

**Commission on Expansion of Medicaid Managed Care
for Medicaid Recipients in Mississippi**

**Created by Senate Bill 2836
2018 Regular Legislative Session**

**Presented to
Governor Phil Bryant
Lieutenant Governor Tate Reeves
The Mississippi Senate
Speaker Philip Gunn
and the Mississippi House of Representatives**

December 1, 2018

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- Tab B.** The Commission recommends for consideration and final determination by the Legislature that the Division of Medicaid study the feasibility of implementing a pilot program to provide an alternative managed care payment model for individuals with behavioral health issues receiving services from a regional mental health/intellectual disability commission established under 41-19-33 located in the State of Mississippi. The managed care payment model would establish an organization to function as an integrated behavioral health care network with a capitation agreement with managed care entities, which would redirect funding to provide Medicaid services to the behavioral health population under a partnership contract and not require any additional funding from the State General Fund. If a pilot program is deemed feasible, a report of findings and recommendations shall be prepared for the 2020 Regular Session.
- Tab C.** The Commission recommends for consideration and final determination by the Legislature that the responsibilities of the Mississippi Commission on Expanding Medicaid Managed Care be transferred to and become a permanent function of the Medical Care Advisory Committee within the Division of Medicaid in order to continue monitoring the feasibility of including additional categories of Medicaid-eligible beneficiaries and otherwise revising the Medicaid Managed Care payment program.

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COMMISSION MEMBERS

1. Executive Director of the Division of Medicaid, Drew Snyder, Drew.Snyder@medicaid.ms.gov
2. MSMA Executive Director, Chairman Kanosky, ckanosky@msmaonline.com
3. Chairman of the Senate Medicaid Committee, Brice Wiggins, bwiggins@senate.ms.gov
4. Chairman of the Senate Appropriations Committee, Eugene "Buck" Clark, bclarke@senate.ms.gov
5. Chairman of the House Medicaid Committee, Chris Brown, crbrown@house.ms.gov
6. Chairman of the House Appropriations Committee, John Read, jread@house.ms.gov
7. Commissioner of the Mississippi Department of Insurance, Mike Chaney, mike.chaney@mid.ms.gov
8. Pharmacist, Judy Clark, judithpclark@gmail.com
9. Licensed mental health professional, Dave Vann, dvan@region8mhs.org
10. Magnolia, Aaron Sisk, ASISK@CENTENE.COM
11. Molina, Bridget Galatas, Bridget.Galatas@molinahealthcare.com
12. United, Jeff Wedin, jeff_wedin@uhc.com
13. Long-term care industry representative, Bobby Beebe, bbeebe@asimgt.com
14. Representative of a hospital that operates in Mississippi appointed by the Speaker of the House, Kevin Cook, kscook@umc.edu
15. Member of the House of Representatives appointed by the Speaker of the House, Joel Bomgar, jbomgar@house.ms.gov
16. Member of the Senate appointed by the Lieutenant Governor
17. Licensed physician appointed by the Lieutenant Governor
18. Senate Staff Attorney, Robert Davidson, BDavidson@senate.ms.gov
19. Principal Analyst, PEER Committee, Lonnie Edgar, Jr., Lonnie.Edgar@peer.ms.gov
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22. Legislative Services, Angie Rucker, ARucker@senate.ms.gov



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December 1, 2018

Honorable Phil Bryant
Governor
State of Mississippi

Honorable Tate Reeves
Lieutenant Governor
Mississippi State Senate

Honorable Philip Gunn
Speaker of the House
MS House of Representatives

Dear Governor Bryant, Lieutenant Governor Reeves and Speaker Gunn:

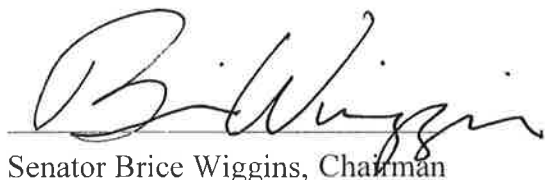
This report represents the culmination of many hours of hearings and discussions by the Commission on Expansion of Medicaid Managed Care created by Senate Bill 2836 in the 2018 Regular Session. The Commission has met regularly beginning in August 2018, and in its deliberations has reached the findings and recommendations which are presented in this report and which the Commission feels are practical and achievable. Senate Bill 2836 states that "no expansion of Medicaid managed care program contracts may be implemented by the division without enabling legislation from the Mississippi Legislature," and our understanding of the purpose of the Commission is to compile data and provide oversight with recommendations as to whether the existing Medicaid managed care program should be expanded. It became apparent to all members, if not already so, the complexity of the Medicaid program, in general and as it pertains to managed care. To a member, it was clearly beneficial to be "in a room" to discuss and work through these complex and detailed issues. With the limited time, we could not address and solve all that needed to be done and thus we recommend that the work of this Commission continue, most efficiently and economically by the statutorily created Medical Care Advisory Committee. The Commission kept the focus on improving health outcomes, controlling costs and budget predictability, keeping pace with the ever-changing dynamics of healthcare with the idea for beneficiaries to focus on preventative treatment.

Managed care is the use of a planned and coordinated approach to providing health care with the goal of quality care at a lower cost. The idea is that by assigning patients to doctors and resources that help them focus on illness prevention, Medicaid recipients will stay healthier and more readily avoid costly emergency treatment. Four in five of the nation's 70 million Medicaid clients are on managed care, and in Mississippi 65% of the Medicaid clients are served by Managed Care Organizations (MCOs). The remainder of the clients receive services on a Fee-for-Service (FFS) basis where the provider receives payment on a per-service basis according to a fee schedule set for each service and/or procedure to be provided and the patient's total bill will vary by the number of services actually received. Capitation forces providers to practice preventive medicine to make a profit and it is the responsibility of the Division of Medicaid and the Legislature to determine whether the reimbursement rates those providers accept are high enough to keep them viable, while at the same time not allowing abuse of the system. Managed care arrangements have become a viable alternative to states seeking innovative strategies to provide medical assistance beneficiaries with quality health care in a cost-effective manner.

As stated during the Commission hearings, Mississippi's foray into Medicaid managed care is in the "toddler stage" having been adopted by the Legislature in 1997. The system is maturing and reviewing its practices and procedures is necessary to provide a viable, efficient system to the beneficiaries and the taxpayers to be able to take it to the next stages. During debate on the 2018 Medicaid "technical amendments bill," much information was put out about managed care either not being viable, other states don't do it and/or fee-for-service is the only way Medicaid should be run. As the information contained herein establishes, managed care in the Medicaid program has been going on in other states to a varying degree for over 20 years. Through this process it is clear there are interests impacted by the Medicaid program who either benefit from the status quo, are afraid to change or both. However, there is no other program that appears to be changing more and faster than healthcare, and Mississippi's Medicaid program has to adapt so its budget and system are not crushed from within. In 1996 the Legislature initially studied this issue with the Commission making its findings and facts at this time. This Commission report is building on that with an eye that these recommendations and findings will be used in the near future. However, many related issues for the development of a sound Medicaid managed care program in Mississippi are in need of further study, and having learned much through this process, the Commission is requesting to continue this oversight responsibility.

By consensus of the Commission there is a unanimous finding that a pilot program to address critical care children should be developed as soon as practicable, details of which are contained herein. Specific consensus recommendations regarding certain network programs under waivers are included in this report, as well as specific recommendations of individual provider members of the Commission; also coming out of the Commission is the understanding that the major payment mechanism for mental health care is Medicaid and that there is a willingness of the mental health provider community to explore options to bring predictability and consistency to the treatment and funding of community mental health services in Mississippi. The Commission strongly urges that these recommendations be given every consideration.

On behalf of the Commission, it was a valuable and worthwhile process and it is our hope that the Legislature will seriously consider the information from this endeavor.

A handwritten signature in black ink, appearing to read "Brice Wiggins". The signature is fluid and cursive, written over a horizontal line.

Senator Brice Wiggins, Chairman

MINUTES
OF
MEETINGS

Commission on Expanding Medicaid Managed Care
Meeting Minutes of September 25, 10:00am
New Capitol Building – Room 113
501 N. West Street, Jackson, MS 39201

I. Call to Order

Meeting was called to order by Drew Snyder, Division of Medicaid (DOM) Executive Director

II. Roll Call

Present: Drew Snyder, Executive Director, Division of Medicaid (DOM); Charmain Kanosky, Executive Director, MS State Medical Association (MSMA); Bob Williams proxy for Mike Chaney, Commissioner of Department of Insurance; Judith (Judy) Clark, pharmacist; Dave Van, licensed mental health professional; Aaron Sisk, Magnolia; Bridget Galatas, Molina; Jeff Wedin, United Healthcare; Kevin Cook, University of MS Medical Center; Representative Joel Bomgar; Senator Brice Wiggins

Absent: Representative Chris Brown, Chair House Medicaid Committee; Eugene “Buck” Clarke, Chair Senate Appropriations Committee; John Read, Chair House Appropriations Committee

III. Approval of meeting minutes

n/a

IV. Old Business – Presentations

n/a

V. New Business – Presentations and Discussions

- Drew Snyder began the meeting with a brief introduction and overview.
- Drew Snyder made the motion that Roberts Rules of Order be used for commission meetings.
 - Second: Senator Brice Wiggins
 - The motion was approved unanimously.
- Drew Snyder made the motion that Brice Wiggins be elected chairman.
 - Second: Charmain Kanosky
 - The motion was approved unanimously.
- Senator Brice Wiggins reviewed the purpose and requirements of the commission as written in Senate Bill 2836 and noted that a report to the legislature is due no later than December 1, 2018. It is anticipated that meetings of this commission will be approximately every two weeks.
- Senator Brice Wiggins requested that all commission members introduce themselves and the organizations and/ or medical field represented. Additionally, it was requested that committee members state what they would like the outcome from the commission to be.
- Senator Brice Wiggins clarified that the job of the commission is to set the course going forward with Managed Care as well as and assist Medicaid with alternative payment model regarding medically complex children.
- Commission members were asked to discuss wants and needs from Commission meetings.
 - **The Division of Medicaid, Drew Snyder, Executive Director:** Figure out what is best for the taxpayers and beneficiaries; Determine what managed care offers that is different from fee for service; Determine what the primary population is that they are serving; Conduct an analysis of CCO payment model; Understand the numbers and administrative impact on the agency
 - **Department of Insurance, Bob Williams, proxy for Commissioner Chaney:** Emphasized the importance on focusing on the taxpayers and beneficiaries
 - **Pharmacy, Judith Clark:** Ensure that reimbursement for pharmaceuticals is fair, payments are prompt, pharmacy provider access is open to all pharmacies, and pharmacy rules are concise and fair. Clarity is needed for specialty pharmaceuticals, i.e. open to local specialty providers and payment structure-as pharmacy or medical claims. Prior authorization should be promptly addressed and responses are quick as are Medicaid's. Be mindful that Medicaid's preferred drug list (PDL) does not include all covered drugs. Non-PDL drugs should be handled consistently with managed care as with Medicaid.

Encouraged managed care entities to continue to work collaboratively with DOM Pharmacy to stream line processes and programs.

- **House Representative, Joel Bomgar:** Stressed the importance of a cost benefit analysis
- **Mental Health, Dave Vann:** Beneficiaries are our primary responsibility. Our goal is to assist beneficiaries in order to avoid mental health crisis and keep beneficiaries out of institutionalization. Hopes that the commission can assist in the approval and denial process and ensuring it takes place in a timely manner to ensure services are provider to beneficiaries.
- **Molina, Bridget Galatas:** We are the new partner at the table. We are more than willing to be a good resource during the duration of the commission.
- **Magnolia, Aaron Sisk:** Magnolia is for Medicaid Managed Care expansion. Managed care is a financial benefit to the State because it provides Medicaid budget predictability. We provide better level of care and services and a more expansive reach than fee for service.
- **Unitedhealthcare, Jeff Wedin:** Interested in expanding services into the long term care population. We have been looking into preterm birth rates, C-sections obesity, diabetes, and family planning.
- **Hospitals, Kevin Cook:** Stated that many, if not most, hospitals in this state are in an economic and are crisis are under a lot of economic pressure. Access to care in the state is problematic. At Batson Children's hospital, about 80% of inpatients are on Medicaid. Hospitals are interested in a value based program to partner with CCOs to help carry the financial burden to ensure beneficiaries are getting the care they need. He proposed a look into an economic alignment and hopes the rates for the managed care companies can be adjusted. He would like to see the hospitals get a chance to provide a managed care program.
- **MSMA, Charmain Kanosky:** Expressed the importance of putting the patients first and producing better outcomes. She appreciates the CCOs working with physicians and providing a positive experience and good results. She hopes that some burdens can be released in relation to prior authorization paper work and the time it takes to complete them. There is a need for extra funding for residency spots at UMMC to train more physicians for MS.
- Commission members and legislators were allowed to make closing remarks or ask additional questions.
 - **Pharmacy question, Judith Clark:** What numbers of beneficiaries are using the CCOs use nurse coordinators? What disease states, outcomes and etc. are you seeing from this program?
 - **CCO response:** Will provide those numbers in next meeting
 - **Senator Bryan remarks:** Wants to figure out how to structure things so that people can get the best services for the best price. He agreed with Wiggins that the meetings should only focus on managed care. He wants to ensure that there are protections for providers in reference to reimbursement. He referred to Cooks mention on the hospitals getting a chance to provide the managed care programs internally and said it was something to be considered.

VI. Final Comments/ Action Items

- Charmain Kanosky made the motion that Judith Clark be elected secretary of the Commission.
 - Second: Drew Snyder
 - The motion was approved unanimously.
- Requirements in the Senate Bill were assigned to the most appropriate areas/organizations. Commission members are requested to provide a five minute presentation on their assigned topic and written materials in advance of the next Commission meeting:
 - Review the program's financial metrics: DOM
 - Review the program's product offerings: DOM

- Review the program's impact on insurance premiums for individuals and small businesses: Department of Insurance
- Make recommendations for future managed care program modifications: tabled for now
- Determine whether the expansion of the Medicaid managed care program may endanger the access to care by vulnerable patients: Nursing Homes representative
- Review the financial feasibility and health outcomes of populations health management as specifically provided in paragraph (2) above: MSMA
- Make recommendations regarding the pilot program to evaluate an alternative managed care payment model for medically complex children: Hospital representative

VII. Next Meeting – October 9, 2018

IX. Adjournment

Commission on Expanding Medicaid Managed Care
Meeting Minutes of October 9, 10:00am
New Capitol Building – Room 216
501 N. West Street, Jackson, MS 39201

I. Call to Order

Chairman Wiggins called meeting to order.

II. Roll Call

- **Voting members in attendance were:** Drew Snyder, Executive Director of Division of Medicaid (DOM); Charmain Kanosky, Executive Director of MS State Medical Association (MSMA); Bob Williams proxy for Commissioner Mike Chaney, Department of Insurance; Judith (Judy) Clark, pharmacist; Dave Van, licensed mental health professional; Becky Waterer, M.D, proxy for Aaron Sisk, Magnolia; Bridget Galatas, Molina; Jeff Wedin, UnitedHealthcare (UHC); Charles O'Mara, M.D. proxy for Kevin Cook, UMMC; Bobby Beebe, representing long term care , Senator Brice Wiggins
- **Voting members not in attendance were:** Representative Joel Bomgar, Representative Chris Brown Senator Eugene (Buck) Clarke, Representative John Read

III. Approval of meeting minutes from September 25, 2018

- *Meeting minutes were approved unanimously as amended*

IV. Old Business – Presentations

Chairman Wiggins reiterated to the members that the purpose of this commission is to recommend to the legislature that Managed Care in MS Medicaid remain as it is now, or add some of the currently excluded categories of eligibility.

Chairman Wiggins stated that there is inadequate time during this meeting to analyze each of the one pagers submitted by the members. Commission members are asked to review the one pagers prior to the next meeting. Members are to be prepared to discuss the pros and cons regarding recommendation to the legislature regarding inclusion of currently excluded categories to the expansion of Managed Care.

a. One pagers of issue areas:

-Mental Health: Dave Van presented the one pager for Mental Health outlining their concerns and access to those services for MSCAN members. There is a current DOJ issue with State of MS/Department of Mental Health regarding increasing the availability of home and community based services in MS. MH is an advocate for access to care. MH works to bridge the gaps and provide services to keep MH patients from being incarcerated. Mr. Van expressed his appreciation for including Mental Health in this discussion. He urged the MCOs to include mental health as a voice at the table as they are with FFS Medicaid. The Mental Health document is included in these minutes.

-Nursing Homes: Bobby Beebe gave an overview of his NH one pager. Since 2013-2014, NHs have had a budget neutral methodology. There are nursing homes located in every county of the state other than Issaquena County. That means that NHs are accessible for the patients and their families. If there is consolidation of NHs into larger/urban areas, it will impede access to care and family interactions with NH residents. The Nursing Home one pager is included these minutes.

-MSMA: Charmain Kanosky stated she would present at the next meeting on public policy issues, specifically smoking cessation, safety, and other health indicators that should be discussed. Ms. Kanosky mentioned state smoking related illnesses represent \$300M in costs. She asked the MCOs about telehealth in the MSCAN universe, primarily in the consultation of specialists. The MSMA one pager is included in the minutes.

Senator Wiggins asked the committee to bring questions and the next agenda would have time for open discussion. He also stated that UMMC was still working in their one pager and could present at the next meeting.

V. **New Business – Presentations**

DOM Executive Director, Drew Snyder, presented multiple DOM handouts, which are included in the minutes. Handouts included Medicaid Fee For Service (FFS)/MSCAN comparison chart; MSCAN product offerings of Magnolia, Molina, and UnitedHealthcare; Medical Loss Ratio reporting; and Medical Services covered under FFS describing the excluded categories of eligibility now being considered for managed care expansion. Mr. Snyder discussed excluded beneficiary populations that are excluded from managed care. Said programs include ICF/IDD institutional care; waiver populations such as Assisted Living, Healthier Mississippi, Family Planning, Elderly and Disabled, Independent Living, Traumatic Brain Injury/Spinal Cord Injury, and Intellectual Disabilities/Developmental Disabilities; Dual Eligibles, and Nursing Facilities.

Mr. Snyder stated that MCOs are not losing money in Mississippi, but they are not making much money either. Mr. Snyder mentioned that it is worth discussing whether to add the waiver populations to managed care. He added that the enrollment and expenditures of the waiver population are increasing overall; this increase in the waiver population is due in part to a focus on community-based settings versus institutional settings. Nursing home expenditure and enrollment growth has been flat in recent years. Currently, less than 40 % of the Medicaid beneficiary population is enrolled in FFS; however, this is a high-acuity population. Children, who constitute a large number percentage of MCO enrollees, are generally less expensive and are often low utilizers of services.

Dr. Waterer, representing Magnolia, explained care management from the managed care perspective as being disease specific with follow up telephonic education and support. Every member is eligible but may opt out. Also, Magnolia helps to connect vulnerable members with philanthropic resources. One such example is a Magnolia member, with cancer, who cannot pay their utilities, was connected with the MS Chapter of the American Cancer Society which can provide financial help in this regard.

Jeff Wedin, UHC, stated that UHC adhere to the 'whole person' approach. UHC's community health workers impact care through social determinates including, but not limited to, work, housing and adhering to healthy adaptations as part of care management such as 'farm to fork' food program encouraging fresh fruits and vegetables, medication adherence, etc.

Bridget Galatas (Molina) explained that while they are new to the state but also look at best clinical practices in other markets and are learning from them. Molina plans to incorporate best clinical practices in MS Medicaid with their member enrollment.

Judith Clark, pharmacy representative, discussed a DOM pharmacy program, Complex Pharmacy Care Program contracted with the clinical PDL vendor, currently being used in the FFS population. This program has been successful with providing the appropriate drug at the appropriate dose and duration of high cost pharmaceuticals while saving Medicaid substantial money. DOM is seeing a ROI of 12:1 representing \$6M in savings/400 beneficiaries/in the past 24 months. She asked about like programs available through the MCOs.

Senator Wiggins requested the information provided at the meeting be put into the record for the Commission's report and would include minutes as well.

V. **Final Comments/ Action Items**

VIII. **Next Meeting – October 23, 2018 New Capitol Building – Room 216**

IX. **Adjournment**

Commission on Expanding Medicaid Managed Care

Meeting Minutes of October 23, 10:00 am

New Capitol Building – Room 216

501 N. West Street, Jackson, MS 39201

I. Call to Order

Chairman Wiggins called meeting to order. Chairman Wiggins acknowledged Commissioner Mike Chaney in attendance.

II. Roll Call

- **Voting members in attendance were:** Drew Snyder, Executive Director of the Division of Medicaid (DOM); Charmain Kanosky, Executive Director of MS State Medical Association (MSMA); Bob Williams proxy for Commissioner Mike Chaney, Department of Insurance; Judith (Judy) Clark, pharmacist; Phaedra Cole, proxy for Dave Van, licensed mental health professional; Aaron Sisk, Magnolia; Dr. Tom Joiner, proxy for Bridget Galatas, Molina; Jeff Wedin, UnitedHealthcare (UHC); Kevin Cook, UMMC; Bobby Beebe, nursing home representative; and Senator Brice Wiggins
- **Voting members not in attendance were:** Representative Joel Bomgar, Representative Chris Brown Senator Eugene (Buck) Clarke, Representative John Read

III. Approval of meeting minutes from October 23, 2018

- *Meeting minutes were approved unanimously as amended*

IV. Old Business – Presentations

- *None*

V. New Business

a. Presentations

- **MSMA:** Dr. Mansour, President of MS State Medical Association and speaking on the behalf of MSMA, presented information on managing medical costs by preventative and behavioral changes. He stated that medical costs adhere to the 80-20 rule, that is, 20% of the patient population is responsible for 80% of the healthcare costs. Disabled and/or chronically ill are the most expensive patient populations, regardless of age, to manage. Determinants of well-being are: 40% personal behaviors; 20 % social behaviors; 30% genetics; and 10% healthcare. Trends show that preventative primary healthcare costs increased by 18% while total healthcare spending decreased by 18%. National research reveals that an increase of 10% spending in public/preventative medicine results in a decrease of 1/7 deaths over 13 years. Preventative medicine goals are to decrease illnesses, increase access and lower overall costs. One such preventative health measure is to decrease smoking. In MS, tobacco use accounts for \$1.2 Billion in direct medical cost, and \$320 Million in direct Medicaid costs. 23% of Medicaid beneficiaries smoke. MSMA suggested that the State consider a ‘user fee’ per package of cigarettes which could result in \$165 Million of revenue per year. When Dr. Mansour was asked “What is the most important (preventable health) issue in MS?” he replied “smoking.” A recent study in Hattiesburg and Starkville revealed that banning smoking in public venues decreased heart attacks between 11-17%.

Recommendations include enhancing and promoting the use of telehealth as an important tool for MS healthcare providers to link specialists with practitioners in rural and remote areas. Other recommendations were increased web-based portals, such as for prior authorizations, for payers, promote wellness screenings, reimbursement at 100% Medicare rate for screenings, and evaluate MCOs for wellness screenings.

- **UMMC:** Kevin Cook, representing UMMC and speaking on the behalf of hospitals in MS, gave a presentation of Developmental of Business Model for Children with Medical Complexity (CMC).

Mr. Cook related that it is his goal to have the MS specific data on CMC to the Commission by the next meeting. There are about 15,000 pediatric medically complex patients in MS with the great majority living at home. Approximately 700 are seen at UMMC with their interdisciplinary model and a small percentage of the CPC live permanently at Batson. CMC are a significant driver of healthcare costs. While these children comprise about 6 % of the Medicaid population nationally, they represent 40% of the Medicaid spend for children. Other states have formed a Kids Care project or pilot using an ACO (Affordable Care Organization) model to manage costs while providing for better life for these children and their families. The goal of such a program is to mitigate the need for long term care for this patient population, assign this patient population to an appropriate network of providers closer to home and educate/assist families in the care of these patients.

