

Idaho Medicaid
Challenges and Choices
Idaho Legislative Healthcare Task Force
September 10, 2012

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COMMUNITY & STATE

UnitedHealthcare Community & State

UnitedHealthcare Community & State is the **largest Medicaid and CHIP** managed care company in the United States and is part of **United Health Group** which provides health benefit solutions to more than **38 million people**

- **4 million beneficiaries** of publicly funded health benefit programs in **25 states** and the District of Columbia, including TANF, CHIP, ABD, SNP, LTC, childless adults, uninsured and other beneficiaries (e.g. developmentally disabled, rehabilitative services, etc.)
- More than **29 years** of experience serving these populations
- We have more than **4,000 employees** dedicated to serving Medicaid and CHIP programs
- Awarded 25 contracts in 15 states within the last three years.
- UnitedHealthcare currently covers over 70,000 Idahoans in employer sponsored, individual and Medicare health benefit programs.

UnitedHealthcare Community & State National Footprint

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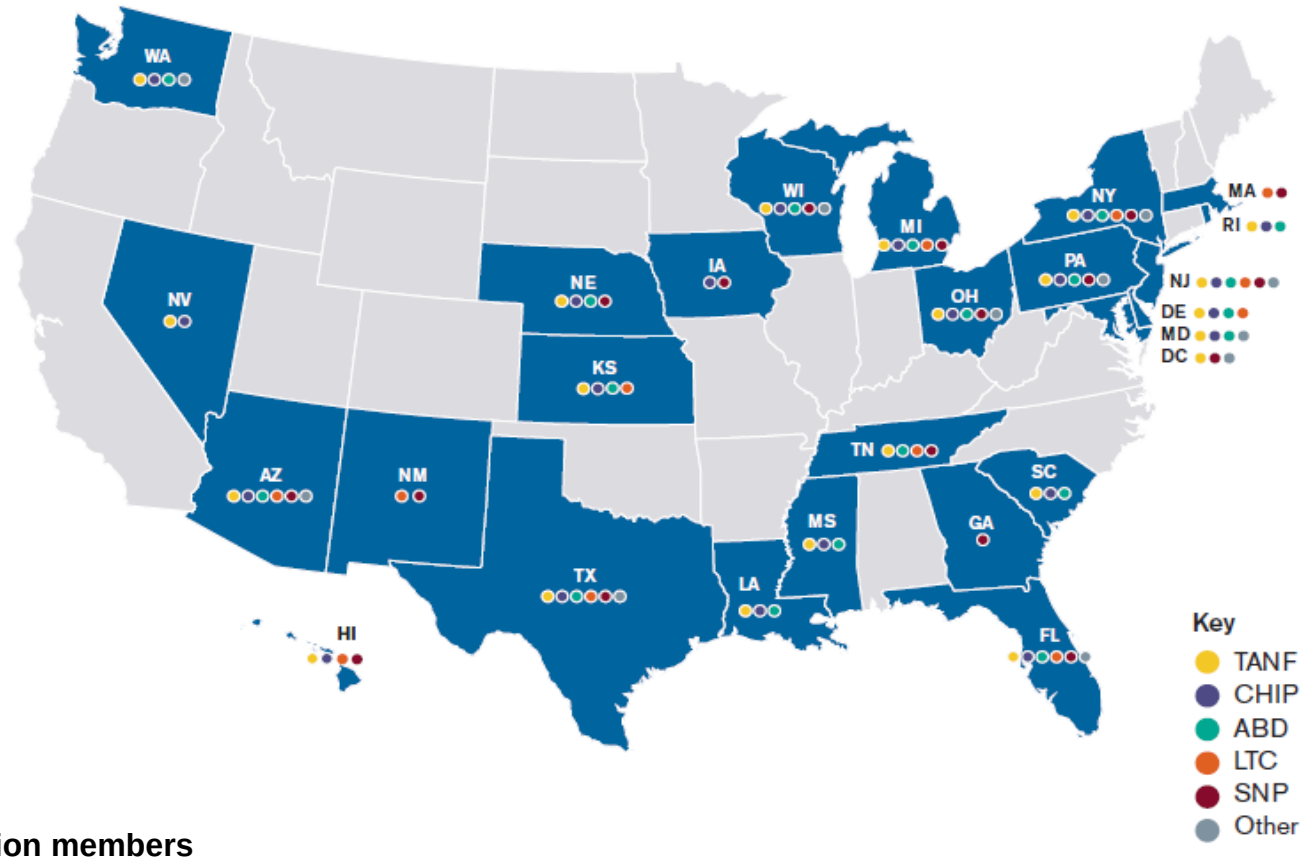

4 million members
25 states and Washington, DC

Medicaid Challenges and Choices

- Health reform considerations
  - Whether or not to expand Medicaid?
    - If expansion chosen Idaho Medicaid enrollment could grow by 100,000 to 150,000
  - If decision is to expand; when should expansion occur?
  - What are the implications of the anticipated wood-work effect if expansion is implemented?
  - Insurance Exchange Options
    - State Based Exchange
    - State Partnership Exchange
    - Federally-Facilitated Exchange
- How to deal with individuals eligible for both Medicaid and Medicare; relatively small population driving large spend?
- How to achieve more integrated and coordinated care?
  - Not uncommon for Medicaid enrollees to have some portion of their health care dollars going to more than 15 different agencies or programs.

