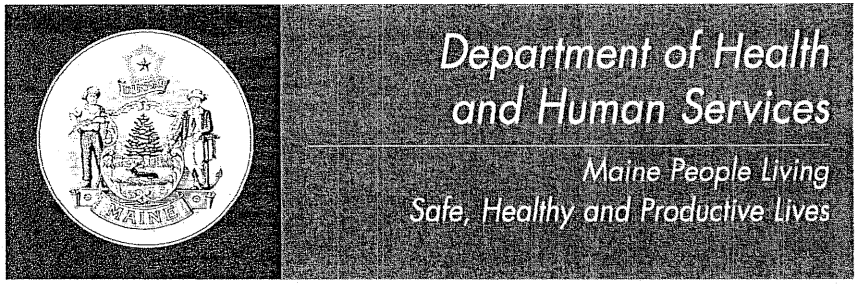


John E. Baldacci, Governor *Brenda M. Harvey, Commissioner*

Managed MaineCare Initiative

Joint Select Health Reform Committee

10/1/10

Background

- Maine initiated medical care management (Schaller Anderson) and behavior health utilization (APS) review in 2007.
- Legislature mandated a feasibility study of "capitated managed care" in 2009.
- Department, in cooperation with Muskie, delivered study to HHS in March, 2010.
- HHS voted to proceed with the work.
- Legislature approved initial start up funds which provide $2 million with federal match.
- Legislature mandated the formation of stakeholder advisory committee and quarterly legislative reports from Department.

Goals of the Initiative

- Improve the health status of MaineCare members
- Reduce the growth rate in per person spending

Key Objectives

- Measure and reward quality outcomes and member satisfaction.
- Align the incentives of the State, managed care contractors, providers and members.
- Mandatory program with at least two options.

What are the potential benefits for Maine?

- Constructive engagement and integration of providers, members
- Sustainability, predictable costs
- Population health focus

Context

- Affordable Care Act
  - Payment reform incentives
  - Exchange and universal coverage
  - Opportunities for Medicare/Medicaid cooperation on dual eligibles
  - Expansion of childless adult membership in 2014
  - Money Follows the Person Grant
- CHIPRA Quality Grant
- HITECH Act

Context, continued

State Reform Initiatives

- Maine Health Management Coalition
- MeHAF Payment reform and Medicaid Managed Care support
- MaineGeneral / State employees Accountable Care
- Patient Centered Medical Home
- Payment reform workgroup of ACHSD

National Experience

Preponderance of peer-reviewed literature reports that managed care is associated with..				
...greater likelihood of a usual source of care for members	... less emergency department use	... reduction in preventable hospital admissions	... greater smoking cessation and prenatal care among pregnant women	... greater use of community services, and less use of institutional services among persons with long-term support needs

A more limited number of studies found adverse outcomes, including one in which emergency department use went up, and another in which pregnant women did better in fee-for-service than in managed care.

Maine Managed Care in the 90's: Highlights of Lessons Learned

- Strong partnership needed between state and contractors, not a short-term vendor relationship.
- Contractor and state capacity to provide and process encounter data is essential.
- Quality oversight is needed from the beginning; quality measures need to be built into RFP.
- Need strong infrastructure for member education, enrollment, issue identification and grievance resolution.
- State and contractors need capacity for technical support for providers.

