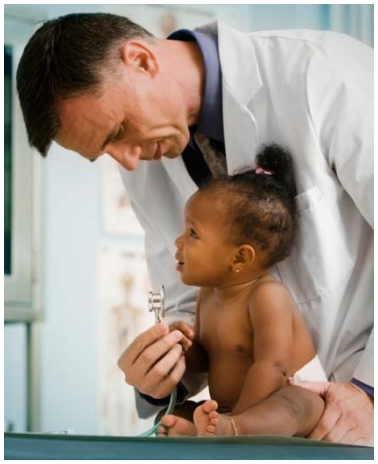
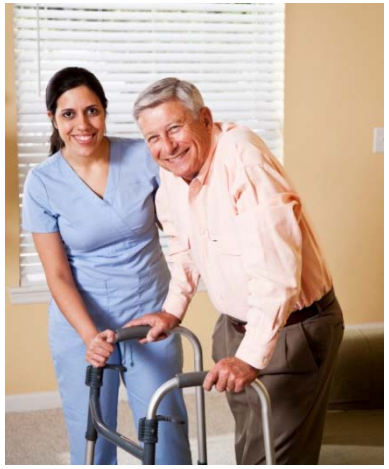
TennCare







Trends in Medicaid Managed Care

Virginia Medicaid Innovation and Reform Commission
October 21, 2013

Darin Gordon, Tennessee Medicaid Director
Health Care Finance and Administration

TennCare, the Beginning

- In 1994, Tennessee restructured its Medicaid program and became the first state in the nation to enroll its entire Medicaid population into managed care, as well as being the only state to offer Medicaid to all uninsured and uninsurable citizens – regardless of income.

- This restructured and expanded Medicaid program was renamed “TennCare”.

- At inception, the thought was the cost-savings from a managed care model would allow the state to cover an expanded population (individuals who would not qualify under traditional Medicaid eligibility standards) and additional benefits.

- As a revolutionary model, this approach brought about some challenges which prompted the program to change and evolve to become the program it is today.

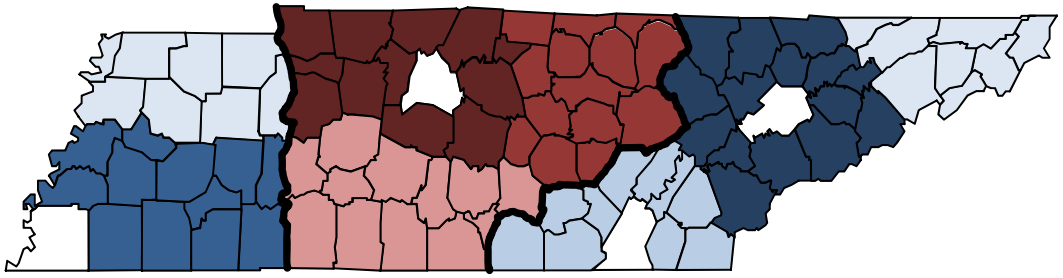
TennCare 1994

1994 Overview

At TennCare's inception, there were 12 different community service areas (CSAs) and a dozen health plans - only two were statewide. TennCare did not restrict the number of health plans; nor did it require a procurement process for plan selection. Prior to TennCare, Tennessee Medicaid was entirely fee-for-service.

- 12 Plans total – 8 HMOs; 4 PPOs
- Risk Model – All plans were "at-risk"
- Total Enrollment – 1.1 million

1994 Service Areas



Services

Carved In

- Physical
- Dental
- Pharmacy
- Routine Mental Health Services

Carved Out

- Long-Term Care
- Specialized Mental Health Services

Quality Monitoring

TennCare outlined basic quality management requirements in the contracts with the health plans and contracted with an External Quality Review Organization (EQRO) to review and report on MCO quality. Out of necessity, the EQRO's primary focus was on getting health plans to a point where they had appropriate policies in place.

Quality of encounter data – poor

Network monitoring focused on Geoaccess mapping of MCO reported primary care providers

Appeals were handled by MCOs

TennCare Satisfaction Survey: **1994 – 61%**

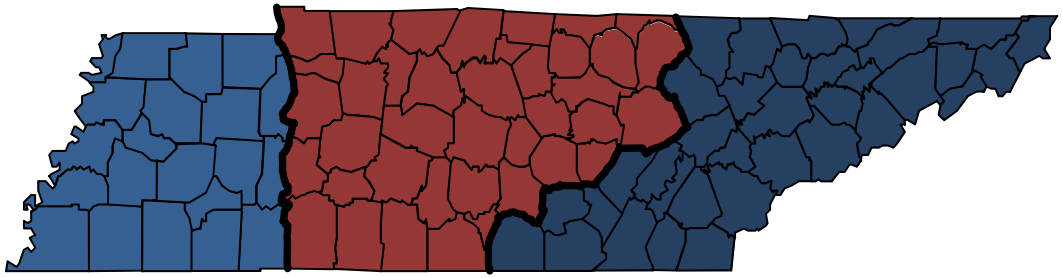
TennCare 2003

2003 Overview

By 2003, TennCare required all health plans to be HMOs and serve all areas within each Grand Region in which they participate, resulting in three Service Areas (West, Middle and East). At this time, health plans had begun to experience problems, and some were at risk of becoming insolvent which caused the state to bring them into an Administrative Service Organization (ASO) arrangement. Contributing factors included the impact of lawsuits/consent decrees and a lack of experience and capital on the part of some MCOs.