Medicaid Challenges and Choices

- How to improve outcomes and quality in the most cost efficient manner?
- Reform Medicaid via pilots and demonstrations vs. state wide program.
- Carve out some populations and/or services vs. include all populations and services.
- Implement reform via provider driven Community Care Organizations (CCO) or Accountable Care Organizations (ACO)
  - Fee for service, gain share or partial risk share
- Implement reform via Managed Care Organizations (MCO)
  - Capitated risk transfer

Developing Effective Managed Care Models

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Unmanaged and Unsustainable → **Managed and Sustainable**

	Unmanaged FFS	PCCM/DM	Accountable Care Organization	Medicaid Managed Care TANF, CHIP, ABD Acute	Integrated Medicaid Managed Care
Financing	State Holds Risk	Admin fee, some risk sharing	Capitation w/ risk sharing corridor	Full capitation with risk adjustment	Full capitation with risk adjustment, LTC Financing, dual integration
Geography	Individual practices, not connected	Local, Regional or Statewide	Local or Regional	Regional or Statewide	Regional or Statewide
Clinical Model	Limited DM, CM	Partially Integrated CM, DM, UM	Integrated CM, DM, UM	Full UM, DM, CM, Rx Mgt., Prior Auth	Full UM, DM, CM, Rx Mgt, Prior Auth, Integrated LTC and waivers
Quality	No public metrics	QA, QI, NCQA, contractor incentives	Varies by Model	QA, QI, NCQA Contractor Provider incentives	QA, QI, NCQA Contractor and provider Incentives, NH diversion
Cost Savings Potential	None, State retains risk	Moderate if contractor is at risk	Moderate, stakeholders at risk	High, Contractor at risk	Highest, contractor at risk, LTC utilization shift

What We Recommend

- MCO-based capitated Medicaid program
- Covering all populations and all services
  - Populations: TANF, CHIP, Aged, Blind, Disabled and Medicaid/Medicare Dual Eligibles
  - Services: Physical Health, Behavioral Health, Dental, Rx and Long Term Care (Nursing Home and Home and Community Based Services)
- Select two plans to provide member choice and create competitive environment to drive health plan performance and reduce complexity for providers and state agencies
- Withhold 2% to 3% of plan capitation to be paid if performance objectives are achieved
  - Year 1 performance criteria should focus on administrative process measures such as timely claims payment, member service metrics, appeals and grievance processing and/or reporting on quality metrics to establish later year quality benchmarks
  - Year 2 and later should focus on achievement of appropriate quality metrics that align with state priorities, improve HEDIS and other quality measures appropriate for populations covered (HEDIS is not an effective measure of quality for long term care members)
- Require MCOs to bid on a statewide basis
- Require MCOs to work with Medical/Health Home initiatives planned or operational in the state
- Require plans to pay at least 100% of the state Medicaid fee schedule
- Allow plans to pay providers who are offered 3 opportunities to contract but refuse, a discount of 10% from the Medicaid fee schedule (EMTALA services would still be paid at 100% of the Medicaid fee schedule)

Why We Recommend MCO-Based Managed Care Approach

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- **Budget Predictability**
  - Capitation ensures predictable expense
  - Risk shifts to Managed Care Organizations
- **Sustainability**
  - Managed care can reduce state Medicaid costs in the first year depending upon populations and services covered
  - Managed care can lower cost trend for future years
  - Systemic shift in reliance on costly services from ER, hospital and nursing home to primary and preventive care and community based services
  - Improved management of chronic conditions prolongs individual independence and reduces or delays the need for costly nursing home placement

Why We Recommend MCO-Based Managed Care Approach

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- **Single Entity Accountable for Quality results**
  - Quality programs
  - Evidence-based practice guidelines
  - Physician engagement and intervention
  - Outcomes tracking via HEDIS and CAHPS
- **Increased Access**
  - Physician Incentives
    - Pay for Value
    - Medical/Health Homes
  - Technology and care coordination provider support
    - HCBS providers
    - FQHC partnerships
    - Medical Homes
    - Health Homes
    - Accountable Care Communities

Managed Care Potential: Louisiana Example

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Metric	State of Louisiana	UnitedHealthcare Community & State
ABD Inpatient days/1000	4,514	1,333
TANF Inpatient days/1000	606.4	309.0
ER Usage - TANF	1,307/1,000 members	651/1,000 members
NICU Births	16.5%	11.9%
Caesarean Birth Rate	44%	29%
Average Length of Stay – NICU	21.85 days	15.22 days
Average Length of Stay – Normal Newborn	5.22	2.8 days

Note: State of LA data was calculated by Mercer who was retained by LA Dept. of Health and Hospitals as consulting actuary using SFY 2009 data. UHC data was for the same time period and reflects our nationwide average.

Questions?