Arkansas Health Care Reform Task Force

TSG Update Report

November 24, 2015

Excerpts prepared for Speaker Presentation 1-21-16

State Care Management/Medicaid Payment Reform Models: 2014

- Managed Care/Capitated Full Risk Based: 26 states: AZ, CA, DE, GA, HI, KS, KY, MI, MN, MO, NE, NV, NH, NM, NY, OH, OR, PA, SC, TX, TN, UT, VA, WA, WI, MS
- MCO and PCCM (Primary Care Case Management): 13 states: CA, CO, FL, IA, IL, IN, LA, MA, NV, ND, RI, WA, WV
- PCCM only: 9 states: AL, AR, ID, ME, MT, NC, OK, SD, VT
- No comprehensive MCO: 3 states: AL, CT, WY
- ACO in place: 8 states: CO, IA, IL, MN, OR, SC, UT, VT (CA, MD, ME, NJ, PA planned for 2015)

Quality in Texas Medicaid Managed Care Programs

- Milliman/Sellers Dorsey conducted "A Review of Access to Services, Quality of Care, and Cost Effectiveness" of all Texas capitated managed care programs from 2009 through 2014.
- The study found that the MCOs provided strong network access adequacy to protect member's rights, engaged innovative solutions to provider specialty shortages and after hours urgent care, and offered no cost to the state added value beneficiary services targeting prevention and wellness.
- The Texas MCOs were found to have achieved:

➢ An average of 93% of child and adolescent members reporting having a PCP and 90% visiting their PCP during the year

Quality in Texas Medicaid Managed Care Programs

- Surpassed national performance expectations on child well visits and childhood immunizations
- No Interest List wait to access community based waiver services (LTC)
- High level of customer satisfaction with 83% of child members reporting overall positive experience with their health plan
- Cost savings for the state of 7.9% over fee for service
- Texas MCO children's health quality standards exceeded national standards in several key clinical conditions related to potential hospitalization:
- Asthma: Rates declined 22% from 2009 to 2011
- Diabetes Short-Term Complications: Rates declined from 25.18 per100,000 in 2009 to 18.58 per 100,000 in 2011, a 26% decrease

Quality in Texas Medicaid Managed Care Programs

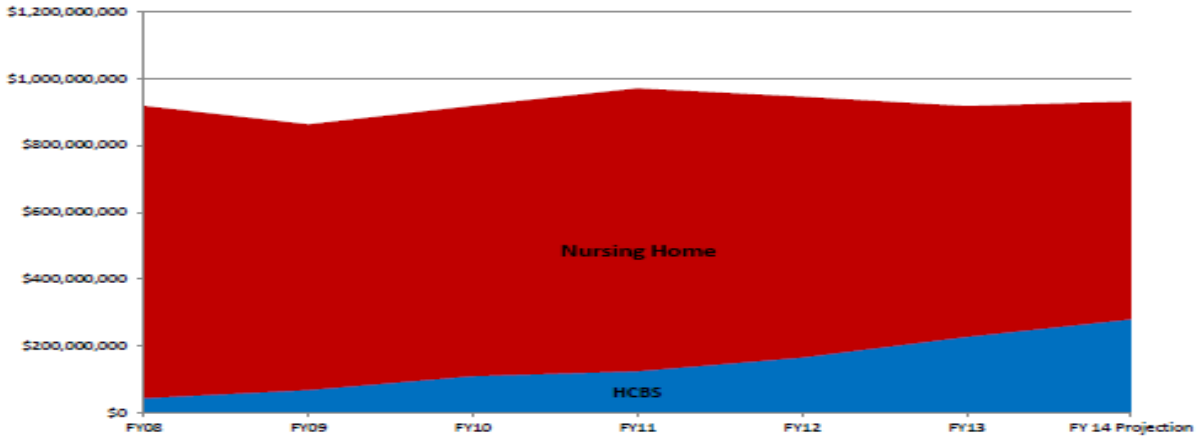
- Gastroenteritis: Rates decreased approximately 37% from 2009 to 2011. Moreover, rates of gastroenteritis in 2011 (45 per 100,000) fell substantially below HHSC Dashboard Standards (146 per 100,000)
- Urinary Tract Infection: Rates decreased by nearly 20% from 2009 to 2011. The 2011 rates (31) were significantly lower than the HHSC Dashboard Standard of 53 per 100,000
- Quality Standards for adults with disabilities resulted in:
- Diabetes Short-Term Complications rate decreased 31% between 2009-2011
- Bacterial Pneumonia rate decreased 19% between 2009-2011
- Urinary Tract Infection rate declined 31% between 2009- 2011