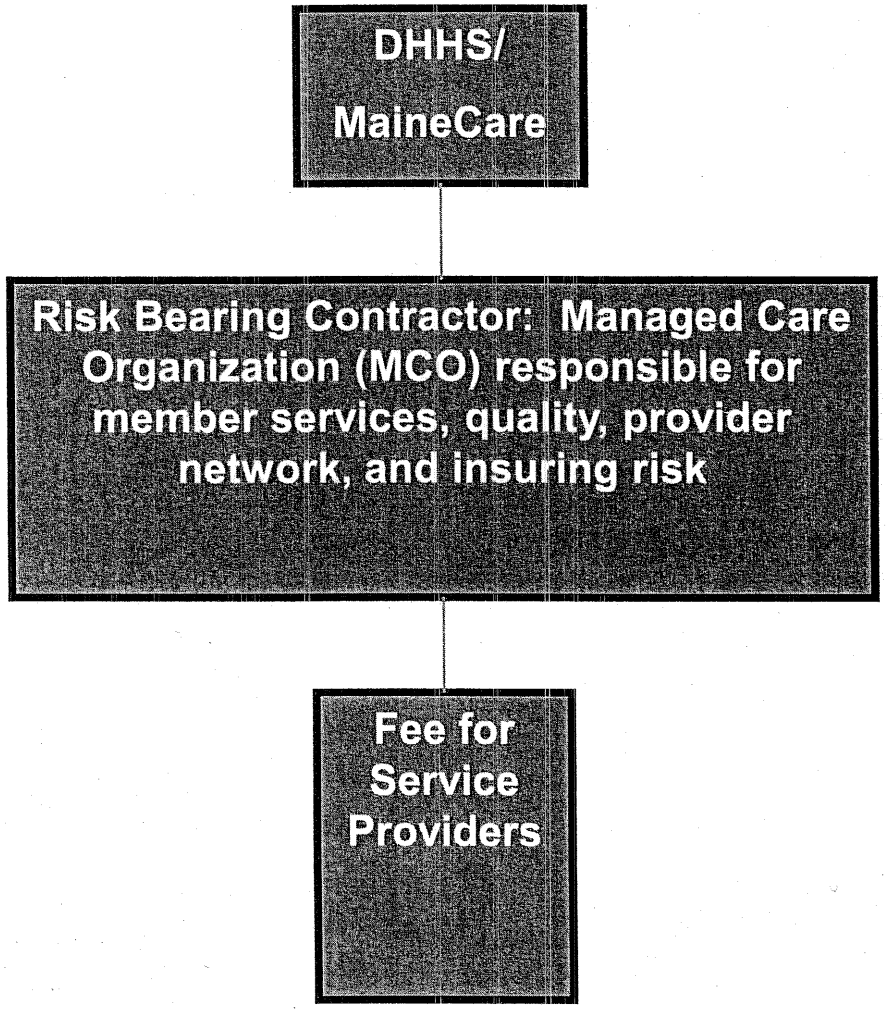
Contractor Capacity and Interest

- Request for Information (RFI) issued 12/21/09 to 92 insurers, providers and other interested parties
- 22 responses
  - 9 national organizations, 6 of which are willing to bear full risk (4 on a statewide basis)
  - 2 hospital-based systems, 1 statewide and 1 covering 6 western counties
  - 5 individual hospitals
  - 5 primary care or specialty provider organizations
  - 1 organization offering consulting services

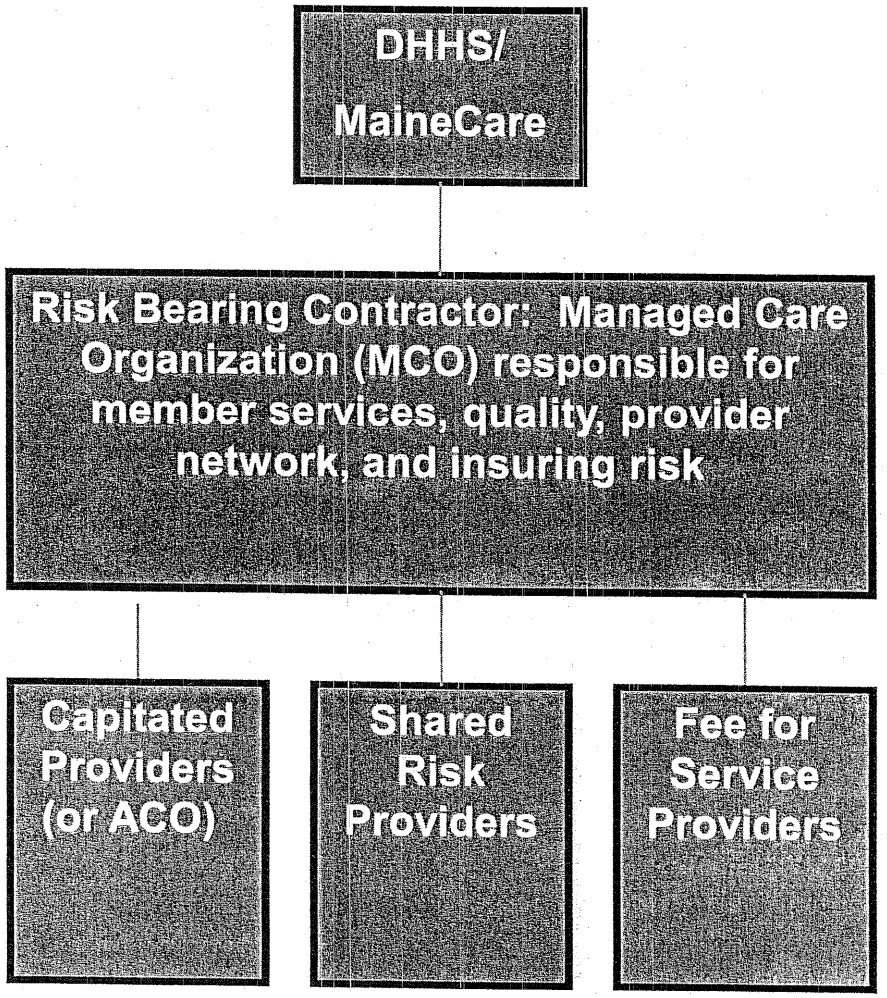
Starting Assumptions

- All MaineCare groups will be enrolled, but are phased-in over a three-year period.
- All services are included, but long-term services and supports are phased-in.
- Program is statewide
- Full-risk arrangement between MaineCare and contractors

