Managed Care Outlook

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Health System Transformation

Executive Summary

- Managed care expansion into long term care is heavily cost driven
- States are interested in cost containment and shifting risk downstream
- Plans are focused on potential new business opportunities through capturing and retaining more covered lives at a higher capitation rate
- Experience with these approaches is very limited among states, plans as well as CMS capacity to oversee such potentially large number of programs
Managed Care Architecture

<table>
<thead>
<tr>
<th>Model</th>
<th>Medicare Advantage</th>
<th>Model 2: Medicaid LTSS-Only</th>
<th>Model 3: Medicaid-Only</th>
<th>Model 4: Medicare-Medicaid Integration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Services for which Managed care contractor is at risk*</td>
<td>None</td>
<td>Home and Community-Based Services (HCBS) Nursing Center</td>
<td>HCBS Nursing Center Medicaid-Covered Primary Care Services Medicaid-Covered Pharmacy</td>
<td>HCBS Nursing Center Medicaid-Covered Primary Care Services Medicaid-Covered Pharmacy</td>
</tr>
</tbody>
</table>

Provider Impacts are both Volume and Price Related

Source: Avalere Health, LLC
Costs are Driving the Medicaid Reform Dialogue

Source: Centers for Medicare and Medicaid Services Office of the Actuary – National Health Expenditure Projections 2010 – 2020

State Government is Downsizing

By 2014, Approximately 28 States Likely will be Operating MLTSS Programs


MLTSS Financial Flow

*Enhanced Federal Medical Assistance Percentages (EFMAP) are available under several programs: Money Follows the Person, Community First Choice, & Balancing Incentives Payment Program.
Medicaid Spending and Plan Interest

Medicaid Spending
- $118
- $220
Total = $338 Billion

Medicaid Managed Care Expenditures
- $4
- $67
Total = $71 Billion

Approximately $114 billion is at stake

Note: In 2011 Dollars. Total annual Medicaid Spend in 2013 is approximately $432 billion. Sources: National Health Expenditure Survey; Kaiser Family Foundation Annual 50 State Medicaid Report

Opportunity to Spread Risk and Manage Across Populations

Low Cost Populations
- Medicaid Expansion
- Children
- Traditional Children and Families

High Cost Populations
- LTSS Users
- Duals
- Others with multiple chronic conditions
Nationwide Major Plans Dominate; NY Market is Local

Market Share by Corporate Type

- Private For-Profit: 44%
- Private Non-Profit: 32%
- Public or Quasi-Public: 25%


Four For-Profit Carriers Dominate the Market

- UnitedHealthCare
- WellPoint/Amerigroup
- Centene
- Molina Healthcare

State Activity: Dual Eligible/MLTC Expansion

- Of the 22 states with the highest Medicaid expenditures:
  - 3 already utilize mandatory MLTC
  - 8 pursuing FAI demo
  - 4 implementing mandatory MLTC
  - 3 in early stage MLTC planning