Currently UMMC has a pilot program for 700 patients that utilizes physicians, case managers, social workers, dieticians, nursing, medical office assistants and respiratory therapists to care for the CMS population. UMMC is requesting a shared savings approach with the MCOs. Shared savings will not remove the patient from MCO but allow an enhanced reimbursement for this provider and patient population. The goal is for the provider to be able to meet their costs, hire more practitioners at the UMMC base as well as fund a statewide network throughout the state. This will allow the only children's hospital in MS to be accessible for all children and families in MS. This presentation is included in the minutes. Mr. Cook indicated that UMMC would be willing to engage in "downside" risk sharing arrangements provided the facility was given an adequate transition period.

b. Topics to Explore/Discuss

i. Fee for Service vs managed care: other states -- PEER to compare other states, with more managed care, like Kansas, to MS. Commission is requesting a chart or map.

ii. Negative effect hospitals, True or False?

The perceived need for provider sponsored plan aka Senator Bryan's proposal was discussed. Mr. Cook stated that there is continued interest in a provider-sponsored plan, and it will not go away any time soon. When asked if it was self-interest or in the best interest of Medicaid, his response was both.

iv. Long Term Care: yea or nay. Mr. Beebe requested that nursing homes be carved out of Medicaid expansion due to their one pager presented at a prior meeting. Chairman Wiggins asked if carving out this industry is done in other states. Mr. Snyder offered additional information as to other states that have been in managed care for longer periods of time and stated that HCBS and nursing homes are a conversation that could be handled together.

v. Prescription drugs: cost and management. Mrs. Clark stated that she could not comment on the specific numbers regarding the increased costs of prescription drugs. However, there are increased costs with generic drugs because of fewer generic companies producing these products, increased raw ingredient costs, and FDA regulations regarding manufacturing and quality standards with non-oral drugs. The trend is more designer/specialty new drugs coming to market and these products carry a high cost per user. Payers can control prior authorizations to assure that the right patient gets the right drug at the right time, and using therapeutic alternatives when appropriate. Payers cannot control the costs of drugs, only what they pay providers. We need Congress' help to control prescription drug costs.

VI. Structure of Report

a. Recommendations vs. data/info collects with assistance from Bob Davidson: Mr. Davidson presented a 1996 legislative report regarding Managed Care and MS Medicaid. The 1996 report was suggested to be the model for the Commission's 2018 report to the legislature. Said report includes findings and recommendations. This report is included in the minutes.

V. Final Comments/ Action Items

- a. PEER report
- b. Prescription drug costs and management
- c. Report for Legislature

VIII. Next Meeting –November 6, 2018; New Capitol Building – Room 216

IX. Adjournment

I. Call to Order

Chairman Wiggins called meeting to order. Chairman Wiggins acknowledged Representatives White and Mims in the audience. Chairman also reminded Commission members that the next meeting is Tuesday, November 13, 2018. There will be no meeting the week of Thanksgiving and the Commission will reconvene on November 27, 2018. The 1996 Managed Care Legislative Report will be used as a potential guide for the Commission's report to the legislature due on 12-1-2018.

II. Roll Call

- **Voting members in attendance were:** Drew Snyder, Executive Director of the Division of Medicaid (DOM); Charmain Kanosky, Executive Director of MS State Medical Association (MSMA); Bob Williams proxy for Commissioner Mike Chaney, Department of Insurance; Judith (Judy) Clark, pharmacist; Dave Van, licensed mental health professional; Mike Todaro, proxy for Aaron Sisk, Magnolia; Bridget Galatas, Molina; Jeff Wedin, UnitedHealthcare (UHC); Kevin Cook, UMMC; Bobby Beebe, representing the long term care industry ; and Senator Brice Wiggins.
- **Voting members not in attendance were:** Representative Joel Bomgar, Representative Chris Brown Senator Eugene (Buck) Clarke, and Representative John Read.

III. Approval of meeting minutes from October 23, 2018

- *Meeting minutes were approved unanimously as amended*

IV. Old Business – Presentations

Mr. Cook, UMMC, representing hospitals: We are working with DOM on the data request, but unsure if it will ready by the final report date. As a recap, nationally there are 2 Million children with complex medical care issues. This is approximately 6 % of the population but account for 40% of the spend. We are looking at pilot projects to reduce the costs for this special needs population. We are looking at other state's programs to see if they are viable in MS. One such example is MO's program.

V. New Business

a. Presentations

- **Managed Care in Other States by PEER:** Lonnie Edgar, representing PEER, provided a presentation on Medicaid managed care nationally. In MS, MCO enrollment was 7% more than the same time frame in March of 2018. The change in numbers is thought to be indicative of a better economy in MS and more jobs. In MS Medicaid, 65% of the total beneficiary population are enrolled in MCOs and account for 46.5% of the total DOM (Division of Medicaid) budget. Other states with managed care range between 65-90% of their total population in managed care. PEER's handouts are included in the minutes.
- **Pharmacy Costs and Management:** Judith Clark, representing pharmacy, provided a presentation on prescription drugs and management techniques. Payers, commercial and Medicaid, have no control over the costs of prescription drugs: they can negotiate rebates on brand drugs and industry must offer Medicaid the 'best price' offered to any other payer. Payers can control what is paid to the pharmacy provider. Pharmacies can belong to purchasing groups and buy prudently. There is an exponential growth in branded drug due to many being specialty drugs used to treat a small patient pool, such as various types of cancer, cystic fibrosis, etc. Mental health drugs compromise a large percentage of payers' budgets; this is especially true for Medicaid.

Tools used by some insurance plans to control prescription drug costs for their members are to hire pharmacy benefits managers (PBMs). PBMs are pharmacy benefits managers contracted by companies or insurers to help manage the pharmacy costs for their members. Many PBMs started as claims payers decades ago and have morphed into huge entities. Large PBMs like Express Scripts, CVS Caremark and OptumRX manage the vast majority of prescription claims in the US. (NCPA). To control pharmacy costs, PBMs utilize formularies and prior authorization programs; limited pharmacy networks, reduced pharmacy reimbursement both for ingredients and dispensing fees; encouraging/mandating the use of mail order pharmacy programs; increasing patient copays or coinsurance; aggressive pharmacy audits by (non-clinical) auditors, including clawbacks or DIR, drug indirect remuneration fees taken from pharmacies. Clark's presentation is included in this report.

- b. Topics to Explore/Discuss
 - Chairman Wiggins explained and encouraged consensus recommendations by the Committee.
 - Chairman Wiggins directed the Managed Care Companies to present at the next meeting. MCOs can present individually or collectively.
 - MCOs and program areas on the Commission are to prepare a one-pager with recommendations for the commission to review and discuss.

VI. **Structure of Report**

Commission will use the 1996 legislative report regarding Managed Care and MS Medicaid as the model for the Commission's 2018 report to the legislature.

V. **Final Comments/ Action Items**

- a. MSMA requested additional information from PEER regarding managed care in states more like MS demographically.
- b. MCOs: presentation to the commission and one pagers for the commission to review
- c. Program areas are to present their recommendations to the Commission.

VIII. **Next Meeting** –November13, 2018 at 10:00 am; New Capitol Building – Room 216

IX. **Adjournment**

I. Call to Order

Chairman Wiggins called the meeting to order. Chairman Wiggins acknowledged Representative White in the audience. Chairman also reminded Commission members the next meeting is Tuesday, November 27, 2018. There will not be a meeting the week of Thanksgiving. The 1996 Managed Care Legislative Report will be used as a potential guide for the Commission's report to the Legislature due on 12-1-2018. Chairman Wiggins requested the removal of item 5) c, an ethics presentation, from today's agenda.

II. Roll Call

- **Voting members in attendance were:** Dr. Jason Dees, proxy for Drew Snyder, Executive Director of the Division of Medicaid (DOM); Phyllis Williams, proxy for Charmain Kanosky, Executive Director of MS State Medical Association (MSMA); Phillip Strickland, proxy for Commissioner Mike Chaney, Department of Insurance; Judith (Judy) Clark, pharmacist; Dave Van, licensed mental health professional; Aaron Sisk, Magnolia; Bridget Galatas, Molina; Jeff Wedin, UnitedHealthcare (UHC); Kevin Cook, UMMC; Bobby Beebe, representing the long term care industry; and Senator Brice Wiggins.

- **Voting members not in attendance were:** Representative Joel Bomgar, Representative Chris Brown Senator Eugene (Buck) Clarke, and Representative John Read.

III. Approval of meeting minutes from November 6, 2018

- Meeting minutes were approved unanimously

IV. Old Business – Presentations

Chairman Wiggins expressed his appreciation for the assistance and hard work of the Commission. He stated that he anticipated that today's meeting would be lengthy. Additionally, he stated that all presentations are part of the minutes and will be available as part of the record.

V. New Business

Presentations

- **Mental Health:** Dave Van---there are two major components providing mental health services in MS: Department of Mental Health (DMH) and Community Mental Health Centers (CMHS). The role for these two entities has changed over the past 5 years with the transition from institutional care to more services provided in the

Commission on Expanding Medicaid Managed Care

Meeting Minutes of November 13, 2018 10:00 am

New Capitol Building – Room 216

501 N. West Street, Jackson, MS 39201

community. MDH, which is primarily funded from the federal grants, state's general fund, provides inpatient services and administrative oversight. CMHC oversee outpatient centers and are covering more acute services. CMHCs receive 70% through the fee for service model with 65-70% from Medicaid. There are 14 CMHCs, employing about 4500 staff members, which provide care in all 82 counties. During the last year, about 106,000 consumers, primarily from the mid to low income, received care from the CMHCs.

CMHCs strive to control costs while providing mental health care throughout MS. One concern is the Medicaid reimbursement rate for child psychiatrists; CMHCs have to pay more than Medicaid allowable rates to hire these practitioners to care for their patients. We have found that telemedicine works in some scenarios but the human contact is important for many of our patients. Mr. Cook, representing the hospital industry and UMMC, stated that UMMC's fastest growing area of telemedicine is pediatric behavioral medicine. Dr. Dees, from DOM, stated that the MCOs are doing something similar now with parent-child-physician model. Children are treated onsite at the schools. Currently, there is an ongoing pilot program with the MCOs in Hinds County (looking at preventable mental health readmissions).

Mental Health needs more rather than fewer options to treat this patient population. Patients with severe mental illnesses live an average of 25 years less than non-mentally ill patients. We believe that managed care is here to stay and we wish to partner with the MCOs in an integrated program to provide both mental and physical health needs. Region 8 Annual Report is included with the minutes.

- Multiple documents were submitted by each MCO and a power point was presented by Michelle Bentzien- Purrington from Molina representing all 3 MCOs. All are included in the minutes.

Managed care is about enhanced coordination and relationships among agencies and providers. MCOs strive to partner and provide more value-based treatment to the entire person—sociologically, psychologically and biologically. One such example is that MCOs provide training programs and respite for those unpaid family caregivers, such as a one-week break/month of respite care. Stakeholder engagement is imperative. Stakeholders are all concerned parties, i.e. advocates, providers, associations, faith based institutions, Medicaid beneficiaries, etc.

Magnolia's Aaron Sisk stated that the goal is to manage medical trends. UHC's Wedin stated in the past several years' hospitals have seen many changes affecting their bottom line such as: trend from inpatient to outpatient services, shorter inpatient stays and more competition in the market. Mr. Cook stated that the hospital crisis issue is multi-factorial especially with the rural hospitals. He continued stating that

2/3 of MS hospitals are under severe pressure and ½ are underwater. Problems hospitals are experiencing from MCOs are lack of uniform credentialing, administrative burdens with prior authorization denials, and uniform admission criteria is particular challenge to hospitals. Molina’s presentation is included in the minutes.

- UMMC, Kevin Cook and Dr. Mary Taylor explained the proposed pilot for medically complex children. They are requesting a collaborative venture for UMMC and MCOs to provide care and shared savings as well as shared investments. “Development of Business Model for Children with Medical Complexity” is included in the minutes.
- Judy Clark presented the Commission with 2 letters from pharmacy associations opposed to adding additional populations into managed care along with a request to have pharmacy services carved out for all Medicaid beneficiaries. Those are included in the minutes.
- Kevin Cook also presented the Commission with a letter from MHA voicing concern of commission time constraints and the need for further study as to value of expanding managed care populations. The letter is included in the minutes.
- Consensus Recommendation Discussion- led by Sen. Wiggins and Dr. Dees with commission members agreeing the conversations initiated by the commission should continue beyond Dec 1.

VI. Structure of Report

Commission will use the 1996 legislative report regarding Managed Care and MS Medicaid as the model for the Commission’s 2018 report to the legislature.

VII. Next Meeting

November 27, 2018 at 10:00 am; New Capitol Building – Room 216

VIII. Adjournment

Commission on Expanding Medicaid Managed Care
Meeting Minutes of November 27, 2018 10:00 am
New Capitol Building – Room 113
400 High Street
Jackson, MS 39201

I. Call to Order

Chairman Wiggins called the meeting to order. The Chairman reminded Commission Members that the legislative session begins January 8, 2019 and all Commission members are urged to attend. Chairman Wiggins recognized Representative Chris Brown in the audience. The 1996 Managed Care Legislative Report will be used as a potential guide for the Commission's report to the Legislature due on December 1, 2018.

II. Roll Call

Voting members in attendance were: Drew Snyder, Executive Director of the Division of Medicaid (DOM); Charmain Kanosky, Executive Director of MS State Medical Association (MSMA); Bob Williams, proxy for Commissioner Mike Chaney, Department of Insurance; Judith (Judy) Clark, pharmacist; Dave Van, licensed mental health professional; Aaron Sisk, Magnolia; Bridget Galatas, Molina; Jeff Wedin, UnitedHealthcare (UHC); Kevin Cook, UMMC; Bobby Beebe, representing the long term care industry; Representative Chris Brown in the audience, and Senator Brice Wiggins.

Voting members not in attendance were: Representative Joel Bomgar, Senator Eugene (Buck) Clarke, and Representative John Read.

III. Approval of meeting minutes from November 13, 2018

Revised meeting minutes were approved unanimously

IV. Old Business

Chairman Wiggins expressed his appreciation for the assistance and hard work of the Commission.

V. New Business : Discuss Proposed Report

Chairman Wiggins stated that a motion was needed to incorporate additional responses, i.e. five additional items, for the Final Report. Said items submitted after report was drafted are: letters from MS Pharmacists Association (MPHA), MS Dental Association, WellCare, and a PowerPoint from MS State Medical Association (MSMA). Chairman Wiggins stated that the deadline for submission of any other documents would be at the end of the meeting. Mr. Sisk objected to the third party responses especially the MS Dental Association, MS Hospital Association (MHA), and the WellCare letters. There was robust discussion among the commission members regarding how best to address this issue. Chairman Wiggins suggested that any information in the third party responses could be discussed by the MCAC. Mr. Sisk agreed with that and expressed that neither he nor many other members of the Commission had a chance

Commission on Expanding Medicaid Managed Care

Meeting Minutes of November 27, 2018 10:00 am

New Capitol Building – Room 113

400 High Street

Jackson, MS 39201

to review the five documents. Director Snyder explained the MCAC for committee members who were not familiar with it. The recommendation from the Commission was “no submission from outside of the committee membership as established by law via the legislature” would be accepted for inclusion in the Final Report. Mr. Sisk motioned that any materials not submitted through a committee member not be included, and the motion passed. The following discussion involved whether to include the three consensus recommendations with enacting legislation in the report, or the three consensus recommendations only. A motion to include only the three consensus recommendations in the report without the accompanying draft legislation passed with no objections. The Commission moved on to Provider Recommendations. Mr. Sisk objected to the inclusion of Tab E, which included letters presented by commission members previously, i.e. MPHA, MSMA, and MHA. Mr. Sisk’s motion to not include recommendations from MHA was seconded by Mr. Wedin but failed by a vote of 3-5. Voting in favor were Mr. Sisk, Mr. Wedin, and Mrs. Galatas. Voting against were Mrs. Clark, Mr. Cook, Mr. Beebe, Mr. Van, and Mrs. Kanosky. More robust discussion ensued regarding location of these documents in the report. The Commission voted to place the MPHA, and MSMA documents in the Individual Provider Recommendation section, Tab E, and the MHA letter in the Findings section of the report. This was approved without objections.

The draft transmittal letter written by Chairman Wiggins was reviewed and revised by the Commission. Motion to accept transmittal letter with revisions was made by Mr. Van, seconded by Mr. Sisk and approved unanimously.

Mr. Van made the motion to accept findings consensus, i.e Tabs A (Complex Children Pilot-directs DOM to seek waiver regarding implementation of pilot program), B (Study of Mental Health-directs DOM for a prospective study regarding alternative payment model for mental health), and C (Transfer commission functions to Medical Advisory Committee to continue monitoring the feasibility of adding other categories into Managed Care). Director Snyder reminded the commission members that DOM does not require legislation to implement Tab A or B. This issue was referred to PEER to review legislative requirements for consensus findings. Commission members asked if the commission can continue without legislation. Response from PEER was “not officially.”

The Final Report acceptance motion was made by Chairman Wiggins and seconded by Bob Williams. This report will be available in Room 212 when changes have been finalized.

VVIII. Adjournment

This document is a draft of meeting minutes from the final meeting of the Commission and cannot be considered a final document due to the dissolution of the Commission effective December 1, 2018.

1048 (i) The Chairmen of the Senate Medicaid
1049 Committee and the Senate Appropriations Committee and a member of
1050 the Senate appointed by the Lieutenant Governor;
1051 (ii) The Chairmen of the House Medicaid
1052 Committee and the House Appropriations Committee and a member of
1053 the House of Representatives appointed by the Speaker of the
1054 House;
1055 (iii) The Executive Director of the Division
1056 of Medicaid, Office of the Governor;
1057 (iv) The Commissioner of the Mississippi
1058 Department of Insurance;
1059 (v) A representative of a hospital that
1060 operates in Mississippi, appointed by the Speaker of the House;
1061 (vi) A licensed physician appointed by the
1062 Lieutenant Governor;
1063 (vii) A licensed pharmacist appointed by the
1064 Governor;
1065 (viii) A licensed mental health professional
1066 or alcohol and drug counselor appointed by the Governor;
1067 (ix) The Executive Director of the
1068 Mississippi State Medical Association (MSMA);
1069 (x) Representatives of each of the current
1070 managed care organizations operated in the state appointed by the
1071 Governor; and



1072 (xi) A representative of the long-term care
1073 industry appointed by the Governor.

1074 (b) The commission shall meet within forty-five
1075 (45) days of the effective date of this section, upon the call of
1076 the Governor, and shall evaluate the Medicaid managed care
1077 program. Specifically the commission shall:

1078 (i) Review the program's financial metrics;

1079 (ii) Review the program's product offerings;

1080 (iii) Review the program's impact on
1081 insurance premiums for individuals and small businesses;

1082 (iv) Make recommendations for future managed
1083 care program modifications;

1084 (v) Determine whether the expansion of the
1085 Medicaid managed care program may endanger the access to care by
1086 vulnerable patients;

1087 (vi) Review the financial feasibility and
1088 health outcomes of populations health management as specifically
1089 provided in paragraph (2) above;

1090 (vii) Make recommendations regarding a pilot
1091 program to evaluate an alternative managed care payment model for
1092 medically complex children;

1093 (viii) The commission may request the
1094 assistance of the PEER Committee in making its evaluation; and



1095 (ix) The commission shall solicit information
1096 from any person or entity the commission deems relevant to its
1097 study.

1098 (c) The members of the commission shall elect a
1099 chair from among the members. The commission shall develop and
1100 report its findings and any recommendations for proposed
1101 legislation to the Governor and the Legislature on or before
1102 December 1, 2018. A quorum of the membership shall be required to
1103 approve any final report and recommendation. Members of the
1104 commission shall be reimbursed for necessary travel expense in the
1105 same manner as public employees are reimbursed for official duties
1106 and members of the Legislature shall be reimbursed in the same
1107 manner as for attending out-of-session committee meetings.

1108 (d) Upon making its report, the commission shall
1109 be dissolved.



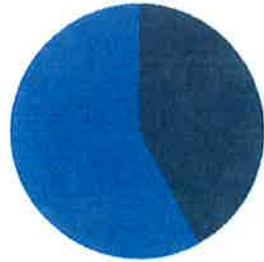
FINDINGS

Tab A

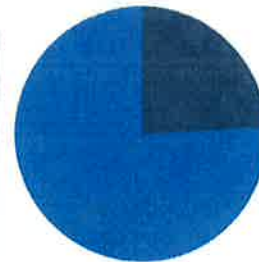
MEDICAID IN MISSISSIPPI

September 2018

2.9 million
total MS population



42%
of MS population is low-income (<200% FPL)



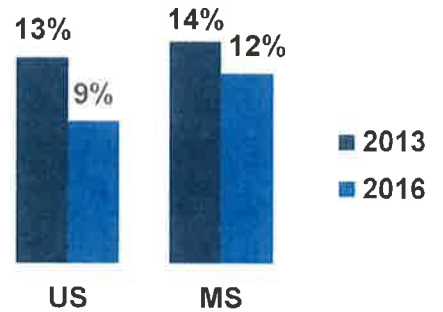
24%
of MS population is covered by Medicaid/CHIP

MS Expansion Status:
Not Adopted

Adults in Coverage Gap:
99,000



Uninsured Rates



In MS, Medicaid Covers:



1 in 7 adults, ages 19-64



1 in 2 children



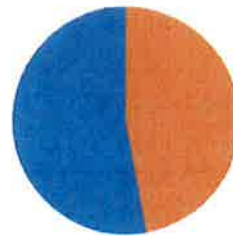
3 in 4 nursing home residents



4 in 9 individuals with disabilities

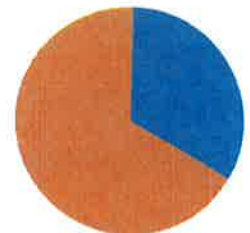


2 in 7 Medicare beneficiaries



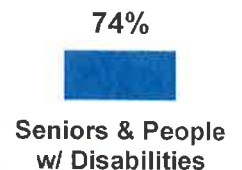
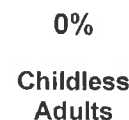
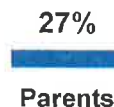
47%
of adult Medicaid enrollees are working in MS

67%
of children with special health care needs are covered by Medicaid in MS



100% of FPL: \$20,780 for a family of three; \$12,140 for an individual

MS Median Eligibility Levels
(as a % of FPL)

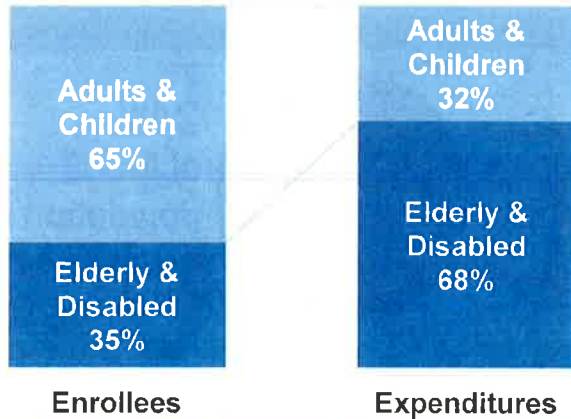


Headquarters / 185 Berry Street Suite 2000 San Francisco CA 94107 / 650 854 9400
Washington Offices and Conference Center / 1330 G Street NW Washington DC 20005 / 202 347 5270

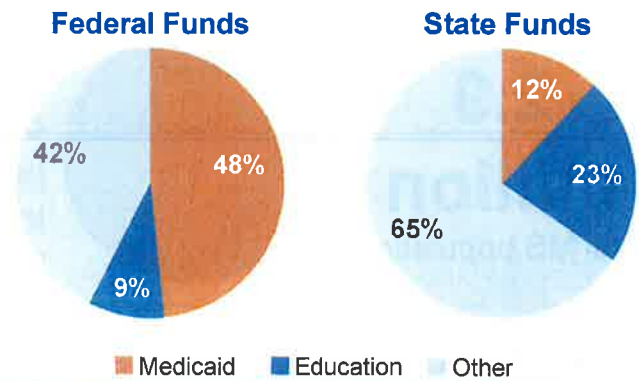
kff.org / Email Alerts: kff.org/email / facebook.com/KaiserFamilyFoundation / twitter.com/KaiserFamFound

