

Medicaid Cost Containment Strategies

MaineCare Redesign Taskforce
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Seema Verma, SVC
Robert Damler, Milliman



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Federal Medical Assistance Percentage Impact of Updated Rates

Federal Fiscal Year *	Federal Share	State Share	State Budget Impact
2012	63.27%	36.73%	
2013	62.57%	37.43%	1.9%
2014	61.55%	38.45%	2.7%

* These rates are based on the Federal Fiscal Year, running Oct.-Sept.

Medicaid Per Enrollee Cost Summary

FFY 2009 Comparison

State	Eligibility Category			
	Aged	Disabled	Adults	Children
Maine	\$9,242	\$17,899	\$2,126	\$3,879
United States	\$13,186	\$15,453	\$2,926	\$2,313
New Hampshire	\$19,616	\$16,793	\$3,185	\$2,918
Iowa	\$14,207	\$18,236	\$2,109	\$1,993
Oklahoma	\$10,464	\$13,952	\$2,913	\$2,414

Source: statehealthfacts.org : Based on FY 2009 MSIS and CMS-64 reports

Short- Term: Changes to Mandatory Benefits

Service	MaineCare Limits & Prior Authorization Requirements	Examples of States with Policies more Restrictive than MaineCare	Potential Cost Savings
Inpatient hospital	<ul style="list-style-type: none"> Requires PA: Newborn Infants only if medically necessary Dental services during inpatient hospital stay Private Rooms Supplies and Equipment 	<ul style="list-style-type: none"> Arizona has limited inpatient hospital stays to 25 days Texas has a 30 day limit on inpatient hospital stays Arizona requires PA for all non emergency admissions except for maternity Maryland requires PA for elective admissions Consolidate payment for readmit within 7 days to 1 stay 	
Outpatient hospital	<ul style="list-style-type: none"> Observation Services must be ordered and cannot exceed 2 days 	<ul style="list-style-type: none"> Georgia requires PA for specified procedures Arizona requires PA for certain surgical procedures and rehab services Florida has a \$1,500 year limit on non-emergency services Idaho limits ER visits to six per year Non-emergency, emergency visit counts towards physician visit limit Iowa has coverage limits for cardiac rehab and behavioral health and substance abuse Mississippi only allows 6 ER visits per year New Hampshire has a 12 visit limit 	

Maine's policies retrieved from <http://www.maine.gov/sos/cec/rules/10/ch101.htm>

Other State's policies effective October 2010; retrieved from Kaiser Family Health Foundation Medicaid Benefits: Online Database.

Short- Term: Changes to Mandatory Benefits

Service	MaineCare Limits & PA Requirements	Examples of States with Policies more Restrictive than MaineCare	Potential Cost Savings
Rural health clinic services	<ul style="list-style-type: none"> PA for specified procedures and services 	<ul style="list-style-type: none"> Louisiana limits coverage to 12 visits per year Mississippi limits coverage to 12 visits per year North Carolina limits enrollees to 22 ambulatory visits/year included in limits with other specified practitioners - limits set annually by the legislature 	
Nursing facility	<ul style="list-style-type: none"> 10 hospital leave days per year and 36 therapeutic leave days per year limit 2 hour limit per day for PT & OT 	<ul style="list-style-type: none"> Missouri only allows 3 leave days & limits therapeutic leave to 12 days Michigan requires copayment on therapies and customized medical equipment 	
Home health	<ul style="list-style-type: none"> No limits on duration Requires PA No Reimbursement for duplicated services 	<ul style="list-style-type: none"> Maryland limits 1 visit/type of service/day Minnesota only allows 1 nursing or home health aide visit per day 	
Physician services	<ul style="list-style-type: none"> Require PA for specified procedures and services 	<ul style="list-style-type: none"> Michigan limits visits to 10 for psychiatric care Minnesota has 3 telemedicine limits per week Louisiana has a 12 visits per year visit regardless of setting 	

Short-Term: Changes to Mandatory Benefits

Service	MaineCare Limits & PA Requirements	Examples of States with Policies more Restrictive than MaineCare	Potential Cost Savings
FQHC services	<ul style="list-style-type: none"> No substantive limitations 	<ul style="list-style-type: none"> New York Limits 10 visits per year Ohio limits it to 24 visits per year 	
Lab & X-ray	<ul style="list-style-type: none"> PA for specified Procedures Co-pay of \$0.50 - \$1/day up to \$10/month 	<ul style="list-style-type: none"> Arkansas has a \$500 per year limit on all lab and most x-ray services 	
Midwife Services	<ul style="list-style-type: none"> Require PA for specified procedures and services 	<ul style="list-style-type: none"> Maryland limits enrollees to 1 visit per day Florida limits to 10 prenatal visits per year and 2 postpartum visits per year 	
Certified Pediatric & Family Nurse Practitioner services	<ul style="list-style-type: none"> PA for specified procedures 	<ul style="list-style-type: none"> Pennsylvania limits frequency of visits by service 	
Freestanding Birth Center services	<ul style="list-style-type: none"> No substantive limitations 	<ul style="list-style-type: none"> Charges a facility fee Limited to certain birthing services necessary for care 	
Transportation to medical care	<ul style="list-style-type: none"> No reimbursement for no shows PA for out of state transports Implementing transportation broker 	<ul style="list-style-type: none"> Alabama limits 2 trips per month Florida limits it to those who cannot arrange for transportation by other means Indiana limits enrollees to 20 one-way trips per year 	

Maine's policies retrieved from <http://www.maine.gov/sos/cec/rules/10/ch101.htm>

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Short- Term: Changes to Optional Benefits

Service	MaineCare Limits & PA Requirements	Recent MaineCare Change Made?	Examples of States with Policies more Restrictive than MaineCare	Potential Cost Savings
Clinic services	<p>School clinics do not cover:</p> <ul style="list-style-type: none"> •educational services •vocational services •recreational activities •custodial care services <p>PA required for specific services No duplication of services</p> <p>Flu clinics</p> <ul style="list-style-type: none"> •Provider must be enrolled with Maine CDC 	Repealed STD screening clinic services	<p>Public Health clinics not covered</p> <ul style="list-style-type: none"> • AL, AK, GA, MA <p>Clinic selection</p> <ul style="list-style-type: none"> • ID: Clinics must be state-contracted <p>Service limits</p> <ul style="list-style-type: none"> • FL, MD: 1 visit/day • MS: 12 visits/yr. • NC: 22 visits/yr. • OH: 24 visits/yr. 	

