for-Service to statewide PCCM
- Oklahoma - Moved from Fee-for-Service, to a mixed Model (MCOs and PCCM), to statewide PCCM

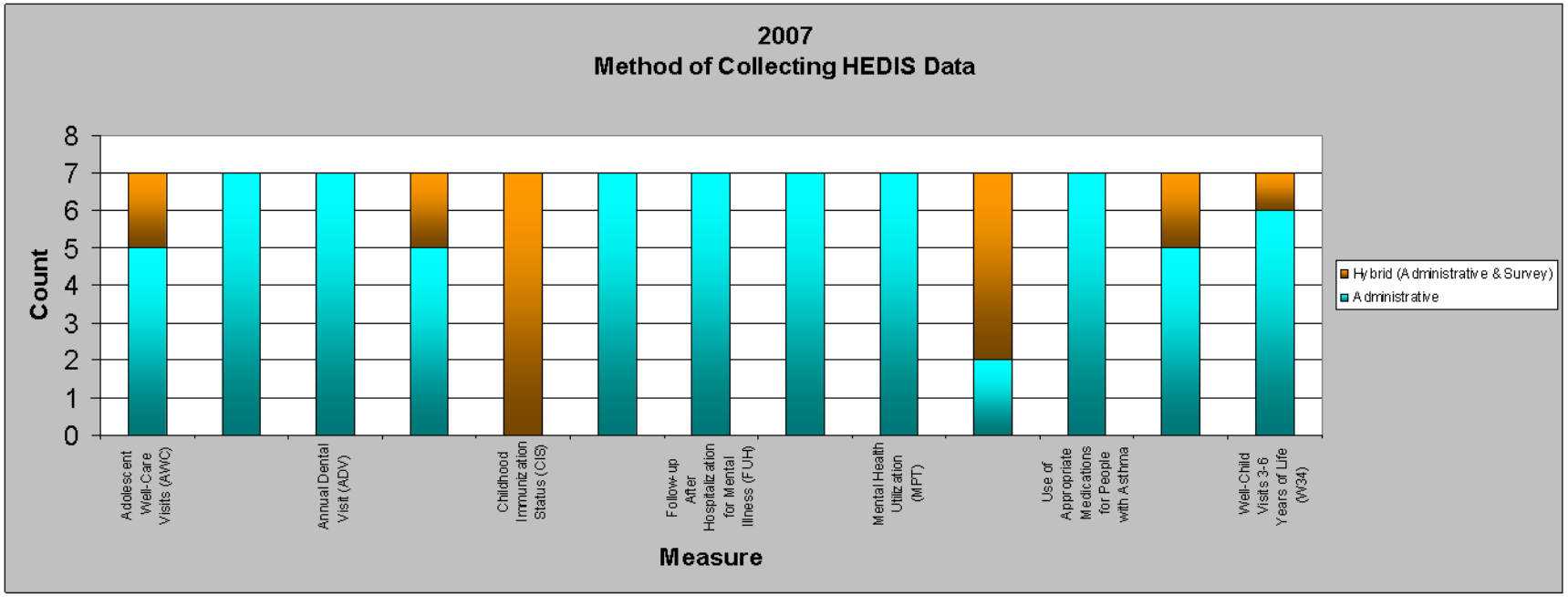
RESEARCH METHODOLOGY

- HEDIS and HEDIS-like measures for fee-for-service developed by MO HealthNet
  - Well-Child Visits, first 15 months: 6+ visits
  - Well-Child Visits 3rd through 6th Year
  - Childhood Immunizations
  - Timeliness of Prenatal Care
  - Postpartum Care
  - Cervical Cancer Screening

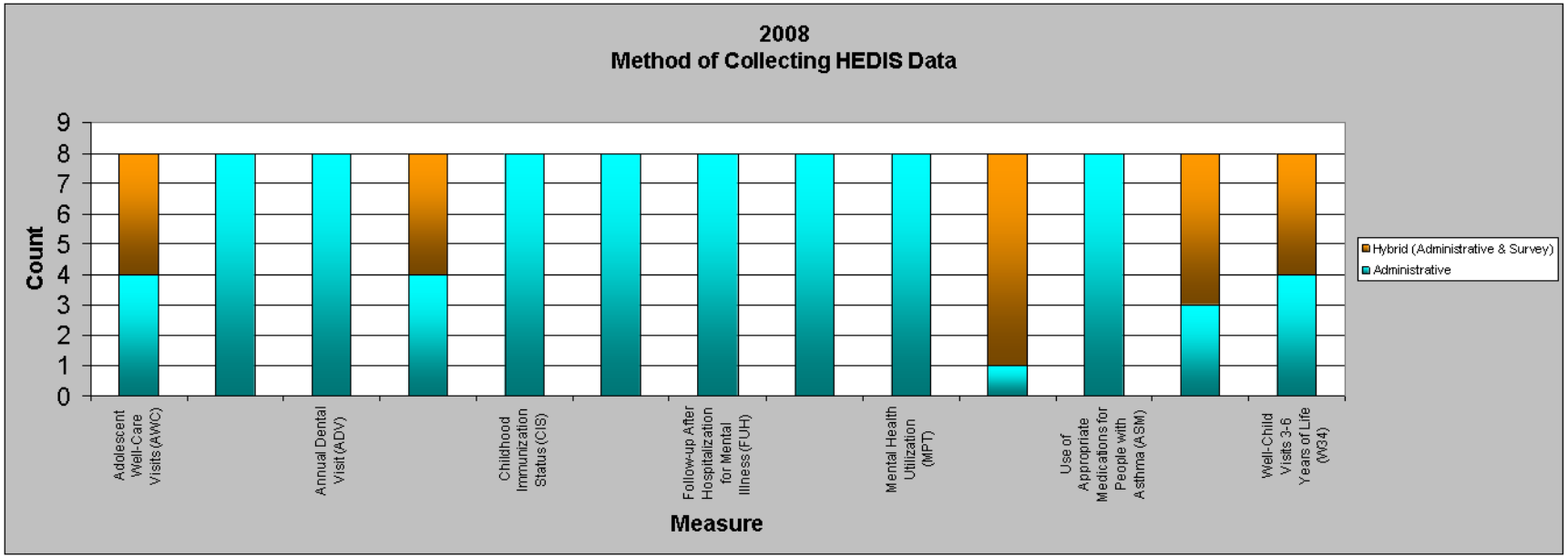
HEDIS vs. ADMINISTRATIVE DATA

- Both Fee-for-Service and Managed Care report administrative data (paid claims, encounter data)
- MCOs also report on HEDIS measures using supplemental data (i.e. sample chart reviews, surveys)

MCO HEDIS METHODS: ADMINISTRATIVE vs. HYBRID



MCO HEDIS METHODS: ADMINISTRATIVE vs. HYBRID (cont.)



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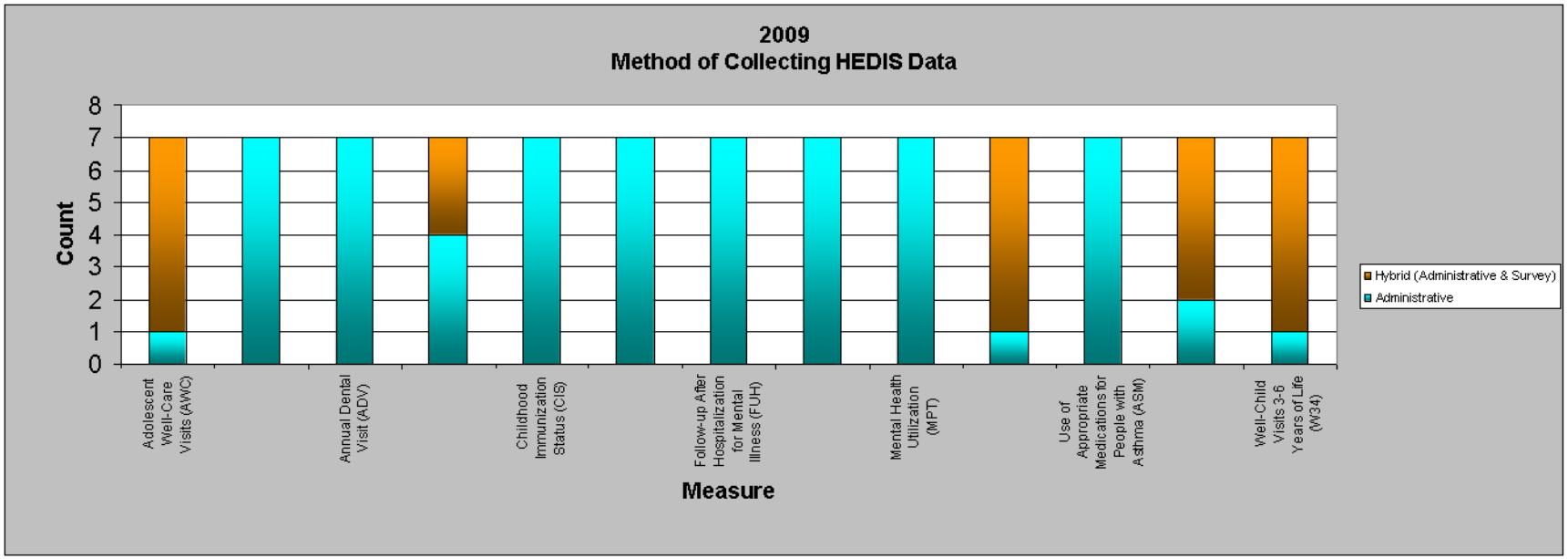
MCO HEDIS METHODS: ADMINISTRATIVE vs. HYBRID (cont.)