<table>
<thead>
<tr>
<th>MCO</th>
<th>Net Expenditures</th>
<th>% of Total</th>
<th>$ on MCO</th>
</tr>
</thead>
<tbody>
<tr>
<td>New York</td>
<td>$16,510,096,023</td>
<td>$51,577,226,502</td>
<td>32.0%</td>
</tr>
<tr>
<td>California</td>
<td>$11,498,756,300</td>
<td>$48,883,017,432</td>
<td>23.5%</td>
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<tr>
<td>Texas</td>
<td>$9,879,029,821</td>
<td>$27,521,481,436</td>
<td>35.9%</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>$6,778,850,576</td>
<td>$20,215,741,634</td>
<td>33.5%</td>
</tr>
<tr>
<td>Florida</td>
<td>$1,277,272,591</td>
<td>$17,794,004,730</td>
<td>18.4%</td>
</tr>
<tr>
<td>Ohio</td>
<td>$6,582,882,799</td>
<td>$16,241,807,775</td>
<td>40.0%</td>
</tr>
<tr>
<td>Illinois</td>
<td>$668,189,299</td>
<td>$13,216,199,698</td>
<td>5.1%</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>$3,026,972,994</td>
<td>$12,660,753,340</td>
<td>39.9%</td>
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<tr>
<td>Michigan</td>
<td>$3,664,445,409</td>
<td>$12,377,502,267</td>
<td>29.8%</td>
</tr>
<tr>
<td>North Carolina</td>
<td>$0</td>
<td>$12,074,012,547</td>
<td>0.0%</td>
</tr>
<tr>
<td>New Jersey</td>
<td>$3,709,810,760</td>
<td>$10,263,014,973</td>
<td>36.1%</td>
</tr>
<tr>
<td>Tennessee</td>
<td>$5,520,629,017</td>
<td>$8,791,502,481</td>
<td>63.1%</td>
</tr>
<tr>
<td>Minnesota</td>
<td>$3,765,905,494</td>
<td>$8,661,424,765</td>
<td>43.5%</td>
</tr>
<tr>
<td>Missouri</td>
<td>$1,083,294,572</td>
<td>$8,620,708,526</td>
<td>12.6%</td>
</tr>
<tr>
<td>Georgia</td>
<td>$2,567,793,832</td>
<td>$8,299,096,366</td>
<td>30.9%</td>
</tr>
<tr>
<td>Arizona</td>
<td>$5,952,660,529</td>
<td>$7,902,956,657</td>
<td>67.7%</td>
</tr>
<tr>
<td>Maryland</td>
<td>$2,343,035,241</td>
<td>$7,164,182,204</td>
<td>31.0%</td>
</tr>
<tr>
<td>Washington</td>
<td>$1,731,048,767</td>
<td>$7,452,641,090</td>
<td>25.2%</td>
</tr>
<tr>
<td>Indiana</td>
<td>$1,715,281,988</td>
<td>$7,450,035,538</td>
<td>23.1%</td>
</tr>
<tr>
<td>Louisiana</td>
<td>$1,742,457,202</td>
<td>$7,056,159,315</td>
<td>10.5%</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>$1,815,546,534</td>
<td>$6,978,470,509</td>
<td>26.0%</td>
</tr>
<tr>
<td>Virginia</td>
<td>$1,939,017,993</td>
<td>$6,806,627,571</td>
<td>28.5%</td>
</tr>
</tbody>
</table>

Source: CMS
Slide Credit: Health Management Associates, Greg Nersessian
New York MLTC Plan Penetration

MLTC PACE enrolled 5,123, concentrated among eight plans, including:

<table>
<thead>
<tr>
<th>PLAN NAME</th>
<th>COUNTY</th>
<th>TOTAL ENROLLED</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARCHCARE SENIOR LIFE</td>
<td>NEW YORK</td>
<td>296</td>
</tr>
<tr>
<td>CHS BUFFALO LIFE</td>
<td>ERIE</td>
<td>147</td>
</tr>
<tr>
<td>COMPLETE SENIOR CARE</td>
<td>NIAGARA</td>
<td>79</td>
</tr>
<tr>
<td>COMPREHENSIVE CARE MGMT</td>
<td>WESTCHESTER</td>
<td>3,139</td>
</tr>
<tr>
<td>EDDY SENIOR CARE ALBANY</td>
<td>SCHENECTADY</td>
<td>144</td>
</tr>
<tr>
<td>INDEPENDENT LIVING FOR SENIORS</td>
<td>MONROE</td>
<td>445</td>
</tr>
<tr>
<td>PACE CNY ONONDAGA</td>
<td>436</td>
<td></td>
</tr>
</tbody>
</table>