- 9 plans – all HMOs
- Risk Model – All plans were brought into an ASO arrangement (no risk)
- Total Enrollment – 1.35 million

2003 Service Areas



Services

Carved In	Carved Out
• Physical	• Behavioral Health • Dental • Pharmacy • LTSS

Quality Monitoring

By now the EQRO was able to focus on adherence to policies.

Encounter data quality had improved. By the late 90's, TennCare had commissioned several studies on quality including delivery of preventative services, prenatal care and ER utilization. In addition, an annual Women's Health report was now being produced.

Network requirements were expanded to include specialty standards

Management of appeals shifted to TennCare

TennCare Satisfaction Survey : **2003 – 83%**

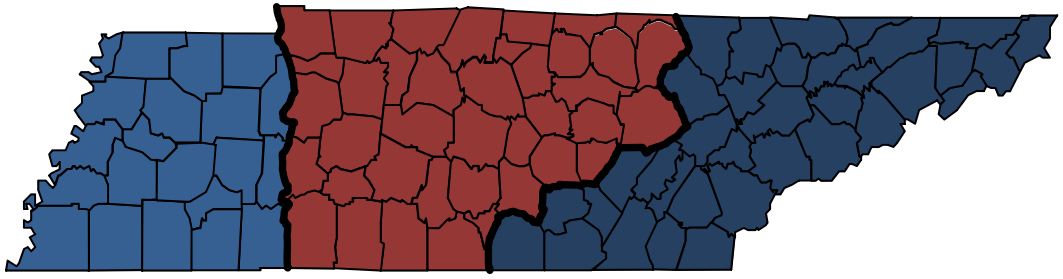
TennCare 2006

2006 Overview

By 2006, TennCare reform was nearly complete and relief had been obtained from a particularly burdensome consent decree. After the release of a study by McKinsey & Company in 2004 showing that the growth of TennCare was projected to require every new state dollar in just a few short years, the state had to make some difficult decisions to keep the program operating. The most difficult decision was reducing enrollment, but children and mandatory Medicaid enrollees were protected from these reductions. Program reductions included imposing a limit on prescription drugs for most adults and eliminating adult dental coverage. These steps were challenging but necessary and allowed TennCare to return to firm financial footing.

- 7 plans – all HMOs
- Risk Model – ASOs (no risk)
  - However, TennCare was in the process of restructuring the program and request for proposals were made for at-risk plans in 1 of the 3 regions.
- Total Enrollment – 1.2 million

2006 Service Areas



Services

Carved In	Carved Out
• Physical	• Behavioral Health • Dental • Pharmacy • LTSS

Quality Monitoring

In 2006, TennCare became the first Medicaid agency in the country to require all MCOs be NCQA accredited. In addition, TennCare began requiring that all MCOs report annually on the full set of HEDIS measures.

EQRO role shifted to focus on Tennessee specific concerns and to assure annual on-site monitoring

Provider network monitoring was enhanced to include validation of MCO reported data and confirmation of time to appointment

Medical necessity rules were promulgated to assure evidence-based decision making

TennCare Satisfaction Survey: **2006 – 87%**

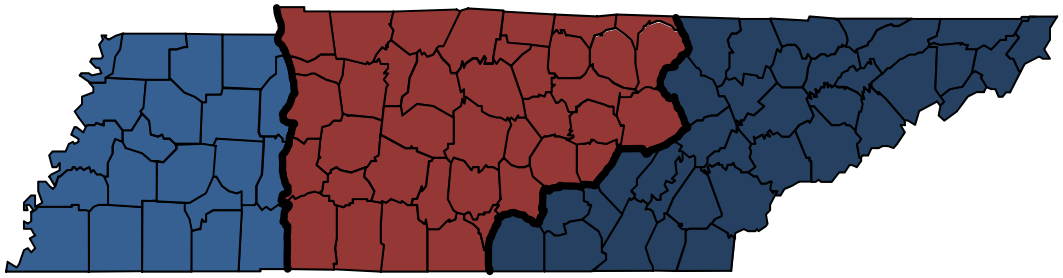
TennCare 2009

2009 Overview

By 2009, TennCare had secured contracts with two well-capitalized and experienced MCOs in each region. The plans were operating at full risk. These MCOS were selected through a competitive bid process. In addition, one health plan contracted to operate statewide to serve a select population of members and to function as a back-up health plan should another plan falter. Rates were determined by an outside actuary to ensure the rates were sufficient for the plans to provide necessary care and maintain stability. TennCare had also begun implementation planning for the new TennCare CHOICES in Long-Term Care program that would eventually bring LTC services for the elderly and adults with physical disabilities into managed care.