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HEDIS RESULTS: FFS vs. MANAGED CARE

MO HealthNet Division 09/2009

FFS and Managed Care HEDIS-Like Measures
Managed Care HEDIS* Measures

			2006 FFS	2007 FFS	2006 Managed Care	2007 Managed Care	2007 Medicaid HEDIS Avg.
Well Child Visits in the First 15 Months of Life - 6+ Visits	HEDIS-Like**	Numerator	3,042	3,112	3,368	4,183	
		Denominator	5,405	5,503	7,359	8,965	
		Percent	56.28%	56.55%	45.77%	46.66%	
	HEDIS*	Percent			51.74%	51.24%	55.6%
Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	HEDIS-Like	Numerator	65,387	53,130	109,951	95,368	
		Denominator	170,890	135,337	263,542	215,132	
		Percent	38.26%	39.26%	41.72%	44.33%	
	HEDIS*	Percent			57.81%	53.69%	66.8%
Prenatal Care	HEDIS-Like	Numerator	1,295	932	1,770	1,674	
		Denominator	13,367	8,293	18,421	12,689	
		Percent	9.69%	11.24%	9.61%	13.19%	
	HEDIS*	Percent			79.88%	77.95%	81.2%
Post-Partum Care	HEDIS-Like	Numerator	5,542	3,438	6,569	4,433	
		Denominator	13,367	8,293	18,421	12,689	
		Percent	41.46%	41.46%	35.66%	34.94%	
	HEDIS*	Percent			61.69%	58.68%	59.1%
Childhood Immunizations (Combo 2)	HEDIS-Like**	Numerator	63	2,123	197	2,162	
		Denominator	7,943	8,501	12,219	12,952	
		Percent	0.79%	24.97%	1.61%	16.69%	
	HEDIS*	Percent			60.01%	55.73%	73.4%
Cervical Cancer Screening	HEDIS-Like	Numerator	6,506	5,219	13,017	12,094	
		Denominator	11,659	8,233	23,626	18,960	
		Percent	55.80%	63.39%	55.10%	63.79%	
	HEDIS*	Percent			65.77%	56.78%	65.7%

*HEDIS measures submitted by MHD managed care health plans.

**Data source only had data available from 2005 to the present. These measures look back 15 months (Well Child Visits) to two years (Childhood Immunizatons, Cervical Cancer Screenings) therefore for data year 2006 we would need 2004 thruogh 2006 data. Only having 2005 and 2006 data will result in lower numbers for data year 2006; 2007 data year will not be affected.

ALICIA SMITH & ASSOCIATES, LLC
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RESEARCH METHODOLOGY

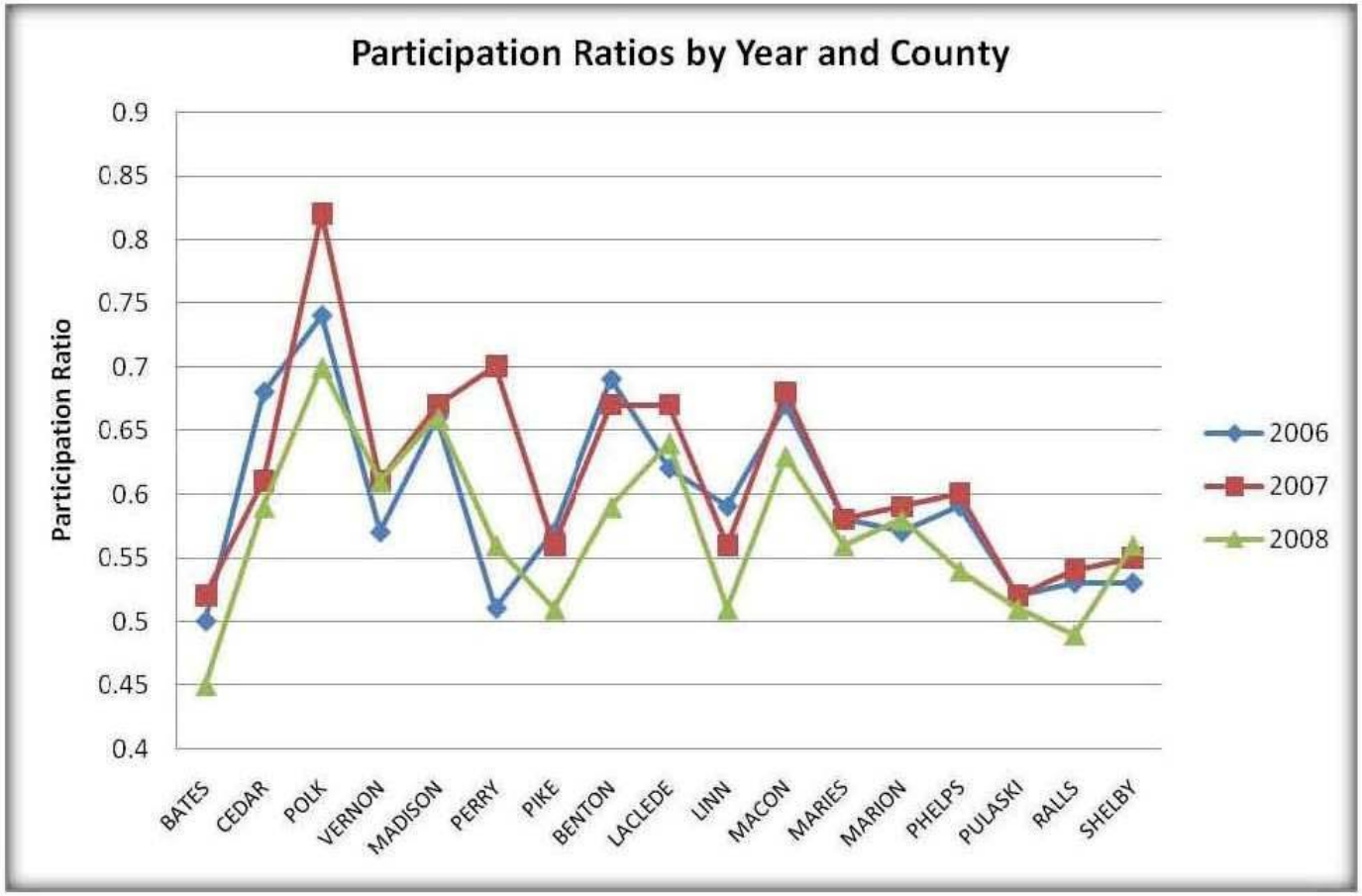
- Early and Periodic Screening, Diagnosis and Treatment program
  - Participation Rate (percentage of eligible children who received at least one well-child screen)
  - Screening Rate (percentage of total expected screens that occurred)
  - Referred for Treatment

2007 EPSDT PARTICIPANT RATIO COMPARISON – TOP TEN STATES

STATE	RATIO
INDIANA	100%
NORTH CAROLINA	79%
MASSACHUSETTS	78%
DISTRICT OF COLUMBIA	73%
ARIZONA	70%
ILLINOIS	69%
MISSOURI	69%
FLORIDA	68%
HAWAII	68%
IOWA	68%