Short- Term: Changes to Optional Benefits

Service	MaineCare Limits & PA Requirements	Recent MaineCare Change Made?	Examples of States with Policies more Restrictive than MaineCare	Potential Cost Savings
Self-Directed personal assistance services	<ul style="list-style-type: none"> •Financial eligibility •Restrictions on type/amount of services •PA required for medically necessary services beyond cap •No more than 1 person providing care at a given time •Skills training cannot exceed 14.25 hr./yr. •Care coordination cannot exceed 18 hr./yr. • Personal Support Services (PSS) limit one hour/day 	No	<p>Do not cover services</p> <ul style="list-style-type: none"> •AL, CO, CT, DE, FL, & 15 other states <p>Care must be provided in certain settings</p> <ul style="list-style-type: none"> •CA: in home, adult day center, or place of work •ID: in home or assisted living (not place of work) 	
Inpatient psychiatric services for individuals under 21	<ul style="list-style-type: none"> •Medically necessary •Complete evaluation, plan of care, & certification of need for services prior to reimbursement •PA required at admission 	No	<p>Limits on coverage</p> <ul style="list-style-type: none"> •HI: max. 40 days/yr. •NE, NH: facilities must be approved •SC: must be residential tx. facility <p>Require periodic re-authorization</p> <ul style="list-style-type: none"> •KY 	

Short- Term: Changes to Optional Benefits

Service	MaineCare Limits & PA Requirements	Recent Maine Care Change Made?	Examples of States with Policies more Restrictive than MaineCare	Potential Cost Savings
Rehabilitative Services (Traumatic Brain Injury)	<ul style="list-style-type: none"> Limit 18 hr./week Initial clinical assessment limit 8 hr. Reassessment limit 8 hr./yr. 	No	<ul style="list-style-type: none"> MI: In institutional setting, short-term, post acute , comprehensive, intensive, goal-directed rehab services for TBI over age 18. May authorize residential or outpatient rehab based on need. 	
Prosthetics	<p>Limits:</p> <ul style="list-style-type: none"> Restore basic function (no “deluxe” function) Prescribed by physician No duplicated services Cover limited dental <p>PA:</p> <ul style="list-style-type: none"> If substitute for missing body part If cost exceeds \$699 	Criteria for PAs under consideration	<p>Service limits</p> <ul style="list-style-type: none"> AR: max. \$20,000/yr. CA: To restore function only KY: max. \$1,500/yr. MA: Non-medical items not covered NJ: Post-trauma care or gross deformities covered only NM: One every 3 years WI: Post-surgery care 	

Short- Term: Changes to Optional Benefits

Service	MaineCare Limits & PA Requirements	Recent Maine Care Change Made?	Examples of States with Policies more Restrictive than MaineCare	Potential Cost Savings
Rehab Services (BH & Substance Abuse)	<p>Crisis resolution:</p> <ul style="list-style-type: none"> 6 face-to-face visits over 30 days; additional may be authorized <p>Crisis Residential</p> <ul style="list-style-type: none"> PA for up to 7 consecutive days; extension when medically necessary <p>Outpatient:</p> <ul style="list-style-type: none"> Comprehensive assessments limited to 2/hrs annually; when change in level of care or new provider, additional 1 hr authorized Individual outpatient limited to 2 hrs/week Substance Abuse outpatient limited to 3 hrs/week for 30 weeks in a 40 week period Group therapy: 90 minutes/week with some exceptions 72 quarter hour units per year; additional when certain requirements met <p>Med Management:</p> <ul style="list-style-type: none"> Adults: Up to 1 hr Children: Up to 2 hrs All subsequent sessions limited to 30 minutes <p>Children's ACT</p> <ul style="list-style-type: none"> Requires PA Up to 6 continuous months with PA; services beyond 6 mos must be reauthorized <p>Children's Home & Community Based Treatment</p> <ul style="list-style-type: none"> Limited to 10 hours of billable face-to-face collateral contacts per member/yr Requires PA 	Weekly rate for Opioid Treatment (Methadone) reduced from \$72 to \$60/week	<ul style="list-style-type: none"> AR: Substance abuse services require primary mental health diagnosis CO: Outpatient substance abuse limited to 25 sessions/year & 36 group sessions/year IA: Limited to services for treatment of chronic mental illness KY/SD: Substance abuse limited to pregnant women LA: Substance abuse not covered MO: Limited to severely mentally ill NV: Rehab potential required 	

Maine's policies retrieved from <http://www.maine.gov/sos/cec/rules/10/ch101.htm>

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Short- Term: Changes to Optional Benefits

Service	MaineCare Limits & PA Requirements	Recent MaineCare Change Made?	Examples of States with Policies more Restrictive than MaineCare	Potential Cost Savings
Podiatry	Limited to individuals who if illness was left untreated may cause loss of limb or treatment by a non-professional could be hazardous	10% rate cut	<ul style="list-style-type: none"> • 7 states don't cover • AR: 2 visits/yr • CA: limited to pregnant or institutionalized • MO: Limited to pregnant, blind, nursing facility residents 	
Optometry	<p>Eye Exams:</p> <ul style="list-style-type: none"> • Under 21 : 1/yr • 21 & over: 1 every 3 rolling CY unless indicated as standard of care for specific dx (eg. diabetes) or medication use <p>Eyeglasses:</p> <ul style="list-style-type: none"> • Under 21: When the refractive error meets specified parameter • Adults:1 pair per lifetime when power equal or greater than 10.00 diopters 	New visit limits imposed for adults	<ul style="list-style-type: none"> • 6 states don't cover eyeglasses • AZ: limited to emergency eye care & treatment of medical conditions; vision exams limited to post cataract surgery • CO: limited to services to dx or treat injury or disease of eye, or after eye surgery • DE: Routine not covered • FL: Limited to determining presence of disease or reported vision problem • KS: 1 refractive exam/4 years • MI: Routine vision not covered • MS: 1 refractive exam/5 years 	

Short- Term: Changes to Optional Benefits

Service	MaineCare Limits & PA Requirements	Recent MaineCare Change Made?	Examples of States with Policies more Restrictive than MaineCare	Potential Cost Savings
Dental	<ul style="list-style-type: none"> • Orthodontic only for children & requires PA • PA required for specific dental services <p>Adults:</p> <ul style="list-style-type: none"> • Oral surgical & related medical procedures not involving the dentition or gingiva • Adults not residing in ICF-ID eligible for Temporomandibular Joint Services with limitations • Most diagnostic, preventive, restorative & treatment (e.g., endodontic, periodontics, etc) for those residing in an ICF-ID with some restriction • Surgery post accident • Extraction for severely decayed & pose threat of infection during surgical procedure of the cardiovascular system, skeletal or during radiation treatment for tumor • Treatment to relieve pain, eliminate infection • Other dental services medically necessary to correct underlying medical condition or if determined cost- effective in comparison to provision of other covered services for the treatment of that condition 	No	<ul style="list-style-type: none"> • 3 states don't cover 	

Short- Term: Changes to Optional Benefits

Service	MaineCare Limits & PA Requirements	Recent MaineCare Change Made?	Examples of States with Policies more Restrictive than MaineCare	Potential Cost Savings
Dentures	<ul style="list-style-type: none"> • Members with dysphagia aspiration or other choking-risk conditions will qualify in some special circumstances • Members with <ul style="list-style-type: none"> • An underlying medical condition • With medical condition causing documented inappropriate weight loss greater than 10% for body weight within the last 12 months or less and whose weight lost will be corrected or improved with dentures • With severe medical or psychiatric complications due to secondary dental pain or psychiatric complication of being without teeth • Department may provide dentures where extenuating medical conditions exist • Replacement dentures are provided where medically necessary and cost effective 	No	<ul style="list-style-type: none"> • 17 States don't cover 	