Total MLTC PACE Enrollment 5,123

Race to Gain New Program Capabilities

- Medicaid MCO participation in new programs requires:
  - The development of new skills/capabilities
    - Exchange: Billing, underwriting, network contracting, sales and marketing, manage cost-sharing, web strategies
    - Duals: Medicare Advantage/Part D, member assessments, advanced care mgmt, LTSS, network contracting
  - Capital
    - Centene: Analysts anticipate equity capital raise of $300M to $500M
    - Amerigroup: Acquired by WellPoint Dec. 2012 for $4.9 billion
    - Coventry: Acquired by Aetna May 2013 for $7.3 billion
- Early years of new programs can be challenging ➔ volatile financial performance
  - Exchange: How competitive is exchange pricing? Take-up rates? Adverse selection? Network adequacy?
  - Dual eligible: Capitation rates adequate? Adverse selection due to opt-out? Continuity of care?
- Implication: Too many companies trying to do things they’ve never done before ➔ expect winners and losers to emerge

Source: Health Management Associates
New York MLTC Partially Capitated Plans

MLTC partial capitated plans enrollment totaled 108,454 concentrated among eight plans, including the top three:

- VNS Choice totals: 17,974, concentrated in Manhattan
- Guildnet totals: 13,931, concentrated in Manhattan
- Senior Health Partners totals: 10,345, concentrated in Manhattan, Westchester, Nassau
- Eldercare totals: 10,192, concentrated in Manhattan
- Other major plans include: Elderserve, Fidelis and CCM Select
- AHCA/NCAL with Health Management Associates provided a tool to describe detailed plan enrollment information by plan by county.

State-Level Concerns

- Rapidity of expansion or implementation
- Expectation of savings rather than budget predictability
- Ability to set capitation rates and risk-adjust for LTSS
- Capacity of state agency staff to oversee complex MLTSS programs
- Ability of External Quality Review Organizations (EQRO) to perform oversight for possibility unfamiliar LTSS arrangements
Plan-Level Concerns

- Lack of experience with people using LTSS and their families
- Understanding of how to work with LTSS providers
- Understanding of participant direction and individual budgeting
- Ability to deliver services 24/7
- Understanding of and ability to deliver or coordinate with non-medical and social supports
- Importance of administrative simplification for LTSS providers, particularly smaller providers
- Potential layers of care coordination

CMS-Level Concerns

- Weak Data Capacity and ability to assess performance
- Need to broaden technical assistance to LTSS providers
- Clarity on managed care ombudsman functions and availability of Medicaid match for such functions
- Guidance to states on medical loss ratio, continuity of care requirements including any willing provider, network adequacy
- Requirements for appeals and grievances tailored to people using LTSS
- Need to review and possibly alter managed care rules including specialized requirements for MLTSS readiness review
- Section 1115 waiver transparency rules does not include amendments
### Elements in New York

<table>
<thead>
<tr>
<th>General Protection Language</th>
<th>New York Area of Concern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Require use of state set rates with provider assessment built into rates</td>
<td>Require fee-for-service or benchmark rates or negotiated rate acceptable to plans and NF.</td>
</tr>
<tr>
<td>Require the state set rates to include a capital component inflation factor</td>
<td>After two year NF will continue to receive the capital calculated benchmark rate.</td>
</tr>
<tr>
<td>States should require plans to share savings with providers</td>
<td>State will facilitate and develop strategies/financial incentives for plans and providers to share savings (i.e. ACOs, bundled payment).</td>
</tr>
<tr>
<td>State should work with NH providers to address the historical Medicaid FFS shortfall for NH before setting a base rate for future trending</td>
<td>Allows historical FFS expenditures to be trended forward to the rate period and rates will accommodate nursing home and allows NF population to be tracked.</td>
</tr>
</tbody>
</table>

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</tr>
</thead>
<tbody>
<tr>
<td>Require plans to maintain reserves to cover provider payments in the event of plan failure</td>
<td>Establish reinsurance programs and reimbursement risk pools</td>
</tr>
<tr>
<td>Quality incentives should standardized across plans, be designed to reflect industry standards such as AHCA’s Quality Initiative, and not plan-designed quality requirements</td>
<td>Quality incentive program; nursing home quality pool; quality withhold as part of FIDA</td>
</tr>
<tr>
<td>State should phase implementation across the state rather than going state wide after NYC</td>
<td>NF would like smooth transitions to billing the MCO’s including training in contracts</td>
</tr>
<tr>
<td>State should include plan penalties in plan contract language for failure to meet prompt pay requirements</td>
<td>30 days for prompt pay, and new admissions to NF to the NF enrolled in plan.</td>
</tr>
</tbody>
</table>
Protection Language