Source: CMS 416 Report

PARTICIPATION RATIOS BY YEAR AND COUNTY



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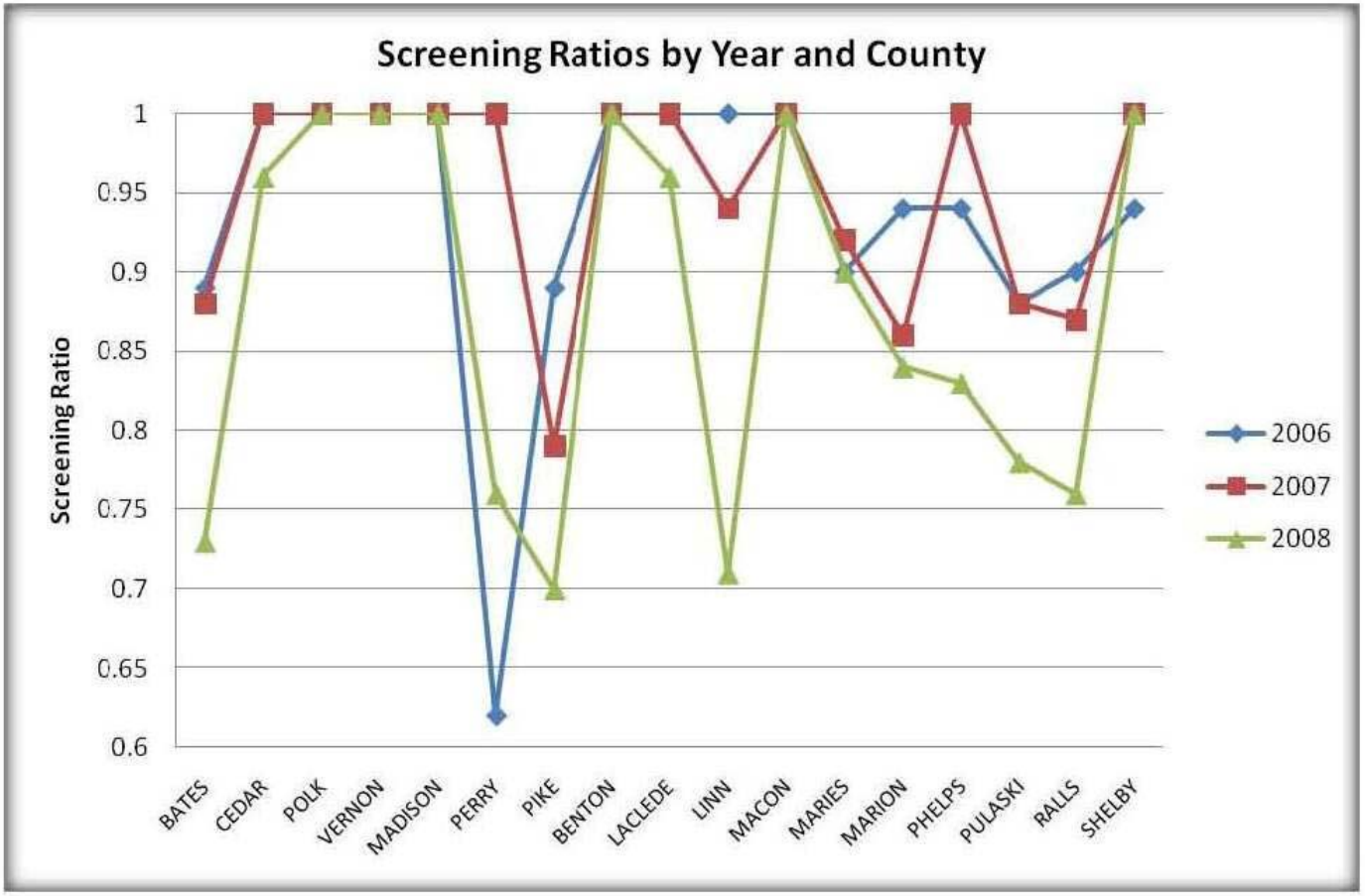
PARTICIPATION RATIOS BY YEAR AND COUNTY



RATIO OF ELIGIBLES THAT WERE REFERRED FOR CORRECTIVE TREATMENT

	Fee For Service			Managed Care		
	Total Eligibles Referred for Corrective Treatment	Total Eligibles Receiving at least One Initial or Periodic Screening Service	Ratio	Total Eligibles Referred for Corrective Treatment	Total Eligibles Receiving at least One Initial or Periodic Screening Service	Ratio
2006	69,755	107,961	0.65	97,531	167,140	0.58
2007	69,666	107,990	0.65	95,883	167,628	0.57
2008	60,376	92,279	0.65	111,313	186,343	0.60

RESEARCH METHODOLOGY

- Birth trends and Outcomes
- Data reported by Department of Insurance
- 1994-2008
  - Low Birth Weight (<2500grams)
  - Pre-term Births (<32 weeks)
  - Inadequate prenatal care

BIRTH TRENDS: FFS vs. MANAGED CARE

	Percent Change Low Birth Weight 1993-2008	Percent Change Inadequate Prenatal Care 2003-2008	Percent Change Low Birth Weight < 2500 grams 2003-2008	Percent Change Pre-Term Births <32 weeks 2003-2008
Managed Care	-32.0%	+ 12.7%	-9.3%	-23.6%
Fee-For-Service	-27.2%	+5.3%	-2.5%	-14.9%

PROVIDERS TO PARTICIPANTS RATIOS

- Primary Care Providers (PCP) to Participants
- Dentists to Participants
- Mental Health Providers to Participants

FFS PROVIDER NETWORK ACCESS

PROVIDER TYPE	Number of unique FFS providers that had more than 50 paid claims in SFY 2009	Number of unique FFS providers as of 01/01/2009 (per ad-hoc)
Doctors	7,855	12,848
APRNs	619	1,153
Dentist	292	612
Psych & Counselors	1,146	3,276

PCPs TO PARTICIPANTS

2008 Managed Care PCP to Enrollee Ratios

EAST	PCPs	Enrollees	PCP/Enrollee Ratio
Harmony	611	10,294	1 / 17
Healthcare USA	931	117,951	1 / 127
Molina Healthcare of Missouri	921	64,277	1 / 70
			1/71

CENTRAL	PCPs	Enrollees	PCP/Enrollee Ratio
Healthcare USA	506	26,061	1 / 52
Molina Healthcare of Missouri	451	5,764	1 / 13
Missouri Care	789	40,413	1 / 51
			1/39

WEST	PCPs	Enrollees	PCP/Enrollee Ratio
Blue Advantage Plus	455	27,557	1 / 61
Childrens Mercy Family Health Partners	585	48,284	1 / 83
Healthcare USA	760	37,280	1 / 49
Molina Healthcare of Missouri	605	7,675	1 / 13
			1/51

2008 Fee for Service PCP to Enrollee Ratios

PCPs	Enrollees	PCP/Enrollee Ratio
7,066	**471,583**	**1/67**

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DENTISTS TO PARTICIPANTS

2008 Managed Care Enrollees -DENTISTS to Enrollees

EAST	Dentists	Enrollees	Dentist/Enrollee Ratio
Harmony	148	10,294	1 / 70
Healthcare USA	198	117,951	1 / 596
Molina Healthcare of Missouri	204	64,277	1 / 315
			1/327

CENTRAL	Dentists	Enrollees	Dentist/Enrollee Ratio
Healthcare USA	36	26,061	1 / 724
Molina Healthcare of Missouri	30	5,764	1 / 192
Missouri Care	55	40,413	1 / 735
			1/550

WEST	Dentists	Enrollees	Dentist/Enrollee Ratio
Blue Advantage Plus	116	27,557	1 / 238
Childrens Mercy Family Health Partners	196	48,284	1 / 246
Healthcare USA	101	37,280	1 / 369
Molina Healthcare of Missouri	141	7,675	1 / 54
			1/226

2008 FFS Enrollees -DENTISTS to Enrollees

Dentists	Enrollees	Dentist/Enrollee Ratio
561	**471,583**	**1 /841**

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MH PROVIDERS TO PARTICIPANTS

2008 Managed Care Enrollees - MH PROVIDERS

EAST	MH Providers	Enrollees	MH Provider/ Enrollee ratio
Harmony	264	10,294	1 / 39
Healthcare USA	1,081	117,951	1 / 109
Molina Healthcare of Missouri	187	64,277	1 / 344
			1/164

CENTRAL	MH Providers	Enrollees	MH Provider/ Enrollee ratio
Healthcare USA	202	26,061	1 / 129
Molina Healthcare of Missouri	334	5,764	1 / 17
Missouri Care	415	40,413	1 / 97
			1/81

WEST	MH Providers	Enrollees	MH Provider/ Enrollee ratio
Blue Advantage Plus	2,567	27,557	1 / 11
Childrens Mercy Family Health Partners	858	48,284	1 / 56
Healthcare USA	308	37,280	1 / 121
Molina Healthcare of Missouri	575	7,675	1 / 13
			1/50