- 3 plans – all HMOs
- Risk Model – At-risk
- Total Enrollment – 1.2 million

2009 Service Areas



Services

Carved In	Carved Out
• Physical • Behavioral Health	• Dental • Pharmacy • LTSS

Quality Monitoring

By 2009, all MCOs were NCQA accredited and HEDIS scores were improving, particularly in the area of child health. Integration of behavioral health allowed for reporting of behavioral health HEDIS measures for the first time. Quality initiatives targeting emergency department over-utilization, comprehensive diabetes care and adolescent well care were underway.

EQRO tasked with producing annual summary of HEDIS results that includes statewide weighted averages as well as comparisons across MCOs and to national benchmarks. Reports published on TennCare website.

P4P program in place relative to selected HEDIS measures

TennCare Satisfaction Survey: **2009 – 92%**

TennCare 2013

2013 Overview

Today, TennCare has extended contracts with its MCOs in order to maintain stability throughout health reform planning. The CHOICES program was fully implemented in August of 2010, bringing LTC for the elderly and adults with physical disabilities into the managed care model and increasing HCBS options for members. Integration of physical health, behavioral health and LTC services promotes improved coordination of care for the "whole person."

- 3 plans – all HMOs
- Risk Model – At-risk
- Total Enrollment – 1.2 million

Services

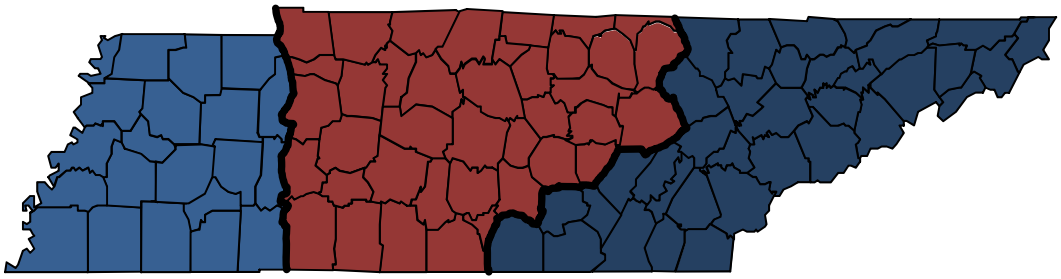
Carved In

- Physical
- Behavioral Health
- LTSSS(for E/D)

Carved Out

- Dental
- Pharmacy
- LTSS (for ID)