Short- Term: Changes to Optional Benefits

Service	MaineCare Limits & PA Requirements	Recent MaineCare Change Made?	Examples of States with Policies more Restrictive than MaineCare	Potential Cost Savings
Chiropractic	<ul style="list-style-type: none"> Limited to 12 visits/yr Limited to acute conditions Rehab potential must be documented 	Limited visits	<ul style="list-style-type: none"> 25 states don't cover CA: limited to pregnant or institutionalized adults NC: 8 visits/yr OR: services limited to funded conditions on priority list UT: Adult coverage limited to pregnant women VT: 10 visits/yr 	
Private duty nursing	<ul style="list-style-type: none"> Beneficiaries must meet specific LOC Annual payment ceiling based on LOC 	No	<ul style="list-style-type: none"> AR: Limited to ventilator dependent & those with tracheotomy requiring suctioning & oxygen supplementation CO/VT: limited to technology dependent beneficiaries UT/IN: limited to ventilator dependent only 	
Personal care	<ul style="list-style-type: none"> Must meet specific LOC Annual payment ceiling based on LOC ADLs: 4 hour weekly maximum for highest LOC 1 hr/day 7 days/week 	No	<ul style="list-style-type: none"> 20 states don't cover 	

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Short- Term: Changes to Optional Benefits

Service	MaineCare Limits & PA Requirements	Recent MaineCare Change Made?	Examples of States with Policies more Restrictive than MaineCare	Potential Cost Savings
Hospice	<ul style="list-style-type: none"> 2 - 90 day periods & additional 60 day periods as needed Plan of care required before services start 	<ul style="list-style-type: none"> No 	<ul style="list-style-type: none"> 1 state doesn't cover GA/KY: 2 90 day periods & one 30 day period with physician certification 	
Case Management	<ul style="list-style-type: none"> Limitations vary by service & provider 	<ul style="list-style-type: none"> 2 target groups eliminated Added medical eligibility criteria for homeless 	<ul style="list-style-type: none"> 1 state doesn't cover 	
Services for Individuals Age 65 or Older in an Institution for Mental Disease (IMD)	<ul style="list-style-type: none"> 10 hospital leave days/yr. 36 therapeutic days/yr. 	<ul style="list-style-type: none"> No 	<p>Other states have more restrictive hospital leave & therapeutic leave days:</p> <ul style="list-style-type: none"> 10 states hospital leave days not covered 3 states with lower hospital leave stays (as low as 3) Multiple states with lower therapeutic leave stays (22) 7 states don't cover 	
Services in an intermediate care facility for the intellectually disabled	<ul style="list-style-type: none"> 25 hospital leave days/yr. 52 therapeutic leave days/yr. 	<ul style="list-style-type: none"> No 	<p>Other states have more restrictive hospital leave & therapeutic leave days:</p> <ul style="list-style-type: none"> 9 states hospital leave days not covered 25 with lower hospital leave days (ranging from 3 days to 18) Multiple states with lower therapeutic leave days (as low as 5 days/yr) 3 states don't cover 	

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Short- Term: Changes to Optional Benefits

Service	MaineCare Limits & PA Requirements	Recent MaineCare Change Made?	Examples of States with Policies more Restrictive than MaineCare	Potential Cost Savings
Physical Therapy	Adults: <ul style="list-style-type: none"> • Rehab potential • Following acute hospital stay only • 1 visit/year • Sensory integration limited to 2/year 	<ul style="list-style-type: none"> • 10% rate cut • 2 hr/day limit • 1 visit/yr for palliative or maintenance care 	<ul style="list-style-type: none"> • 15 states don't cover • Some states limit to certain adult eligibility groups: <ul style="list-style-type: none"> • MO: blind, pregnant, nursing facility • UT: pregnant • FL: limited to services pertaining to wheelchair evaluations & fittings • Some states limit number of visits: <ul style="list-style-type: none"> • AZ: 15 outpatient visits/yr. • Some states limit total benefit: <ul style="list-style-type: none"> • IA: \$1,590 max. benefit/yr. 	
Occupational therapy	Adults: <ul style="list-style-type: none"> • Rehab potential • Following acute hospital stay only • 1/yr • Sensory integration 2/yr 	<ul style="list-style-type: none"> • 10% rate cut • 2 hr/day limit • 1 visit/yr for palliative or maintenance care 	<ul style="list-style-type: none"> • 18 states don't cover • MO: limited to blind, pregnant, nursing facility • FL: limited to services pertaining to wheelchair evaluations & fittings • MA: Limited to 20 visits/yr. 	
Speech, hearing & language disorder services	Limited to under 21: <ul style="list-style-type: none"> • Hearing aid eval & related procedures • Hearing or hearing aid recheck • Ear molds Adults: <ul style="list-style-type: none"> • Documented rehab potential • Reevaluation every 6 mos • Decline in oral communication or ability to chew or swallow 	No	<ul style="list-style-type: none"> • 15 states don't cover • Some states limit to certain adult eligibility groups <ul style="list-style-type: none"> • CA: pregnant or institutionalized • Mo: pregnant, blind, nursing facility • UT: Pregnant women • FL: Limited to services for provision of augmentative and assistive communication systems • NE: Limited to 60 visits/yr. 	

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Short Term Strategy: Reimbursement Changes

Budget cuts were done “Pursuant to PL 2009, c. 571, Part 000, Sec. 000 (Maine June 2010 Supplemental Budget).”

Recent MaineCare Provider Rate Changes	Date	Scope
Support services for adults with intellectual disabilities	2010	Respite per diem rate reduced from \$100 to \$90
Nursing facilities	7/1/10	Additional inflation of 12.37% to routine cost component for SFY 11; calculates the upper limit on the base year cost per day based on the median multiplied by 88.73% for direct care & routine cost components; staff enhancement payments removed
Rehab & Community Support Services for Children with cognitive impairments/physical limitations	6/1/11 – retro to 9/1/10	Correction in error to calculating rates
Developmental & behavioral clinic services	7/1/10	10% reduction
Behavioral health services	7/1/10	2% reduction: Children’s Home and Community Based Treatment & collateral contacts 10% reduction: Family Psychoeducation Treatment Program Services, Neurobehavioral Status exam, Psychological testing, and Opioid Treatment
Transportation	8/1/10	6.5% reduction
Occupational & physical therapy	4/1/12	10% reduction
Podiatrist	4/1/12	10% reduction
Private non-medical services	10/1/10	Treatment Foster Care Services: 3.2% PNMI Residential Child Care Facilities: 3.56%
Family planning	7/1/11	Family Planning agencies reimbursed at same rate as other providers.
Community Support services	7/1/10	3% reduction: Community integration 4% reduction: All other services

Short Term Strategy: Rate Changes

Provider Type/Services-10% Reduction	Potential Savings (State and Federal - Millions)
Medical Equipment & Supplies	\$ 2.4
Home health	\$ 1.7
Outpatient hospital	\$ 2.7
Chiropractor	\$ 0.2
Dental	\$ 3.5
Physician	\$ 12.4
Lab & X-Ray	\$ 2.4
Optometry, Optician, Ophthalmology	\$ 1.4
Private Duty Nursing	\$ 0.3
Hospice	\$ 0.2
Targeted Case Management	\$ 4.7
IMD/ICFMR	\$ 4.4

Mid-Term Strategy: Eligibility Changes

- Individuals over 100% FPL in some optional groups will be eligible for tax credits through private products offered in Exchanges in 2014.
 - Medically Needy Program
 - Working Disabled
 - HIV/AIDS Waiver
 - Breast & Cervical Cancer Program
 - Non-Cats (Childless Adults)
- State programs may overlap with tax credit available in Exchanges in 2014.
- Considerations:
 - Duals are not eligible for tax credits
 - Some States are considering expanding Medicare Savings Programs to assure duals have coverage for deductibles and copays, while eliminating coverage under medically needy/spend down programs
 - Some services may not be covered within the Essential Health Benefits
 - Analyze utilization to identify what services are being utilized and determine if these will be addressed in EHBs
 - State can consider developing smaller limited programs that target individuals with high needs to address populations that may be better served by Medicaid vs. Exchange coverage

Other Eligibility Changes:

- Increase asset test for Working Disabled
- Reduce eligibility period from 6 months to monthly or quarterly for Medically Needy/Spend Down
- Evaluate current medical expenses that are considered for determination of spend-down eligibility & impose stricter limits.