2008 FFS Enrollees - MH PROVIDERS

MH Providers	Enrollees	MH Provider/ Enrollee ratio
3,648	**471,583**	**1 /129**

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MANAGED CARE SPECIFIC DATA

- CAHPS (Community Assessment of Healthcare Providers and Systems)

CAHPS RESULTS 2006-2008

2006 Show Me Consumer's Guide:
Medicaid (MC+) Managed Care
Member Satisfaction*
(8/8/06) (2005 data year)

		Getting Needed Care			Customer Service			Rating of Plan		
XNAICID	Plan Name	% Not Prob	Z-stat	Z-test	% Not Prob	Z-stat	Z-test	% 8,9,10	Z-stat	Z-test
4717131	Blue-Advantage Plus of Kansas City, Inc.	81%	0.81	AV	77%	0.46	AV	81%	0.75	AV
9563631	Children's Mercy Family Health Partners	82%	1.40	AV	80%	0.06	AV	82%	1.29	AV
9560931	Community Care Plus	80%	-0.04	AV	72%	0.43	AV	79%	-0.33	AV
9536431	FirstGuard Health Plans	80%	0.22	AV	79%	0.16	AV	79%	-0.65	AV
9531832	Healthcare USA of Missouri-Central	79%	-0.85	AV	71%	0.13	AV	79%	-0.41	AV
9531831	Healthcare USA of Missouri-Eastern	80%	0.01	AV	77%	0.30	AV	86%	3.96	HI
9531833	Healthcare USA of Missouri-western	79%	-0.63	AV	71%	0.23	AV	77%	-1.71	AV
9530931	Mercy MC+	80%	-0.21	AV	75%	0.97	AV	83%	2.08	AV
9571531	Missouri Care Health Plan	79%	-0.47	AV	71%	0.28	AV	73%	-3.17	LO
999999	Statewide 2005	80%			75%			80%		

** Numerators and denominators are not shown since all measures (except Overall Ratings) are composites of multiple questions with varying numerators and denominators.*

CAHPS RESULTS 2006-2008 (cont.)

2007 Show Me Consumer's Guide:
Medicaid (MC+) Managed Care
Member Satisfaction*
(2/6/08) (2006 Data Year)

		Getting Needed Care			Customer Service			Rating of Plan		
XNAICID	Plan Name	% Not Prob	Z-stat	Z-test	% Not Prob	Z-stat	Z-test	% 8,9,10	Z-stat	Z-test
4717131	Blue-Advantage Plus of Kansas City, Inc.	80%	0.00	AV	64%	0.01	LO	82%	1.20	AV
9563631	Children's Mercy Family Health Partners	83%	1.73	AV	86%	0.00	HI	83%	1.65	AV
9560931	Community Care Plus	81%	0.75	AV	73%	0.80	AV	78%	-1.15	AV
9531832	Healthcare USA of Missouri-Central	82%	1.12	AV	70%	0.21	AV	81%	0.43	AV
9531831	Healthcare USA of Missouri-Eastern	79%	-0.95	AV	76%	0.43	AV	82%	1.01	AV
9531833	Healthcare USA of Missouri-western	73%	-3.99	LO	67%	0.05	AV	79%	-0.77	AV
9530931	Mercy MC+	81%	0.75	AV	73%	0.80	AV	78%	-1.15	AV
9571531	Missouri Care Health Plan	81%	0.97	AV	79%	0.04	AV	78%	-1.28	AV
999999	Statewide 2006	80%			73%			80%		

** Numerators and denominators are not shown since all measures (except Overall Ratings) are composites of multiple questions with varying numerators and denominators.*

CAHPS RESULTS 2006-2008 (cont.)

2008 Show Me Consumer's Guide:
Medicaid (MC+) Managed Care
Member Satisfaction*
(9/26/08) (2007 Data Year)

XNAICID	Plan Name	Getting Needed Care			Customer Service			Rating of Plan		
		% Not Prob	Z-stat	Z-test	% Not Prob	Z-stat	Z-test	% 8,9,10	Z-stat	Z-test
9591631	Blue-Advantage Plus of Kansas City, Inc	82%	2.56	AV	74%	0.57	AV	80%	1.05	AV
9563631	Children Mercy Family Health Partners	80%	1.42	AV	74%	0.47	AV	85%	3.59	HI
1122931	Harmony Health Plan	67%	-3.22	LO	61%	0.06	AV	71%	-1.82	AV
9531832	HealthCare USA of MO - Central	81%	2.46	AV	81%	0.00	HI	84%	3.70	HI
9531831	HealthCare USA of MO - Eastern	82%	2.42	AV	78%	0.03	AV	84%	3.37	HI
9531833	HealthCare USA of MO - Western	80%	1.61	AV	74%	0.48	AV	79%	0.66	AV
9560931	Mercy Care Plus - Eastern	80%	1.31	AV	75%	0.24	AV	78%	0.44	AV
9560933	Mercy Care Plus - Western	65%	-3.50	LO	60%	0.02	AV	63%	-3.33	LO
1291331	Missouri Care Health Plan	80%	1.69	AV	69%	0.50	AV	75%	-1.03	AV
999999	Statewide 2008	77%			72%			78%		

** Numerators and denominators are not shown since all measures (except Overall Ratings) are composites of multiple questions with varying numerators and denominators.*

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CONCLUSIONS AND RECOMMENDATIONS

- We did not observe any consistent difference in access to care or quality of care between fee-for-service and managed care. Managed care performed better on access and birth outcomes and on providing education to participants. Fee-for-Service performed better on Well-Child Screenings for newborns and the early initiation of prenatal care.

- However, managed care does provide the state with an accountable system, backed by improved reporting (HEDIS)

- MO HealthNet should be applauded for their efforts to develop HEDIS-like measures to provide a comparison between fee-for-service and managed care.

CONCLUSIONS AND RECOMMENDATIONS (cont.)

- MO HealthNet should consider eligibility and enrollment strategies to improve access for pregnant women to prenatal care
- HEDIS results on immunization rates for children are significantly below the national average for both fee-for-service and managed care.
- There was a slight difference in the percentage of children who received a well-child screen who were referred on for corrective treatment between FFS and managed care.
- MO HealthNet should consider additional measures in both FFS and managed care to audit provider networks.

Angela L. WasDyke, A.S.A., M.A.A.A

Angie WasDyke is a Principal and the Government Human Services Consulting (GHSC) Practice Leader in Mercer's Minneapolis office. Angie leads the Minneapolis GHSC state service teams in actuarial and other Medicaid projects. Angie combines more than 18 years in actuarial health care consulting with almost 10 years experience dedicated to consulting to state Medicaid programs.

During these nearly 10 years, Angie has served as the MO HealthNet Lead Actuary for managed care rate development and other financial activities involving pharmacy program management, non-emergent medical transportation, foster care and child welfare, clinical effectiveness, and the Program for the All-Inclusive Care for the Elderly. Angie's experience includes:

- Consulting on the pros and cons of different managed care programs (e.g., mandatory vs. voluntary programs, PCCM vs. full risk HMO programs), and strategizing with agencies on where to implement managed care, which populations to cover, and which benefits to capitate
- Assisting with strategy, design, and implementation of enhanced PCCM and disease management programs, including request for proposal development, proposal evaluations, capitation rate development, and vendor financial accountability such as return on investment, guaranteed savings calculations and risk sharing arrangements
- Developing rate-setting methods based on multiple sources of data, including FFS data, health plan financial data and encounter data
- Presenting rate-setting methods at technical assistance sessions for potential contractors and other interested parties
- Assisting with rate negotiation strategies for states and negotiating with health plans
- Designing and implementing state programs for the uninsured populations, including pricing of benefits and capitation rate setting
- Providing strategy on the design, implementation, and evaluation of Medicaid reform initiatives for CHIP programs and pharmacy management and purchasing

Before joining Mercer in January 2000, Angie gained experience working with other consulting firms and insurance companies – evaluating provider contracts, developing capitation rates, estimating claim liabilities and establishing rating methods. She is an Associate in the Society of Actuaries and a Member of the American Academy of Actuaries. Angie has a bachelor's degree in Actuarial Science from Maryville College – St. Louis.

