Medicaid: Managed Care and Health Reform Opportunities and Key Considerations for The State of Montana

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About UnitedHealthcare’s Experience

**Medicaid Business**

- **25 States + DC**
- **Payment Models:** Full Risk & Managed Services – mix of mandatory enrollment
- **Medicaid:** TANF, CHIP, Childless Adults, Dual SNP, ABD, HCBS, Foster Care, Special Needs Children, DD/D, SSI
- Operate under multiple waivers: 1115, 1915(c), HCBS
- **Delivery Systems:** Accountable Care, ACA Health Homes, Medical Homes, Personal Care Model, PCP Gatekeeper
- **HIT Enablement:** Medical Home Population Registries, HIE, eMR, Risk Stratification, EBM, Enrollee Exchanges

**Optum Health Services**

**OPTUMHealth™**
- Individuals Served: 59M
- A national leader in health and wellness services
- Operates the only major bank dedicated exclusively to the health care industry
- Helps consumers navigate the health care system, finance their health care needs and better achieve their health and well-being goals

**OPTUMInsight™**
- Individuals Served: N/A
- A leader in the field of health care information, services and consulting
- Operates in more than 50 countries
- Clients include hospitals, physicians, health care payers, Fortune 500 companies, governments, health insurers and pharmaceutical companies

**OPTUMRx™**
- Individuals Served: 12M
- One of the largest pharmacy benefit managers in the United States
- Offers retail, mail order, specialty pharmacy and clinical services
- Serves employer groups, union trusts, seniors and commercial health plans
The studies present compelling evidence that Medicaid managed care programs can yield savings. The studies also suggest that certain populations or services are especially likely to generate savings in a managed care delivery system. We summarize these findings below.

- **First**, the studies strongly suggest that the Medicaid managed care model typically yields cost savings. While percentage savings varied widely (from half of 1 percent to 20 percent), nearly all the studies demonstrated a savings from the managed care setting.

- **Second**, the studies provide some evidence that Medicaid managed care savings are significant for the Supplemental Security Income (SSI) and SSI-related population.

- **Third**, various studies demonstrated that states' Medicaid managed care cost savings are largely attributable to decreases in inpatient utilization.

- **Finally**, pharmacy was also an area where Medicaid managed care programs yielded noteworthy savings.
Our Understanding of Montana’s Current Managed Care Environment

1. **Passport to Health** waiver section 1915(b)
   - **Network:** contracted PCPs
   - **Membership:** 70% of enrollees
   - **CM Model:** PCP & Authorizations required for out-of-network
   - **Cost:** $3 PMPM and state at-risk for medical costs
   - **Exclusions:** Duals, Nursing Home and Foster care

2. **Health Improvement Program** waiver 1915(b)
   - **Network:** 13 FQHCs & 1 Tribal Center
   - **Membership:** 3000 with acute conditions & expected high costs
   - **CM Model:** Care coordination services (such as appointment reminders, arranging transportation, medication review)
   - **Cost:** $3.75 PMPM and state at-risk for medical costs

3. **Team Care** waiver section 1915(b)
   - **Network:** contracted PCPs
   - **Membership:** Enrollees with above average claims costs
   - **CM Model:** 24 hour nurse line with care from one PCP & one Rx
   - **Cost:** $6 PMPM and state at-risk for medical costs

4. **Other state programs** under 1115 & HCBS

   Total Spend is about $900M – significant increase in enrollment in 2010 especially children -> June ‘10 at 64K up 20k from 2009.
Medicaid Expansion: Anticipated Health Experience

- In 2010, UnitedHealthcare participated in a project with the Center for Health Care Strategies (CHCS) and select states to understand the needs of the Medicaid Expansion population.
- Specific programs and results vary from state to state, but the overall findings are consistent:
- These individuals are characterized as follows:
  - Poor* and low-income adults
  - Do not live with an eligible child (childless)
  - Do not have a disability
  - Higher rates of uninsured
  - Relatively high health care needs

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>AZ</th>
<th>IN</th>
<th>PA</th>
<th>ME</th>
<th>OR</th>
<th>NY</th>
</tr>
</thead>
<tbody>
<tr>
<td>On average, childless adults more cost per year than the TANF population</td>
<td>✓</td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
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</tr>
<tr>
<td>On average, individuals at the lower end of the poverty scale incur disproportionately high costs</td>
<td></td>
<td>✓</td>
<td></td>
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<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Childless adults tend to be associated with high utilization (particularly for services related to chronic conditions, mental health, and substance abuse)</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>
Health Care Reform Expansion in Montana