2013 Service Areas



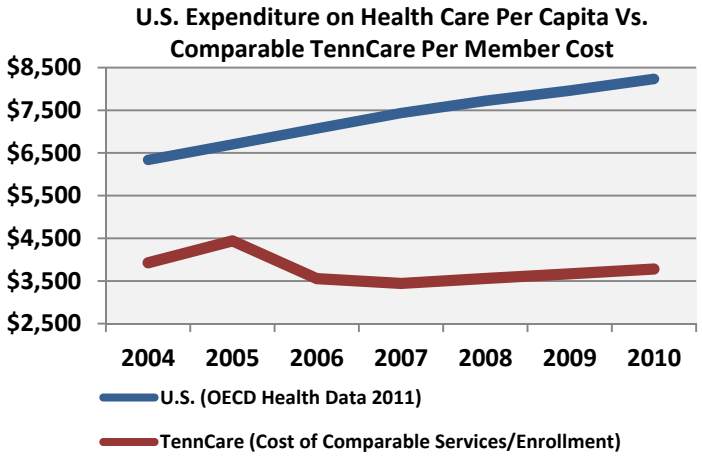
Quality Monitoring

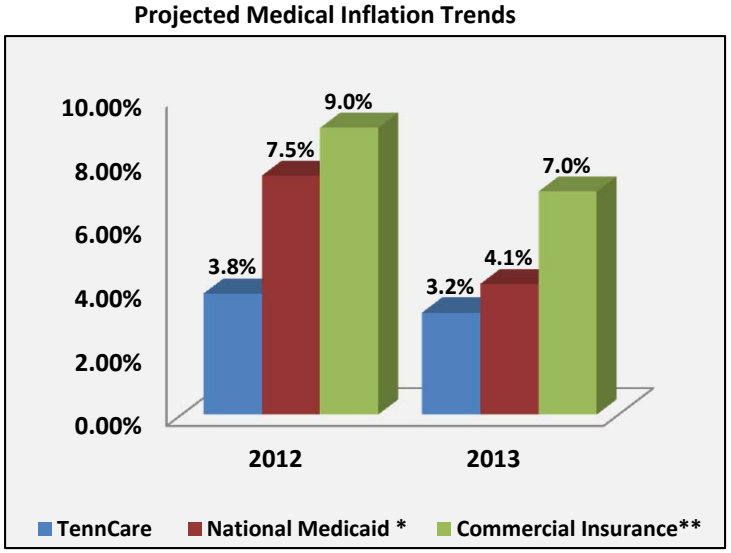
Today, TennCare rates above the national Medicaid average in many quality measures and continues to demonstrate improvement. With the integration of LTC into the managed care model, efforts to monitor quality of care in the elderly and disabled population are a new focus of attention.

We continue to enhance quality standards – recently added contractual requirement for all plans to utilize hybrid methodology in HEDIS reporting in cases where either hybrid or administrative is acceptable to NCQA

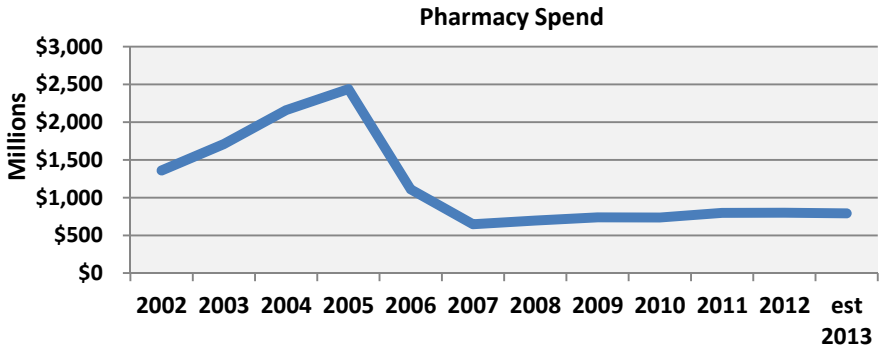
TennCare Satisfaction Survey: **2013 – 95%**

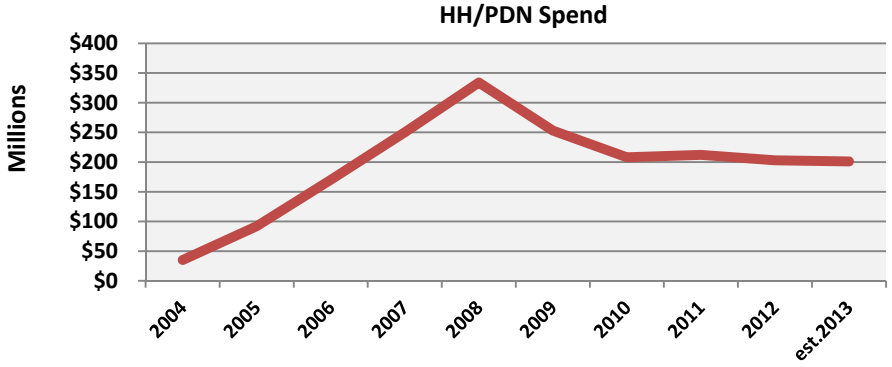
TennCare - Bending the Trend





*Source: OMB 2012; Kaiser 2013 **Source: PricewaterhouseCoopers





Examples of tools to control trend…

Pharmacy
- Point of Sale Edits
- Preferred Drug List/Drug Rebates/Generics
- Prescription Limits

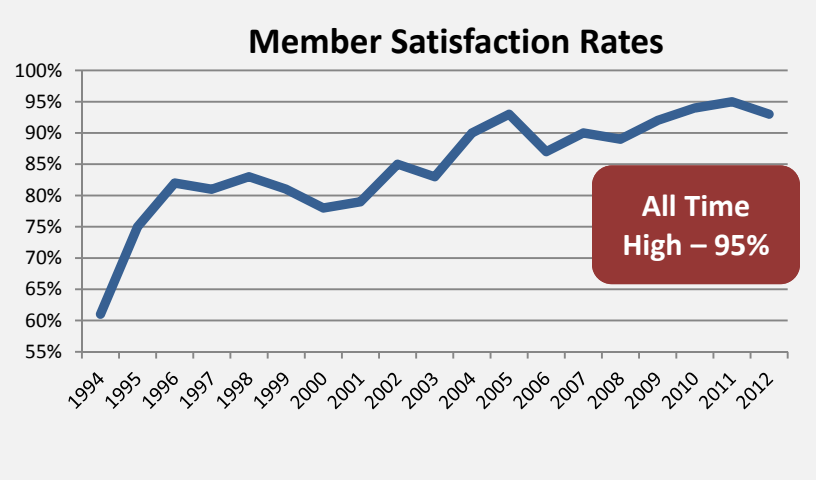
Medical
- Prior authorization
- Medical Home
- Network Consolidation
- Disease Management
- Case Management