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October 27, 2009

MO HealthNet Managed Care Cost Avoidance Model

State of Missouri

Angela WasDyke, ASA, MAAA

Michael Cook, FSA, MAAA

Managed Care Cost Avoidance Model
Overview

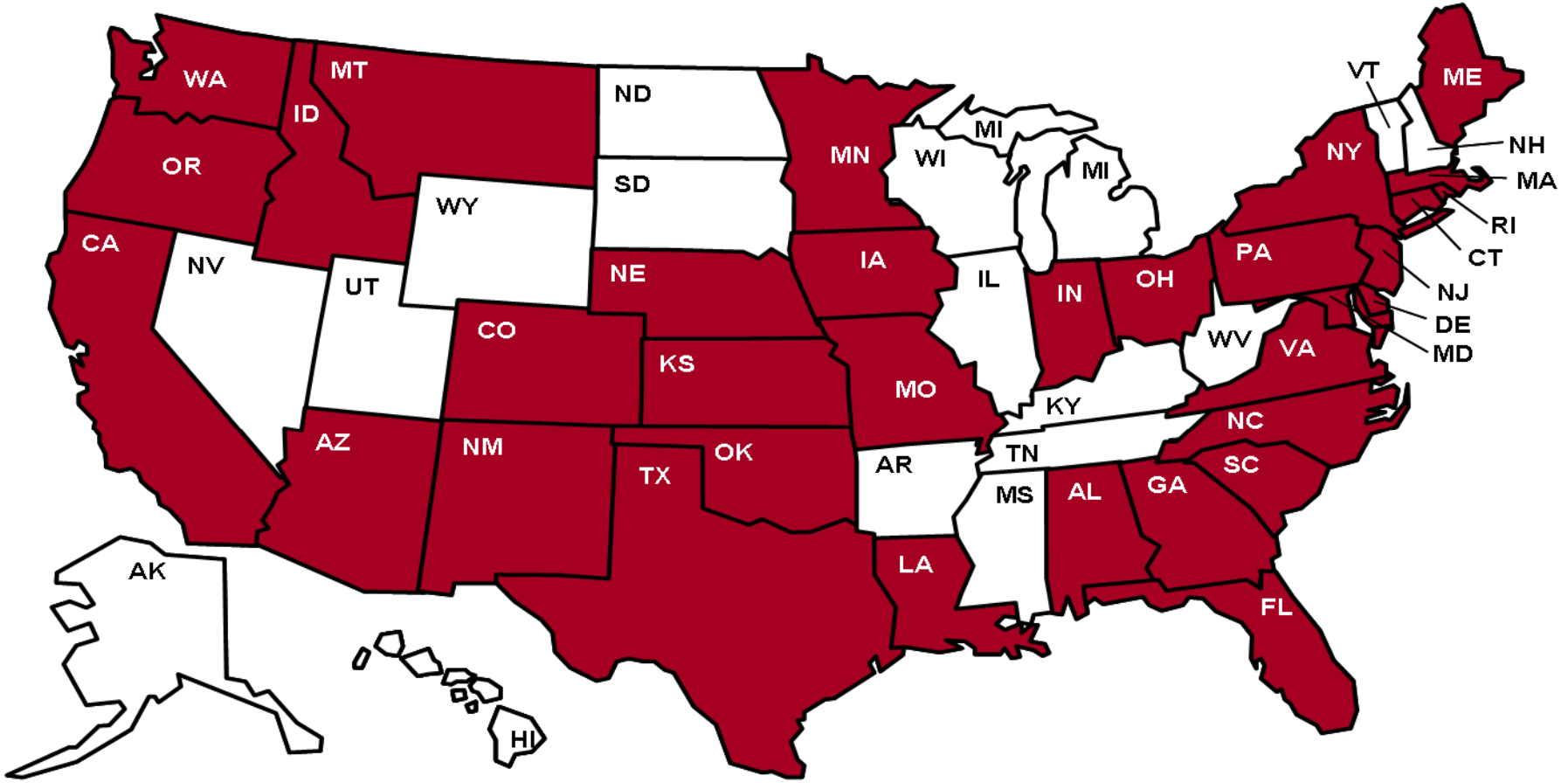
- Introduction
- Background
- Model Goals
- Managed Care Versus Benchmark Population Expenditures
- Mercer Recommendations
- Current Status
- Questions

Managed Care Cost Avoidance Model
Introduction

- Mercer Government Human Services Consulting (Mercer)
  - Dedicated to assisting publicly-funded health and welfare programs be efficient purchasers of health care
  - Consulting to state governments since 1985
  - Has worked with more than 30 state governments and currently holds contracts with over 20 states
- Mercer's range of services in Medicaid
  - Managed care (MC) and FFS rate development/financial support (acute and long term care)
  - Clinical quality assistance across physical health and mental health services
  - Pharmacy program management
  - CMS compliance support for waivers, SPAs, and external quality review
  - Uninsured program design and pricing

Managed Care Cost Avoidance Model
Introduction

Mercer's State Experience



Managed Care Cost Avoidance Model
Introduction

- Mercer was asked to review existing model evaluating managed care cost avoidance
- Mercer has conducted this work since beginning rate setting in 1985
  - Prior to implementation of BBA and Managed Care Regulations, this was a CMS rate-setting requirement
  - CMS substantially incorporated Mercer's approach to rate setting into a "Checklist" for developing rates under the Managed Care Regulations
  - Still determine cost avoidance for some states as a method of program evaluation

Managed Care Cost Avoidance Model
Background – Managed Care

- Similarities between FFS and MC delivery systems
  - Identical eligibility criteria; determined by State
  - Nearly identical benefit set
  - Nearly identical needs for administrative services
- Differences between FFS and MC delivery systems
  - Reimbursement
  - Party assuming claims risk
  - Cost control mechanisms
  - MC capitation levels include consideration for additional care management activities, other administrative functions and target profit
  - Some services are “carved out” from the MC capitation payments and are the responsibility of FFS

Managed Care Cost Avoidance Model

Background - Medical Loss Ratio Components

- FFS system includes medical and administrative expenses to State
- MC system includes medical and administrative expenses as well as profit or loss to health plan
- Medical Loss Ratio (MLR) is the percentage of health plan capitation dollars expended on medical services
- Capitation rates recently developed using about 88% MLR
  - Consistent with historical experience
  - Typically set profit as a longer-term goal of 2% - 4% over 3 to 5 years for mature MC programs
  - MO MC program pricing is consistent with this goal

Managed Care Cost Avoidance Model

Background - Managed Care Savings

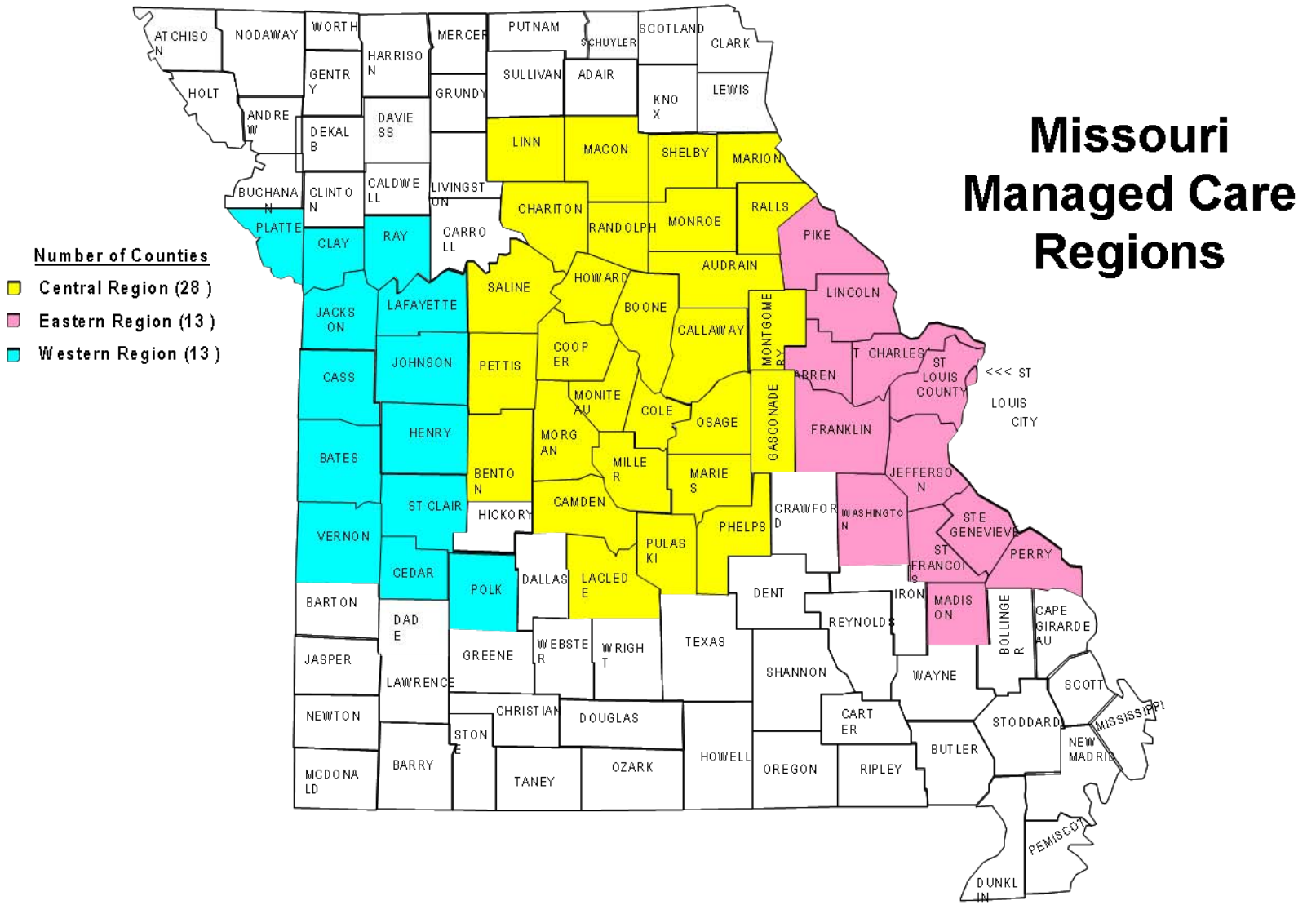
- Level of savings experienced through MC varies based on many factors
  - Rural versus urban population
  - TANF versus ABD population
  - Level of provider acceptance of managed care
  - Effectiveness of managed care organizations
  - Maturity of managed care program
  - Sophistication of existing FFS care management
- Typical long-term savings for a TANF-like population are 3 – 6%
- States experience a wide range in MC savings based on their actual environment in regards to the factors above