84% Expansion Increase
76,000+ New Enrollees
$2.5+ Billion Increase

Figure 1, 2, 3: Source: UnitedHealth Center for Health Reform analytical modeling
Impact of the ACA on Medicaid in Montana

• The Affordable Care Act (ACA) is projected to bring over 70,000 individuals into Montana’s Medicaid program by 2019. This represents a substantial increase over the current number of Medicaid consumers in the State and many of the newly eligible will be childless adults.

• National studies suggest that this new Medicaid population may have different healthcare needs.

• If these national results are extrapolated to the State of Montana, we would expect the Medicaid Expansion population to differ from the current Medicaid population in the following ways:
  – More likely to consider themselves in fair or poor mental health and general health
  1
  – More likely to have two or more chronic conditions
  1
  – More likely to be associated with high utilization (particularly for services related to chronic conditions, mental health, and substance abuse)
  2


2. Source: “Covering Low-Income Childless Adults in Medicaid: Experiences from Selected States.” Available at: http://www.chcs.org/usr_doc/Medicaid_Expansion_Brief.pdf
Physician Capacity in Rural Communities

- The coverage expansions established by the Affordable Care Act (ACA) will place unique pressure on rural communities.

- Primary care plays a central role in delivering care within rural communities, yet in remote rural areas there are fewer than half the number of primary care physicians per 100,000 population than in urban areas.

- Primary care capacity will likely experience further strain as consumers gain new coverage through Medicaid and Exchanges.

- Scope of practice laws, which govern the scope of responsibility for nurse practitioners and other non-physician health professionals, may be one mechanism for relieving primary care capacity concerns.

- Other changes to the delivery system, such as Health Homes and Accountable Care Organizations (ACOs), e-Visits, Telemedicine may also help by improve primary care capacity, care coordination, and multidisciplinary teamwork.


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Healthcare Reform offers Models aimed at CMS Triple Aim - Cost, Care, & Quality

**ACA Health Care Reform**

**MEDICAID:**
- Section 2403. Money Follows the Person Rebalancing
- Section 2601. 5-Year Period for Demonstration Projects
- Section 2703. Medical Home State Option
- Section 2704. Integrated Care Around A Hospitalization
- Section 2705. Medicaid Global Payment System
- Section 2706. Pediatric Accountable Care Organization
- Section 2707. Medicaid Emergency Psychiatric

**MEDICARE:**
- Section 3021. Center for Medicare and Medicaid Innovation
- Section 3022. Medicare Shared Savings Program
- Section 3024. Independence At Home Pilot Program
- Section 3502. Establishing Community Health Teams to Support Patient-Centered Medical Home

**OTHER:**
- Section 4101. School Based Health Centers

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**Sec. 2703 – Health Home**

- State option to provide health homes for enrollees with chronic conditions. Provide States the option of enrolling Medicaid beneficiaries with chronic conditions and behavioral health into a health home.
- ACA incentivizes state to pursue this option by authorizing a temporary 90% federal match rate (FMAP) for health home services.
- Effective January 2011.

**Accountable Care Organizations**

- ACOs are defined as a group of providers that has the legal structure to receive and distribute incentive payments to participating providers.
- Typically At-risk models
- Episode of Care Payments

**Patient-Centered Medical Home**

- Simplified and Coordinated Health Care Experience
- Improved Care Transitions
- Population Management Focused
- Evidence-based Medicine Driven
Evolution of Historical Managed Care Models to today’s Accountable Care Communities

**Evolution through 2011**

**Independent Teams**
- Utilization Management & Prior Auth
  - ER Diversion
  - Complex Cases
- Standalone Case Management
  - Top 1% Impact Pro High Risk
- Disease Management

**Multi-Disciplinary Team Approach**
- Utilization Mgmt Multi-Disciplinary Team
  - Concurrent Review
  - Complex Case Management
  - ER Diversion
- CM / Disease Management