Fraud and Abuse
- Narcotic Controls
- Pharmacy Lock-In
- Outlier Monitoring

TennCare – Quality Improvement

Background

- In 2006, TennCare became the first state in the country to require NCQA accreditation across 100% of its fully Medicaid managed care network.
- NCQA is an independent, nonprofit organization that assesses and scores managed care organization performance in the areas of quality improvement, utilization management, provider credentialing and member rights and responsibilities.
- TennCare MCOs are also required to report the full set of HEDIS measures. HEDIS is a set of standardized performance measures that makes it possible to track and compare MCO performance over time.



UT surveys random sampling of TennCare households for annual satisfaction report.

Data - HEDIS

Table 2-5a. HEDIS 2012 Plan-Specific Rates: Effectiveness of Care Measures

Measure	Amerigroup	BlueCare		TennCare *Select*	UnitedHealthcare			HEDIS 2011 National Medicaid 50th Percentile
		-East	-West		-East	-Middle	-West	
Diuretics	88.08%	91.75%	91.22%	92.63%	91.83%	89.78%	89.39%	85.8%
Anticonvulsants	74.17%	77.70%	72.46%	74.64%	77.22%	73.72%	72.47%	68.6%
Total	**86.57%**	**89.97%**	**89.37%**	**78.60%**	**90.26%**	**87.93%**	**88.18%**	**84.2%**
Measures Collected Through CAHPS Health Plan Survey								
Medical Assistance With Smoking and Tobacco UseCessation (MSC)**								
Advising Smokers and Tobacco Users to Quit	78.55%	79.34%	66.67%	64.04%	74.80%	75.79%	65.67%	74.82%
Discussing Cessation Medications	43.15%	40.93%	33.98%	35.71%	41.86%	39.07%	37.21%	42.71%
Discussing Cessation Strategies	33.73%	43.44%	41.11%	46.43%	29.65%	33.82%	31.00%	38.14%

**For ASM age stratification changed for 2012 HEDIS; hence, there are no National data.*

The 2012 HEDIS results showed:

- Improvement in 88% of measures tracked since 2006.
- Improvement in 31 of 41 measures introduced more recently.
- TennCare's health plans continue to be ranked among the top 100 Medicaid health plans in the country, with our highest ranking plan moving from 37th in 2011 to 30th.

Overview of TennCare Experience

Then	Now
Rapidly Escalating Costs	Significantly Reduced Cost Trends
Volatile Health Plans	Stable, Well-Capitalized and Experienced Health Plans
Few Quality Measures	NCQA Accreditation & Full Set of HEDIS Measures & CAHPS
Limited Long-Term Care Options	More Home and Community Based Options for More People
Fragmented Health Care Delivery System	Integrated Health Care Delivery System

TennCare Lessons Learned

On Effective Contracting and Implementation	1. The MCO procurement process and implementation must be well thought out. 2. Contracts with MCOs must be detailed, with each requirement carefully defined, and with appropriate reporting and monitoring processes to ensure compliance. 3. New skill sets are required of staff as you shift from FFS to managed care. 4. Contracts should be routinely reviewed and amended – continuous improvement. 5. There must be different types and levels of incentives and sanctions to ensure compliance. 6. Remember – this is a partnership. Be willing to take a look at issues when circumstances arise that could not have been foreseen.
On Quality	1. Access to reliable encounter data as quickly as possible is extremely important. 2. Quality requirements should be spelled out for health plans – e.g. accreditation requirements and timelines, performance measure reporting requirements. 3. Independent, external review (EQRO, accrediting body like NCQA) is a must. 4. MCO required reporting of standardized, evidenced-based performance measures allows for tracking trends over time and for comparison to national norms (e.g. HEDIS). 5. Pay for Performance incentives tied to specific performance measures can be used effectively to target attention to your highest priorities. 6. Tracking and analysis of enrollee appeals can be an important quality monitoring tool
On Cost Containment	1. Savings estimates must be realistic. 2. Aligning financial incentives is key. 3. MCOs need multiple tools to manage benefits and cost. Careful consideration must be given to the division of responsibilities between the Medicaid agency vs. the MCOs. 4. Data analytics & tailored dashboards have been invaluable to state-level monitoring efforts. 5. Not all problems can be solved by the managed care organizations themselves. Be willing to consider state-level action (e.g. benefit and eligibility changes) when necessary. 6. Constant vigilance is needed to defend against special interest groups intent on undermining managed care cost containment efforts.