Traditional Medicaid Managed Care Model



Preferred Initial Model



Likely Short-term MaineCare/MCO/Provider Relationship

- Relies on MCOs' experience and financial viability with Medicaid managed care to launch in 2012.
- MaineCare selects MCOs based in part on willingness of MCOs to include payment reform in contracts with providers, incentivizing through capitation or shared savings, moving gradually away from fee for service payments.
- Demonstration of provider financial and quality accountability will be encouraged and incentivized in MaineCare contract with MCOs.

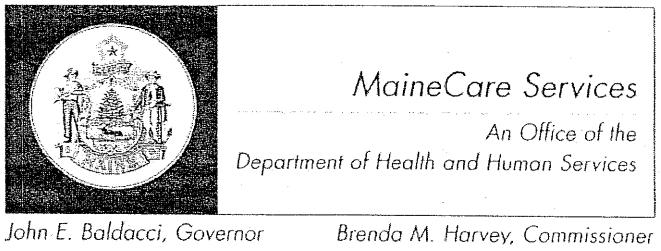
Relationship to Health Reform

- Maine may apply for global payment, dual eligible, medical home, and other federal demonstration funding in conjunction with this initiative.
- Contract requirements will include participation in payment reform initiatives.
- Health coverage design symmetry (to the extent possible) and administrative simplicity will be encouraged with the exchange.

Managed MaineCare Initiative (MMI) Working Timeline as of 6/14/10

June 2010	Project Launch
	Planning and engagement
April 2011	RFP issued: Most Parents and Children
January 2012	Enrollment begins: Most Parents and Children
April 2012	RFP issued: SSI and other Special Needs (excluding dually eligible persons; LTSS*)
January 2013	Enrollment begins: SSI and other Special Needs
April 2013	RFP issued: Dually Eligible Persons; LTSS
January 2014	Enrollment begins: Dually Eligible Persons; LTSS