**Health Plan to Member Model**

**Community-Centric Approach**
- Multi-Disciplinary
  - Concurrent Review
  - Complex Case Management
  - ER Diversion
- Collaborative Team
  - EBM Adherence
  - Patient Registries
  - Enhanced Patient Access
  - Care Advocate Role
  - Community-Based Services

**Health Plan to Member Model**

**Today**

**Support Resources**
- Patient-Centered Medical Home
- Accountable Care
- Guided Care Management
- Home & Community Based Services

**Accountable Care Model**
- Multi-Disciplinary Team Approach
  - Concurrent Review
  - Complex Case Management
  - ER Diversion
  - ER Diversion
  - Care Advocate Role
  - Community-Based Services

**Evolution through 2011**

**Today**

**Evolution of Managed Care Models to today’s Accountable Care Communities**

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**Health Plan to Member Model**

**Community-Centric Approach**
- Multi-Disciplinary
- Collaborative Team
- Support Resources

**Accountable Care Model**
- Multi-Disciplinary Team Approach
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**Evolution through 2011**

**Today**

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**Accountable Care Model**
- Multi-Disciplinary Team Approach
- Support Resources
Example Impact of Movement to New Models of Care

Example Health Plan Medicaid Bed Day Management

- 26% Bed Day Reduction over prior 3 years

From Independent Utilization Management and Case Management to Accountable Care Communities

Example Medical Home Impact Since Program Inception

Medicaid admits/1,000 have decreased 17 percent, and bed days/1,000 decreased 26 percent:

- PRACTICE A: Medical Home Impact Medicaid Trend Admits: 1,800
- PRACTICE A: Medical Home Impact Medicaid Trend Days: 1,800

Medicare admits/1,000 have decreased 45 percent, and bed days/1,000 decreased 46 percent:

- PRACTICE A - Medical Home Impact Medicare Trend Admits: 1,000
- PRACTICE A - Medical Home Impact Medicare Trend Days: 1,000

From Independent Utilization Management and Case Management to Accountable Care Communities

UnitedHealthcare
COMMUNITY & STATE
Dual Eligible Opportunity

• ACA created opportunities to better integrate benefits for Dual Eligibles.

• The Federal Coordinated Health Care Office, is charged simplifying processes for Dual Eligibles, improving coordination between States and the Federal government, eliminating regulatory conflicts between Medicare and Medicaid, and ultimately improving the quality of healthcare for Duals.

• UnitedHealthcare Community & State aims to create a truly integrated Dual Eligibles Demonstration that is tailored to meet state needs and focuses on the following:
  • Member-centered integration of Medicare, Medicaid and applicable waiver benefits
  • Integration of all administrative functions, including member materials, and a seamless member experience
  • Development of a funding mechanism that provides incentives for improved utilization, benefits both Federal and state governments, and appropriately aligns incentives

• This opportunity could be leveraged by states regardless of whether they received federal grant funding to pursue a Dual Eligibles demonstration.
# Medicaid Managed Care Best Practices in Moving to Full Capitation