Filling the need for trusted information on national health issues: the Kaiser Family Foundation is a nonprofit organization based in San Francisco, California

MS Medicaid Enrollees & Expenditures



Distribution of MS Spending by Fund & Category



Nationally Medicaid Pays For:

\$\$\$\$\$\$\$

1 in 6 dollars in the health care system

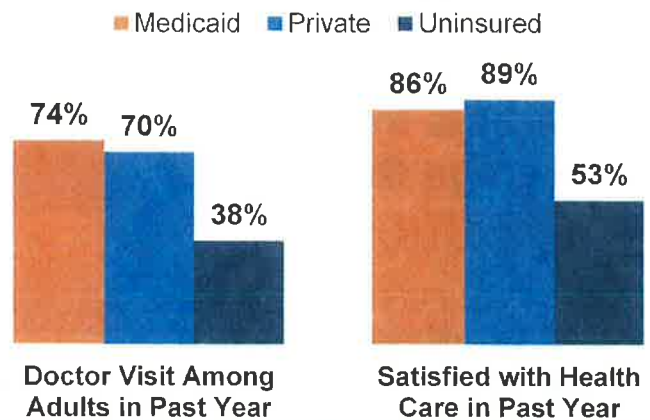
\$\$\$

>1 in 3 dollars to safety-net hospitals and health centers

\$\$

1 in 2 dollars on long-term care

National Access & Satisfaction Measures



Governor
(No 2018 Election)

US Senate

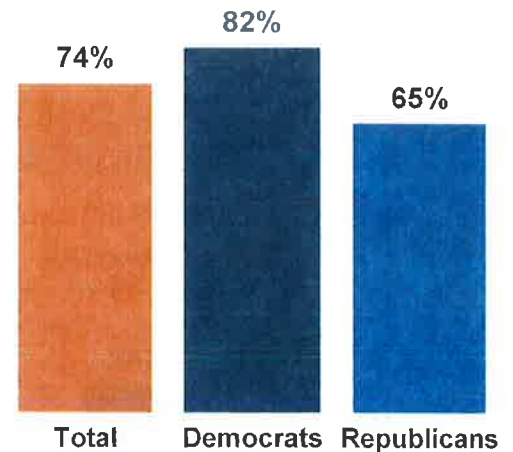
US Congress

Current:
Phil Bryant (R)

Roger Wicker (R) (2018)
Cindy Hyde-Smith (R) (2018)

of Representatives: 4
Party: 1-D, 3-R

National Share of Those that Hold Favorable Views of Medicaid



MS State Legislature Party Affiliation



"Top 5" States: Largest # of MCOs (March 2018)

California	24
New York	24
Texas	19
Florida	17
Wisconsin	16

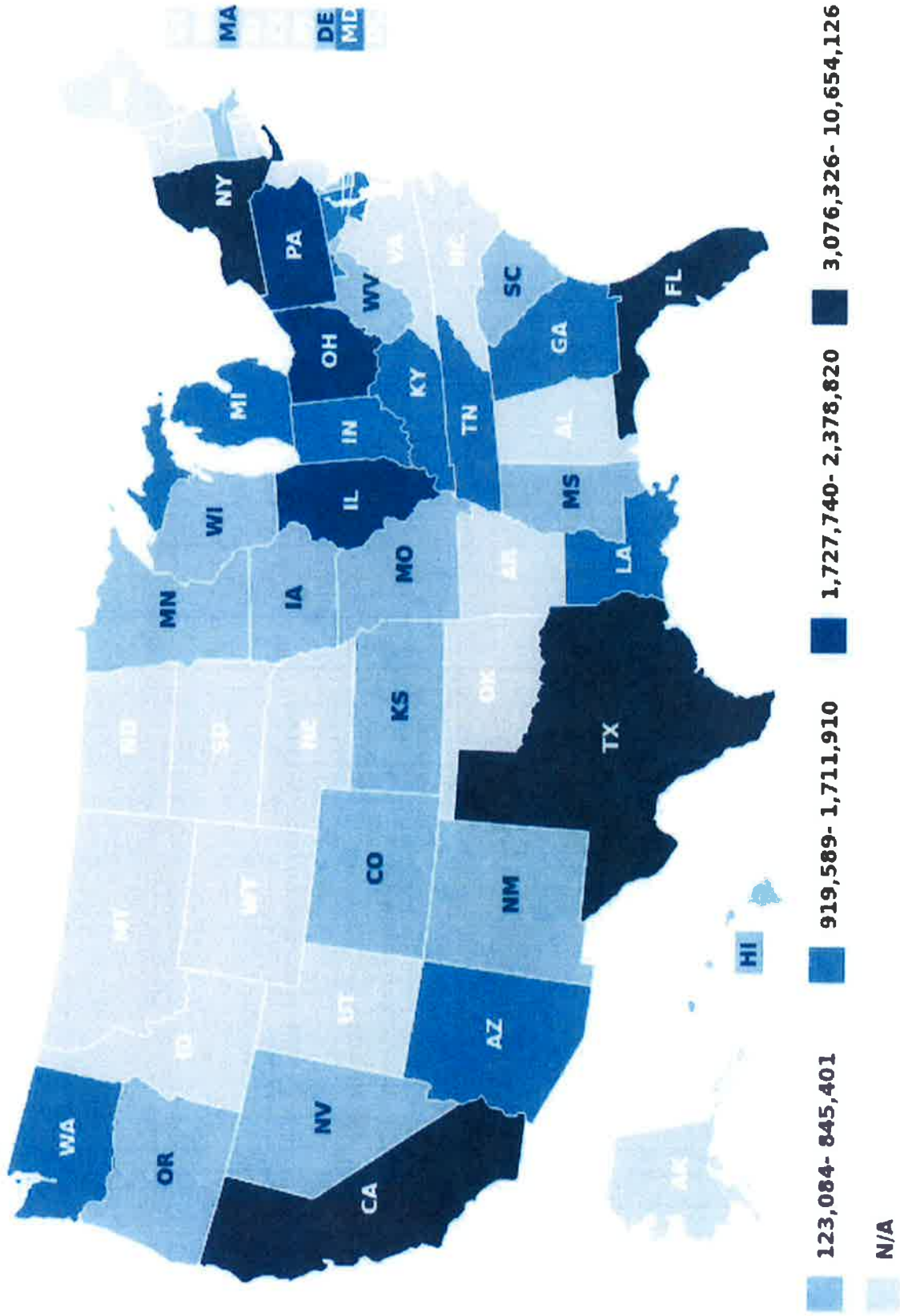
"Bottom 5" States: Fewest # of MCOs (March 2018)

Delaware	2
Iowa	2
Mississippi*	2
New Hampshire	2
North Dakota	1

*MS now has 3 MCOs operating the MSCAN program.

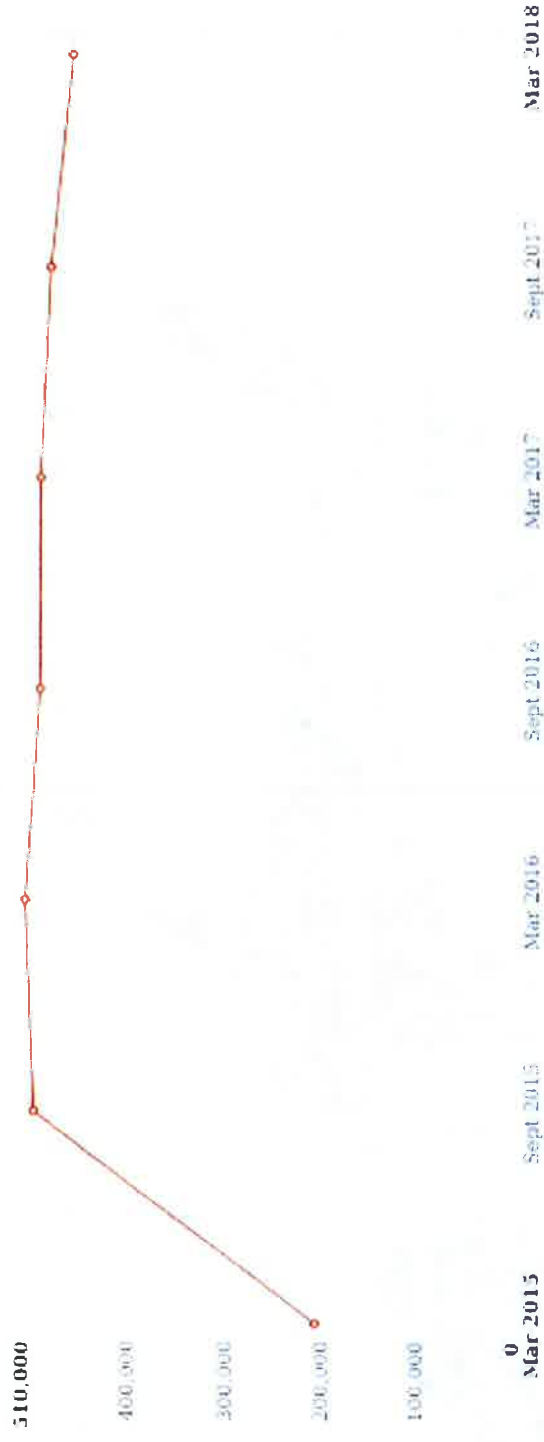
Source: <https://www.kff.org/medicaid/state-indicator/total-medicare-mcos/?currentTimeframe=0&selectedDistributions=total-medicare-mcos&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

Total Medicaid MCO Enrollment: Medicaid MCO Enrollment, Mar 2018



SOURCE: Kaiser Family Foundation's State Health Facts.

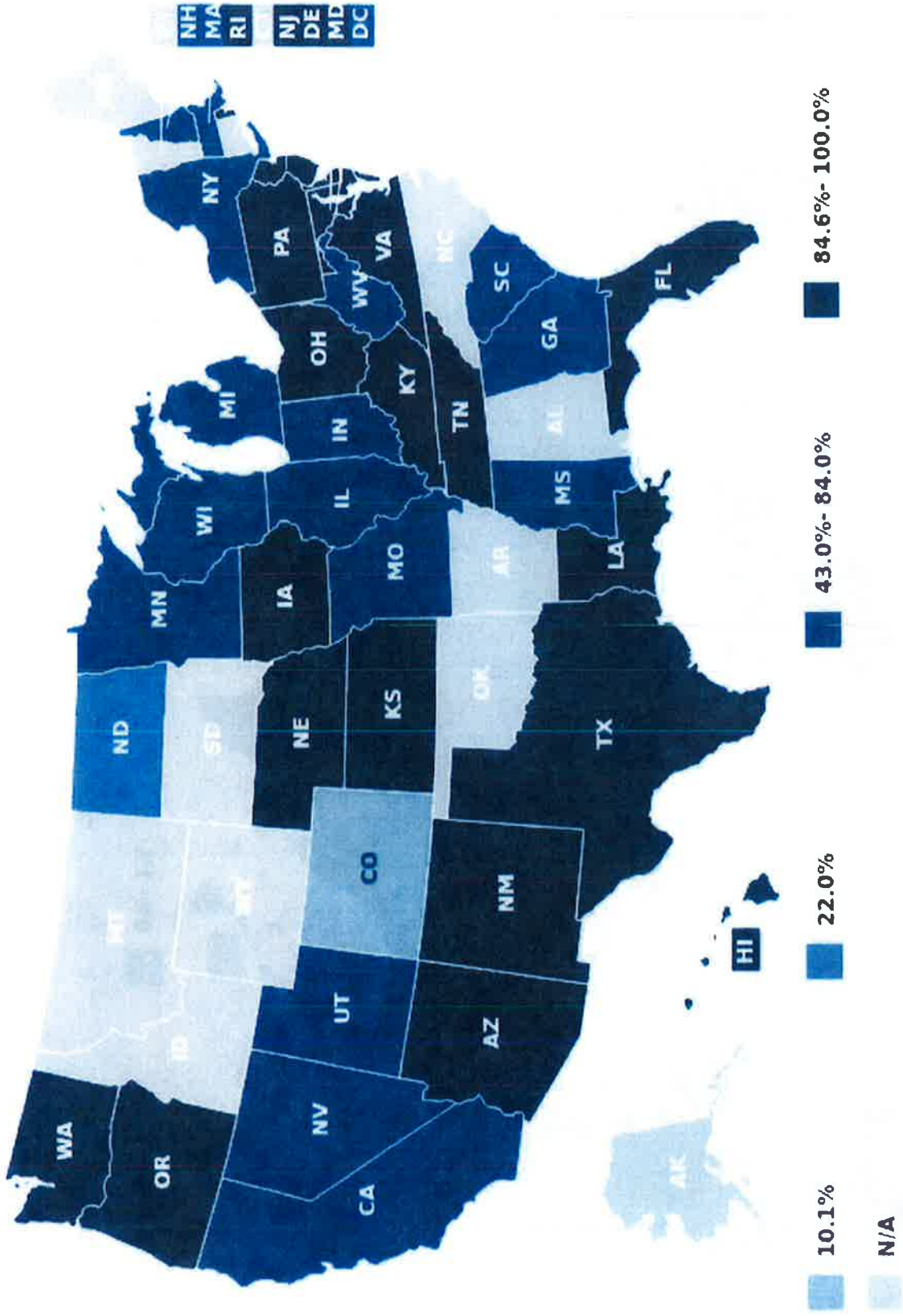
Total Medicaid MCO Enrollment: Medicaid MCO Enrollment, Mar 2015 - Mar 2018



○ Medicaid MCO Enrollment
■ Mississippi

SOURCE: Kaiser Family Foundation's State Health Facts.

Share of Medicaid Population Covered under Different Delivery Systems: Percent of Medicaid Population in MCO, as of July 1, 2018



SOURCE: Kaiser Family Foundation's State Health Facts.

"Top 5" States: Largest % of Medicaid Population in Managed Care (July 1, 2018)

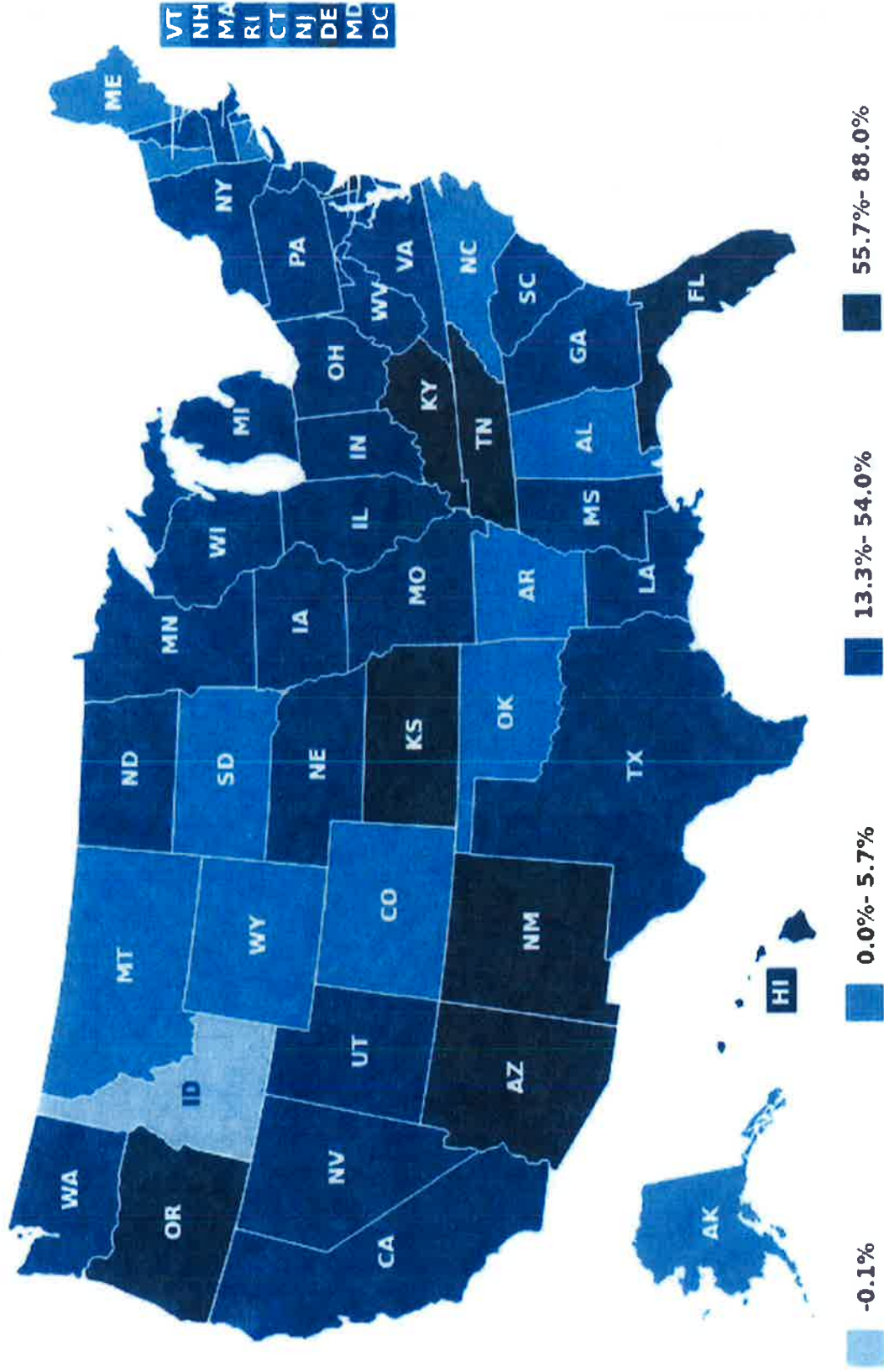
Tennessee	100%
Hawaii	99.9%
Nebraska	99.7%
Delaware	97.0%
Kansas	95.0%
New Jersey	95.0%

"Bottom 5" States: Smallest % of Medicaid Population in Managed Care (July 1, 2018)

Wisconsin	67.0%
Mississippi	65.0%
Massachusetts	43.0%
North Dakota	22.0%
Colorado	10.1%

Source: <https://www.kff.org/medicaid/state-indicator/managed-care-penetration-rates-by-eligibility-group/?activeTab=map¤tTimeframe=0&selectedDistributions=total-population&sortModel=%7B%22colId%22:%22Total%20Population%22,%22sort%22:%22desc%22%7D#note-3>

Total Medicaid MCO Spending: As a % of Total Medicaid Spending, FY 2016



SOURCE: Kaiser Family Foundation's State Health Facts.

"Top 5" States: Largest % of MCO Spending in Total Medicaid Spending (FY 2016)

Kansas	88.00%
Delaware	85.20%
Hawaii	82.10%
New Mexico	79.80%
Arizona	72.50%

"Bottom 5" States: Smallest % of MCO Spending in Total Medicaid Spending (FY 2016)

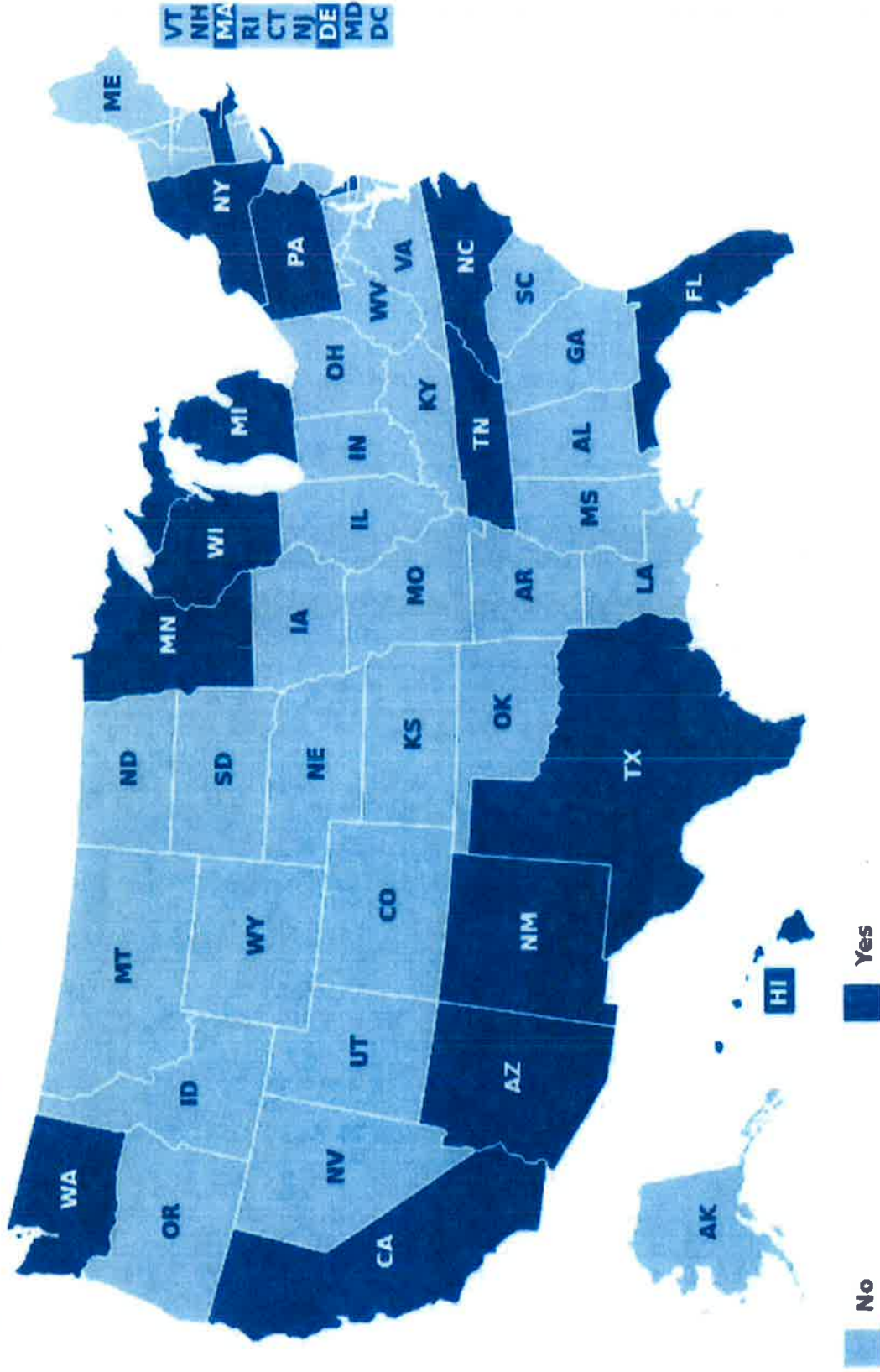
Nebraska	28.70%
Wisconsin	27.30%
Missouri	13.30%
Colorado	5.70%
Wyoming	1.00%

Other States:

Tennessee	64.30%
Mississippi	46.50%

Source: <https://www.kff.org/other/state-indicator/total-medicaid-mco-spending/?activeTab=map¤tTimeframe=0&selectedDistributions=as-a-percent-of-total-medicaid-spending&sortModel=%7B%22colId%22:%22As%20a%20%25%20of%20Total%20Medicaid%20Spending%22,%22sort%22:%22desc%22%7D>

Total Medicaid Enrollment in Managed Long-Term Services and Supports (MLTSS): MLTSS Program in Place, 2012



SOURCE: Kaiser Family Foundation's State Health Facts.

Medicaid MCO Quality Ratings (2018)

State	Medicaid MCO	NCQA Accredited	NCQA Overall Plan Rating (0-5)	NCQA Quality Rating: Consumer Experience (0-5)	NCQA Quality Rating: Prevention (0-5)	NCQA Quality Rating: Treatment (0-5)
Mississippi	Magnolia Health Plan	Yes	3	4	2	2
Mississippi	UnitedHealthcare Community Plan	Yes	2.5	4	2	2

Notes: Data reflect NCQA's 2018 ratings of Medicaid managed care plans. The plans included in the NCQA data do not always match the MCOs in other tables in the Medicaid Managed Care Market Tracker, or they may appear under different names. Discrepancies may be due to differences across reports and sources, timeframes, and other factors. MCOs not accredited or rated by NCQA may be accredited or rated by other organizations.