✓ Long-term care managed care technical advisory workgroup (TAG) — Before project implementation, the agency shall establish a technical advisory workgroup to assist in developing:
  ▪ The method of determining Medicaid eligibility pursuant to state law
  ▪ The requirements for provider payments to nursing homes pursuant
  ▪ The method for managing Medicare coinsurance crossover claims
  ▪ Uniform requirements for claims submissions and payments, including electronic funds transfers and claims processing
  ▪ The process for enrollment of and payment for pending individuals pending

The advisory workgroup must include representatives of providers & plans

✓ Minimum Medical Loss Ratio (MMLR) – State should include a MMLR in it’s contracts at a minimum of 95%

✓ Administrative Simplification – ACA included several key requirements for consistency across plans regarding certain business transactions

Federal Update
Recent CMS Guidance has been Inadequate

- MLTSS Policy and Program Guidance – Limited information and virtually no discussion of facility-based services
- MLTSS EQRO Guidance – Very little detail on how states should operationalize the guidance in EQRO contracts
- Provider Technical Assistance – None offered

Request that CMS open the Medicaid Managed Care Rule to address issues and support LTSS

State Example and Strategies
### Florida

**Long-Term Care Community Diversion Program**

**Element** | **Design Element**
---|---
State and Lead Agency | Department of Elder Affairs via agreement with Agency for Health Care Administration
Inception | 1998
Medicaid Enrollment Authority | Section 1915(a) and Section 1915(c)
Evolution | Following a pilot in four counties, the program was expanded incrementally through 2010, when it became authorized statewide. The program operates in 46 of Florida’s 67 counties. Moving to include remaining 11, now
Enrollment (April 2012) | 19,283
Medicare Integration | No
Provider Rates | For NF, set by state
Provider Network | Long Term Care Provider may form provider networks
Eligibility | Conducted by state

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**Program Elements & Strategies**

**Element** | **Design Element** | **Advocacy Strategy**
---|---|---
State and Lead Agency | Structure of MOU/A between or among state agencies | Argue of streamlined business operations and transparent provider processes
Medicaid Enrollment Authority | Determines mandatory or voluntary | Argue for voluntary
Evolution | Statewide or by region | Develop argument for multi-year phase in with benchmarks for state and plan performance
Provider Involvement | Varying requirements for Medicaid stakeholder comment | Long-term care managed care technical advisory group (LTC TAG)
Capitation Rate Setting | Provider Assessment Risk Adjustment | Ensure provider assessment payments are in rates
Plan Performance | Medical Loss Ratio (MLR) | Highlight need for MLR of at least 95%
Provider Network | Selective contracting or any willing provider | Argue that MCOs must contract with all Medicaid NFs for first years of operation
Eligibility | State or Plan | Ensure state continues to determine LOC
AHCA/NCAL Action: Several Areas of Work

- MLTSS Guiding Principles
- MLTSS Literature Review
- MLTSS Tool Kit
- Three-Part MLTSS Webinar Series
- MLTSS Coalition formed by AHCA/NCAL and LeadingAge
- Liaison with CMS
  - Center for Medicare and CHIP Services
  - Medicare-Medicaid Coordination Office

Other Trends in Managed Care
Conclusion
Key Industry Advocacy Points

- States set rates rather than plan negotiated
- Provider assessment supplemental payments must be included in rates or directed payment within capitation
- Ensure technical assistance for LTSS providers is available as well as an ongoing forum for input and problem solving
- Administrative Simplification must be included in program design
- Section 1115 Transparency Requirements
- State administrative law on reviewing or viewing RFPs and contract language
- Medical Loss Ratio (MLR) requirements to ensure funds are spend on people and services