<table>
<thead>
<tr>
<th>Factor</th>
<th>Most Common</th>
<th>Best Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>RFP vs. Application</td>
<td>RFP – 60% use RFPs; most new states</td>
<td>RFP-TN, TX, OH, AZ, MI, PA, NV, CT, RI, DC, GA</td>
</tr>
<tr>
<td>Number of Plans</td>
<td>Limited: Rural 2-3, Metro 3-5</td>
<td>Limited: Rural 2-3, Metro 3-5 proportional to population; low rural population with high risk often just 1</td>
</tr>
<tr>
<td>Member assignment to new plans</td>
<td>New Plans receive auto-assigned members for defined period or to set threshold; rare- positive enrollment</td>
<td>Texas provided auto-assigns (if history matches network provider) to new plan for up to 15,000 members</td>
</tr>
<tr>
<td>Priced Bids</td>
<td>State sets ‘take it or leave it’ rates</td>
<td>States set rates (actuarially sound)</td>
</tr>
<tr>
<td>Access to Historical Claim Data</td>
<td>Yes</td>
<td>Yes – Nearly all states</td>
</tr>
<tr>
<td>Covered Populations</td>
<td>TANF, CHIP, Non-Dual/Non LTC ABD</td>
<td>All covered including Duals – TX, AZ, NY, TN</td>
</tr>
<tr>
<td>Benefit Carve Outs (Rx, BH, LTC, Dental)</td>
<td>Rx 10%, BH 25%, LTC 75%, Dental 35%</td>
<td>No Carve Outs - NY, TN, MI, WI, NE, RI, GA; TX has proposed Rx add back</td>
</tr>
<tr>
<td>Network Adequacy</td>
<td>Contracts, LOIs and Plan</td>
<td>Contracts, LOIs and Plan</td>
</tr>
<tr>
<td>Out of Network Payments</td>
<td>Limited to Medicaid Fee Schedule</td>
<td>5%-10% less than Medicaid</td>
</tr>
<tr>
<td>Open Enrollment</td>
<td>Annual with lock in 60%; others monthly option</td>
<td>Annual with lock in; few switch in ‘open’ states</td>
</tr>
<tr>
<td>Auto Assignment</td>
<td>Consider PCP history, Plan network, zip code</td>
<td>High-HEDIS plans gain preference MI, AZ, NY</td>
</tr>
<tr>
<td>Require PCMH / Accountable Care</td>
<td>No</td>
<td>Encourage adoption AZ, MI, HI, LA, NE, WI</td>
</tr>
<tr>
<td>Performance / Quality Incentives</td>
<td>Most have targets; few pay bonuses to plans; often penalties</td>
<td>Publicize plan performance TX, TN, PA, AZ, NY</td>
</tr>
</tbody>
</table>
Considerations for Health Exchanges to Minimize Anticipated Churn

A common phenomenon in Medicaid, a study published in Health Affairs demonstrates that there will be frequent movement between Medicaid and the Exchange as incomes fluctuate. Within a year 28 million or 50% of adults will experience a shift from Medicaid to the Exchange or vice versa. The Exchange and Medicaid eligibility proposed rules appear to advance one critical step in a strategy to diminish churn as they emphasize the need and requirement for a seamless, one-stop shop enrollment process and a more simplified approach toward recertification.

- A single point of entry and eligibility determination, based on annual and current income
- A single application for eligibility (web, phone, in-person, mail)
- Significant reliance on attestations and pre-populated data from the Federal Hub, state wage reports and other sources when available
- Ability to complete the enrollment process, including plan selection online via the Exchange or through a link to Medicaid
- If the Exchange determines the applicant is eligible for Medicaid/CHIP, it must transmit that information to the State without requiring further steps to determine eligibility
- Annual recertification and auto-renewal when reliance on a data match is possible
Appendix: Expansion & the Exchange
Expansion Projections (2019 View)

- **Non-subsidized coverage**
  - >400% FPL

- **Premium subsidies available to families with incomes between 133-400% FPL (to purchase insurance through the Exchanges)**
  - 400% FPL
  - 300% FPL
  - 200% FPL
  - Current Medicaid

- **States have the option to create a Basic Health Plan for uninsured individuals with incomes between 133-200% FPL who would otherwise be eligible to receive premium subsidies in the Exchange.**
  - 133% FPL

- **Medicaid Expansion: Uniform 133% FPL and new definition (Modified Adjusted Gross Income, or MAGI)**
  - ~16,000,000 individuals
  - ~8,000,000 individuals
  - ~15,000,000 individuals
  - ~16,000,000 individuals

Note: This visual is scaled to FPL. Numbers do not necessarily reflect all net new coverage. Sourced from CBO estimates, available at: http://www.cbo.gov/budget/factsheets/2011b/HealthInsuranceProvisions.pdf
The Churn Phenomenon

A common phenomenon in Medicaid, a study published in Health Affairs demonstrates that there will be frequent movement between Medicaid and the Exchange as incomes fluctuate. Within a year 28 million or 50% of adults will experience a shift from Medicaid to the Exchange or vice versa.

• Interestingly, the Health Affairs study introduction notes, “...research shows that 43 percent of newly enrolled adults in Medicaid experience a disruption in coverage within twelve months.” (Sommers BD. Loss of health insurance among non-elderly adults in Medicaid)

• As it relates to the churn analysis, “The sample was made up of adults ages 19–60 whose family income at the outset of the survey was 200 percent of poverty or less. Our sample included only adults, who constitute the population directly affected by the new Medicaid eligibility rules.”