The NCQA plan overall rating scale is 0-5 (0 is lower performance, 5 is higher performance). NCQA accreditation is as of June 30, 2018. For more information about how NCQA rates plans, please see [NCQA's methodology](#).

Sources: [NCQA Health Insurance Plan Ratings 2018-2019 - Summary Report \(Medicaid\)](#). Special Data Request, October 2018.

Source: <https://www.kff.org/medicaid/state-indicator/medicaid-mco-quality-ratings/?currentTimeframe=0&selectedRows=%7B%22medicaid-mcos%22:%7B%22mississippi%22:%7B%22all%22:%7B%7D%7D%7D&sortModel=%7B%22collid%22:%7B%22state%22,%22sort%22:%7B%22asc%22%7D>

HIGHLIGHTS FROM THE KFF MEDICAID MANAGED CARE TRACKER

“Top 5” States: Largest # of MCOs (March 2018)

California	24
New York	24
Texas	19
Florida	17
Wisconsin	16

“Bottom 5” States: Fewest # of MCOs (March 2018)

Delaware	2
Iowa	2
Mississippi*	2
New Hampshire	2
North Dakota	1

*MS now has 3 MCOs operating the MSCAN program.

Source: <https://www.kff.org/medicaid/state-indicator/total-medic-aid-mcos/?currentTimeframe=0&selectedDistributions=total-medic-aid-mcos&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

Total Medicaid Managed Care Enrollment (March 2018)

Mississippi: 457,903

Source: https://www.kff.org/other/state-indicator/total-medic-aid-mco-enrollment/?activeTab=graph¤tTimeframe=0&startTimeframe=6&selectedDistributions=medicaid-mco-enrollment&selectedRows=%7B%22states%22:%7B%22mississippi%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Mar%202017_Medic-aid%20MCO%20Enrollment%22,%22sort%22:%22desc%22%7D

“Top 5” States: Largest % of Medicaid Population in Managed Care (July 1, 2018)

Tennessee	100%
Hawaii	99.9%
Nebraska	99.7%
Delaware	97.0%
Kansas	95.0%
New Jersey	95.0%

“Bottom 5” States: Smallest % of Medicaid Population in Managed Care (July 1, 2018)

Wisconsin	67.0%
Mississippi	65.0%
Massachusetts	43.0%
North Dakota	22.0%
Colorado	10.1%

Source: <https://www.kff.org/medicaid/state-indicator/managed-care-penetration-rates-by-eligibility-group/?activeTab=map¤tTimeframe=0&selectedDistributions=total-population&sortModel=%7B%22colId%22:%22Total%20Population%22,%22sort%22:%22desc%22%7D#note-3>

“Top 5” States: Largest % of MCO Spending in Total Medicaid Spending (FY 2016)

Kansas	88.00%
Delaware	85.20%
Hawaii	82.10%
New Mexico	79.80%
Arizona	72.50%

“Bottom 5” States: Smallest % of MCO Spending in Total Medicaid Spending (FY 2016)

Nebraska	28.70%
Wisconsin	27.30%
Missouri	13.30%
Colorado	5.70%
Wyoming	1.00%

Other States:

Tennessee	64.30%
Mississippi	46.50%

Source: <https://www.kff.org/other/state-indicator/total-medicaid-mco-spending/?activeTab=map¤tTimeframe=0&selectedDistributions=as-a-percent-of-total-medicaid-spending&sortModel=%7B%22colId%22:%22As%20a%20%25%20of%20Total%20Medicaid%20Spending%22,%22sort%22:%22desc%22%7D>

Exhibit __: Medicaid Managed Care Information by State

State	Total MCO Enrollment (March 2017)	Total MCO Enrollment (March 2018)	Change in Medicaid MCO Enrollment (Number)	Change in Medicaid MCO Enrollment (Percent)	Percent of Medicaid Population in a MCO	Total Medicaid MCO Spending (FY 2016) ^s	MCO Spending as a % of Total Medicaid Spending (FY 2016)
Alabama	--	--	--	--	--	\$0	0.00%
Alaska	--	--	--	--	--	\$0	0.00%
Arizona	1,558,147	1,492,542	-65,605	-4.0%	93.0%	\$8,052,145,751	72.50%
Arkansas	--	--	--	--	--	\$0	0.00%
California ¹	10,722,895	10,654,126	-68,769	-1.0%	83.0%	\$39,553,377,985	48.30%
Colorado	108,678	123,084	14,406	13.0%	10.1%	\$450,466,947	5.70%
Connecticut	--	--	--	--	--	\$1,738	0.00%
Delaware ²	NR	197,724	NR	NR	97.0%	\$1,608,877,880	85.20%
D.C.	NR	NR	NR	NR	77.0%	\$959,117,110	34.60%
Florida	3,233,235	3,076,326	-156,909	-5.0%	92.0%	\$14,418,537,911	66.00%
Georgia	1,318,412	1,505,813	187,401	14.0%	83.0%	\$3,600,385,081	36.60%
Hawaii	356,445	359,559	3,114	1.0%	99.9%	\$1,810,835,120	82.10%
Idaho	--	--	--	--	--	(\$1,368,243)	-0.10%
Illinois	1,849,166	1,727,740	-121,426	-7.0%	80.0%	\$8,690,424,652	45.00%
Indiana	1,128,399	919,589	-208,810	-19.0%	84.0%	\$4,021,243,503	38.50%
Iowa	573,001	413,903	-159,098	-28.0%	92.6%	\$1,825,712,004	38.10%
Kansas	NR	395,134	NR	NR	95.0%	\$2,882,134,289	88.00%
Kentucky ³	1,205,548	1,260,100	54,552	5.0%	91.0%	\$6,314,405,637	65.30%
Louisiana	1,466,469	1,479,366	12,897	1.0%	91.2%	\$3,920,822,599	45.40%
Maine	--	--	--	--	--	\$0	0.00%
Maryland	1,157,159	1,200,835	43,676	4.0%	86.0%	\$4,578,840,809	43.70%
Massachusetts ⁴	842,334	769,520	-72,814	-9.0%	43.0%	\$5,599,370,528	32.70%

State	Total MCO Enrollment (March 2017)	Total MCO Enrollment (March 2018)	Change in Medicaid MCO Enrollment (Number)	Change in Medicaid MCO Enrollment (Percent)	Percent of Medicaid Population in a MCO	Total Medicaid MCO Spending (FY 2016) ^a	MCO Spending as a % of Total Medicaid Spending (FY 2016)
Michigan	1,757,412	1,711,910	-45,502	-3.0%	77.6%	\$7,620,780,123	45.10%
Minnesota	784,933	832,210	47,277	6.0%	84.0%	\$4,784,971,548	42.90%
Mississippi	491,661	457,903	-33,758	-7.0%	65.0%	\$2,519,670,607	46.50%
Missouri	485,815	683,328	197,513	41.0%	76.0%	\$1,315,531,229	13.30%
Montana	--	--	--	--	--	(\$671,887)	0.00%
Nebraska	NR	NR	NR	NR	99.7%	\$576,835,446	28.70%
Nevada ⁵	429,087	448,939	19,852	5.0%	79.0%	\$1,363,587,401	40.50%
New Hampshire	NR	NR	NR	NR	73.8%	\$751,180,587	38.00%
New Jersey	NR	NR	NR	NR	95.0%	\$7,851,716,801	54.00%
New Mexico	700,810	669,705	-31,105	-4.0%	90.1%	\$4,280,315,260	79.80%
New York	4,384,686	4,457,129	72,443	2.0%	77.2%	\$29,443,875,001	46.80%
North Carolina	--	--	--	--	--	\$0	0.00%
North Dakota	NR	NR	NR	NR	22.0%	\$84,823,649	30.00%
Ohio	2,420,763	2,378,820	-41,943	-2.0%	89.5%	\$10,622,877,793	48.90%
Oklahoma	--	--	--	--	--	(\$696)	0.00%
Oregon	865,701	845,401	-20,300	-2.0%	93.0%	\$4,674,475,197	55.70%
Pennsylvania	2,287,369	2,334,009	46,640	2.0%	84.6%	\$11,512,969,437	41.80%
Rhode Island	NR	NR	NR	NR	91.0%	\$1,276,485,224	52.70%
South Carolina	770,035	772,937	2,902	0.0%	77.0%	\$2,540,298,603	40.70%
South Dakota	--	--	--	--	--	\$0	0.00%
Tennessee	1,479,756	1,446,478	-33,278	-2.0%	100.0%	\$6,119,439,351	64.30%
Texas	3,518,094 ⁶	3,571,507 ⁷	53,413	2.0%	94.0%	\$17,797,008,456	44.10%
State	Total MCO Enrollment	Total MCO Enrollment	Change in Medicaid	Change in Medicaid	Percent of Medicaid	Total Medicaid MCO Spending	MCO Spending as

	(March 2017)	(March 2018)	MCO Enrollment (Number)	MCO Enrollment (Percent)	Population in a MCO	(FY 2016) ⁸	a % of Total Medicaid Spending (FY 2016)
Utah	NR	NR	NR	NR	80.2%	\$835,187,866	39.00%
Vermont	--	--	--	--	--	\$0	0.00%
Virginia	NR	NR	NR	NR	95.0%	\$3,021,837,108	35.30%
Washington	1,350,336	1,488,092	137,756	10.0%	92.0%	\$5,362,957,560	49.00%
West Virginia	380,100	410,081	29,981	8.0%	80.0%	\$1,268,201,441	34.30%
Wisconsin	753,456	756,807	3,351	0.0%	67.0%	\$2,113,053,709	27.30%
Wyoming	--	--	--	--	--	\$5,803,409	1.00%

1. California data include enrollment in six Health Insuring Organization (HIOs), member plans in California's County Organized Health Systems (COHS).

2. Delaware data reflect July 2018 MCO enrollment.

3. Kentucky data reflect February 2018 MCO enrollment.

4. Massachusetts data reflect September 2017 enrollment.

5. Nevada data reflect June 2017 MCO enrollment.

6. Texas data reflect October 2017 enrollment.

7. Texas data reflect February 2018 enrollment.

8. The data reflect FY 2016 state Medicaid premium payments to managed care organizations (MCOs) providing comprehensive services to Medicaid enrollees, including comprehensive acute care services and, in some cases, long-term services and supports as well. Medicaid premium payments to prepaid ambulatory health plans (PAHP), prepaid inpatient health plans (PIHP), and Programs of All-Inclusive Care for the Elderly (PACE) are not included. Negative managed care spending reflects adjustments to previous periods.

Definitions:

--: State had no Medicaid contracts with MCOs.

NR: Medicaid MCO enrollment data were not reported on the state's Medicaid website.

SOURCE: Henry J Kaiser Family Foundation, Medicaid Managed Care Market Tracker, <https://www.kff.org/state-category/medicaid-chip/medicaid-managed-care-market-tracker/> (accessed on November 8, 2018).

FINDINGS

Tab B

Development of Business Model for Children
with Medical Complexity

October 23, 2018



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MEDICAL CENTER

CMC Affects Both Healthcare Costs and Families in Mississippi; the Current State is Not Sustainable

- Children with Complex Medical Conditions (CMC)¹ are a **significant driver of healthcare costs²**, but Mississippi currently does not have targeted CMC programs in place to enhance patient care and family support while reducing costs.
- Costs for providing care to Children with CMC range from **\$134 - \$320 PMPM²**, but programmatic interventions in other states have yielded **reductions in Medicaid spend by 2.5% - 5%** after one year of implementation

The Issue

More than 2 Million Children with significant chronic and medically complex conditions require intense care management.

While these children comprise only 6 percent of the Medicaid population, they represent 40 percent of the Medicaid spend for children.

- CARE Award program statement

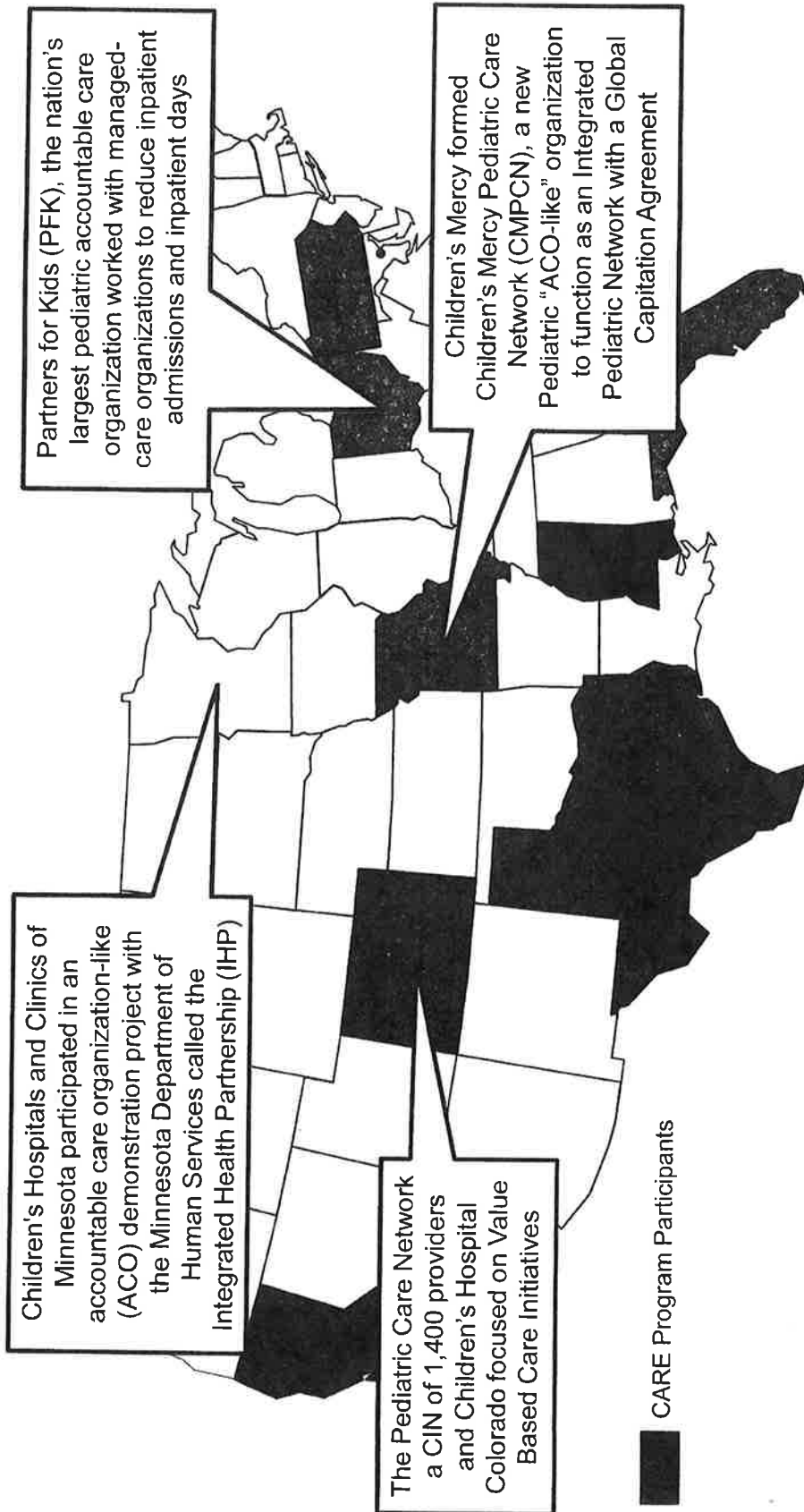
CARE Award: The CARE Award-the largest study of CMC-targeted care delivered in hospital-based complex care clinics at children's hospitals and community-based primary care practices to improve care coordination and ensure a high quality of care across all settings.

<https://www.childrenshospitals.org/care>

1. Children under 18 with a chronic, physical, developmental, behavioral or emotional condition that (1) affects two or more body systems; (2) requires intensive care coordination to avoid excessive hospitalizations or ED visits; or (3) meets the criteria for medical complexity using risk adjustment methodologies.
2. CMC accounts for as much as one-third of health care spending for all children (i.e., ~\$100B) and hospital readmission rates for CMC equal or exceed the rates of elderly Medicare beneficiaries (>20%)
3. The Children's Hospital Association

*PMPM (Per Member Per Month): Applies to a revenue or cost for each enrolled member each month. Often used to describe premiums or capitated payments to providers, but can also refer to the revenue or cost for each enrolled member each month.

What Other States Have Done to Manage CMC Populations, Costs, and Patient/Family Experiences



*ACO (Accountable Care Organization): groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to the Medicare patients they serve through quality based payment models
 *CIN (Clinically Integrated Network): collection of healthcare providers, such as physicians, hospitals, and post-acute care treatment providers, that come together to improve patient care and reduce overall healthcare cost.



UMMC's Pilot Yielded Improvements in Hospital & ED Utilization as Well as Significantly Reduced Average Charges per Patient Among the Study's Cohort

<p>Aims</p> <ul style="list-style-type: none"> • Create a full spectrum care pathway across inpatient, outpatient, and community settings • Identify measurable outcomes to track improvements • Maintain and promote improved communication leveraging technology • Develop care transition plans for complex pediatric patients, then successfully transitioning to adult care as needed 	<p>Major Components</p> <ul style="list-style-type: none"> • Hospital Inpatient Complex Care Service • Palliative Care Service • NICU/PICU • Home Ventilator Service and Clinic • High-Risk Newborn Follow-up Clinic • Jackson Medical Mall Complex Care Clinic <p>Multi-specialty care groups formed to work towards achieving holistic, coordinated care pathways</p>
<p>Conditions</p> <ul style="list-style-type: none"> • Congenital Defects of Systems • Premature Infants and Associated Disorders • Acquired Diseases • Developmental Disorders • Any disease state that requires multiple specialists and a high need for coordinated care over the life span 	<p>Coordination Tools</p> <ul style="list-style-type: none"> • Integrated EPIC procedures • Risk classification & patient flags • Shared patient lists & permanent treatment notations among full care team • Notifications for ED & hospital visits to care team

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Despite additional overhead resources to the Complex Care Clinic, UMMC's reimbursement remained the same for the primary care visit regardless of complexity of care delivered.

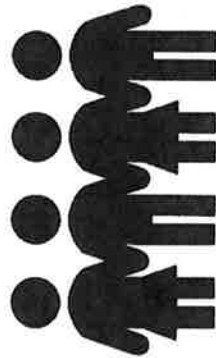


UMMC's Pilot Utilizes Care Teams in Conjunction with Multiple Access Points to Provide Coordinated Care

The UMMC Pilot Program uses Physicians, Case Managers, Social Workers, Dietitians, Nurses, Medical Office Assistants, and Respiratory Therapists to care for the CMC population. Some of the Clinical Resources are minimal compared to the size of the patient population

700+ Patients Limited Clinical Resources 6 Clinical Access Locations

2.5 Physicians	Hospital Inpatient Complex Care Service
1.0 Case Manager	Palliative Care Service
1.0 Social Worker	NICU/PICU
	Home Ventilator Service and Clinic
	High-Risk Newborn Follow-up Clinic
1.0 Clinical Dietitian	Jackson Medical Mall Complex Care Clinic



An Effective Statewide Care Model for Children with CMC Will Integrate the Needs of all Stakeholders

Key Stakeholders Motivations

Medicaid MCOs

- Improve coordination across the care continuum
- Enhance access to reliable and actionable data
- Decrease unnecessary utilization (e.g., hospital days, ED discharges, etc.) through enhanced coordination

Medicaid

- Increase access to care
- Improve quality of care
- A sustainable care model to manage the patient population
- Mitigate the long term cost of care for these patients from first contact to transition age

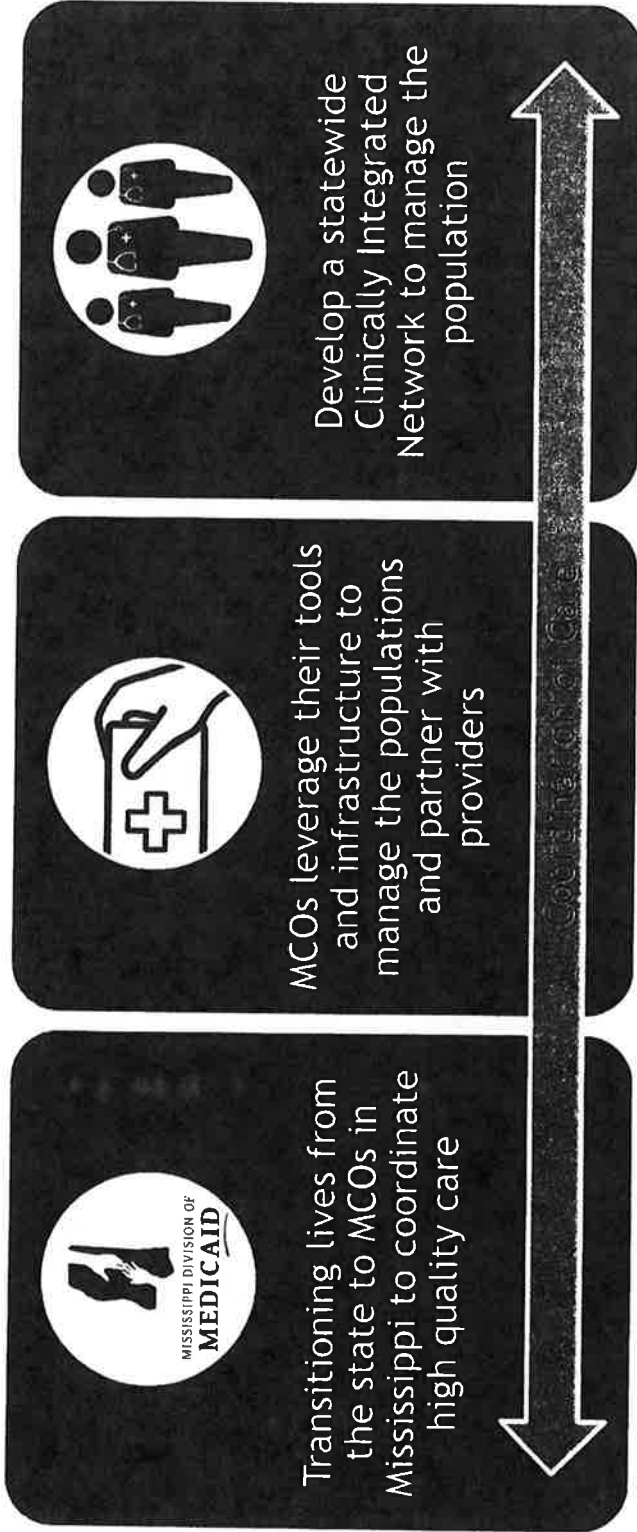
Patients / Families

- Enhance patient experience of care
- Increase care coordination
- Access to more convenient and lower cost care settings (e.g., in-home)
- Decrease caregiver burden

Providers & Associations

- Enhance patient experience of care
- Provide the right care at the right time in the right setting
- Enhance access to reliable and actionable data
- Potential Shared Savings based on improving the care model for patients

Balancing the Stakeholder Needs as we Develop the Conceptual Model



As the MCOs and providers build out the infrastructure and capabilities to manage the care of this population, improved communication, collaboration, and data sharing will improve quality and affordability of care.

Case Study #1 - Children's Hospitals and Clinics of Minnesota (CHC)

Children's Hospitals and Clinics of Minnesota – Minnesota

<p>Goal</p> <ul style="list-style-type: none"> Contract with State Medicaid department to provide health care for ~15k children in Minnesota; <i>Integrated Health Partnership</i> 	<p>Results</p> <ul style="list-style-type: none"> Enhanced care coordination for patients and families Reduced inpatient days rate by 41% for patients attributed to the ACO more than 2 years Reduced costs by 16% for patients attributed to the ACO more than 2 years Reduced ED visits 6% for patients attributed to the ACO more than 2 years
<p>Solution</p> <ul style="list-style-type: none"> Developed an ACO infrastructure around CHC health care homes and patient attribution model¹ Remained at risk for meeting quality and risk-adjusted cost targets (e.g., HEDIS measures) Exempted providers and clinics from any shared savings—if costs were below the target, CHC shared savings equally with the State Medicaid agency 	

1. Attribution models rely on pre-specified rules that determine the specific patients, types of health care services and the duration of care for which providers and organizations are responsible. Attribution of patients to providers is necessary to link indicators of patient-level health care quality and spending to specific providers for the purpose of profiling and accountability.