Managed Care Cost Avoidance Model
Background - MO HealthNet MC Eligibility

- MO HealthNet MC Eligibles
  - TANF children
  - Low income custodial adults
  - Pregnant women
  - CHIP children
- Not MC Eligible
  - Old Age Assistance
  - Permanently and Totally Disabled
  - Aid to the Blind
  - Blind Pension
  - Qualified Medicare Beneficiary
  - Missouri Children with Developmental Disabilities
  - MAF in a Vendor Institution

Managed Care Cost Avoidance Model

Background - MO HealthNet MC Eligibility



Managed Care Cost Avoidance Model

Background – Cost Avoidance Model

- Model currently used by the State to evaluate level of any cost avoidance achieved through the MC program
- Model complicated by the fact that there are no equivalent populations to compare between FFS and MC
  - Geography
  - Eligibility criteria
- Model further complicated by payments made outside claim system
- Mercer was asked to review model and make recommendations for revisions, if needed
  - Not all recommendations have been implemented/researched
  - Model and results still in development

Managed Care Cost Avoidance Model
Model Goals

- Model goal is to answer the following question:

  If the MC program did not exist, what would the cost of the existing MC eligibles be in the FFS delivery system?

- Historical financial analysis of MC program
- Not a direct comparison between the existing FFS and MC populations and delivery systems
  - Tool for historical financial performance of MC program
  - Not a depiction of anticipated savings associated with MC expansion opportunities
- Development of Benchmark population and cost to compare to MC costs
- Comparison done on a per member per month (PMPM) basis

Managed Care Cost Avoidance Model

Managed Care Versus Benchmark Population Expenditures

Expenditure Category	Managed Care Capitation Payment	Managed Care Paid Through FFS	FFS Benchmark
Medical Services Claims	X		X
MC Carve-Out Services Claims		X	X
FQHC/RHC Cost Settlements		X	X
Hospital Add-On Payments – (Direct Medicaid Hospital, GME, Outlier Payments)		X	X
Administration	X	X	X
Health Plan Profit	X		
Geographic Adjustment			X

Managed Care Cost Avoidance Model

Managed Care Versus Benchmark Population Expenditures

Administration Category	Managed Care Capitation Payment	Managed Care Paid Through FFS	FFS Benchmark
Prior Authorization	X	X	X
Member Services	X	X	X
Provider Credentialing	X		X
Care Management	X		
Staff and Facilities	X		X
State MC Program Oversight		X	
Claims Processing/Payment	X	X	X

Managed Care Cost Avoidance Model

Mercer Recommendations

- Adjust MC eligible count to be on same basis as Benchmark
- Review allocation methodology for add-on payments between FFS managed care-like eligibles and other FFS eligibles
- Review allocation methodology of State administrative costs
- Apply geographic adjustment to Benchmark
- Reflect MC FFS window claims as MC carve-out
- Reallocate retroactive mass adjustment payments from “year of payment” to “year of eligibility” to reduce distortions caused by delayed payments

Managed Care Cost Avoidance Model
Current Status

- Not all of Mercer's recommendations have been implemented yet
  - Retroactive mass adjustments
  - FFS claims prior to enrollment in health plan
- Next steps
  - Complete final research and revisions to model
  - Consider developing "incurred" model

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Chronic Care Improvement Program Overview

MO HealthNet Oversight Committee

October 27, 2009

CCIP History

In late 2006, APS Healthcare contracted with MO HealthNet Division to assist chronically ill MO HealthNet participants.

- **CCIP began managing participants in February 2007**

CCIP Goals -

- **improve the quality of care for MO HealthNet participants with chronic health conditions**
- **decrease complications and reduce costs**
- **connect participants with a health care home**

CCIP Eligibility

- Active MO HealthNet (Medicaid) Participants
  - Fee-for-Service (not Managed Care)
  - Including Dual Eligibles Covered by Medicare
- MO HealthNet participants with selected chronic health conditions
  - Voluntary - with the option to decline the program benefits (opt out)

Initial CCIP Conditions

COVERED CONDITIONS

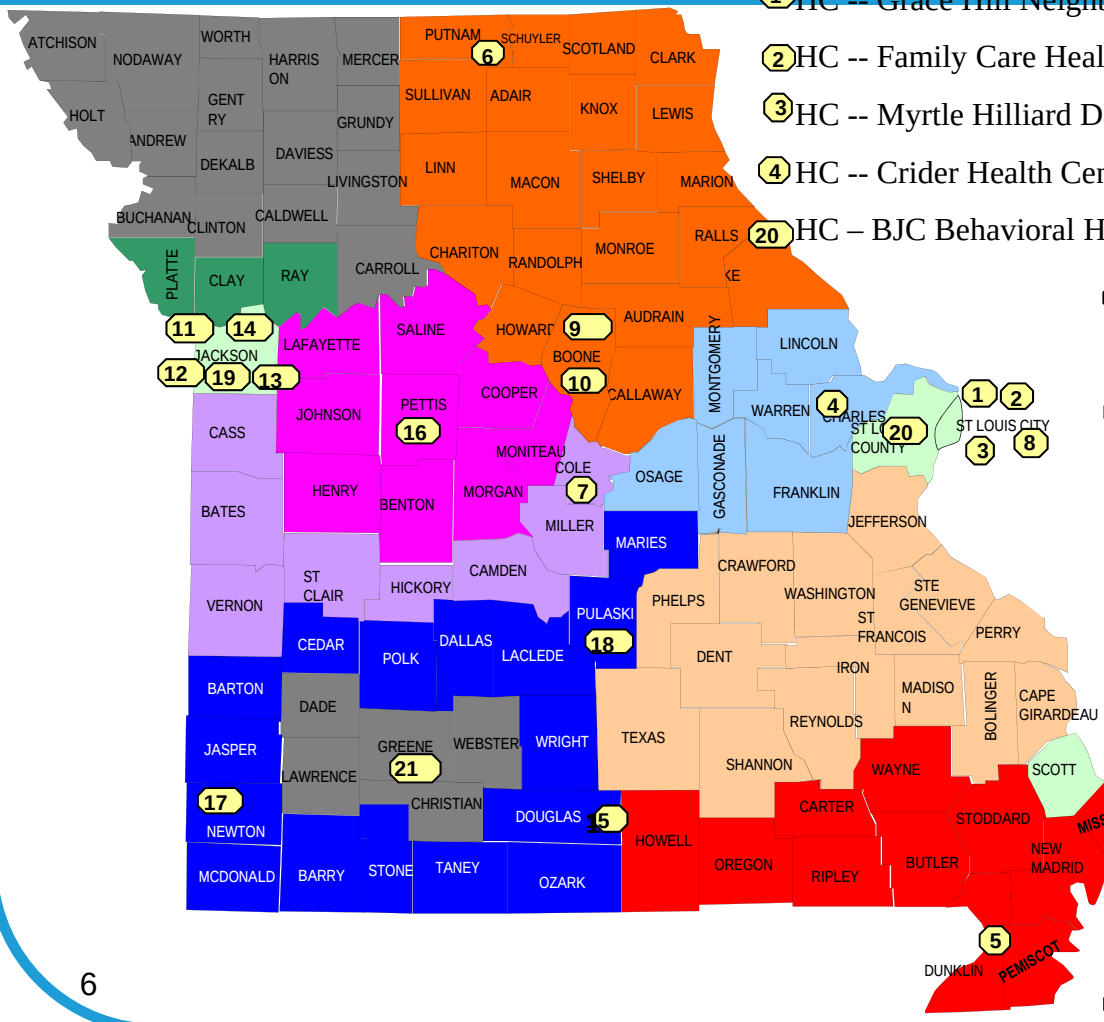
- Asthma
- Diabetes (including Gestational Diabetes)
- Chronic Obstructive Pulmonary Disease (COPD)
- Gastroesophageal Reflux Disease (GERD)
- Congestive Heart Failure/Cardiovascular Disease
- Sickle Cell Disease