• “Our results show that 35 percent of the adults in our sample would have experienced a change in eligibility within six months, and 50 percent would have experienced a change within one year…”

• “Perhaps of even greater concern, 24 percent would have experienced at least two eligibility changes within a year, and 39 percent would have experienced such churning within two years.”

• Though states will need to conduct their own state specific evaluations, these findings suggest there will be considerable movement or churn between programs as incomes fluctuate.

Source: Benjamin D. Sommers and Sara Rosenbaum, Health Affairs, “Issues In Health Reform: How Changes In Eligibility May Move Millions Back And Forth Between Medicaid And Insurance Exchanges” (February 2011)
**Implications of Churn**

- Individuals with fluctuating income will move between Medicaid and Exchange eligibility.
- Key aspects of coverage, such as benefits, provider network, and out of pocket costs, may be disruptive and confusing.
- Though Exchange consumers at lower income levels will receive substantial premium subsidies, their cost to purchase coverage will be significant.
- Individuals experiencing such shifts may require additional support and assistance as they navigate the effects of coverage changes.

*This diagram assumes that Medicaid covers up to 138% FPL and assumes no Basic Health Plan*

**Income of $14,702 per year**
*(135% FPL in 2011 dollars)*

- Medicaid Benefits
- No Premium
- No Cost Share
- Essential Benefits
- Commercial Network (likely restricted)
- Significant (yet subsidized) Premium
- Copays, Coinsurance

**Income of $15,246 per year**
*(140% FPL in 2011 dollars)*

- Medicaid Care Management (If MCO)
- Different Care Management (or potentially no care management)
It’s Impact On Consumers

Absent strategies to address churn, frequent shifts between programs will cause confusion, disruption and continuity of care issues (access, benefits, services) for Maryland consumers.

• Can I still go to my doctor or health care professional?

• Which ID card should I use?

• Who do I call?

• Which program are my children in? How can our family stay together?

• Why isn’t this benefit covered any more?

• I still don’t have a car and need a ride to my doctor!

• I don’t speak English, can a translator help me?

• Can I stay with my same health plan?

• What do you mean I have to pay for care (a new copay/premium for someone moving from Medicaid to the Exchange?)
And Then There Is The “Cliff”

Though Exchange consumers at lower income levels will receive substantial premium subsidies, their cost to purchase coverage will be significant. Premiums, copayments, deductibles…the terminology may lead to confusion for Medicaid consumers who move to the Exchange. The cost obligations may be overwhelming and lead them not to purchase coverage.

<table>
<thead>
<tr>
<th>Annual Income</th>
<th>%FPL (Family Size 1)</th>
<th>Eligibility</th>
<th>Premium (after subsidy)</th>
<th>Expected Cost Sharing</th>
<th>Total Out of Pocket</th>
</tr>
</thead>
<tbody>
<tr>
<td>$14,702</td>
<td>135%</td>
<td>Medicaid</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>$15,246</td>
<td>140%</td>
<td>Exchange</td>
<td>$518</td>
<td>$343</td>
<td>$861</td>
</tr>
</tbody>
</table>

Consumers will enter and have their eligibility determined via the Exchange. A modest change in income, in this example and increase of $544 pre-tax dollars annually, can lead to a substantial increase in an individuals cost obligation (in this case $861 annually in after-tax dollars).
## Potential Levers to Address “Churn”

<table>
<thead>
<tr>
<th>Potential Levers and Requirements</th>
<th>Policy</th>
<th>Product</th>
<th>Tool</th>
</tr>
</thead>
<tbody>
<tr>
<td>End to End Eligibility, Recertification and Enrollment Via Exchange</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Align the Benchmark and Essential Health Benefits</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Basic Health Plan</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Common Health Plans across Medicaid, The Exchange, and BHP</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Common Providers across Medicaid, The Exchange and BHP</td>
<td>✓</td>
<td></td>
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<tr>
<td>A Focus on Affordability, the Right Price Points</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Special Enrollment Rules For Health Plans that Operate In Medicaid &amp; The Exchange</td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Same Member ID Card For All Programs</td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Pro-Actively Track and Conduct Outreach to Help Families In Transition, including Health Insurance Literacy</td>
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<td></td>
<td>✓</td>
</tr>
<tr>
<td>Consistent Enrollment Rules, Timeframes, and Definitions for Medicaid and the Exchange</td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>