Mid-Term Strategy: Pharmacy Targeted Reforms

Strategy	Other States' Use of Strategy	Potential Cost-Savings
PDLs & PA	Denial rate should be 4-5%?	
MAC Rates-Blood Factor Pricing	Could be some opportunities for savings for Novaseven and Xyntha	
Increased use of generics	Maine is at 74% use of generics, which is about the national average. Top tier States are closer to 80%. Must be considered in context with rebates for brand drugs.	
Rebates	Rebates for drugs where Medicaid is the secondary payor. Medicare Part B Cross over claims. Commerical Payors.	
HIT	Opportunities for review of prescribing patterns. Restricted Card Program in addition to PCCM.	

Mid-Term Strategy: Program Integrity

- Program Integrity refers to proper management of Medicaid to ensure quality and efficient care and appropriate use of funds with minimal waste
- PI Efforts work to :
 - Prevent and detect waste, fraud, and abuse
 - Increase program transparency and accountability
 - Recover improperly used funds
- PI Tools:
 - Contracting strategies and review
 - Oversight through audit, data review, survey, and certification
- PI initiatives underway:
 - Currently there are a variety of federal programs that aid states in PI activities
 - Many states have begun aggressive PI initiatives that have generated significant cost savings, for example Utah identified \$20 million in costs savings after a modest PI initiative.

Mid-Term Strategy: Pharmacy Targeted Reforms

Strategy	Current MaineCare Initiative?	Other States' Use of Strategy	Potential Cost-Savings
Enhanced management for high cost & overprescribed drugs		MD: Launched peer review for use of antipsychotics in children under 10; PA required for Tier 2 & non-preferred antipsychotic medications ages 10 & up	
Move from AWP-15% to 16%			
340b Payment at Cost	Yes	Target Blood Factor. Partnerships with Federally Qualified Hemophilia Treatment Center	
Pharmacy TPL – Cost Avoidance		Use of TPL vendor. Cross-over claims for Medicare Part B-rebates.	

Managed Care

Overview: PCCM vs. MCO Model

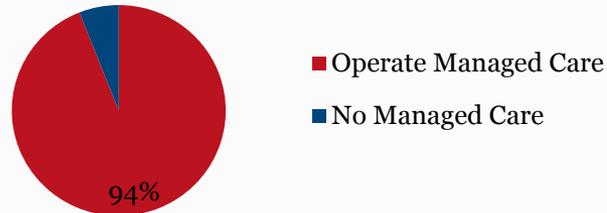
PCCM

- State contracts directly with providers
- Providers responsible for management of beneficiaries assigned to their panel
- Typically, PCPs receive a small per member/per month fee in addition to FFS payments for services rendered

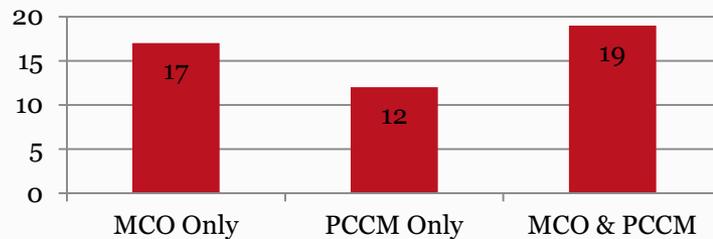
MCO

- State contracts with Managed Care Organization (MCO)
- MCO receives monthly PMPM capitation & is responsible for managing all covered benefits for assigned population

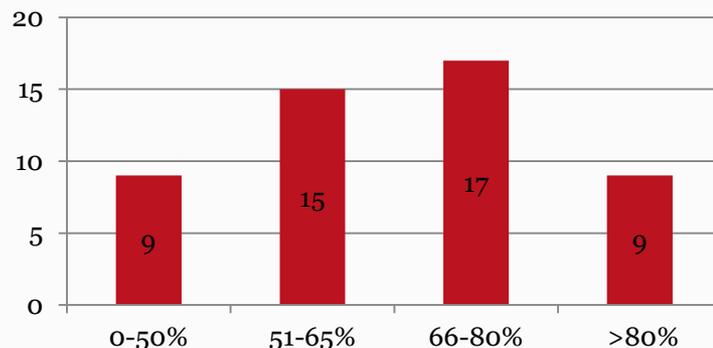
States Operating Medicaid Managed Care Program



Type of Managed Care Arrangement Across the States



Managed Care Penetration Rates Among States



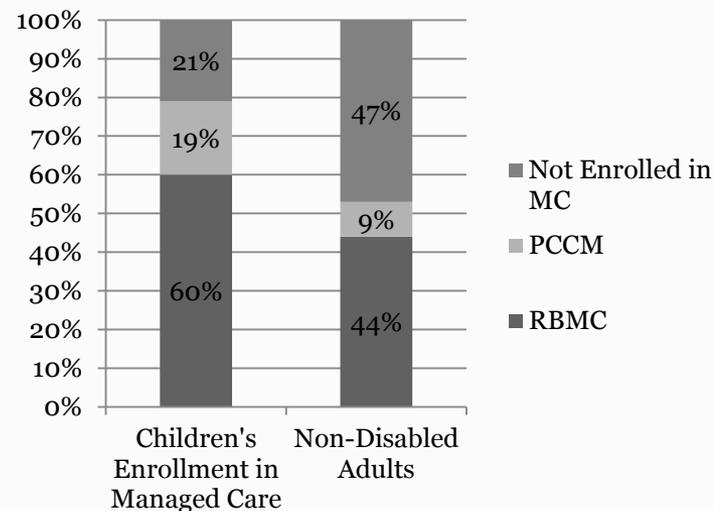
Overview: Medicaid Managed Care Nationwide

- The vast majority of States operate Medicaid managed care programs
- 1/2 of states with managed care also contract with prepaid health plans (PHP), limited benefit risk-based plans
 - Common benefits provided by PHPs include:
 - Mental health
 - Substance abuse
 - Dental
 - Transportation
 - Prescription drugs

- The majority of Medicaid children are enrolled in managed care
- The use of managed care is less prevalent among non-disabled adults, though still widespread
- Aged and disabled Medicaid enrollees are less likely to be enrolled in managed care, though there has been a trend of States moving toward expanding mandatory managed care enrollment for individuals with special healthcare needs