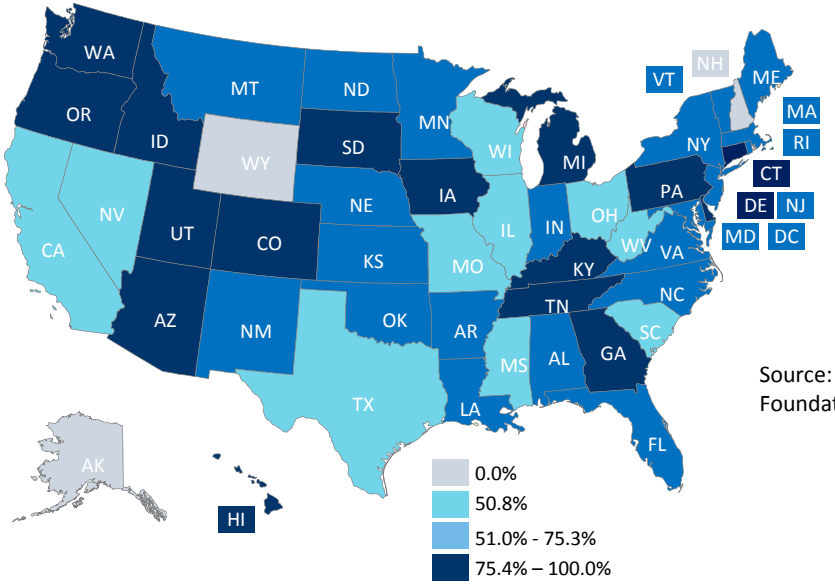
National Trends

Common Themes

National Trends

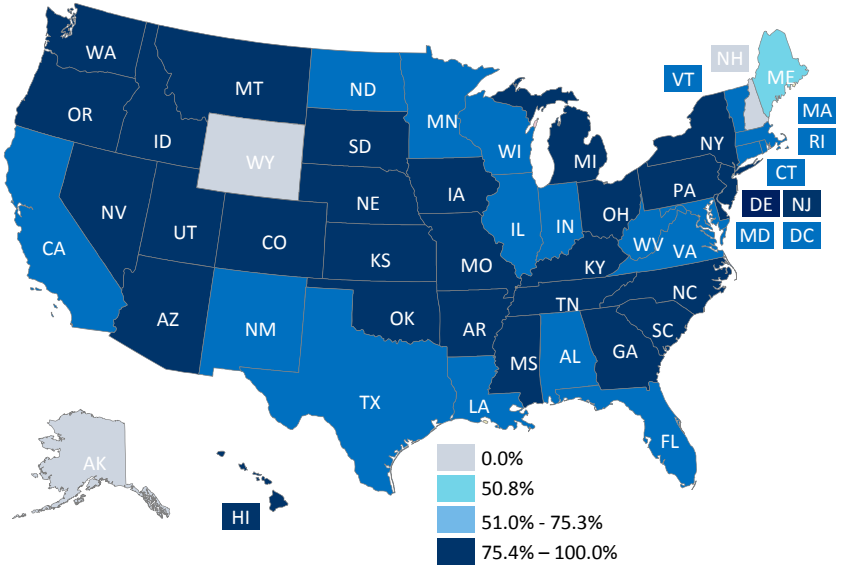
Managed Care Expansion

Penetration of Medicaid Managed Care, 2004

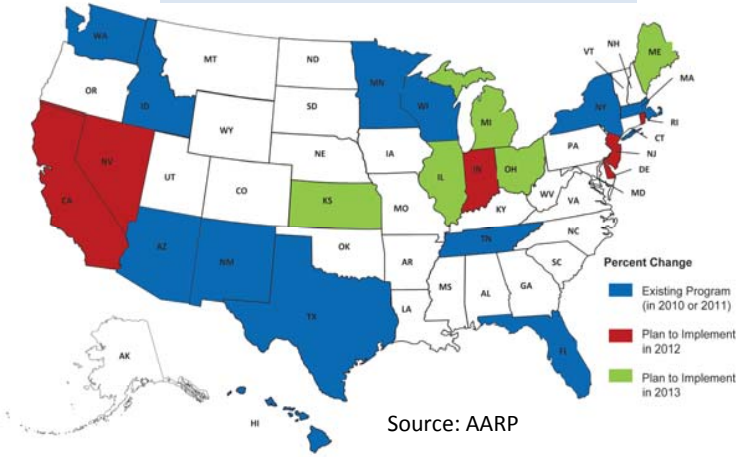


Source: Kaiser Family Foundation

Penetration of Medicaid Managed Care, 2011



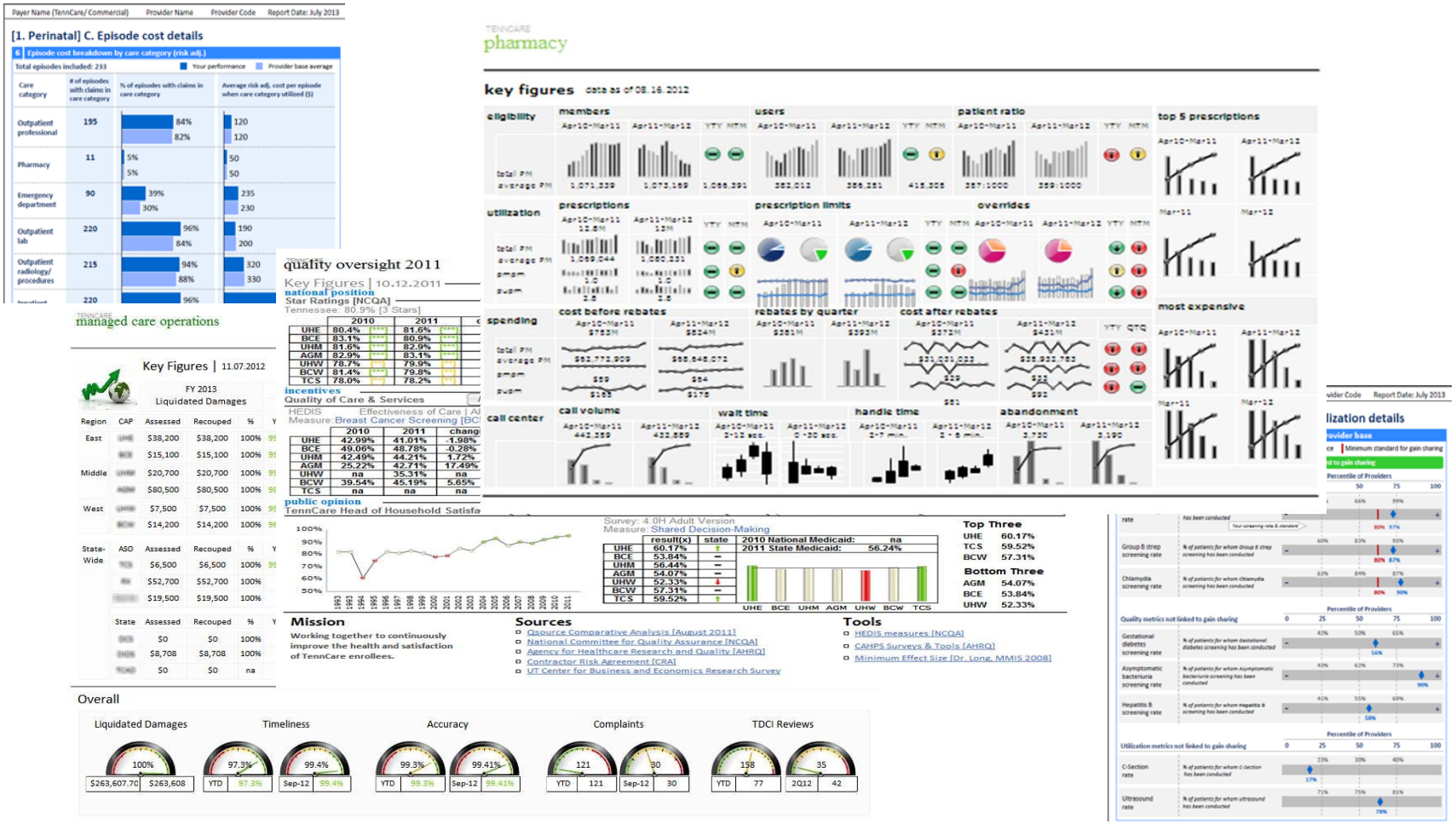
States with Medicaid Managed LTSS



Source: AARP

National Trends

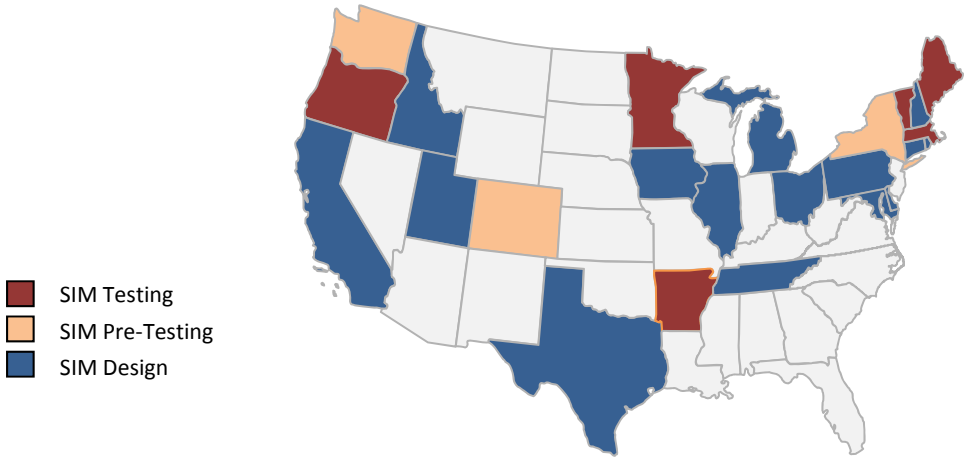
Advanced Data Analytics



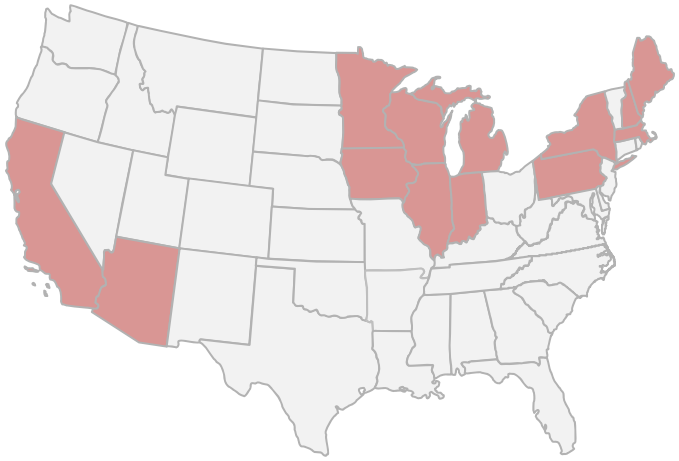
National Trends

New Payment Models and Delivery Structures

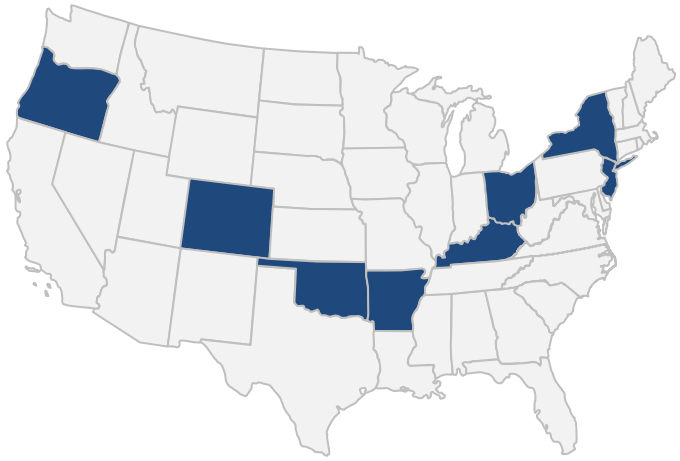
State Innovation Model Testing States



Pioneer ACO States



Comprehensive Primary Care Initiative States