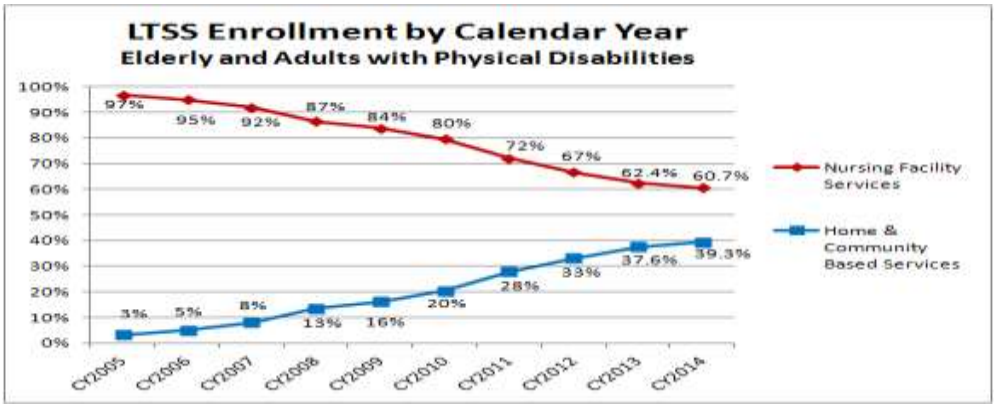
TennCare Quality and Cost Control

- TennCare currently exceeds HEDIS national averages in 64 of 99 measures.
- TennCare beneficiary satisfaction measure has exceeded 90% for the past six years.
- NCQA ranks TennCare MCOs at the “Commendable” level: based on HEDIS, CAHPS (AHRQ survey), and NCQA measures.
- In FY 2016 the TennCare capitated integrated managed care system saved $285 million compared to estimated fee for service system.
- TennCare’s comprehensive rebalancing of long term care, based on SB 4181, has resulted in budget neutrality in LTC and cost avoidance of $250 million between FY 2010 and FY 2014.

TennCare Quality and Cost Control

- TennCare LTC Budget Neutrality:





Kansas Managed Care for LTSS Experience Update

- **Presentation on Managed Long-Term Services and Supports in Kansas**
- **By Kari Bruffett, Secretary, Kansas Department for Aging and Disability Services - July 7, 2015**

Why Reform?

(Source: Presentation By Kari Bruffett, Secretary, Kansas Department for Aging and Disability Services - July 7, 2015)

Kansas Medicaid and CHIP had used managed care models for children and families since the 1990s.

But Kansas Medicaid historically was not outcomes oriented.

The most complex consumers were in the fee-for-service model, with services defined by the programs they were in.

Fueled by fragmentation, costs rose at an annual rate of 7.4 percent over the decade of the 2000s. In Old Medicaid, budget concerns would trigger rate reductions and create waiting lists for certain services.

Kansas

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What Did Kansas Choose to Do?

Kansas developed KanCare, a coordinated managed care program for nearly all beneficiaries and services.

A centerpiece of KanCare was **integrating managed long term services and supports (MLTSS) with physical and behavioral health**.

After an initial one-year delay of the inclusion of MLTSS for members with intellectual or developmental disabilities (ID/DD), now all HCBS services are included.

(Source: Presentation By Kari Bruffett, Secretary, Kansas Department for Aging and Disability Services - July 7, 2015)