Overview: Medicaid Managed Care Trends

Nationwide Medicaid Managed Care Enrollment



Statewide Managed Care Enrollment

States' Operating Statewide Managed Care – By Model Type

PCCM	MCO
24	24

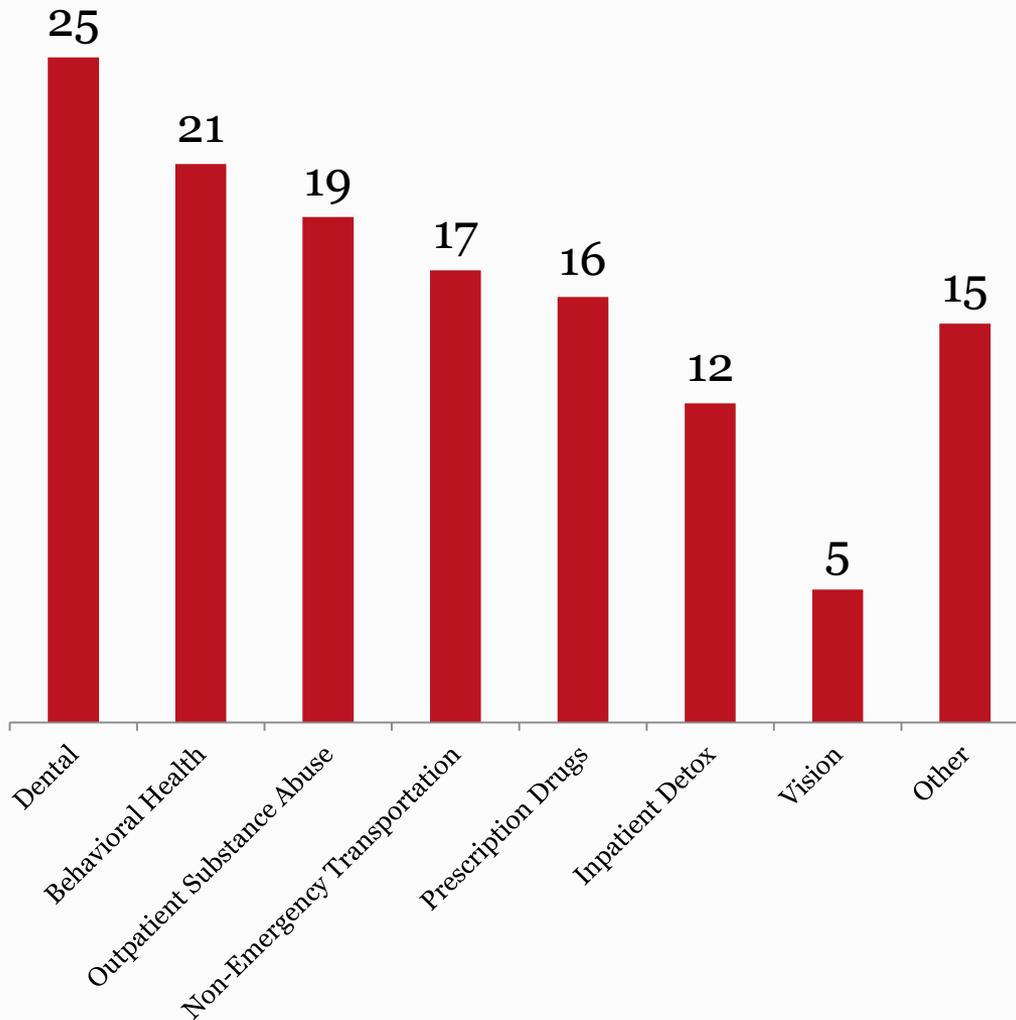
- Statewide Medicaid MCO & PCCM programs are common across the nation
- PCCM model is used by states in rural counties where there is not sufficient enrollment to attract MCOs
- PCCM is also used alongside MCOs to provide enrollees with choice

Managed Care – Mandatory & Optional Enrollment Across the States

Eligibility Group	Mandatory	Voluntary	Excluded
SSI Children	26	21	8
Foster Children	21	21	14
Children with special healthcare needs	32	20	5
M-CHIP	34	8	0
Other Children	46	12	0
Pregnant women	44	13	1
Parents & Caretakers	44	12	2
Aged (Non-Dual)	29	15	10
Blind & Disabled (Non-Dual)	33	14	8
Institutionalized	9	10	32
HCBS	18	15	22

- States can mandate managed care enrollment for the majority of populations
- Eligibility groups such as disabled children & duals are exempt from mandatory enrollment, though States can seek waivers
- Enrollees must have the choice of at least 2 entities or in rural areas MCO choice can be limited if there is choice of at least 2 physicians
- Only 2 states have voluntary statewide enrollment
- Groups more likely to be excluded from managed care enrollment in States are:
 - HCBS
 - Institutionalized
 - Foster Children

States' Use of MCO Carve-Outs



Managed Care Carve-Outs

- All states except Minnesota carve-out certain acute-care benefits from their MCO contracts
- Carved-out services are provided either through a PHP or FFS
- For prescription drug carve-outs, states have both full & partial carve-outs (i.e., only certain drugs carved-out). States are also evaluating carving-in pharmacy now that rebates can be collected under the ACA

- Federal guidelines require States to have
 - Written quality strategy
 - Contract requirements on compliance with State standards
 - Annual external quality reviews
- All MCO States & the majority of PCCM require HEDIS & CAHPS (or other enrollee survey)
 - Common PCCM measures:
 - Access
 - Provider Rating
 - Preventive Care
 - Management of Chronic Conditions
 - Common MCO measures:
 - Prenatal & Postpartum
 - Access
 - Children's health
 - Preventive health
 - Management of Chronic Conditions
- 16 of 36 MCO states require NCQA accreditation
- Majority of states publicly report quality data

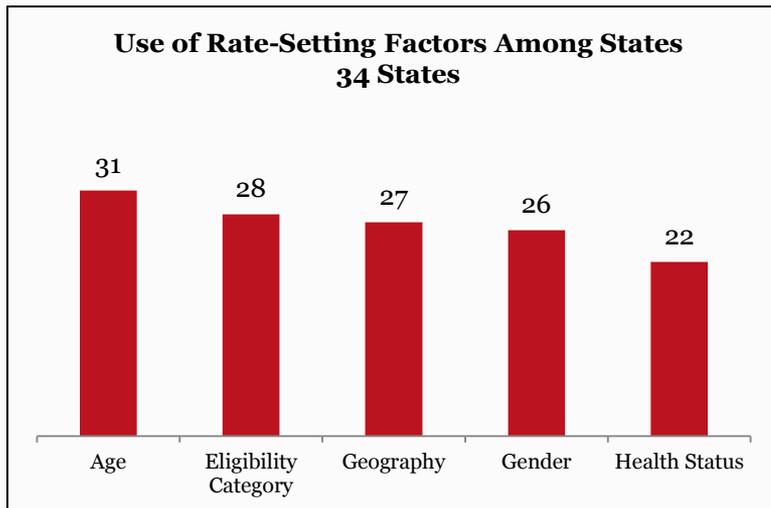
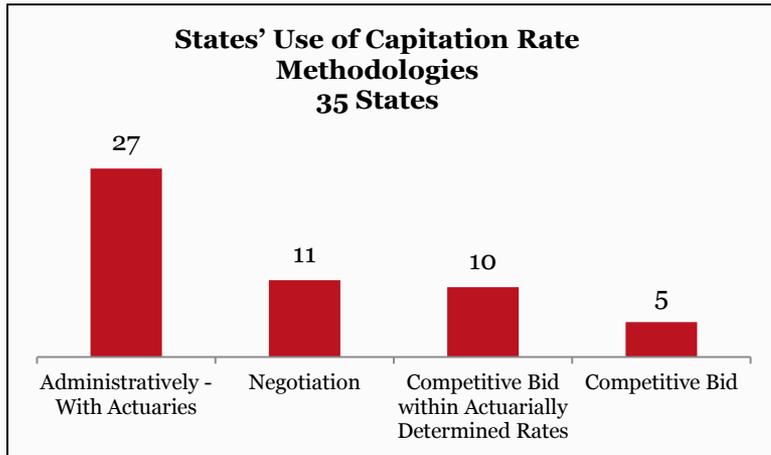
State Monitoring Activities & Quality Initiatives