Co-morbidities are managed in conjunction with the initial targeted condition

CCIP Health Management Services

- ✓ **Health Care Home for Participants**
- ✓ **24/7 Access to Health Coaches (RNs) Toll-Free**
- ✓ **Participant Educational Materials**
- ✓ **Electronic Plan of Care with Individual Nursing Care Plans**
- ✓ **Reinforcement of Provider's Plan of Care**
- ✓ **Remove Social Barriers Through Appointment Reminders, Transportation Assistance, etc.**
- ✓ **Telemonitoring / Medication Reminders**
- ✓ **Periodic Risk Assessment for Participants**
- ✓ **RN Health Coaches On-Site in Field Clinics**

Community Outreach Staffing



1 HC -- Grace Hill Neighborhood

2 HC -- Family Care Health Centers

3 HC -- Myrtle Hilliard Davis

4 HC -- Crider Health Center

20 HC – BJC Behavioral Health

EASTERN REGION

5 HC -- Family Counseling Center

6 HC -- Putnam County RHC

7 HC -- Community HC of Central MO

8 HC -- People's Health Centers

WESTERN REGION

9 HC -- Family Health Center

10 DMC -- Family Health Center

11 HC -- Samuel U. Rodgers, HC

12 HC – Swope Health Services

13 DMC – Swope Health Services

14 HC -- Swope Health Services

Independence & Northland

15 HC -- Home Based RN

16 HC -- Katy Trail Community Health

17 HC -- Ozark Tri-County Community

18 HC -- Central Ozarks Medical Ctr.

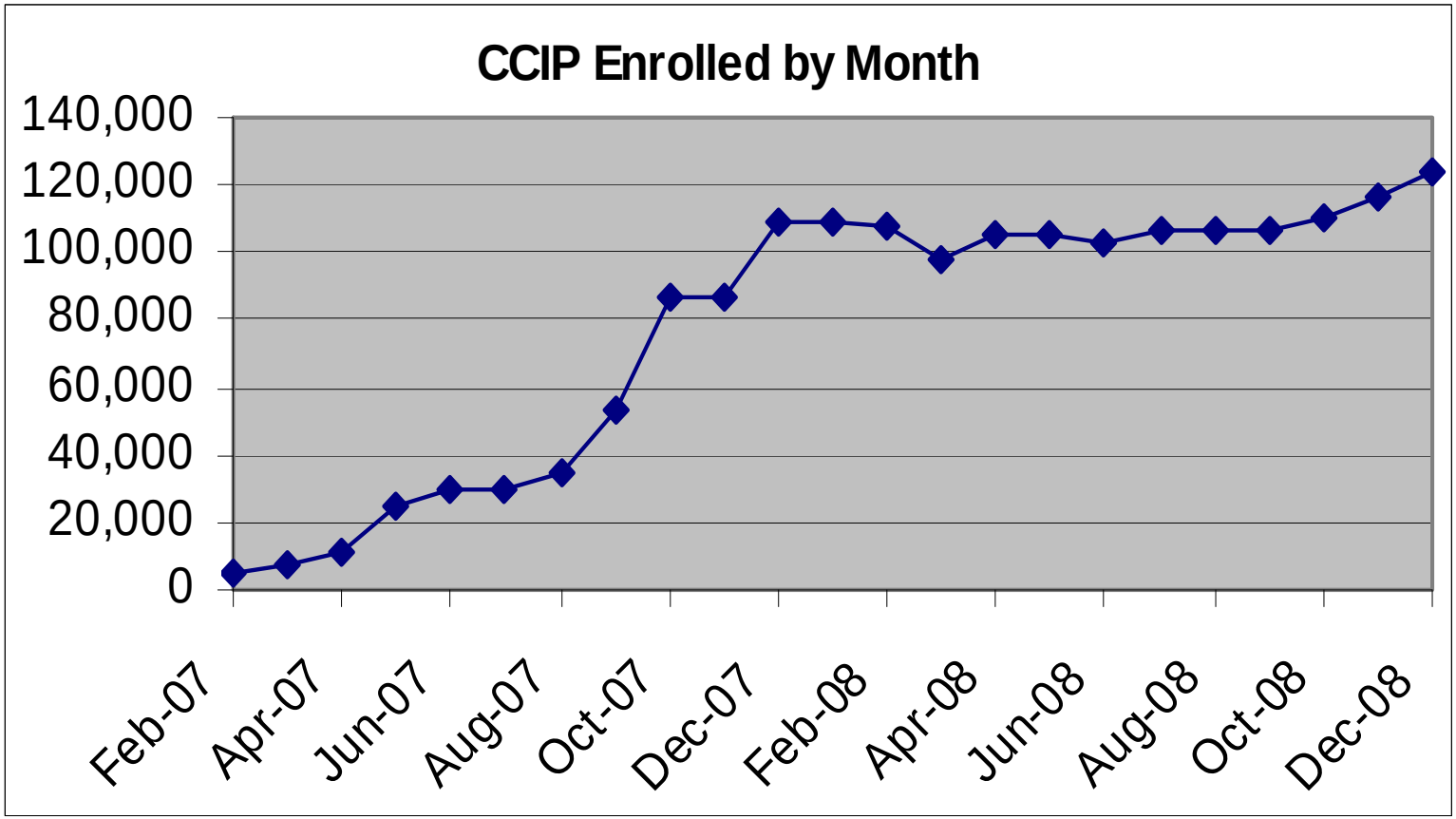
19 HC – Truman Health Center

21 HC – Jordan Valley

MoHealthNet

Missouri Department of Social Services

CCIP Enrollment



Enrollment in CCIP began in the I-70 corridor (Feb to July 2007) and then grew regionally throughout the remainder of 2007 with the addition of the Northeast (Aug), Southeast (Sept) and Southwest (Oct) regions.

MoHealthNet

Missouri Department of Social Services

CCIP Enrollment Breakdown as of 12/31/2008

CCIP Enrolled	
Total	**123,610**

Gender Distribution	
Gender	**Count**
F	78,577
M	45,033
Total	**123,610**

Age Distribution	
Age	**Count**
100+	42
90 - 99	1,327
80 - 89	6,981
70 - 79	13,369
60 - 69	19,879
50 - 59	26,487
40 - 49	21,879
30 - 39	11,078
20 - 29	7,340
10 - 19	8,497
1 - 9	6,731
Total	**123,610**

Dual Eligible in 12/2008	
Total	**64,922**

Primary Diseases	
Disease	**Count**
Adult Diabetes	27,067
Asthma_Adult	6,531
Asthma_Child	10,113
CAD	18,491
CHF	22,555
Child Diabetes	726
Cholesterol	4,540
COPD	4,428
GERD	8,041
Hypertension	18,734
Metabolic_Syndrome	448
Pre-Diabetes	756
Sickle_Cell	1,180
Total	**123,610**

All Diseases	
Disease	**Count**
Adult Diabetes	50,097
Asthma_Adult	48,486
Asthma_Child	11,787
Back	28,861
CABreast	2,889
CAColon	1,457
CAD	33,898
CALung	1,663
CANonSpecific	2
CAProstate	999
CHF	22,699
Child Diabetes	1,046
Cholesterol	59,861
COPD	38,730
Depression	39,311
Diabetes_Depression	8
GERD	83,905
Hemophilia	431
Hemophilia_Child	38
HIV	1,176
Hypertension	73,062
Maternity	6,606
Maternity_Hi-Risk	2,672
Metabolic_Syndrome	2,858
Obesity	30,939
Pre-Diabetes	25,671
Schizophrenia	11,373
Sickle_Cell	1,180
Wellness	26,393
Total	**608,098**