Note: Arkansas, Colorado, New Jersey, and Oregon all have statewide pilots. New York's pilot is focused in the Capital District-Hudson Valley Region, Ohio and Kentucky's pilot is focused in the Cincinnati-Dayton Region, and Oklahoma's is focused in the Greater Tulsa Region

National Trends

New Payment Models and Delivery Structures

Both upside and downside risk

Exclusively upside opportunity

		Select examples	Description
Full risk	**"Payor-led" integrated network**	HIGHMARK. / West Penn Allegheny Health System	▪ Payor-led affiliation or acquisition of health system which seeks full clinical and operational integration to reduce cost, improve member experience, and manage referral volume
	"Provider-led" integrated network	Intermountain Healthcare / Geisinger Health System	Provider system builds a health-plan, leveraging brand name to drive volume to provider system
Risk sharing	**ACO**	CalPERS / CHW / Hill Physicians	▪ An organization of health care providers accountable for quality, cost, and overall care; share cost savings if performance metrics are met
	Episodes of care	Horizon / Arkansas Department of Human Services / TennCare	▪ Covers all aspects of preadmission, inpatient, and follow-up care, including postoperative complications within a set time period for procedures, e.g., hip replacement
Gain sharing	**Patient centered medical home**	CareFirst BlueCross BlueShield	▪ Team of physicians and extenders, coordinated by a PCP coordinate provide high levels of coordinated care; typically tied to P4P contract
	Pay for value	Blue Cross Blue Shield of Michigan	▪ Payment bonus tied to efficiency metrics (e.g., reduction in ER visits, imaging)
Incentive payment	**"Basic P4P"**	BlueCross BlueShield	▪ Payment upside based on performance metrics linked to value creation (e.g. BCSMA Alternative Quality Contract / AQC)

Questions?