State Example: Indiana

IN

- Monthly onsite visits to MCOs & PCCM Care Management Organizations
- All contract requirements are reviewed through strategies such as policy & procedure review, onsite demonstrations, unannounced site visits
- Regular reporting of operational, fiscal & quality measures
- HEDIS, CAHPS, EQR

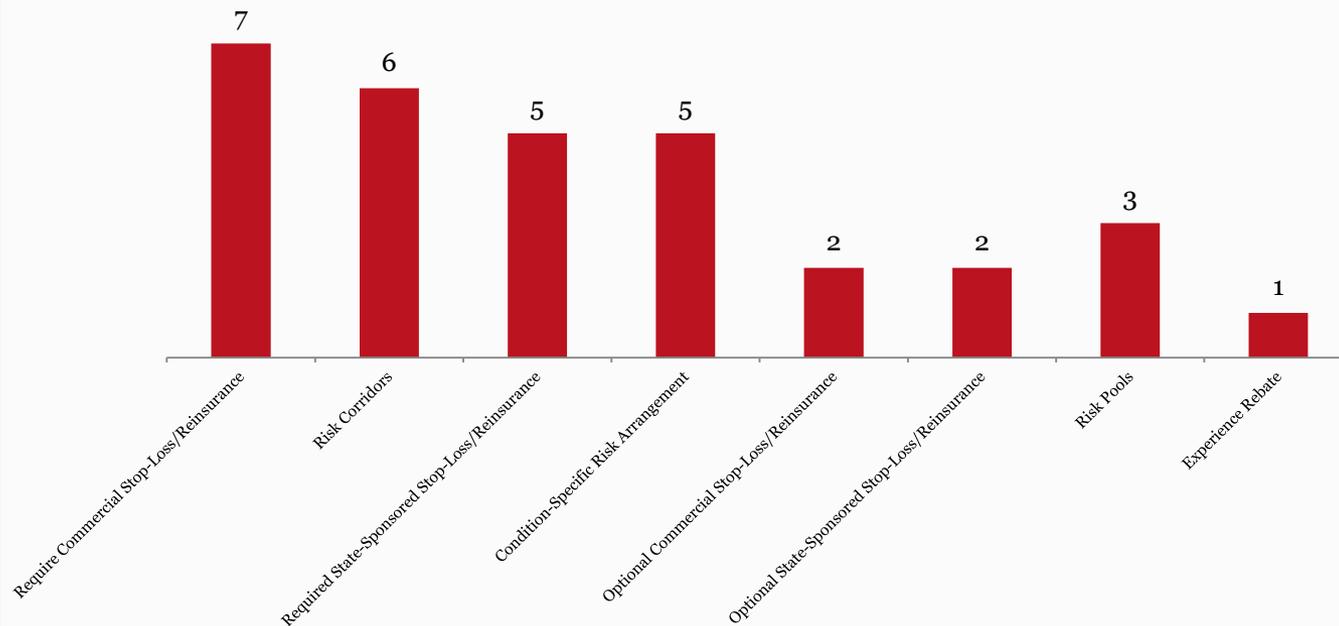
Rate Setting



- Federal regulations require capitation rates be actuarially sound
- Common themes among States in rate setting methodology:
 - Use of 1 rate setting methodology
 - Risk-adjustment
 - Through use of various-risk adjustment & predictive modeling
 - Use of encounter data

States' Use of Risk-Sharing

Use of Risk-Sharing Arrangements Among States
18 States



- 1/2 of States have risk-sharing with their MCOs
- Encourages MCO participation by mitigating financial exposure

Factors Driving Stable MCO Participation

- MCO instability can lead to disruptions for the State, members & providers if the MCO pulls out of the market
- Stable MCO participation driven by
 - Adequacy of capitation rates in relation to:
 - How well rates & utilization controls can be negotiated with providers
 - Ability to negotiate is stronger in areas with high volume, low consolidation of providers and low rates of uncompensated care
 - Enrollment Volume
 - With large enrollment, MCOs better able to spread their risk & negotiate with providers resulting in willingness for MCOs to accept lower reimbursement rates
 - Assessment of administrative costs in relation to:
 - Reporting requirements & State flexibility
 - Quality of partnership with the State
 - State needs to be viewed as strong business partner with consistent vision & stability for the managed care program

Implications of an MCO Model in Rural Settings

- Rural regions present unique challenges for MCO models
 - Low patient volumes prevent negotiation of lower reimbursement
- States have used financial incentives in rural areas to attract & maintain MCO participation
 - Pay higher percentage of historical FFS costs in rural areas vs. urban areas
 - Additional monthly fees to cover individuals in rural counties
 - Regional capitation rates
- Regional & statewide contracting strategies
 - MCOs must serve both rural & urban areas
- State outcomes have varied & multiple New England states have moved away from MCO models

- Managed care provides budget predictability for States
- Despite States' increased use of managed care, there is minimal research on correlation between managed care design features & outcomes
- Most studies on impact to cost, access & quality only look at individual states
- State outcomes have varied & state design varies greatly

Medicaid Managed Care Outcomes

Cost Savings

- State outcomes have varied
- Some examples of cost neutrality & higher costs
- States with historically high FFS rates save money under managed care

Access

- The degree of improved access for enrollees under a managed care model also varies by State
- Some studies show reduced ER utilization & more consistent source of primary care
- Other studies show access to care either reduced or unchanged.

Quality

- The literature on the effectiveness of disease management & care management under managed care is minimal

Medicaid Managed Care Cost Savings: A Sampling of the Data

Study Authors & Year	States Reviewed	Entity Studied	Outcomes
Examples of Studies in which no cost savings were demonstrated			
Duggan & Hayford 2011	US	PCCM & MCO	No cost savings nationally. States that experienced savings had relatively high FFS reimbursement rates prior to introduction of managed care.
Herring & Adams 2012	US	MCO	No cost savings nationally with implementation of MCOs.
Burns 2009	US	MCO	Assessment of prescription, medical & dental care costs between FFS & MC counties for adult SSI recipients did not reveal cost-savings.
Duggan 2002	CA	MCO	Overall costs increased by 12% with shift from FFS. Attributed to increased reimbursement to providers, increased administrative costs & MCO profits.
Examples of Studies in which cost savings were demonstrated			
Momany et al. 2006	IA	PCCM	\$66M (3.8%) savings to the State over 8 years.
Kirby et al. 2003	US	MCO	Modest cost savings attributed to reduced hospital visits.
Verdier et al. 2009	AK, IN, NC, OK, PA	PCCM	Anecdotal evidence of cost savings through effective care management. Limited capacity to control hospital costs.