Case Study #2 - Children's Mercy Pediatric Care Network

Children's Mercy Pediatric Care Network (PCN) – Kansas City

<p>Goal</p> <ul style="list-style-type: none"> • Ensure medical management (e.g., DM and CM) for Kansas City's Medicaid population • Accountable for cost and quality of care for ~85% of the region's Medicaid-covered Children (46 practices and 200 PCPs) 	<p>Results</p> <ul style="list-style-type: none"> • Enhanced provider experience and care coordination; 86% of providers cite a positive impact on patient care in 2016 versus 69% in 2017 • Achieved 14% lower rates of ED visits p/1,000 compared to control totals (584 vs. 679) • Achieved 9% lower rates of Admissions p/1,000 compared to control totals (69 vs. 76) • PMPM (paid medical) show to be 7% lower compared to control groups
<p>Solution</p> <ul style="list-style-type: none"> • Developed an integrated delivery system comprised of a medical home team, Care Navigators, and prior auth. staff • Developed capitated (85k lives) and shared-savings arrangements (15k lives) with Medicaid MCOs • Network providers receive a PMPM payment for engaging in ACO initiatives and additional amounts for quality outcomes they achieve • Developed PCN Provider Portal to provide reliable and actionable real time data to providers 	

Case Study #3 - UCLA Mattel Children's Hospital

UCLA Mattel Children's Hospital - Los Angeles

	Results
<p>Goal</p> <ul style="list-style-type: none"> • Help families of CMC avoid / reduce ED visits • ~300 patients with CMC; 98% (294) of patients covered by Medicaid • UCLA Care Team worked with families to identify issues or diagnoses that would likely lead to a child's decline and require an ED visit • Developed "Access and Contingency Plan" for these issues with steps to take when patient is at baseline (green zone), beginning to deteriorate (yellow zone) or showing severe symptoms (red zone) • Planning is continuous (pre, during, post) • Developed templates for 4-5 most common action plan topics (e.g., respiratory distress, seizures, etc.) <p>Solution</p>	<ul style="list-style-type: none"> • Reduced hospitalizations and ED visits by 50% • Achieved high parental satisfaction; >40% report using their child's action plan in the previous 3 months <p><i>"I brought her into the ER, and they told me she could've gotten worse had I not been on the lookout for these things; I didn't have to admit her, so it's working." – Parent at UCLA Mattel</i></p>

Summary

- Children with CMC are a significant driver of healthcare costs, but Mississippi does not have a targeted statewide model in place to reduce costs
- UMMC is focused on continuous improvement related to CMC, and has piloted a Complex Care Clinic model with some positive improvements in hospital and ED utilization
- Savings generated from a comprehensive statewide model can be reinvested into additional resources (e.g., clinical, data infrastructure, etc.) to support CMC
- Statewide model will not require any additional funding from the State Budget

Immediate Next Steps

- Build out operational and financial conceptual model for input
 - Based on feedback from today's meeting
 - Acquire statewide claims data so all stakeholders can evaluate utilization and spend trends in order to understand the size and scope of the CMC population in Mississippi
- Prepare materials for next Commission meeting to review conceptual model and data analysis

Development of Business Model for Children
with Medical Complexity

November 13, 2018



Today's Agenda:

#	Topic:	Page
I.	Welcome and Agenda	2
II.	Recommended Objective Statement	3
III.	Recap of 10/23 Commission Meeting	4
IV.	Goals of the Commission	5
V.	Case Studies from UMMC's Pilot Program	6
VI.	Working Together	11
VII.	Next Steps	12

Recommended Objective Statement

It is the recommendation of this committee that UMMC work in collaboration with the MCO's to develop a fiscally responsible shared investment/shared savings model that best meets the needs of medically complex children in the State of MS and present to the DOM for evaluation and implementation.

Recap of 10/23 Commission Meeting

On 10/23, the Commission reviewed key health outcomes and financial issues impacting care for children with Complex Medical Conditions (CMC) and their families:

- CMC is a **significant driver of healthcare costs** (6% of Medicaid's children population, representing 40% of Medicaid's children spend)
- **Lower levels of coordinated care and patient / family satisfaction**

Focus of the meeting transitioned to intervention models implemented in other states, including case studies, as well as an existing pilot initiative at UMMC:

- **Intervention Models:** ACOs, CINs and CARE Award Models (e.g., CO, MN, MO, OH)
- **UMMC Pilot Outcomes:** Improvements in IP and ED utilization; reduction in average charge p/patient

The Commission agreed on the need for an effective statewide model in Mississippi that:

1. **Generates savings for reinvestment** into additional resources to support CMC
2. **Requires no additional funding** from the State Budget

Goals of The Commission: Shared Goals Require Collaboration Between all Stakeholders



To provide better overall care for a community in need..

- Improve patient and family satisfaction with care delivery and quality
- Improve access to care
- Reduce the cost of care



...healthcare payers should be aligned...

- Create an infrastructure of care across, and between, MCOs and local providers that has targeted capabilities for managing the care of this population
- Improve communication, collaboration and data sharing



...and the payment model should be transformed.

- Develop a Statewide Payment Model that generates PMPM savings earmarked for reinvestment
- Ensure payment model is budget neutral to the State

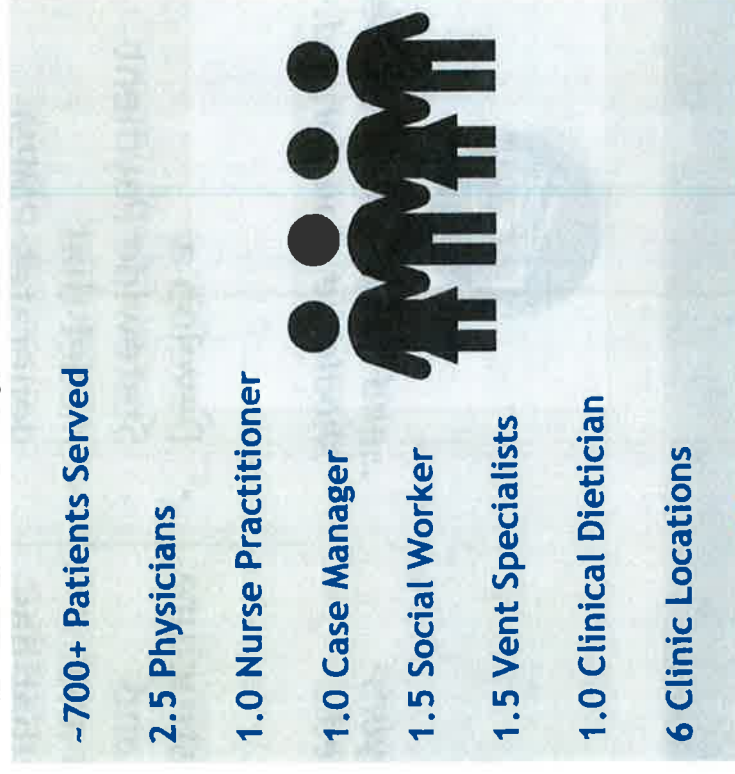
Goals and Objectives

UMMC's Complex Care Pilot Has Resulted in Improved Quality of Life for Patients and Reduced Costs

Four patient case studies have been selected for today's discussion, each resulting in a unique patient outcome (detail provided in slides 6-9):

- I. Johnny - At home care **improved patient health and reduced ED utilization**
- II. Bobby - Deployed Care Team **improved the developmental outlook and reduced hospital readmissions**
- III. Sally -Complex Care Clinic Team developed an **alternative point of contact resulting in improved ability to manage patient needs**
- IV. Jimmy - Integrated multiple specialists into care delivery plan and **improved overall patient health**

UMMC Pilot By the Numbers



Case Studies: Home Care Improved Patient Health and Reduced ED Utilization

The Complex Care Patient Experience - Johnny

Background

- 2 year old male
- Admitted to PICU; chronic lung disease and pulmonary hypertension with an extensive comorbidity list
- Gastrostomy tube dependence
- Stunted growth development

Solution

- Engaged, post discharge, by a multidisciplinary team (complex care NPs and Pulmonology team) tasked with developing a care coordination plan for the patient, including:
- Provided training for home ventilation
 - Referred to dieticians
 - Enrolled in speech and occupational therapy

Results

- Patient achieved improved quality of life scores:
- Gained complete independence from ventilator regimen
 - Enhanced growth development
 - Improved social and regular living ability thanks to speech and occupational therapy
 - Reduced ED utilization

Case Studies: Dedicated Care Team Reduced Rate of Hospital Admissions and Improved Developmental Outcomes

The Complex Care Patient Experience - Bobby

Background

- 2 year old male; ex-27 week premature infant
- History of achondroplasia and chronic lung disease
- Multiple readmissions to the PICU leading to eventual tracheostomy and g-tube insertion; discharged home with oxygen via trach collar

Solution

- Engaged by a Complex Care Team after being re-admitted post discharge with oxygen:
- Provided training for home ventilation and coordination with Home Vent Clinic
 - Initiated physical, occupational, and speech therapy

Results

- Patient's quality of life has improved and the readmissions cycle has been reduced:
- Gained independence to live at home
 - Weaned from daytime ventilation; requires only during sleep cycles
 - Achieved all developmental milestones and can now eat without a feeding tube
 - Required 2 acute illness admissions and 1 ER visit since coming under Complex Care

Case Studies: Alternative Contact Points Reduced Hospitalizations

The Complex Care Patient Experience - Sally

Background

- 15 year old female
- Complex chronic conditions: POT Syndrome, Jarcho-Levin Syndrome, Atrial Flutter, migraines, gastric dysmotility, multiple medication allergies, asthma, vocal cord dysfunction, pre-diabetes, and dysphagia
- Hospitalized 6 times over a 6-month period

Solution

Engaged by a Complex Care Clinic team:

- Provided access and referral to appropriate resources and specialists
- Maintained frequent contact for concerns to reduce ED utilization and readmission
- Initiated additional therapies as needs arose

Results

Patient's quality of life improved and hospitalizations were greatly reduced:

- Decreased number of hospitalizations from 1 every month, to 1 every quarter (over the course of a two-year period)
- Provided a secure messaging platform which increased ability of care team to meet patient needs “on-demand”
- Discontinued the need for home infusions
- Engaged in transitioning to an adult care setting

Case Studies: Integrating Multiple Specialists Improved Overall Patient Health

The Complex Care Patient Experience - Jimmy

Background

- 15 year old male
- Diagnosed with hydrocephalus, Cerebral palsy, and seizures
- Hospitalized and in need of total care home

Solution

Transferred to a Complex Care Clinic:

- Coordinated needed follow-up with neurosurgery
- Initiated an orthopedic check and physical therapy for a hip dislocation
- Coordinated with a nutritionist for evaluation
- Supplied a new bath chair and dressings to treat pressure ulcers

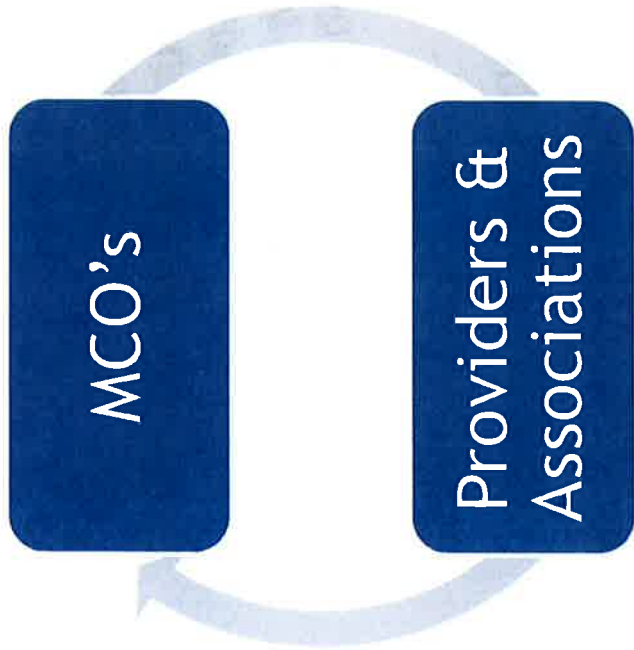
Results

Patient's quality of life improved and she has avoided any readmissions:

- Received a specialty needs car seat and properly fitting wheelchair, reducing discomfort and alleviating the patient's chronic hip issues
- Increased ability to practice activities of daily living
- Improved nutritional mix leading to improvement in overall nutrition

Working Together: Opportunity for MCOs and Providers to Develop a Statewide CMC Model

MCOs, Providers and Associations are **critical** to a successful statewide model, and will need to work collaboratively to deliver a more comprehensive and cost-effective care for this targeted population.



Partner	Asks	Results
MCO's	Payment reimbursement model that aligns provider incentives with the complex care infrastructure they develop	Increase in providers managing patients total cost of care
	Shared data: risk models, financial analytics, patient registries with identifiers for patients needing additional care	Decrease in unnecessary utilization
Providers & Associations	Invest in an infrastructure of care that optimizes clinical, financial and patient experience outcomes	New reimbursement models; quality incentive programs
	Shared data: clinical and administrative (i.e., beyond claims data)	Increased access to technology and analytics

Next Steps:

- Approval for adoption; recommended objective statement:

It is the recommendation of this committee that UMMC work in collaboration with the MCO's to develop a fiscally responsible shared investment/shared savings model that best meets the needs of medically complex children in the State of MS and present to the DOM for evaluation and implementation.

- UMMC to acquire requisite claims data from Division of Medicaid the week of 11/12; will share with Navigant for purposes of analysis
- Next Commission Meeting scheduled for 11/27

FINDINGS

Tab C

PRESCRIPTION DRUGS: COST AND MANAGEMENT

*JUDITH P. CLARK,
PHARMACY CONSULTANT
B.S. PHARMACY, R.PH.*

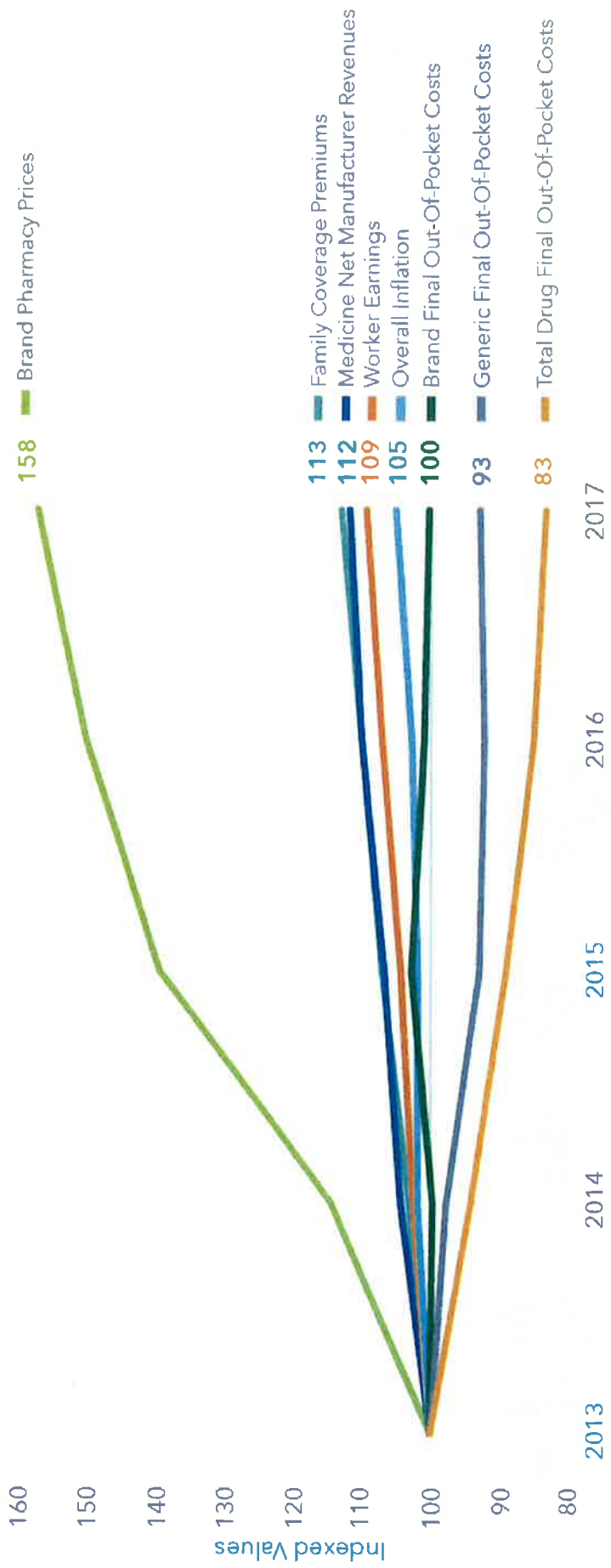


Current issues

- The American economy may be booming and paychecks may be growing, but 1/4 Americans still cannot afford their medications. (*CSRxP*)
- Nine out of ten of the largest drug makers spent 50% more on advertising their products than researching and developing. (*CSRxP*)
- Over the past five years, brand name drug prices have increased at 10 times the rate of inflation.
 - For example: Humira (the world's bestselling drug, commonly used to treat some types of arthritis). Over the last five years, the price of Humira has been raised 12 times, causing a 248 percent price increase. Today, the cost of one prescription is nearing \$40,000. (*Washington Examiner*)
- The unsustainable cost of prescription drugs not only puts pressure on the health care system but increasingly on patients, employers, and providers are faced with high priced medications and now to pay for such.
- Nationally pharmacies are experiencing low reimbursement, drug costs and dispensing fees, and clawbacks or DIR fees for commercial plans. This is threatening the stability of pharmacies which impacts access.



Changes in Healthcare Costs or Cost Drivers 2013-2017, Indexed (2013 Values = 100)



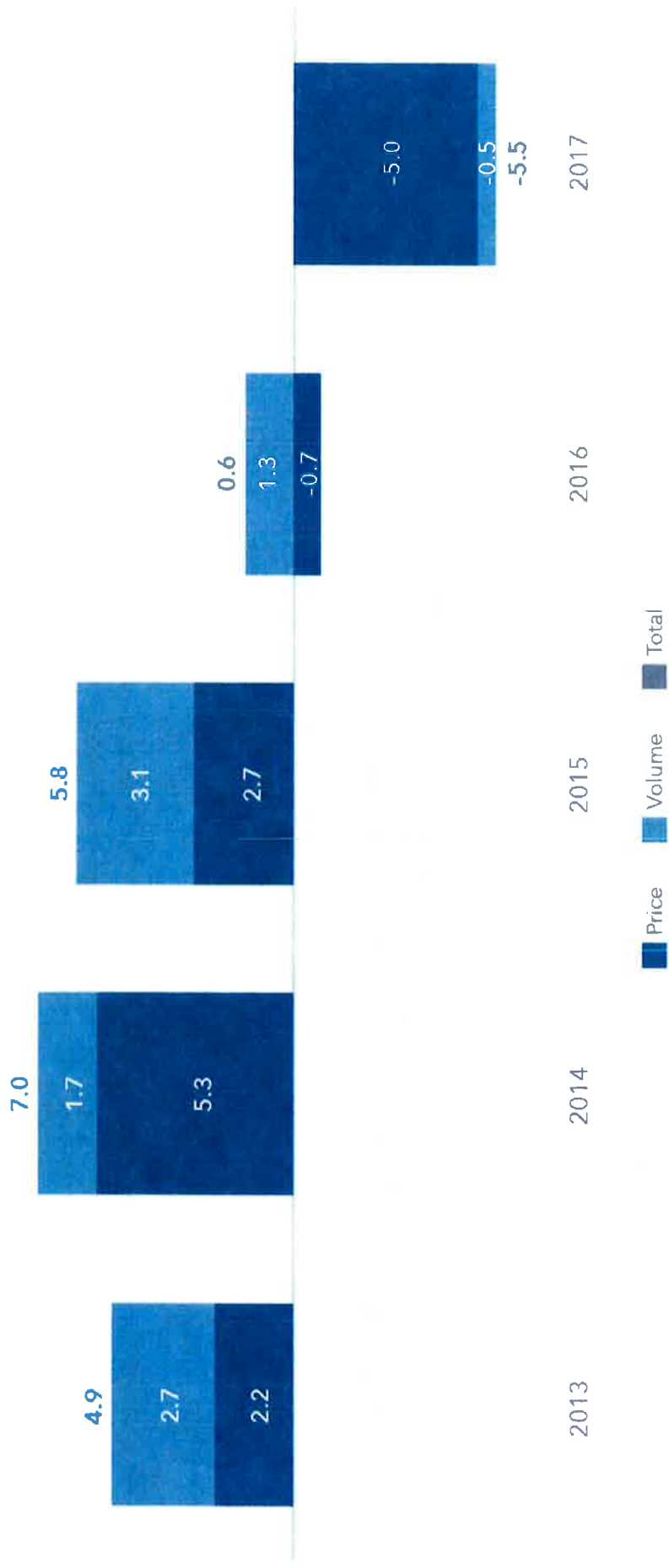
Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2017; IQVIA Formulary Impact Analyzer (FIA), IQVIA Institute, Dec 2017

Chart notes: Indices sourced from Kaiser/HRET Employer Survey⁴ include: family coverage, premiums, workers earnings, overall inflation. Brand, generic and total final out-of-pocket costs and brand pharmacy prices are for commercially insured, Medicare Part D and cash payment types sourced from IQVIA Formulary Impact Analyzer. All charted values are indexed to set their 2013 value equal to 100.

Report: Medicine Use and Spending in the U.S.: A Review of 2017 and Outlook to 2022, Apr 2018



Generic Net Spending Growth US\$Bn

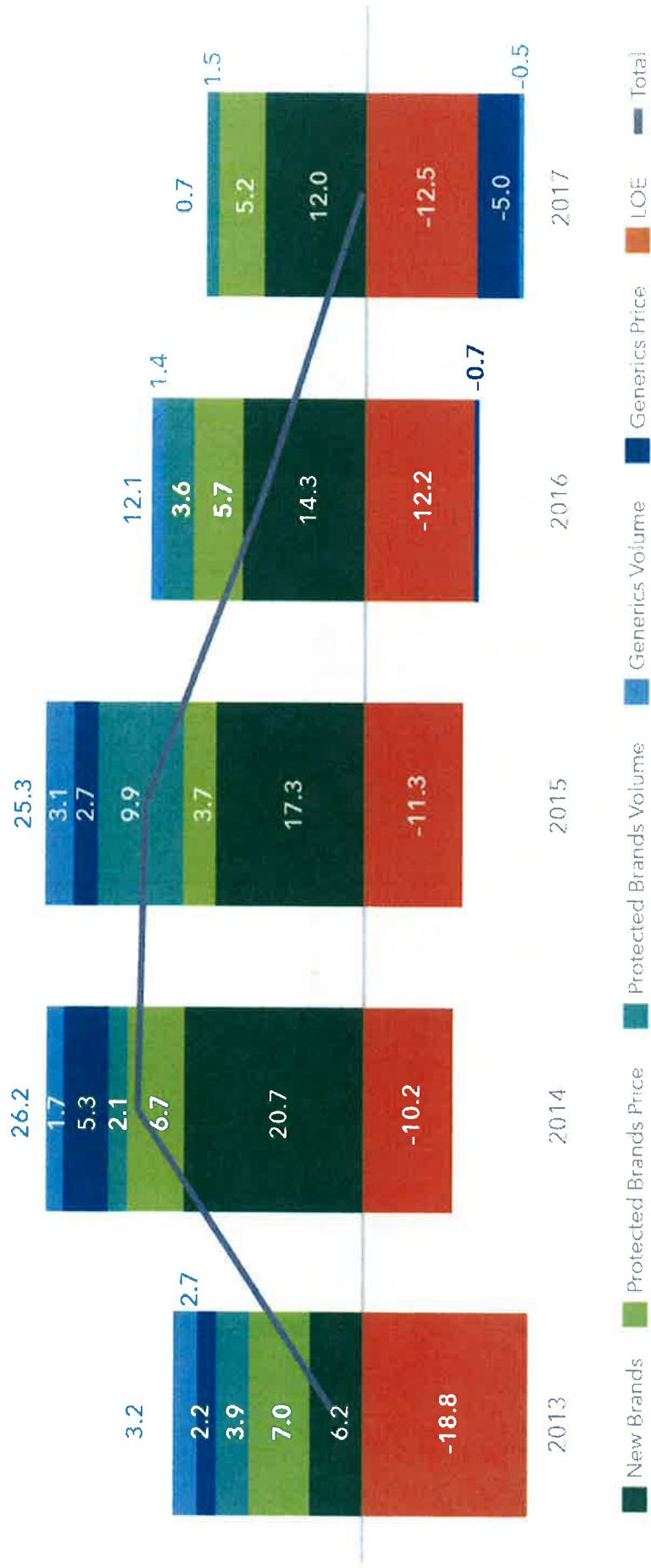


Source: IQVIA National Sales Perspectives, IQVIA Institute, Dec 2017

Chart notes: Generics include both branded and unbranded generics. Price growth is defined as growth due to prices while holding volume constant at the prior year's level. Volume growth is growth due to increased usage as well as changes in the mix of usage of medicines of differing costs where both price and volume changed. Includes all medicines in both pharmacy and institutional settings.