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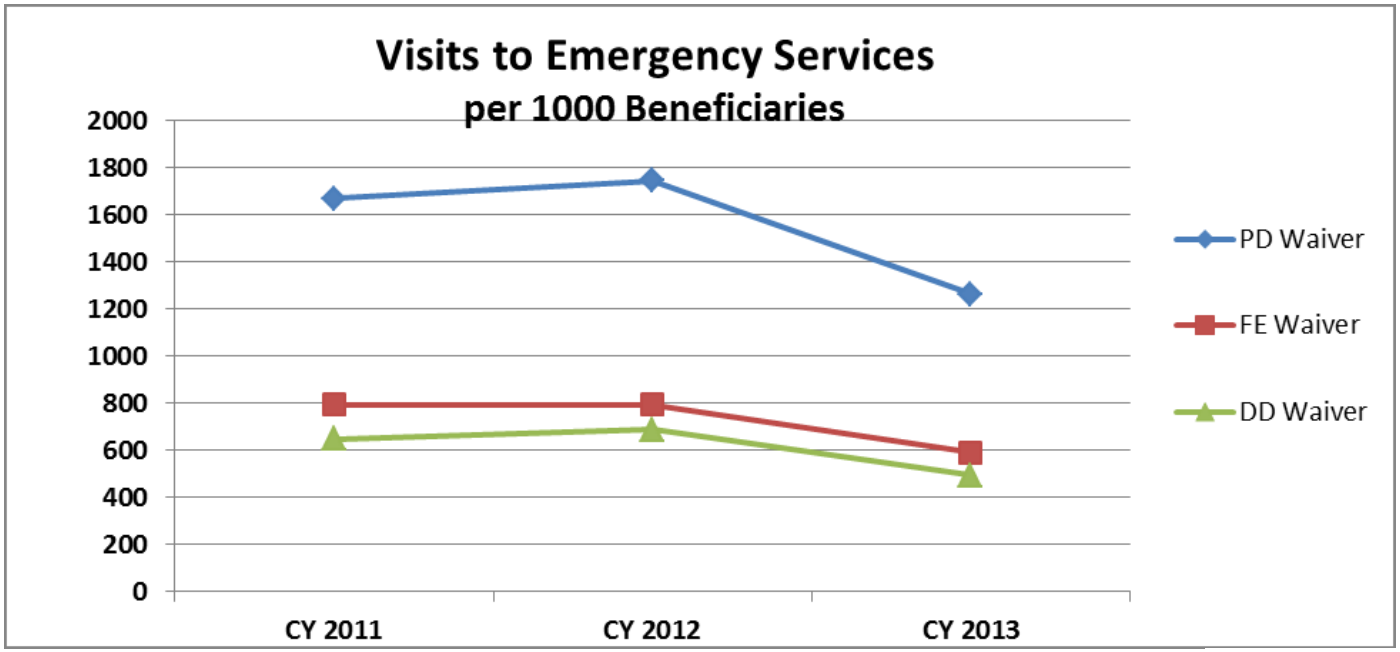
How Is It Working?

Snapshots:

- In just the first year, Emergency Room usage for HCBS Waiver program participants was reduced by 27%.
- (Source: Presentation By Kari Bruffett, Secretary, Kansas Department for Aging and Disability Services - July 7, 2015)



How is it Working?

- Primary Care utilization increased 31%.
- Also saw increased use of:
  - Dental
  - Vision
  - FQHCs/RHCs
- Decreased days:
  - Inpatient hospital

(Source: Presentation By Kari Bruffett, Secretary, Kansas Department for Aging and Disability Services - July 7, 2015)

Waiting List: Current Efforts

Since the inception of KanCare, 3,100 people from the Physical Disability and Intellectual/Developmental Disability waiting lists have been offered services.

PD Waiting List

- 1,448 people are currently on waiting list
- Services have been offered to individuals who have been on the waiting list through May 2014

I/DD Waiting List

- 3,319 people are currently on waiting list
- The "underserved" waiting list has been eliminated

(Source: Presentation By Kari Bruffett, Secretary, Kansas Department for Aging and Disability Services - July 7, 2015)

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How is it Working?

- Low denial rate – 1.5% statewide for I/DD services, excluding duplicate claims denials
- Timeliness of claims processing – Average 6.4 days for HCBS/IDD, 5.7 days TCM/IDD
- Plan of Care – Reductions proposed and reviewed for <2.5% I/DD members in 1½ years
- Decreased institutionalization
- (Source: Presentation By Kari Bruffett, Secretary, Kansas Department for Aging and Disability Services - July 7, 2015)

Other State Examples of Documented Managed Care Cost Savings

- Kansas: Governor's budget for FY 2016 includes $50 million in state funds Medicaid match as a result of implementation of full integrated managed care contracting. Savings have been targeted to address the IDD HCBS waiting list.
- Ohio's FY 2012/2103 Medicaid budget results were $360 million in state match funds below budget. Based on full implementation of managed care in FY 2015 Ohio's Medicaid budget results were $1.8 billion below the appropriated budget of $25.5 billion, 7.6%.
- Louisiana: The state's Medicaid capitated managed care covered 600,000 of 900,000 covered lives in FY 2014. the state achieved a total savings of $135.9 million in FY 2014, a 12% reduction.

Care Management Contracting Issues: Incentives and Sanctions

- Incentives and Sanctions are contracting tools in a risk based contract that states employ to achieve performance objectives related to clinical, evidence based practice and health status improvements and compliance.
- Generally, financial incentives are used to motivate pre-determined clinical outcomes such as unnecessary institutional utilization, child and adult well care visits (PCMH), evidence based practice for identified conditions (Episodes of Care), and a growing emphasis on population health outcomes such as diabetes self management and infection reduction.
- Sanctions are generally monetary penalties for non adherence to contract compliance requirements such as paying claims in the prescribed time period, failure to provide medically necessary care, late filing of financial/HEDIS reports, etc.