What do Enrollees Gain from Managed Care?

- Designated primary care doctor
- Choice of Plans
- Case management
- Disease management
- Access to services not typically offered in FFS
 - Example: 24 hour nurse lines

MCO Concerns

- Administrative costs
- State, provider & member vulnerability if an MCO becomes fiscally insolvent or pulls out of the market
- State resources required to monitor MCO processes & outcomes
- Mixed findings on quality, access & cost-savings

Recent Examples of States Moving Away from MCOs

OK

- Eliminated full capitation in urban areas in 2004 following analysis that:
 - Determined comparable quality outcomes in urban MCO model & rural partial capitation PCCM
 - Determined the PCCM model could be operated in urban areas for 1/4 administrative costs
- Now moving away from partial capitation toward medical home model

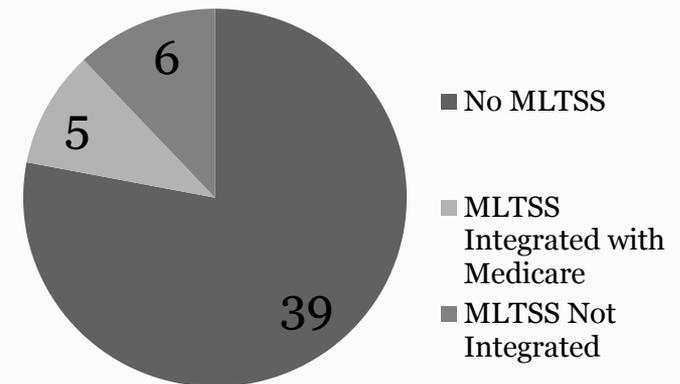
CT

- Had MCO model for 15 years
- Eliminated MCOs in 2012 due to perceived lack of cost savings & desire to implement alternative model for care coordination & quality improvement
- Estimated FY 2012 savings: \$40.5M
- Estimated FY 2013 savings: \$80.2M

Managed Long-Term Services & Supports

- States are increasingly exploring managing long-term services & supports through MCO capitation vs. FFS
 - 2004 Enrollment: 68,100
 - 2008 Enrollment: 173,600
- States' use of these programs is limited; long-term cost-effectiveness studies are in their infancy & inconclusive
 - Evidence of decreased use of institutional services & increased home & community based services
 - Limited findings on cost-savings or consumer impact
 - Proponents argue costs are predictable & services delivered in cost-effective manner
 - Others caution that short-term savings may not be achieved due to scope of covered services, MCO rates & other program costs

States with MLTSS



Of the 11 states operating MLTSS, program design varies. All put MCOs at risk for the community-based long-term services & supports but MCO risk for other services varies.

State	Target Population	Mandatory or Voluntary	Services Covered by MCO	Integrated with Medicare?
AZ	Frail elderly, disabled (except DD)	Mandatory	<ul style="list-style-type: none"> • Community based & institutional LTSS • Medical 	No
FL	Frail elderly	Voluntary	<ul style="list-style-type: none"> • Community based & institutional LTSS • Medical 	Yes
HI	Frail elderly, disabled (except DD)	Mandatory	<ul style="list-style-type: none"> • Community based & institutional LTSS • Medical 	No
MA	Frail elderly	Voluntary	<ul style="list-style-type: none"> • Community based & institutional LTSS • Medical 	Yes
MN	Frail elderly	Voluntary	<ul style="list-style-type: none"> • Community based & institutional LTSS • Medical 	Yes
NM	Frail elderly, disabled (except DD)	Mandatory	<ul style="list-style-type: none"> • Community based & institutional LTSS • Medical 	No
NY	Primarily frail elderly	Voluntary	<ul style="list-style-type: none"> • Community based & institutional LTSS • Limited medical 	Yes
TN	Frail elderly, physically disabled younger adults	Mandatory	<ul style="list-style-type: none"> • Community based & institutional LTSS • Medical 	No
TX	Frail elderly, younger adults with physical & mental disabilities	Mandatory	<ul style="list-style-type: none"> • Community based & institutional LTSS • Medical 	No
WA	Frail elderly, younger adults with disabilities	Voluntary	<ul style="list-style-type: none"> • Community based & institutional LTSS • Medical 	No
WI	Frail elderly, younger adults with physical or developmental disabilities	Voluntary	<ul style="list-style-type: none"> • Community based & institutional LTSS 	Yes

Program of All-Inclusive Care of the Elderly (PACE)

The PACE program, offered in 29 states, provides multi-disciplinary home- and community-based services to over 22,000 Medicare and Medicaid eligible individuals that would otherwise require nursing facility services

PACE organizations receive prospective monthly Medicare and Medicaid capitation payments for each enrollee and assume full financial risk for all needed health care services.

In 2007, the per person per month costs varied by location, ranging from \$1,690 to \$4,250.

Cost Savings

- Utilizing lower-cost adult day & community-based services instead of nursing facility
- Tennessee found a 17% cost savings compared to its MCO/BHO & Nursing Facility system
- Texas found a 14% savings compared to its nursing home & medical care
- Washington found that costs were nearly double that of other HCBS populations for the first year of the program, but saw comparative costs for PACE patients go down over time

Access

- Provide services and referrals for all necessary services, including preventive, primary, acute, rehabilitative, and long-term care
- Offer 24-hour care access to enrollees

Quality

- Enrollee receives coordinated, comprehensive care for medical & non-medical needs
- Texas PACE programs reported fewer hospital admissions and shorter stays
- Research of PACE participants in general found lower rates of inpatient utilization, higher utilization of ambulatory services and a lower mortality rate
- Wisconsin PACE participants reported high levels of respect, privacy, safety, and satisfaction with the services

- Provider run organizations
- Shared responsibility among providers for enrollees' care
- Potential for shared-savings
- Use of quality measures
 - Patient-centered care
 - Increased care coordination
 - Performance based incentives
- ACO models vary

ACO Models Being Explored Around the Nation & Across Payers

- MA Medicaid: Exploring capitated, multi-payer ACO model
- VT Medicaid: Community-based ACO Model
- Aetna: Working with provider organizations to offer risk-based ACO Products
- UnitedHealthcare: Part of effort to promote “value-driven health care”
- Medicare: Allows for alternative models in the ACO Pioneer Program; currently 32 Pioneer ACOs with wide range of design features
- Nationwide estimated 164 ACO Entities
 - 99 hospital based
 - 38 Independent Physician Association
 - 27 insurer based

ACO Models in Medicaid

- Medicaid ACO initiatives are in their infancy
- States' current & historical experience with managed care is influencing their ACO design
- In States with strong MCO model, MCOs are integrated into ACO initiatives
 - MCO coordinating with ACO
 - MCO acting as an ACO
- Current populations eligible for Medicaid managed care arrangements are influencing how States' design their ACO model
 - Some states excluding populations from the ACO model that are excluded from managed care
 - Some states are viewing ACOs as a new opportunity to better integrate care for previously excluded populations & carved-out services
- Unique challenge of how to handle duals