Report: Medicine Use and Spending in the U.S.: A Review of 2017 and Outlook to 2022, Apr 2018

Net Spending Growth by Product Type US\$Bn



Source: IQVIA National Sales Perspectives, IQVIA Institute, Dec 2017

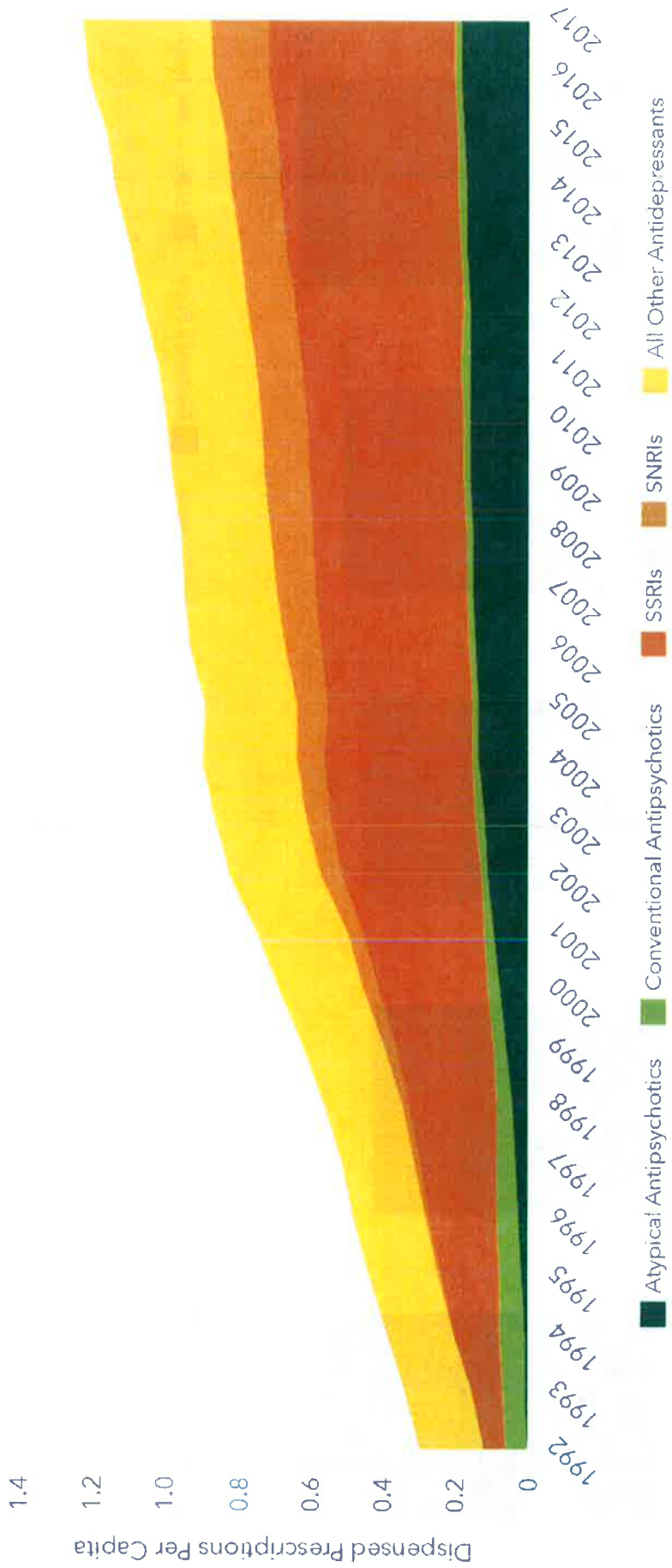
Chart notes: New brands are protected branded products on the market less than 24 months during the year reported. Protected brands are products that are no longer "new" and have yet to reach patent expiry. Loss of Exclusivity (LOE) are brands that were once protected and have since lost patent protection.

Generics include both unbranded and branded generics. All segments are mutually exclusive in each time period. Includes all medicines in both pharmacy and institutional settings. Charted values may not sum due to rounding.

Report: Medicine Use and Spending in the U.S.: A Review of 2017 and Outlook to 2022, Apr 2018



Mental Health Prescriptions per Capita per Year 1992-2017



Source: IQVIA "SMART - Launch Edition", Dec 2017

Chart notes: Therapy areas include medicines used to treat depression and various psychotic diseases. Some medicines are used for more than one disease, and some patients receive multiple medicines. Prescriptions are unadjusted for days supply.

Report: Medicine Use and Spending in the U.S.: A Review of 2017 and Outlook to 2022, Apr 2018



Mississippi Pharmacies

- As of 10-31-18, there are 430 independent pharmacies and 302 chain pharmacies in MS.
- Every county, other than Issaquena, in MS has at least one pharmacy in that county.
- Patients can walk into any retail pharmacy without an appointment and get medical care. Many pharmacies have extended hours, work weekends, or are on call to provide after hour services to their patients.
- Pharmacy services are often the most utilized benefit of a health plan.
- Pharmacies are struggling nationwide due to low reimbursement from commercial plans and Part D.
- National trends
 - chain consolidation, store closures, shorter store hours resulting in less access for patients.
 - erratic generic availabilities and costs
 - cost of brand name drugs with low reimbursement

Techniques used by payers to manage drug costs

- Encourage the use of less expensive therapeutic alternatives
- Case Management
- Copayments or coinsurance changes
- Annual Deductible
- Prior authorization programs
- Drug coverage
 - Commercial-- formulary
 - Medicaid—Preferred Drug Lists

Pharmacy Benefits Managers (PBM)

PBMs are pharmacy benefits managers contracted by companies or insurers to help manage the pharmacy costs for their members. Many PBMs started as claims payers decades ago and have morphed into huge entities. Large PBMs like Express Scripts, CVS Caremark and OptumRX manage the vast majority of prescription claims in the US. (NCPA)

Some PBM management techniques

- Formularies and prior authorization programs;
- Limited pharmacy networks
 - Especially with specialty drugs;
 - MS is an any willing provider state
- Reduced pharmacy reimbursement both for ingredients and dispensing fees;
- Encouraging/mandating the use of mail order pharmacy programs;
- Increasing patient copays or coinsurance;
- Aggressive pharmacy audits by (non-clinical) auditors
 - Including clawbacks or DIR, drug indirect remuneration fees taken from pharmacies



National changes are coming.....

- FDA is approving more generic options at a quicker pace -- 781 generic drugs were approved/FFY 2018. 90% increase from 2014 (*Washington Examiner*)
- Congress recently eliminated gag clauses that prevented pharmacists from advising patients about more affordable medication options. (*NBC News*)
- The Trump Administration moved forward with a proposal requiring pharmaceutical companies to disclose drug prices in direct-to-consumer (DTC) advertising – helping to give patients the information they need to make decision about their healthcare, while also holding industry accountable for the prescription drug prices they set (*CSRxP*)

FINDINGS

Tab D

Commission on Expanding Medicaid Managed Care
 Medical Loss Ratio Reporting



Medical Loss Ratio Reporting for the MississippiCAN Coordinated Care Organizations Since Fiscal Year 2015

Medical Loss Ratio					
Reporting Period	Audited/ Unaudited	Magnolia Health	UnitedHealthcare Community Plan	Combined	National Comparison (A)
July 2014 – June 2015	Audited	89.5%	92.3%	90.7%	90.2%
July 2015 – Dec. 2015	Audited	90.8%	95.4%	93.0%	90.2%
Jan. 2016 – Dec. 2016	Audited	94.1%	95.4%	94.7%	91.9%
Jan. 2017 – June 2017	Audited	94.4%	93.9%	94.2%	91.9%
July 2017 – June 2018	Unaudited	96.4%	95.8%	96.1%	N/A

The Medical Loss Ratio's reported here include allowable expenses for Health Care Quality Improvements and Health Information Technology as per the MSCAN CCO Contracts.

(A) Milliman Medicaid Managed Care Results Reporting for Calendar Year's 2015, 2016 and 2017, CMS National MLR Calculation.

Note: The Milliman Annual Managed Care Report includes states that would have Long Term Services and Supports included in their MLR (higher MLR's) and expansion states (with typically lower MLR's).



Magnolia Health

CentAccount

Magnolia's member rewards program, CentAccount®, offers financial rewards for activities such as EPSDT services, preventive care and appropriate use of health care services.

Magnolia Works

A workforce development and employment support resource program developed by Magnolia to address employment barriers among its members.

Corporate Sponsor for Summer Food Service Program

Magnolia serves as a Corporate Sponsor for this program which provides breakfast and lunch for preschool and school aged children during the summer months. The program has provided over 3 million meals at 500 sites in Mississippi communities.

Molina Healthcare

HealthinHand Mobile Application

Through the HealthinHand mobile application, Molina members are able to view upcoming appointments, schedule transportation, needed immunizations or screenings, and access a wealth of health education material in those areas that matter the most.

Nurse Advice Line

Whether its ongoing meetings with their care managers, Molina provides its members with access to an expertly trained Nurse Advice Line (NAL), as well as a Behavioral Health hotline, interactions with its member services team through both inbound and outbound calls and visits from its Community Connectors to supplement its care management.

Incentive Programs

Molina also offer several strategically targeted value added benefits for its members including expanded office visits, vision, and incentive programs for achieving prenatal care, disease management, weight loss, and smoking cessation milestones.

UnitedHealthcare Community Plan

Farm to Fork

UnitedHealthcare's Farm to Fork program, a partnership with the Alcorn State University Extension Service, which provides farm-fresh vegetables to low-income individuals across the state, has served approximately 16,000 members since the partnership began in 2013.

Fre\$h Savings

The Fre\$h Savings program helps Mississippi Supplemental Nutrition Assistance Program (SNAP) recipients purchase more fresh produce at participating Kroger grocery stores and farmers markets. This AARP Foundation program, in partnership with UnitedHealthcare, USDA and Kroger, incentivizes members to buy more fruits and vegetables.

Kids Fitness Road Tour

UnitedHealthcare's innovative Kids Fitness Road Tour is one of the most creative ways that we encourage participation in health education activities.

In 2016:

- Fun Day at the Club educated 300 Boys and Girls Club youth and completed 35 wellness exams.
- KidzJam included door-to-door community outreach to more than 75 community members and completed over 20 wellness exams on-site.
- Statewide Clinic Days educated over 100 youth and provided full wellness exams.
- Parents and Kids Fitness Fest educated over 1,000 community members.



MississippiCAN Comparison Chart

You can pick a health plan that is right for you!
Use the chart below to compare your existing Medicaid benefits with the new coordinated Care program offered by Medicaid.

Benefits and Services	Mississippi Medicaid	Magnolia Health MississippiCAN	Molina Healthcare MississippiCAN	UnitedHealthcare MississippiCAN
Co-Pays	Co-pays \$3.00 Co-pay 12 per year	No Co-pay	No Co-pay	No Co-pay
Office Visits	(EPSDT-eligible beneficiaries are eligible for more visits if determined to be medically necessary) Unlimited	Unlimited	Unlimited	Unlimited
Hospital Outpatient Visits (ER Visits)	Unlimited	Unlimited	Unlimited	Unlimited
Prescription Drugs	\$3.00 Co-pay 3 per month (EPSDT-eligible beneficiaries are eligible for more visits if determined to be medically necessary) 72 hour supply of emergency drugs	(EPSDT-eligible beneficiaries are eligible for more prescriptions if determined to be medically necessary) 6 per month 72 hour supply of emergency drugs	(EPSDT-eligible beneficiaries are eligible for more prescriptions if determined to be medically necessary) 5 per month	(EPSDT-eligible beneficiaries are eligible for more prescriptions if determined to be medically necessary) 5 per month 3 days of emergency supply available, if needed
Vision Care	1 pair every 5 years (non-EPSDT-eligible beneficiaries) 2 pair per year (EPSDT-eligible beneficiaries are eligible for more services if determined to be medically necessary)	1 eye exam per year and 1 pair of eye glasses EVERY year (non-EPSDT-eligible beneficiaries) 2 eye exams per year and 2 pair of eye glasses per year (EPSDT-eligible beneficiaries are eligible for more services if determined to be medically necessary)	4 eye exam per year and 1 pair of eye glasses EVERY calendar year beginning Jan 1 (non-EPSDT-eligible beneficiaries) 2 eye exams per year and 2 pair of eye glasses EVERY calendar year (beginning Jan 1) for members under 21. In addition to standard coverage an extra \$100 is provided for frames and lenses. (EPSDT-eligible beneficiaries are eligible for more services if determined to be medically necessary)	1 eye exam every year and 1 pair of glasses EVERY 3 years (non-EPSDT-eligible beneficiaries) 2 eye exams per year and 2 pair of eye glasses EVERY year for members under 21. (EPSDT-eligible beneficiaries are eligible for more services if determined to be medically necessary)
Dental Care	\$3.00 Co-pay 4 Limited Oral Evaluations (non-EPSDT-eligible beneficiaries) 2 Comprehensive Evaluation 4 Limited Oral Evaluations (\$2500/annual limit) (EPSDT-eligible beneficiaries are eligible for more services if determined to be medically necessary)	4 Limited Oral Evaluations (non-EPSDT-eligible beneficiaries) 2 Comprehensive Evaluations 4 Limited Oral Evaluations (\$2500/annual limit) Dental Fluoride Varnish (EPSDT-eligible beneficiaries are eligible for more services if determined to be medically necessary)	4 Limited Oral Evaluations (non-EPSDT-eligible beneficiaries) 2 Comprehensive Evaluation 4 Limited Oral Evaluations (\$2500/annual limit) (EPSDT-eligible beneficiaries are eligible for more services if determined to be medically necessary)	4 Limited Oral Evaluations (non-EPSDT-eligible beneficiaries) 2 Comprehensive Evaluations 4 Limited Oral Evaluations (\$2500/annual limit) Dental Fluoride Varnish (EPSDT-eligible beneficiaries are eligible for more services if determined to be medically necessary)
Behavioral Health Services	YES	Will cover all services currently covered by Mississippi Medicaid	Will cover all services currently covered by Mississippi Medicaid	Will cover all services currently covered by Mississippi Medicaid
Home Health Services	25 visits per year (EPSDT-eligible beneficiaries are eligible for more visits if determined to be medically necessary)	25 visits per year (EPSDT-eligible beneficiaries are eligible for more visits if determined to be medically necessary)	25 visits per year (EPSDT-eligible beneficiaries are eligible for more visits if determined to be medically necessary)	25 visits per year (EPSDT-eligible beneficiaries are eligible for more visits if determined to be medically necessary)

Effective 10.1.2018

Revised 06.01.2018

Benefits and Services	Mississippi Medicaid	Magnolia Health MississippiCAN	Molina Healthcare MississippiCAN	UnitedHealthcare MississippiCAN
<p>Reward Program</p>	<p>NO</p>	<ul style="list-style-type: none"> Reward for completing healthy activities are loaded onto your CentAccount® rewards card. You can use your card to buy hundreds of items like groceries, over-the-counter medicines, baby care items and personal care items. Access to a FREE cell phone program for high risk members Start Smart for Your Baby® showers for expectant mothers and Diaper Days for new mothers and their infants. 	<p>Prenatal Care – During pregnancy, visit your OB/GYN for regular exams and receive a car seat.</p> <p>Postpartum Care – After giving birth, visit your doctor as directed and get a \$25 gift card.</p> <p>Well Child/Well Adolescent Care – Take kids ages 1-3 and 12-13 to scheduled checkups to receive a \$25 gift card. Kids ages 4-11 receive a bike helmet or First Aid Only child ID kit.</p> <p>Healthy Behaviors – Pregnant moms who connect with Primary Care or Health Home providers as scheduled get a \$25 gift card.</p> <p>Mammograms – If you qualify, get a \$25 gift card for receiving mammogram services as recommended.</p> <p>Diabetic Treatment – Get your yearly diabetic retinal eye exam and lab work and get a \$25 gift card.</p> <p>No-cost Cell Phone – Get a smartphone to use 24/7 that allows communication with Molina care managers, access to transportation and community organizations, our Health in Hand app for access to covered services and appointment reminders, and more.</p> <p>Farm to Table – Molina distributes fresh vegetables to our members through local churches and community organizations.</p>	<ul style="list-style-type: none"> BabyBlocks™ program supports moms throughout pregnancy and baby's first 15 months of life. <ul style="list-style-type: none"> \$20 Gift Card for signing up. Includes additional Baby Care Rewards for completing scheduled prenatal, postpartum and well-child doctor visits. Community Baby Showers provide expectant moms with important prenatal and well-baby care resources and information. Wellness Reward Program provides a FREE Prepaid Mastercard® Gift Card when selected preventive health and medical screening exams are completed. <ul style="list-style-type: none"> \$25 for eligible EPST exams ages 5-18 \$25 Diabetic Eye exams for ages 18-75 \$25 for Cervical Cancer/TAP exam ages 21-64 \$50 Breast Cancer Exams ages 50-74 Farm-to-Fork provides FREE fresh vegetables May through September. Exclusive Access to KidzHealth® Online Resource Center for healthy advice, videos, tips and much more. Referral Program for FREE cell phone services.
<p>24 Hour Nurse Advice Line</p>	<p>NO</p>	<p>YES</p>	<p>YES</p>	<p>YES</p>
<p>Disease/Care Management</p>	<p>NO</p>	<ul style="list-style-type: none"> Start Smart for your Health®, and Disease Management programs help members with chronic illnesses, complex conditions, disabilities, weight loss and more, manage and improve their health. Start Smart for your Baby® is a program for expecting and new mothers. Quarterly baby showers are held throughout the state where expecting and new mothers can receive information about having a healthy pregnancy, postpartum care and infant care. Personal Care Managers available in clinics, available for home visits and available telephonically for education and coaching. 	<ul style="list-style-type: none"> Pregnancy Program: To help high-risk mothers avoid premature birth, this program provides tools for a healthier pregnancy and baby. Smoking Cessation: We provide access to over-the-counter tobacco cessation products. Weight Watchers™: Molina will enroll eligible members with up to 10 weeks of online Weight Watchers service vouchers. Community Connectors: These community health workers assist in navigating the healthcare system and accessing community-based programs that promote healthy development, independent living, and physical and mental well-being for members with chronic illnesses. Personal Care Managers available in Clinics 	<ul style="list-style-type: none"> Disease Management Program If you have one of the following problems: Diabetes, Asthma, COPD, Heart Disease, or Heart Failure. Healthy First Steps Program is available for expecting and new mothers to receive ongoing maternal health education, care coordination and community resources. Practitioner Care Managers available in clinics. Complex Case Management Program: RN Case Managers and Community Health Workers are available for home visits and telephonic care management to members.
<p>Non-Emergency Transportation</p>	<p>Provides travel to and from Medicaid covered non-emergency services.</p>	<p>Provides travel to and from Medicaid covered non-emergency services.</p>	<p>Provides travel to and from Medicaid covered non-emergency services</p>	<p>Provides travel to and from Medicaid covered non-emergency services.</p>
<p>Outpatient Hospital Services</p>	<p>YES</p>	<p>YES</p>	<p>YES</p>	<p>YES</p>
<p>Inpatient Hospital Services</p>	<p>YES</p>	<p>YES</p>	<p>YES</p>	<p>YES</p>

Effective 10.1.2018

Revised 06.01.2018

FINDINGS

Tab E



MISSISSIPPI INSURANCE DEPARTMENT

MIKE CHANEY
Commissioner of Insurance
State Fire Marshal

J. MARK HAIRE
Deputy Commissioner of Insurance

501 N. WEST STREET, SUITE 1001
WOOLFOLK BUILDING
JACKSON, MISSISSIPPI 39201
www.mid.ms.gov

MAILING ADDRESS
Post Office Box 79
Jackson, Mississippi 39205-0079
TELEPHONE: (601) 359-3569
FAX: (601) 359-2474
WATS: 1-800-562-2957 (Incoming-USA)

October 9, 2018

Impact of Medicaid Expansion in Mississippi

This document outlines high level considerations around the expansion of Medicaid in Mississippi.

Mississippi is one of the most impoverished states. Approximately one fourth of the population is currently eligible for Medicaid without an expansion.

Exchange Background

The Affordable Care Act (ACA) was intended to work in a cohesive manner with the expansion of Medicaid, with the ACA subsidies being offered at 133% of the Federal Poverty Level (FPL), and with Medicaid being available to those under this threshold. In this way, the ACA was intended to bring affordable coverage to all Americans.

Many states elected not to expand Medicaid in the wake of the June 28, 2012 U.S. Supreme Court ruling. According to the Kaiser Family Foundation, as of September 11, 2018, 34 states (including DC) have expanded Medicaid, 3 are considering, and 14 have not adopted the expansion. For these states, the ACA provides subsidies down to 100% FPL, instead of 133%.

For Mississippi, combining our impoverishment with this wide range of FPL available for subsidies translates into the state having the highest percent of members who receive Cost Sharing Reduction (CSR) subsidies on the Exchange for those between 100% and 250% FPL, and the highest percentage of ACA members receiving the Advanced Premium Tax Credit (APTC) subsidy for those between 100% and 400% FPL.

Impact of Medicaid Expansion on the Individual ACA market

Expanding Medicaid would change the subsidy arrangement on the Exchange, moving the threshold for qualifying up to 133% FPL. As a result, virtually all of the membership in the 100%-133% FPL range would move to Medicaid.

Determining the exact impact of this move is difficult to quantify. However, a significant portion of the On Exchange membership would move. According to the 2017 Open Enrollment report from CMS, approximately 55% of the Exchange membership is in the 100%-150% FPL. A significant portion of these perhaps half-would move out of the ACA block. This would reduce overall Exchange membership by perhaps one-fourth to one-third.

The impact to overall ACA rates would likely be a reduction. Morbidity tends to increase with decreasing income levels, and the members in the lowest income tier (100%-133% FPL) likely have the highest utilization and underlying health conditions. Their absence from the risk pool would decrease the overall market risk, and as a result, would directly work to reduce individual premiums. A more precise estimate of rating impact is very difficult to estimate.

FINDINGS

Tab F

October 5, 2018

Senator Brice Wiggins
Commission on Managed Care

RE: Summary for Presentation – Related to Nursing Homes

Dear Senator Wiggins,

Mississippi in general is a very rural state and many SNF facilities are in small communities. More often than not, they are 60 bed units. Every county, except Issaquena, has at least one nursing home. A major concern to our industry would be the removal of resident choice and access to a community nursing home under a managed care model.