Stakeholder Input



REGIONAL FOCUS GROUPS

Member Listening Session - EAST

Member Listening Session - SOUTH

Member Listening Session - WEST

Member Listening Session - NORTH

August / September

MEMBERS' STANDING COMMITTEE

SPECIALIZED SERVICES COMMITTEE

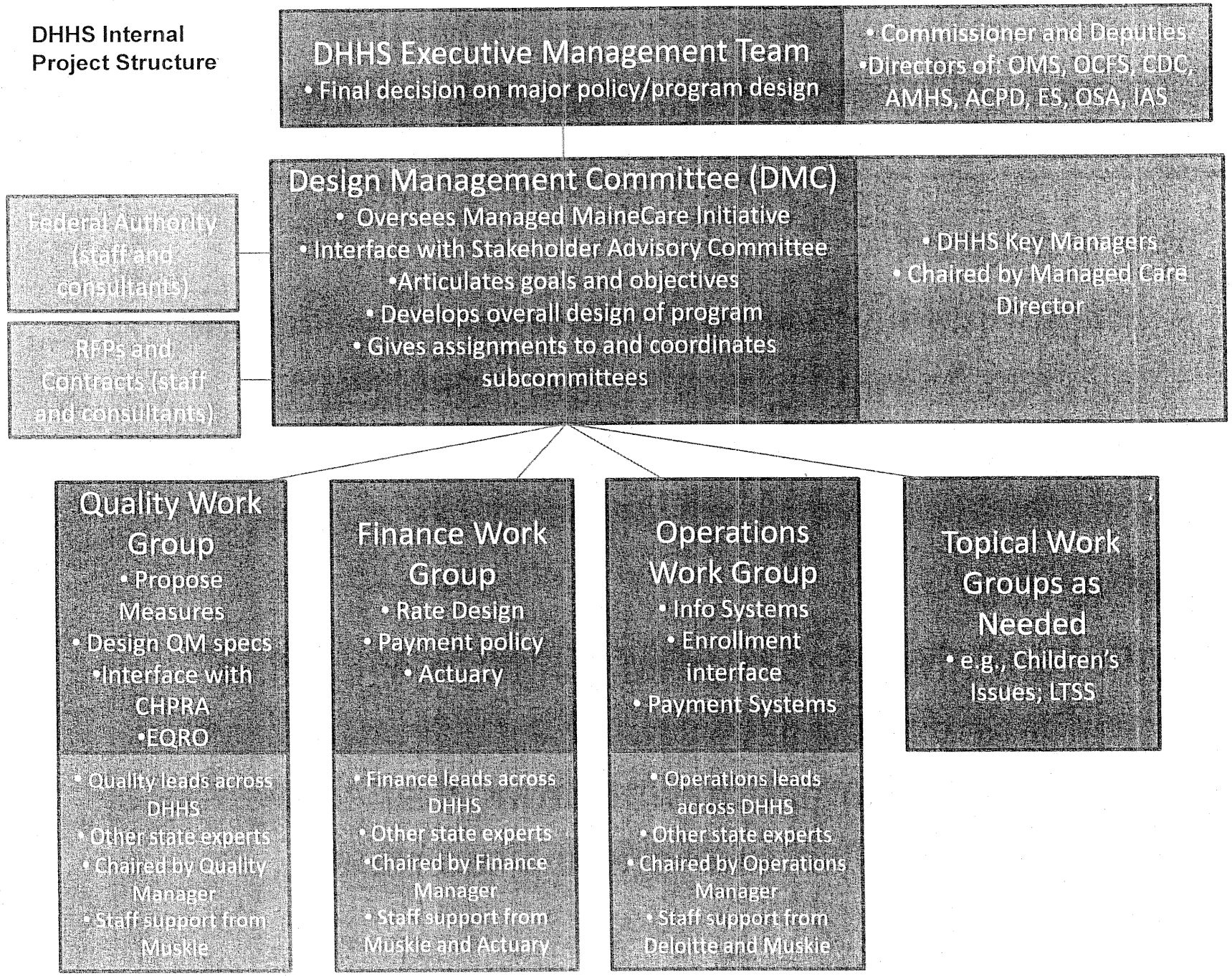
STAKEHOLDER ADVISORY COMMITTEE

Tribes; Reps. From Member's Standing Committee; providers; Advocacy Groups; DHHS Program Directors; Commissioner's Office; MMA, MOA, MHA, MPCA, Dental Assn; Assn of MH Services, Others

Monthly Meetings

DHHS

DHHS Internal Project Structure



Stakeholder Engagement to Date

July / August –

Stakeholder Advisory Committee, Specialized Services Committee, Member Standing Committee and Design Management Committee convened; introduced to initiative.

September –

All committees convened to begin exploring populations and services. The subcommittee of the Design Management Committee convened to begin Quality Measurement discussion.

Stakeholder Engagement to Date, Continued

September –

Four regional Listening Sessions were held to gather feedback on MaineCare Members' experiences with program; report forthcoming.

Next Steps

- Actuarial analysis
- BOI work regarding MCO licensing /quality standards
- Development of quality outcome measures for RFP
- Review draft RFP with Joint Select Committee
- Issue RFP

Resources and Contact Information

Additional resources on this initiative can be found at:

http://maine.gov/dhhs/oms/mgd_care/mgd_care_index.html

For more information, please contact:

sarah.stewart@maine.gov

Appendix:
Managed Care and Related Terminology

- **Primary Care Case Management (PCCM):** Primary care practitioner receives a monthly case management fee per patient to coordinate care and make referrals to specialty care. Services reimbursed on a fee-for-service.
- **Patient-Centered Medical Home (PCMH):** Similar to PCCM, but with greater expectations of the practice. "A model of care provided by physician practices that seeks to strengthen the physician-patient relationship by replacing episodic care...with coordinated care.."(NCQA)
- **Partial Risk Contracting:** Contractor agrees to provide some, but not all services for a set amount per person per month (PMPM). Some services continue to be reimbursed on a fee-for-service basis. Or provider limits risk to a corridor around a targeted amount. An example of a corridor is a cost sharing/gain around +/- 10% of a target amount.
- **Full Risk Contracting:** Contractor agrees to provide all services for a set amount on a per person per month (PMPM) basis (full capitation). The contractor is at risk for costs that exceed the capitation.
- **Accountable Care Organization:** A provider organization which assumes accountability for quality and cost outcomes and shares in savings.
- **Managed Care Organization:** A managed care organization which assumes responsibility for a global budget, outcomes, insurance risk and claims processing.