Discussion

- Questions

Thank you

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October 27, 2009

MO HealthNet Chronic Care Improvement Program (CCIP) Financial Evaluation

State of Missouri

Angela WasDyke, ASA, MAAA

Michael Cook, FSA, MAAA

CCIP Financial Evaluation
Overview

- Introduction
- Evaluation Principles
- Baseline Measurement
- Performance Period Measurement
- Results
- Calculation
- Questions

CCIP Financial Evaluation
Introduction

- Mercer was asked to evaluate the financial performance of the Chronic Care Improvement Program (CCIP)
- Mercer has developed ROI methodologies and/or evaluated other Medicaid disease management programs in the following states:
  - Georgia
  - North Carolina
  - Ohio
  - Pennsylvania
  - Texas

CCIP Financial Evaluation
Evaluation Principles

- Evaluate the effectiveness of care management interventions in terms of financial impact
- Examine a comparable population to assess trends outside of CCIP, limiting reliance on historical trends prior to program implementation, when possible
- Remove influences occurring outside of CCIP
  - Eliminate or minimize impact of MO HealthNet programmatic changes to eligibility, services and reimbursement
  - Account for natural occurrence of “regression to the mean” in a chronic population
- Evaluate on a per member per month (PMPM) basis
- Consider the net cost of the program (medical savings offset by program fees)

CCIP Financial Evaluation
Baseline Measurement

- Goal:

  Identify individuals who would have been enrolled in CCIP if program had existed in Baseline Period and extract their claims data.

- January 1, 2006 to December 31, 2006 (prior to CCIP implementation)
- Applied CCIP eligibility criteria and identified individuals with conditions based on agreed upon criteria between State and APS
- Claims and eligibility included at point of condition identification during baseline if identified with a condition in CY 2005 or CY 2006
- Developed for CCIP regions and non-CCIP regions (comparable population)
- Calculated for managed care like and non-managed care populations

CCIP Financial Evaluation
Performance Period Measurement

- Goal:

  Identify individuals who should be enrolled in CCIP and should be receiving care management and extract their claims data.

- July 1, 2007 to June 30, 2008 (SFY 2008)
- Applied CCIP eligibility criteria and identified individuals with conditions based on agreed upon criteria between State and APS
- Claims and eligibility included at point of condition identification during performance period if identified with a condition in SFY 2007 or SFY 2008
- Developed for CCIP regions and non-CCIP regions (comparable population)
- Calculated for managed care like and non-managed care populations

CCIP Financial Evaluation
Results

- Medical Expenditures
  - Reduced medical expenditures by $15.7M or 1.4% of expected medical costs
  - Reflects CCIP provider payments totaling approximately $14,000 during Performance Period
- Overall Net Expenditures
  - Accounting for CCIP vendor fees, medical savings nearly covered these program costs
  - Overall net cost to the State of $940,000 or 0.1% of expected medical costs

CCIP Financial Evaluation
Results

- Year 1 Observations
  - Reasonable results for first full year of CCIP
  - Still significant ramping up of enrollment in first six months of Performance Period
    - Paying higher vendor fee in Year 1 based on enrollment level
    - Reflecting current, lower vendor fee in SFY 2008 results in fees being reduced by $2.3M (overall net program savings of $1.4M)
  - Reduction in medical trend from expected 10.8% annually to 9.8%
  - Emergency Room Services: annual trend rate of 25.5% is significantly lower than comparable population
  - Inpatient Services: annual trend rate of 8.8% not measurably different from comparable population
  - Evaluation includes impact of dually eligible population

CCIP Financial Evaluation
Results

- Future Outlook/Expectations
  - Year 2 and beyond
    - Expect medical savings (prior to vendor fee) of approximately 2.5% in Year 2: improving trends, time to impact participants and providers, CareConnections tool, provider incentives
    - Reduction in PMPM level of vendor fees
    - Other established programs seeing savings in medical costs (prior to vendor fees) between 2% and 5%
  - Future program evaluation considerations
    - Evaluate CCIP progress with an additional 6 months of experience or with regression analysis
    - Evaluate removing the impact of dually eligible population
    - Evaluate by disease condition to identify conditions contributing to savings for potential refocus of targeted conditions
    - Implement risk corridor associated with vendor fees

CCIP Financial Evaluation

Calculation

Performance Period - Expected Cost				
Base Period PMPM	J	= C		$916.94
Expected Trend	K	= I		16.67%
Expected PMPM w/o CCIP Program	L	= J * (1 + K)		$1,069.79
Actual PMPM in Performance Period	M	= F		$1,054.65
Gross PMPM Program Savings / (Cost)	N	= L - M		$15.14
Gross Program Savings / (Cost)	O	= D * N		$15,682,928
Vendor Fees[4]	P			$16,622,953
Net Program Savings / (Cost)	Q	= O - P		($940,025)
Net PMPM Program Savings / (Cost)	R	= Q / D		($0.91)
Net Program Savings / (Cost) as Percent of Expected PMPM	S	= R / L		(0.08%)

1. Population with identified conditions residing in the Northwest and Southwest regions of the State.
2. Population with identified conditions residing outside of the Northwest and Southwest regions of the State.
3. CCIP Regions includes State payments to providers of approximately $14,000.
4. Reflects monthly fees paid to the vendor during SFY 2008. Does not reflect initial program implementation payments made to the vendor by the State of $975,000 in SFY 2006 and an additional $975,000 in SFY 2007.

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MERCER

MARSH MERCER KROLL
GUY CARPENTER OLIVER WYMAN

CALL TO ACTION

HEALTH REFORM 2009

SENATE FINANCE COMMITTEE CHAIRMAN MAX BAUCUS (D-MONT.)

Health Reform Means Huge Administrative Challenges

- **For HHS and CMS**
  - Massive undertaking
  - Design and implement new payment methods
  - Write regulations providing guidance

- **For State Governments**
  - New laws, regulations, budgets, and PEOPLE
  - New relationships with the private sector
  - Absorb Medicaid expansion newly-covered
  - Workforce challenges
  - Communicate with and educate the public

392,000 Newly-covered by Medicaid

SFY14

- Currently-eligible, Newly-insured
  - 108,000 Children
  - 29,000 Parents

- State cost $127.8m
- Federal cost $235.2m
- Total cost $363.0m

SFY15

- New Children, Parents, and Childless Adults to 133%FPL
  - 255,000 Total

- State cost $90.9m
- Federal cost $1,726.5m
- Total cost $1,817.4m

Senate Finance bill, 10.09

Beyond Medicaid:
Health Insurance Subsidies

- **Individual mandate? Great! – But Must be AFFORDABLE**
- **Subsidies must address both the premiums and cost-sharing provisions of private sector insurance policies.**

- **SFC bill offers premium subsidies for those 133% - 400% FPL if no access to employer-sponsored insurance.**

- **Key determinate of % uninsured gaining coverage**
- **Subsidies represent a large proportion of the total cost of health reform**

Health Insurance Reform: Role of the States

- **Short-term: State high risk pool expansion with subsidy**

- **Develop state-level insurance exchanges for the individual and small business markets**
- **All insurers in these markets must participate**
- **All new policies must comply with defined coverage provisions for benefit categories, e.g., Gold, Silver. . .**

- **"Will stand on the shoulders" of Medicaid expansion**

- **Dramatic administrative challenge for state government**

Senate Finance bill, 10.09

Administrative Considerations

- **The Good**
  - Phases in FY13 and 14, allowing time for consideration of policy options
  - Eligibility determination and other IT systems can be significantly enhanced
- **The Bad**
- 2012 federal elections intervene
- High public expectations may change
  - "Why do I have to wait so long?"
  - "My taxes are going to do What?"

Impact of Health Reform on Medicaid

- **We are Very Excited at the Prospect, But. . . .**
  - **Missouri is Dealing with Budget Challenges Requiring Tough Decisions Now**
  - **Can't Be an Unfunded Mandate**
  - **Can't Touch Eligibility Levels**
  - **Many Optional Services Already Cut in 2005**

- **All That Said**
  - **Medicaid is the Safety Net Expansion in All Plans**
  - **Comprehensive Benefits Package**
  - **Protection from Financial Risk for the Low Income**

The Finish Line