A Snapshot of Medicaid ACO Initiatives

State	Historical Structure	ACO Model
CO	Shifted from MCO to FFS PCCM model. Regional capitated BH carve-out.	<ul style="list-style-type: none"> • PCPs receive FFS + \$4 pmpm • 7 regional care collaborative organizations receive \$13 pmpm to manage network & support PCPs • Data analytics contractor for data warehouse & provider portal
NJ	Majority MCO enrollment	<ul style="list-style-type: none"> • MCOs can contract with ACOs • ACOs eligible for shared savings
OR	Regional MCOs with BH & dental carve-outs	<ul style="list-style-type: none"> • Coordinated Care Organizations as risk-bearing entities • Current MCOs can apply but must integrate services currently carved-out & move toward more provider & community involved governing structure
UT	Shifted from MCO	<ul style="list-style-type: none"> • In Salt Lake City: Looking to renew contracts with health plans & provider systems as ACO • At-risk • ACOs to make incentive payments to providers

State Advancing Work with ACOs

MN

- In 2011, the state initiated another Health Care Delivery System Demonstration to improve health care delivery and payment reform
 - Will continue to encourage health care delivery systems to control costs through incentives & shared savings

Louisiana – Bayou Health

In 2012 Louisiana replaced their PCCM model with Bayou Health, a Coordinated Care Network model composed of both enhanced PCCM & MCOs. Enrollees choose between the 2 models.

Coordinated Care Network – Shared Savings

- Enhanced PCCM model
- Entity receives PMPM fee to provide enhanced PCCM services & PCP care management
- Opportunities for entity to share in cost-savings
- Entity shares portion of savings with PCPs
- **Limited risk – if no savings, return 50% of enhanced PCCM fee**
- Network of primary care providers only
- State's Fiscal Agent processes claims

Coordinated Care Network - Prepaid

- Capitated MCO model
- All MCOs receive same rate
- State withholds portion of rate for not meeting quality expectations
- MCO develops comprehensive provider network

Louisiana – Bayou Health

Carve-Outs

- Dental
- Pharmacy
- Hospice
- Behavioral Health
- Nursing Home
- Personal Care Services
- School-based IEP services
- Targeted Case Management

Excluded Populations

- Duals
- HCBS
- Residents of nursing facility, development center or group home
- Medically Needy (Spend-down with less than 3 months eligibility)
- Recipients receiving single service (e.g., family planning)

Florida Medicaid Reform Efforts

- 2005: Began demonstration waiver to phase-out PCCM & implement MCOs in 5 pilot regions
- Currently seeking federal approval to implement 2011 State legislation
 - Statewide expansion of capitated model to mandatorily enroll all populations
 - Eligible entities
 - Health insurers
 - Exclusive provider organizations
 - HMOs
 - ACOs
 - Provider service networks
 - Achieved Savings Rebate
 - Incentivized shared savings model
 - Plans share income with State based on 3 revenue tiers & may keep up to 7.5% of pretax income
 - Those that exceed quality measures also retain an additional 1% of revenue

Florida Medicaid Reform Efforts

- MCOs can create customized benefit packages to non-pregnant adults
- Carve-outs
 - Services provided in prescribed pediatric extended care facility
 - Provision of anti-hemophilic replacement products

Long-Term Strategy: Member Incentive Programs

WV

- Enhanced coverage for individuals who agree to adhere to healthy behaviors

ID

- \$200 in vouchers to enrollees who seek medical advice regarding weight loss or smoking cessation
- Vouchers can be used for gym memberships, weight loss programs, nutritionist & tobacco cessation

FL

- Enrollees can earn up to \$125 in credits for adhering to “healthy behaviors” such as getting a flu shot or adhering to their medications
- Credits can be used to purchase approved over-the-counter drugs & health-related supplies

IN

- Healthy Indiana Plan: incents individuals to obtain preventative health care by allowing the entire balance of their POWER Account to rollover, reducing their required contribution.
- Outcomes: members have sought preventive services at higher rate than comparable populations

- A few States have experimented with member incentive programs to encourage healthy behaviors
- Outcomes are unclear at this time & research on impact is minimal
- Florida participation since 2006:
 - Several hundred individuals have earned credits for diabetes or hypertension disease management
 - As of 2/12 only 2 individuals had attended smoking cessation & 6 for weight management

Long Term Strategy

A decorative graphic consisting of several horizontal lines of varying lengths and colors (light blue and white) extending from the right side of the text area across the bottom of the slide.

Assessing Options

- Committee Principles
- Impact to participants
 - Choice, satisfaction, services provided
- Market Readiness
 - Provider Impact
 - Rural vs. Urban
- Quality
- Ability to drive savings
- Administration & Implementation

Option 1: State Based

- Further development of State utilization management program
 - Could be managed internally or outsourced
 - If outsourced, contract should contain metrics and payment withholds to achieve certain objectives
- Active risk assessment & case management by State
 - Payment to providers for risk assessment
 - Retrospective review of claims to identify high cost individuals
 - Assignment of case management
 - Development of Disease Specific Management Programs
 - Based on population health data
 - ED High Use, Pregnancy, Asthma, COPD, etc,
 - Could develop different benefit packages according to risk
 - Limits on services for individuals at lower risk
 - Behavioral Health
- DD Population – case management, limits on services, global budgeting
- Targeted Programs
 - Carve Outs (Behavioral Health, etc.)

Option 2:

- Build on Value Based Purchasing Design
 - Build on PCCM & Medical Home
 - Include mental health providers
 - Provide a “management fee”
 - Consider additional incentive payments if providers can achieve certain quality & efficiency benchmarks
 - Add Participant Incentive Program
 - may increase cost in the short term
- Members- choice of plans, possibly additional services
- Could add elements from Option 1 to Option 2
- May be more suitable in rural areas

Option 3: Capitated Models

- MCO
 - For profit/not for profit
- Local Providers
 - ACO
 - Primary Care Doctors
 - PACE program
 - Third Party Vendors
 - Radiology Benefit Manager
 - Disease Management
 - Behavioral Health Management
- Statewide or Specific Counties/Regions
 - Rural vs. Urban
- Capitated Rate Only
- Capitated Rate With:
 - Shared Savings
 - Risk Adjustment
 - Reinsurance
- PCCM
 - Management fee
 - Bonus Payments

What Services Should be Capitated?

- Inpatient/Outpatient
- Mental Health
- Pharmacy
- Long Term Care Support Services
 - Home & Community Based Services
 - Nursing Home
- What programs should be folded in?
 - Money Follows the Person

What Populations Should be Included? Mandatory or Optional?

- Pregnant Women & Children
- Adults (chronic disease)
- Waiver Populations
- NF Level of Care
 - Institutional only
 - Non Institutional –Waiver Population
- Disabled Children
 - Physical disability
 - Intellectually or Developmentally Disabled
- Disabled Adults
 - Physical disability
 - Intellectually or Developmentally Disabled
- Duals
 - Age 65+

Long Term Care Options

- Options:
 - Increase Nursing Facility Home Level of Care
 - Capitation of LTSS
 - Starting from hospital discharge into rehab facilities to nursing home placement
 - Management/Incentives Fee to Hospital Discharge Planners & Rehab facility discharge planners to encourage HCBS
 - Consider group homes as an alternative to personal care costs
 - Global budgets for clients receiving personal care services
 - Limits on services
 - ICMFR- Operational review, number of beds, etc.