Note that for a citizen to admit to a nursing facility, the person must meet certain criteria and be certified by a doctor for nursing home placement. Therefore, we currently have check and balance to our industry.

- | | | | |
|---|-----------------|---|------------|
| ➤ | Passar | ➤ | 317 |
| ➤ | Doctor's orders | ➤ | Reapproval |

With the current tools, the industry has appropriate screening options along with home and community based services. For the year 2016 64% of admits to nursing homes were non-ambulant. Nursing facilities have moved away from board and care models.

As many SNF's are located in small communities, they allow patients to remain near family and loved ones. Not to mention the jobs and tax base for rural areas this is currently providing. Should access become an issue, a person would be required to travel greater distance for services. This would not be a positive outcome for elderly persons or their family members.

By way of quick history, during 2013 and 2014 nursing homes and the Division of Medicaid met to make adjustments to the payment model and agreed to a cost neutral realignment. Therefore, from state fiscal year 2013 to fiscal year 2017, the inflation to the nursing facility budget has been 5%. That's an average of 1% per year. This should verify the industry is stable, yet the addition of a middle man or managed approach would either cost more or damage a stable system.

Currently Medicaid residents have the choice of which nursing home best suits their need as to location and service. If choice were to be restricted, the industry would no longer be on solid footing.

Sincerely,

Bobby L. Beebe
Mississippi Healthcare Association

FINDINGS

Tab G

Region 8

MENTAL HEALTH



EXECUTIVE DIRECTOR

Dave Van
613 Marquette Road
PO Box 88
Brandon, MS 39043
P - (601) 824-0342
F - (601) 824-0349

COMMISSIONERS

Steve Amos - Copeiah
Tillmon Bishop - Lincoln
Melvin Ray - Madison
Jason Womack - Rankin
Clifton Reed - Simpson

SERVICE PROGRAMS

Copeiah County
PO Box 728
Hazlehurst, MS 39083

Lincoln County
620 Hwy 51 North
Brookhaven, MS 39601

Madison County
PO Box 526
Canton, MS 39046

Rankin County
PO Box 88
Brandon, MS 39043

Simpson County
PO Box 578
Mendenhall, MS 39114

Alcohol & Drug Services
PO Box 88
Brandon, MS 39043

Intellectual and
Developmental Disabilities
PO Box 88
Brandon, MS 39043

October 9, 2018

Chairman Brice Wiggins
Managed Care Commission
PO Box 1018
Jackson, MS 39215

Chairman Wiggins,

I would like to respectfully submit the attached one page document with my remarks addressing the topics that the Managed Care Commission has been charged with evaluating.

Thank you for volunteering to Chair the Commission and your leadership as we work to accomplish our assigned task. Please feel free to contact me with any questions you may have regarding my feedback or if I can ever be of any assistance to you.

Sincerely,

A handwritten signature in black ink that reads 'Dave Van'.

Dave Van

MENTAL HEALTH – Dave Van
COMMISSION ON EXPANDING MEDICAID MANAGED CARE
October 9, 2018

(ii) *Review the program's product offerings:*

In addition to the health care services offered by Medicaid, the CAN providers also offer additional benefits not available to Medicaid beneficiaries that are aimed at promoting healthy choices, improving population health and decreasing the overall cost of the program. This is particularly beneficial to Behavioral Health beneficiaries that can have a history of non-compliance with treatment, minimal resources and complex co-morbidity issues.

- Care Managers, prepaid health reward cards for completing preventative health screenings and wellness exams, 24-hour nurse lines to assist with health questions and scheduling doctor's appointments.

(iii) *Review the program's impact on insurance premiums for individuals and small business:*

In a managed care capitated model if the capitated rate paid to CAN providers is too low then it provides incentives for the CAN to seek out healthier beneficiaries and contain costs by restricting access to needed services. It can also have a negative impact on providers that are willing to accept managed care contracts and serve their beneficiaries. In this scenario, when there is a lack of providers for vulnerable/high cost patients and they cannot access the care they need then they end up in emergency rooms and urgent care clinics. This drives up the overall healthcare costs for the entire system. Providers then must make up for this additional cost by charging higher rates to other insurance sources which would increase premiums and make it even more difficult for small businesses to provide affordable health insurance to their employees.

(iv) *Make recommendations for future managed care program modifications:*

Even with the additional benefits and cost savings of the CAN program, providers have issues dealing with the inconsistencies between the different CAN providers. Variations exist between DOM and each of the CAN providers related to prior authorizations for certain services, post-payment reviews, medical necessity determinations, payment processes and the regulations that healthcare providers are expected to comply with. The CAN providers should be required to only impose regulations and processes that are no more burdensome on the providers and beneficiaries than those imposed by DOM. This is extremely important now that a third CAN provider is in place and will be even more important if any others are added in the future.

(v) *Determine whether the expansion of the Medicaid managed care program may endanger the access to care by vulnerable patients:*

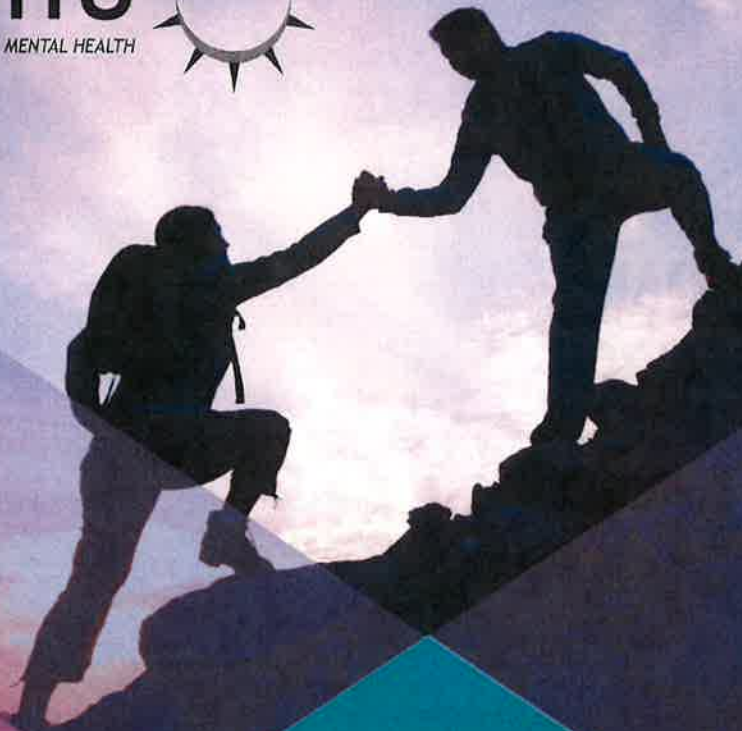
CAN providers are working on a capitated budget and their profitability is based off of having a sufficient number of beneficiaries to address the risks of high-cost patients. If there is an expansion of CAN providers then there will need to be an expansion of beneficiaries. Otherwise the CAN providers will have to take cost-cutting measures to sustain profitability which usually entails limiting access to services for the higher-cost more vulnerable populations. These types of cuts have a significant impact on Behavioral Health beneficiaries that have more intense needs than the general population.

(vi) *Make recommendations regarding a pilot program to evaluate an alternative managed care payment model for behavioral health:*

One model would be an integrated care pilot program that focused on improving the overall health outcomes of the Behavioral Health population with a single healthcare provider being responsible for the primary care and behavioral healthcare needs of each individual. The provider would be paid on a per member per month basis with additional incentives based on the cost savings experienced by the CAN program. Studies show that individuals with a Behavioral Health diagnosis have significant co-morbidity issues. Due to their behavioral health diagnosis and lack of resources, significant medical issues such as diabetes, hypertension, and high blood pressure often go untreated and their life expectancy is 25 years less than the general population.

Region 8

MENTAL HEALTH



ANNUAL REPORT

FY2017

RESTORATION

INTEGRATION

TREATMENT





EXECUTIVE SUMMARY

This year marked 41 years of service for Region 8 Mental Health. Our dedicated staff have done a fantastic job strengthening and expanding our programs to better meet the demands and desires of individuals with behavioral health needs in our communities.

As I reflect over the year, a few highlights from 2017 come to mind. Community Living and Intellectual and Developmental Disabilities Supported Employment services were expanded throughout Region 8's catchment area. The Competency Restoration Project developed by Region 8 and Mississippi State Hospital was implemented to provide relief for the legal system and just opportunity for those in need of competency services. A Prior Authorization Department was implemented to ensure individuals have access to the medically necessary services available. Region 8 decreased commitments to Mississippi State Hospital by 47% between FY2016 and FY2017. In addition, the Brookhaven Crisis Center served over 400 individuals, an 8% increase from 2016, and at the same time diverted over 96% of those individuals from the Mississippi State Hospital.

Our goal at Region 8 is to continue meeting the behavioral health care needs of each individual in our communities through the collaborative efforts of Region 8's professional staff and local, State, and Federal partners. Working together is what makes success stories for many individuals that visit Region 8. Without partnerships of local hospitals, physicians, law enforcement, and government agencies, the road to recovery would be longer and possibilities would be limited. I thank each of these organizations for their tireless efforts in working with Region 8 to ensure the needs of individuals with mental illness are met efficiently and effectively.

It is our desire to believe that every child can grow up to be a healthy, well-functioning adult, every person can live life to its fullest potential and every family can access affordable, behavioral health care. I believe that Region 8 strives to make this possible.

I thank you for every opportunity that Region 8 has to offer its compassionate service to assist those in need. We have a strong commitment to our communities and consumers. I look forward to working with our dedicated Board of Commissioners and faithful staff as we continue this journey to meet every need possible of those served at Region 8.

Warmly,

Dave Van



COMMISSIONERS OF REGION 8

Steve Amos

Copiah County Commissioner

Mr. Amos was born in Copiah County. He attended Copiah Lincoln Community College where he received his Associate of Arts Degree and currently serves on the Board of Trustees there. Later, he earned a Bachelor's Degree in Business Administration from the University of Southern Mississippi. Mr. Amos was elected to Public Office in Copiah County beginning January 1980 as Tax Assessor / Collector and elected to Chancery Clerk, his current position, in 1988. Mr. Amos enjoys hunting, fishing, and golfing. He is an active member of First Presbyterian Church in Hazlehurst.

Tillmon Bishop

Lincoln County Commissioner

Mr. Bishop received his Bachelor of Science Degree in Business/Finance from Mississippi State University. Mr. Bishop was a former Vice President of Trustmark Bank in the area of Corporate/Retail Lending. He also served as Executive Vice President of the Brookhaven/Lincoln County Chamber of Commerce – Industrial Development Foundation. He has been former President of Lincoln County United Way, Brookhaven Kiwanis Club, Copiah-Lincoln Community College Alumni Association and former President of the Mississippi Chancery Clerks Association. He is currently serving his fifth term as Chancery Clerk for Lincoln County. He is an active member of Heucks Retreat Baptist Church. He is also current President of the State Mental Health Commission.

Melvin Ray

Madison County Commissioner

Mr. Ray holds two Master's Degrees: Business Administration from the University of Alabama and School Administration from Mississippi College. Although currently retired, Mr. Ray held the position of Superintendent of Education for the Madison County School District from 1985 to 1995. He taught the Mississippi Alcohol Safety Education Program (MASEP) administered through Mississippi State University for over 30 years. He served as past president of the Canton Lions Club, past president of Canton Dixie Youth Baseball, Vice President of the Madison County Human Resource Agency, President of the 4-H Club, Advisory Council and a member of the MASA, MASS, and ASCB. He served as president to the State Mental Health Commission. Mr. Ray is an active member of the First Baptist Church of Canton where he serves as a Sunday school teacher and deacon.

Jason Womack

Rankin County Commissioner

Mr. Womack was born in Laurel, Mississippi and raised in Rankin County, Mississippi. A graduate of Brandon High School, he received his B.A. in Business Administration from Mississippi College in 1988 and his Juris Doctorate degree in 1991 from Mississippi College School of Law. Mr. Womack is a practicing attorney in Rankin County and also shares business interests with his father in Hinds, Rankin and Scott Counties. He resides with his family in the Reservoir area of Rankin County and is an active member of Pinelake Baptist Church.

Clifton Reed

Simpson County Commissioner

Mr. Reed received a Bachelor of Science in Health and Social Services from Mississippi State University and a Masters in Counseling and Administration from the University of Southern Mississippi. He has served as president of the State Mental Health Commission. Mr. Reed is retired after serving in the field of education as a coach, teacher, counselor, principal, and Superintendent of Education. He is also a retired member of the Mississippi National Guard. He is an active member of the First United Methodist Church in Magee, Mississippi.



SERVICES

MENTAL HEALTH SERVICES

- Community Support Services
- Individual, Family, and Group Therapy
- Psychological Evaluation
- Children's Day Treatment
- Community Outreach Services
- Psychosocial Rehabilitation Services
- Supported Living Program
- Supervised Living Program
- Medical Services
- MAP Team / Interagency Council
- Consultation and Education Services
- Family & Consumer Education Support
- Employee Assistance Program
- School-Based Nursing Services
- Supported Employment
- Competency Restoration

INTELLECTUAL/DEVELOPMENTAL DISABILITIES SERVICES

- Community Support Services
- Prevocational & Work Activity Services
- Supported Employment
- Transition Services
- Employee Assistance Program
- Job Discovery
- Day Service Adult / Day Habilitation
- Supervised Living Program
- Supported Living Program
- Shared Supported Living

CRISIS SERVICES

- Emergency Services
- Mobile Crisis Response Services
- Intensive Crisis Intervention
- Suicide Intervention
- Youth Court Crisis Specialist Program
- Crisis Residential Services

SUBSTANCE ABUSE SERVICES

- Intensive Outpatient Treatment Program (Adult & Children)
- Residential Treatment Program
- Family Therapy
- Substance Abuse Prevention Services
- Recovery Support Services
- Employee Assistance Program
- Family Drug Court
- Youth Drug Court

**MOBILE
CRISIS
HOTLINE**

1-877-657-4098

INTEGRATION

Copiah County

1019 Carroll Drive
Hazlehurst, MS 39083
601-894-2018

Lincoln County

620 Highway 51 North
Brookhaven, MS 39601
601-823-2345

Madison County

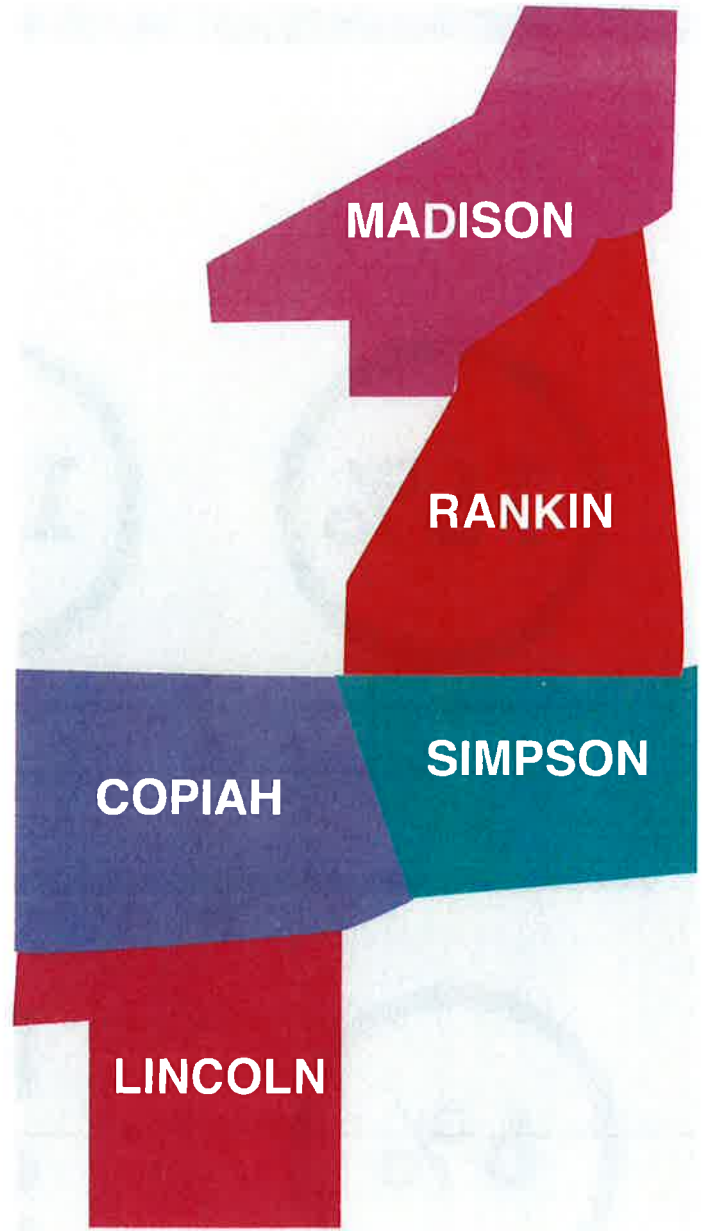
103 South Lake Circle
Canton, MS 39046
601-859-8371

Rankin County

613 Marquette Road
Brandon, MS 39042
601-825-8800
Administration
601-824-0342

Simpson County

3087 Simpson Hwy 13
Mendenhall, MS 39114
601-847-4410



www.region8mhs.org

TREATMENT



Region 8 Mental Health Services

ANNUAL REPORT REVENUE FIGURES SOURCES



Fees for Services



Grants



County Contributions
& Contracts



Other

**REVENUE
SOURCES**
2017

REGIONAL CONSUMER SERVICES DATA

11,953

Mental Health Services

412

**Intellectual &
Developmental
Disabilities Services**

3,862

Substance Abuse Services



TREATMENT

Adults Served

7,066 + 9,161 = 16,227

Children Served

Total Consumers Served



REGION 8 / MSH RESTORATION PROJECT

Restoring Individuals to Competency

Mississippi State Hospital and Region 8 collaborated to develop a Competency Restoration Program that expanded MSH's limited capacity to perform Restoration Services. Due to the limited number of forensic beds at MSH there is a significant waiting list of

individuals that have been determined to be incompetent to stand trial and are being held in local jails around the state until a bed at MSH becomes available. Some individuals are being held in local jails for 4 - 5 years or longer while suffering with a mental illness and receiving no mental health services.

RESTORATION

Through this collaboration, Region 8 goes to local jails and provides competency restoration services to these individuals with the purpose of restoring individuals to competency. This allows the individual to proceed through the legal system, diverting the individual from ever going to MSH and decreasing MSH's wait list. The program also provides regular clinical feedback to MSH on the status of the individuals participating in treatment so better decisions can be made of who to prioritize for admission.

Region 8 has two (2) full-time staff members trained by the forensic staff at MSH to perform competency restoration services. These two (2) staff members include a Master's level Program Coordinator and a Bachelor's level Program Specialist.

This project focuses on the Madison County and the Hinds County Detention Centers. Between these two facilities there are fifteen (15) individuals that MSH has identified as being on the waiting list for the forensic unit and appropriate for this program. Region 8 provides services at each facility at least two (2)

days per week. This schedule allows Region 8 the flexibility to work with these facilities an additional day each week if necessary, to provide restoration services to other local jails within Region 8's catchment area that have a smaller number of individuals on MSHs waiting list and perform training (MANDT / Mental Health First Aid) with jail staff on how to better understand and interact with individuals suffering from a mental illness.

The proposed budget for this project was \$200,000 per year. According to MSH it costs approximately \$100,000 per individual to provide restoration services at MSH. This project will significantly expand the capacity of MSH to provide restoration services at a minimal cost. In addition to expanding service capacity, there is no doubt that local jails are not equipped or trained to treat individuals with mental illness. This Program provides much needed services to individuals suffering with a mental illness in local jails. In the first year of the Restoration Program, eleven individuals were diverted from MSH at a cost savings for the State of over \$900,000.

OUR VISION

Our vision is to meet the unique behavioral health care needs of each individual in our community as expressed through an infinite effort of a team of professionals, with strength beyond the presence of any one person. Our success is measured by the accomplishments and comfort in the lives of those we serve.

OUR COMMITMENT TO YOU

Because this organization is a human institution to serve people, we hope that we are granted the ability to give you peace and rest while you are under our care.

We will strive to understand your needs and to be your home away from home.

We will strive to bring you comfort and pray that those you love be near you in thoughts and dreams.

Every word spoken by staff should bring you hope and closer to contentment.

May the responsible party that brought you our way be blessed and prosperous. When you leave, may your journey be safe.

We are all just passing through between eternities. May these days be pleasant for you, helpful for those you meet, and a joy to those who know and love you best.



MISSION STATEMENT

Region 8 Mental Health Services will provide the highest level of mental health, intellectual and developmental disabilities, alcohol and drug services, in the least restrictive environment possible within the limits of current knowledge.



RESPONSIVE

Our programs evolve in response to community needs.



PERSON CENTERED

Our individuals actively participate in determining their own treatment goals. We also encourage them to be involved in program planning and evaluation.



COMPREHENSIVE

Our programs encompass a full continuum of prevention, early intervention, and treatment services for individuals, families, and the community.



INNOVATIVE

Our programs reflect continual renewal through education, training, and research.



ACCESSIBLE

Our community-based services are available regardless of age, ethnicity, or ability to pay.



SUPPORTIVE

Our work environment encourages individual and team excellence in caring for the individuals we serve.



ANNUAL REPORT 2017

www.region8mhs.org

601.824.0342



FINDINGS

Tab H

Medicaid Managed Care Commission Meeting

October 9, 2018

► REVIEW THE FINANCIAL FEASIBILITY AND HEALTH OUTCOMES OF POPULATION HEALTH MANAGEMENT

Population Health Management focuses on preventing illness and changing behaviors that unnecessarily drive up medical care costs.

3 Core Components of Population Health Management:

1. Health outcomes based on morbidity (the state of one's health), mortality (rate of death in a population) and quality of life (
 - a. Morbidity rate evaluates the incidence of disease across a population, residents of Mississippi.
 - b. Mortality measures the rate of death in a population from a single cause like diabetes
 - c. Quality of life
2. Social determinants of health such as income level, education level and impact of crime and safety
3. Public policies and interventions that link (a.) health outcomes with (b.) social determinants of health.

It is estimated that 40+ % of all hospital admissions are still due to smoking, unhealthy diet, lack of physical activity and alcohol abuse. Only 3 % of Americans do all of those things. Likewise, 40% of all hospital admissions could be avoided if patients controlled these 5 measures:

1. Do not smoke cigarettes/cigars.
2. Eat fruits and vegetables.
3. Exercise three times a week for 20 minutes.
4. Wear a seat belt.
5. Maintain an appropriate body mass index.

Population Health Management keeps patients healthier, rewards responsible behaviors and can reduce Medicaid costs by reducing the incidence of preventable disease.

- Medicaid has previously reported to the Medical Care Advisory Committee that many preventive screenings are covered. Yet, the MCOs have little incentive to encourage providers to maximize adult wellness screenings covered by the program.
 - Better promotion of the covered screenings would increase the number of patients screened.
 - Evaluation of MCOs based on preventive screenings would incentivize the MCO to increase utilization.
- More than 23% of adult Mississippians still use tobacco products. Tobacco-related illness accounts for \$1.23 Billion in direct medical costs including \$320 million in annual Medicaid costs to Mississippi.
 - A statewide ban on smoking in all indoor public spaces would reduce second-hand smoke related illnesses.
 - An increase in tobacco tax of \$1.50 per pack would provoke 26,000 Mississippians to quit smoking and could save Medicaid \$1 million state dollars per year.
- Team-based care is the proven approach for managing non-communicable diseases.
 - Increased use of remote patient monitoring and telehealth tools can help manage chronic disease. □

FINDINGS

Tab I

Commission on Expanding Medicaid Managed Care

Medicaid Services Covered Under Fee for Service



Nursing Facility

- Approximately 20,000 unduplicated residents
 - ✓ Decrease of 3% since 2016
- \$775 million per year
- 16% of total medical services spending

Nursing Facility:

Provides skilled nursing or medical care and related services; rehabilitation needed due to injury, disability, or illness; Long term care-related services not available in the community.

Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)

- Over 2,000 unduplicated residents
- \$227 million per year
- 5% of total medical services spending

ICF/IID:

Serves individuals with intellectual disabilities and other related conditions. Most have other disabilities as well as intellectual disabilities.

Assisted Living Waiver (AL)

- More than 650 unduplicated participants
- \$7.4 million per year
- 30% reduction in cost per person since 2016

AL:

This 1915(c) Home and Community Based (HCBS) Waiver allows individuals who meet nursing facility level of care to reside in an approved assisted living facility as an alternative to institutional care.

Elderly and Disabled Waiver (E&D)

- Over 19,000 unduplicated participants
- \$223 million per year
- 13% increase in cost per person since 2016
- 4% of total medical services spending

E&D:

This 1915(c) HCBS Waiver allows elderly and/or disabled individuals requiring nursing facility level of care to remain living at home or in their community instead of in a nursing facility.

Intellectual Disabilities/Developmental Disabilities Waiver (ID/DD)

- Roughly 2,500 served
- \$104 million per year
- Highest expenditure per person served of the HCBS waivers (over \$40k)
 - ✓ 23% expenditure increase since 2016

ID/DD:

This 1915(c) HCBS Waiver allows individuals with intellectual/developmental disabilities requiring institutional level of care to remain in a home or community-based setting.

Commission on Expanding Medicaid Managed Care

Medicaid Services Covered Under Fee for Service



Independent Living Waiver

- 2,419 unduplicated participants
- ✓ 21% reduction in unduplicated participants since 2016
- \$44 million per year

IL Waiver:

This 1915 (c) HCBS Waiver allows individuals 16 or older, who have orthopedic and/or neurological impairments requiring nursing facility level of care to remain in their home and community.

Traumatic Brain Injury/Spinal Cord Injury Waiver (TBI/SCI)

- 819 unduplicated participants
- ✓ 15% reduction in unduplicated participants since 2016
- \$18 million per year

TBI/SCI Waiver:

This 1915(c) HCBS Waiver allows individuals who have a traumatic brain injury or a spinal cord injury and are medically stable, requiring nursing facility level of care to remain in their home and community.

Healthier Mississippi Waiver

- Full Medicaid benefits
- Average annual enrollment is almost 5,000
- ✓ Over 8,000 unique individuals served
- ✓ High "churn" rate
- \$95 million per year
- 11% increase in cost per person since 2016

Healthier Mississippi:

This 1115(a) Waiver allows coverage for individuals age 65 years old or older, or disabled who are not covered by or entitled to Medicare. If under age 65, individuals must have a disability using the same rules as the Supplemental Security Income (SSI) program.

Family Planning Waiver

- Over 40,000 served
- Currently \$7.2 million per year
- 25% increase in expenditures since 2016
- Only eligible for family planning services
- 90/10 federal match

Family Planning:

This 1115(a) Waiver allows women and men who receive Medicaid benefits limited to family planning services and family planning related services. Includes one annual visit and subsequent visits related to family planning services.

Dual Eligibles

- Approximately 83,000 served in QMB, SLMB, and QI-1 categories
- Nearly 50,000 dual eligible SSI recipients not eligible for MississippiCAN

Dual Eligibles:

Those with Medicare Part A and/or Part B, who have limited income may get help for their medical expenses. The Medicare Cost-Sharing groups include: Qualified Medicare Beneficiaries (QMB), Specified Low-Income Medicare Beneficiary (SLMB), Qualifying Individual (QI).

FINDINGS

Tab J

Magnolia Health Care Management

Jan 1 - August 31, 2018 **10,162** members have been enrolled in Care Management

Primary disease states:

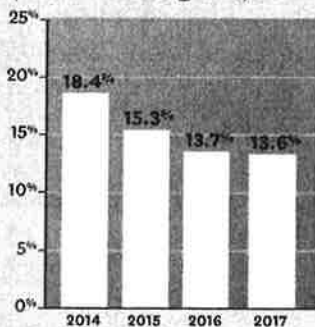
- | | |
|---------------------|-----------------------------|
| 1 Pregnancy | 6 Cancer |
| 2 Asthma | 7 At risk newborns |
| 3 Diabetes | 8 Obesity/weight management |
| 4 Behavioral Health | 9 Cardiovascular Disease |
| 5 Hypertension | 10 COPD |

Focused Care Management – HIV Positive Members in Hinds County

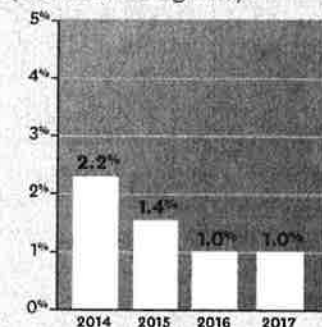
- 2 dedicated Care Managers
- Focus on managing members infected with HIV in Hinds county
- Members are managed through 9 months of care management
- Collaborates with members as necessary for healthy behaviors with a goal of:
 - Decreasing ER visits
 - Decreasing hospitalizations
 - Increasing adherence to medications
 - Increasing adherence to doctor visits
 - Increase understanding of virus
 - Providing needed resources and behavioral health
- 58 members have completed program
- 74% of members have a decrease in Emergency Room visits and hospitalizations

Pre-Term Birth Data

Deliveries resulting in Low Birth Weight infants
(less than 2500 grams):



Deliveries resulting in Very Low Birth Weight infants
(less than 1000 grams):



magnolia health[™]

Prior Pre-Term Birth – Makena Usage

2016 Makena Data:

- **101** members received Makena and delivered in 2016
- **72%** of the babies delivered were healthy and either sent home with mom or placed for adoption/foster care (all born between 34 and 40 weeks gestation)

2017 Makena Data:

- **188** members received Makena and delivered in 2017
- **75%** of the babies delivered were healthy and either sent home with mom or placed for adoption/foster care (all born between 34 and 40 weeks gestation)

Community Health Workers

- Efforts to further enhance the contributions of non-clinical staff in the field
- All of our representatives have trained and passed enhanced courses, and our MemberConnections team is now the Community Health Services Department
- All have completed Centene Community Health Worker Certification
- Representatives will outreach to members in their communities on the full range of issues impacting healthy outcomes including all social, economic, physical, environmental, and health literacy factors.
- Allows for real-time delivery of solutions, such as health education, peer counseling, and social and health systems navigation, with no wait for service.
- Since January 1, 2018 these Community Health Workers have completed more than 4,000 member home visits

FINDINGS

Tab K

Molina Healthcare of Mississippi: Managed Care Study Committee Discussion

Background

MississippiCAN provides medical and behavioral health services for 70% of Mississippi Medicaid enrollees through coordinated care organizations (CCOs). The 30% of Medicaid beneficiaries not receiving coordinated care, however, are among the Mississippi's most expensive and complex. They account for more than \$1.5 billion in program costs and frequently have multiple health and social needs. Including these individuals and their services in the CCOs could improve quality of care, reduce costs to the State, and build upon Mississippi's course of health care transformation.

There are currently ten categories of services covered under fee-for-service (FFS) in the MS Medicaid program. Bringing those programs into the managed care programs over time would assist in the management of the programs along with providing additional budget predictability for the division. Currently the Healthier Mississippi Waiver has an enrollment of approximately 5,000 with an annual spend in 2016 of \$95 million and medical costs in excess of 11%. This far exceeds the typical trend experienced in a managed care setting. In addition, there is significant "churn" of this population between FFS and managed care, creating confusion for the member and making it more difficult to manage the underlying medical conditions of the population. Bringing this population into a full-time managed care setting could help decrease costs to the state and improve quality of care.

The waiver for intellectual and developmental disabilities (ID/DD) serves roughly 2,500 enrollees and represents the highest expenditures per person of all the waiver populations. Adding this population to managed care could assist with managing those expenditures, providing budget predictability and improve quality/outcomes.

The Nursing Facility benefit for MS Medicaid serves approximately 20,000 enrollees. The expenditures are approximately \$775M annually and represent almost 16% of total medical services spend for the division. A Managed Long-Term Services and Supports (MLTSS) program could provide the Division of Medicaid (DOM) budget predictability and cost savings, while delivering higher quality, coordinated care to Mississippi's most vulnerable population¹.

Benefits of MLTSS for Mississippi

- ✓ Improve enrollee health outcomes and quality of life through care coordination and reduction in unnecessary services.
- ✓ Improve Mississippi's standing with the Department of Justice by moving able individuals into the community.
- ✓ Leverage Home and Community Based Services (HCBS) to promote community-based living and independence in accordance with each enrollee's goals and choices.
- ✓ Increase budget predictability and cost management for the Division of Medicaid (DOM) and the State.
- ✓ Reduce Waiver waiting lists and increase consumer choice and access to services.

¹ Molina operates MLTSS plans (including Medicare-Medicaid Plans and Fully Integrated Dual Eligible Special Needs Plans) in 10 states, serving the LTSS needs of almost 240,000 Medicaid enrollees.

Molina Healthcare of Mississippi: Managed Care Study Committee Discussion

Demonstrated Success in Other States

- **Texas:** From SFY2010 – SFY2015 managed care reduced STAR+PLUS costs to the state budget by an estimated 3.8% compared to the expected FFS cost, including revenue from premium taxes.²
- **Florida:** 76% of survey respondents reported that MLTSS improved their quality of life.³
- **Ohio:** Only 5% of enrollees in MLTSS programs reported that they did not feel in control of their life compared to 12-13% in similar non-managed care LTSS programs⁴ and MLTSS spending rates trend downward while FFS costs do not.⁵

Partnering with Providers

MLTSS programs offer providers a variety of benefits and opportunities to grow. A few notable examples include:

- **Program Support.** Molina is committed to establishing strong relationships with all provider types. These relationships enable the development of financial incentives, provide ample education pre-launch, and create direct contacts for ease in answering questions.
- **Provider Protections:** Supporting providers is essential to the success of MLTSS. Potential strategies include mandated prompt payment, so providers continue to meet their cash flow requirements, and payment floors, which require CCOs to pay at least the Medicaid payment rate for a specified service. These strategies have been used successfully in other states to build a collaborative managed care program.
- **Shared Savings:** DOM may want to require the CCOs to provide a portion of their provider payments through alternative payment models. In these models, providers can share in savings related to reduced hospital admissions and readmissions or even benefit from broader risk-sharing arrangements.
- **Tailored Incentives.** Molina supports providers through development of specialized programs such as the Molina Quality of Living Program. This program rewards nursing facilities for high quality and efficient care that meets or exceeds specific performance criteria when providing residential/custodial care to Molina members.

Stakeholder Input

Mississippi's MLTSS program would be set up for the greatest success with an extensive stakeholder input process. Ensuring concerns and considerations are heard and accommodated across the state and across stakeholder groups will help DOM create the best possible program. Stakeholder engagement is critical at all phases of an MLTSS program including design, implementation, and throughout the life of the program for ongoing oversight.

² Medicaid Managed Care in Texas: A Review of Access to Services, Quality of Care, and Cost Effectiveness. February 2015 by Sellers Dorsey and Milliman. Available at: <http://tahp.org/wp-content/uploads/2016/11/Sellers-Dorsey-Milliman-Study-Medicaid-Managed-Care-in-Texas-A-Review-of-Access-to-Services-Quality-of-Care-and-Cost-Effectiveness-February-2015.pdf>

³ The Emerging Role of Managed Care in Long-Term Services and Supports, *Public Policy & Aging Report*, Volume 28, Issue 2, 14 August 2018, Pages 64–70, <https://doi.org/10.1093/ppar/pry011>

⁴ National Core Indicators Aging and Disability Adult Consumer Survey 2016-2017 Ohio Results. Available at: https://nci-ad.org/upload/state-reports/NCI-AD_2016-2017_OH_state_report_FINAL_2.pdf

⁵ MyCare Ohio Progress Report 2017. Available at: http://medicaid.ohio.gov/Portals/0/initiatives/MLTSS/MyCare_Ohio_Progress_Report_2017.pdf

FINDINGS

Tab L

A comparison of nursing home usage in states with and without Medicaid Managed LTSS

Nicholas Johnson, FSA, MAAA
 Andrew M. Keeley, FSA, MAAA
 Ali Khan, FSA, MAAA



Introduction

The U.S. population is rapidly aging. The proportion of people age 65 and older is currently 15%, a record high, and is expected to reach 20% by 2027.¹ The number of people age 80 and over is expected to double between 2018 and 2037. With the oldest Baby Boomers recently reaching age 70, the impact on nursing home care—where the average age of residents is approximately 80—has just begun.

State Medicaid agencies are the primary payers of nursing home care for over 60% of nursing home residents in the United States,² and long-term services and supports (LTSS) already account for over 25% of Medicaid spending in most states.³ Medicaid budgets will be even more strained by LTSS spending as Baby Boomers continue to age and require LTSS, which regularly exceeds \$5,000 per month for beneficiaries requiring facility-based care and regularly exceeds \$1,000 for other members requiring LTSS.

Over the last decade, many state Medicaid agencies have transitioned LTSS from a fee-for-service (FFS) reimbursement structure, where the agency pays LTSS providers for nursing home care and home and community-based services (HCBS), to managed LTSS (MLTSS), where the state Medicaid agency pays managed care organizations (MCOs) a fixed monthly payment to coordinate care and pay LTSS providers for the costs of serving eligible beneficiaries. States often structure MLTSS payments in a way that aligns financial incentives for MCOs with the goal of providing care in the community rather than in a nursing home. If MCOs provide sufficient HCBS to prevent beneficiaries from entering a nursing home and/or transition nursing home residents back into the community,

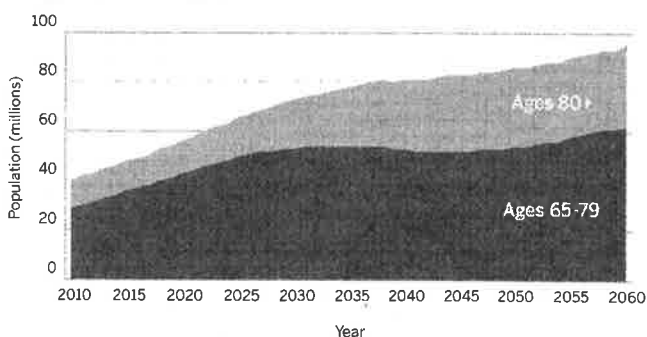
then more beneficiaries will reside in community settings where costs are often lower. Successful MLTSS programs focus on providing person-centered care and offer a full range of HCBS such as personal care attendants, homemaker services, home-delivered meals, caregiver support, and adult daycare that help beneficiaries live more independent lives in community settings.

For many states that have not yet transitioned to MLTSS, the change may provide the opportunity to reduce nursing home utilization and cost of care over the next decade and beyond. For MCOs, MLTSS may provide the opportunity of financial reward for quality care management. As states consider implementing MLTSS programs and as MCOs consider participating in them, it is important to understand what level of savings from managed care may be achievable.

In this paper, we examine Minimum Data Set (MDS) frequency reports and U.S. Census Bureau American Community Survey (ACS) population data to compare nursing home usage in states with MLTSS to states without MLTSS. While Medicaid does not cover all nursing home residents, it is the largest single payer of LTSS, and we believe reviewing state-level data can reveal a correlation between Medicaid policy and nursing home usage.

- 1 U.S. Census Bureau (March 13, 2018). 2017 National Population Projections Datasets. Retrieved July 26, 2018, from <https://www.census.gov/data/datasets/2017/demo/popproj/2017-popproj.html>.
- 2 Kaiser Family Foundation. Distribution of Certified Nursing Facility Residents by Primary Payer Source. State Health Facts. Retrieved July 26, 2018, from <https://www.kff.org/other/state-indicator/distribution-of-certified-nursing-facilities-by-primary-payer-source/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.
- 3 Kaiser Family Foundation. Medicaid and CHIP. State Health Facts. Retrieved July 26, 2018, from <https://www.kff.org/interactive/medicaid-state-fact-sheets/>.

FIGURE 1: U.S. POPULATION, AGES 65+



Current MLTSS landscape

MLTSS programs can take many forms. Some states offer MLTSS that primarily focus on providing Medicaid LTSS benefits through MCOs. According to the National Association of States United for Aging and Disabilities (NASUAD), 20 states had Medicaid MLTSS programs as of 2017.⁴ Other states have implemented MLTSS through partnerships with Centers for Medicare and Medicaid Services (CMS) using one or more of the following models, all of which integrate Medicare and Medicaid (including LTSS) benefits:

- Capitated Financial Alignment Demonstration (dual demonstration):⁵ 10 states
- Medicare Advantage fully integrated dual special needs plans (FIDE SNPs):⁶ 7 states
- Program for All-Inclusive Care for the Elderly (PACE):⁷ 31 states

FIGURE 2: MLTSS PROGRAMS IN 2017

FIDE SNP	Dual Demo	Medicaid MLTSS	PACE
7	10	20	31
Number of States with Program			

For the purpose of our analysis, we considered any state with Medicaid MLTSS, a dual demonstration, or a FIDE SNP as having MLTSS and refer to these states as “MLTSS states” throughout this paper. We excluded states with only PACE, as PACE sites typically serve a small number of members in need of LTSS. All other states are referred to as “FFS LTSS states.”

We acknowledge that MLTSS programs vary in eligibility criteria, covered benefits, voluntary and mandatory enrollment policies, launch date, geographic coverage, integration with Medicare, and other factors. These factors could limit each program’s impact on state-level LTSS trends. Nonetheless, we believe this partition is reasonable for identifying differences in states with MLTSS compared to states without MLTSS.

4 NASUAD. MLTSS Map. Retrieved July 26, 2018, from <http://www.nasuad.org/initiatives/managed-long-term-services-and-supports/mltss-map>.

5 CMS.gov (May 11, 2018). Capitated Model. Medicare-Medicaid Coordination. Retrieved July 26, 2018, from <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/CapitatedModel.html>.

6 Integrated Care Resource Center (February 2015). State Contracting With Medicare Advantage Dual Eligible Special Needs Plans: Issues and Options. Technical Assistance Tool. Retrieved July 26, 2018, from <http://www.chcs.org/media/ICRC-Issues-and-Options-in-Contracting-with-D-SNPs-FINAL.pdf>.

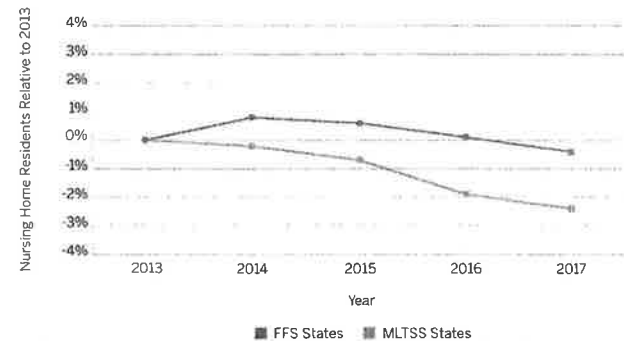
7 National PACE Association, Find a PACE Program in Your Neighborhood. Retrieved July 26, 2018, from <https://www.npaonline.org/pace-you/find-pace-program-your-neighborhood>.

Number of nursing home residents

A primary goal of MLTSS is to reduce the number of residents in nursing homes, so a logical place to begin comparing MLTSS states to FFS LTSS states is the change in nursing home residents over time.

Figure 3 shows the change in nursing home residents between 2013 and 2017, separately for MLTSS states and FFS LTSS states, based on the CMS MDS frequency data. As shown in Figure 3, the number of nursing home residents in MLTSS states has decreased by an average of 2.4% between 2013 and 2017, whereas average nursing home residents in FFS LTSS states decreased by 0.7% over the same time period.

FIGURE 3: PERCENTAGE CHANGE IN NUMBER OF NURSING HOME RESIDENTS



The table in Figure 4 shows the five states with the largest reductions in nursing home residents between 2013 and 2017. Figure 4 shows that four of the five states with the largest reductions in nursing home residents currently have MLTSS programs in place.

FIGURE 4: STATES WITH LARGEST REDUCTION IN NURSING HOME RESIDENTS (2013 - 2017)

	Wisconsin	Montana	Tennessee	Minnesota	Illinois
Reduction in Nursing Home Residents	-12%	-9%	-8%	-8%	-6%
MLTSS	YES	NO	YES	YES	YES

While Figures 3 and 4 seem to suggest that MLTSS states have reduced nursing home utilization at a higher rate than FFS LTSS states, we cannot necessarily conclude that MLTSS programs contributed to the difference. Many other factors—particularly differences in population growth and aging—could be driving differences in the total nursing home usage between MLTSS and FFS LTSS states.

Nursing home utilization rates by age group

To account for two of the major drivers of total nursing home utilization, population growth and age demographics, and to better identify differences in MLTSS states and FFS LTSS states, we converted raw nursing home resident counts from the MDS frequency reports to nursing home residents per capita using population statistics from the ACS. Note that, while MDS data is available through 2017, ACS data is currently only available through 2016. Also note that MLTSS states in this section include only states that had MLTSS programs in place as of January 2016.

Figures 5, 6, and 7 show the relative changes in nursing home residents per capita for MLTSS and FFS LTSS states between calendar year (CY) 2013 and CY2016 for ages 65 to 74, 75 to 84, and over 85, respectively. These figures show that the number of nursing home residents per capita decreased at a faster rate in MLTSS states than in FFS LTSS states for all 65 and over age groups. While MLTSS states had more success in reducing NF utilization, it should be acknowledged that FFS LTSS states also reduced NF residents per capita; this may be attributed to LTSS state initiatives other than managed care that target lower NF utilization.

FIGURE 5: PERCENTAGE CHANGE IN NURSING HOME RESIDENTS PER CAPITA

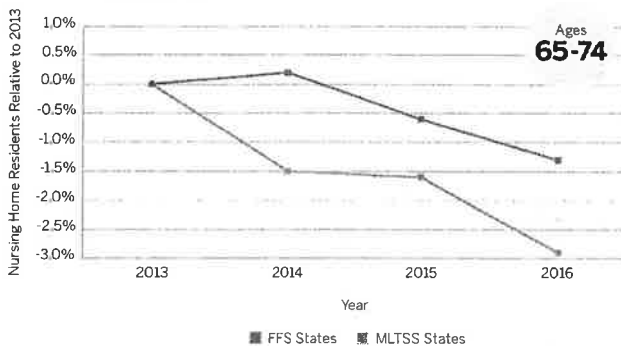


FIGURE 6: PERCENTAGE CHANGE IN NURSING HOME RESIDENTS PER CAPITA

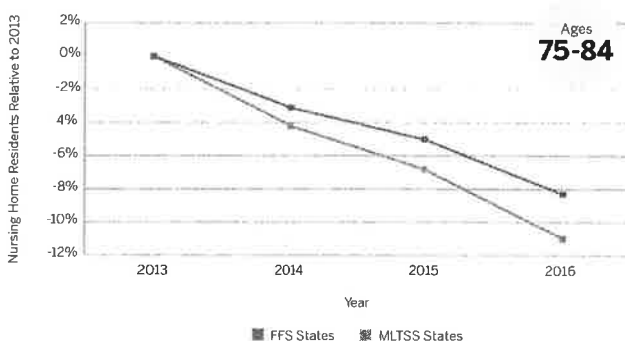
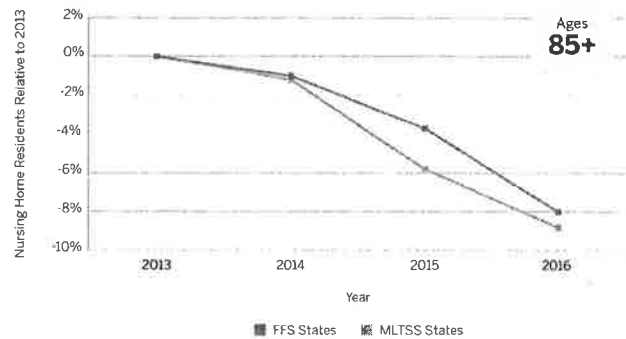


FIGURE 7: PERCENTAGE CHANGE IN NURSING HOME RESIDENTS PER CAPITA



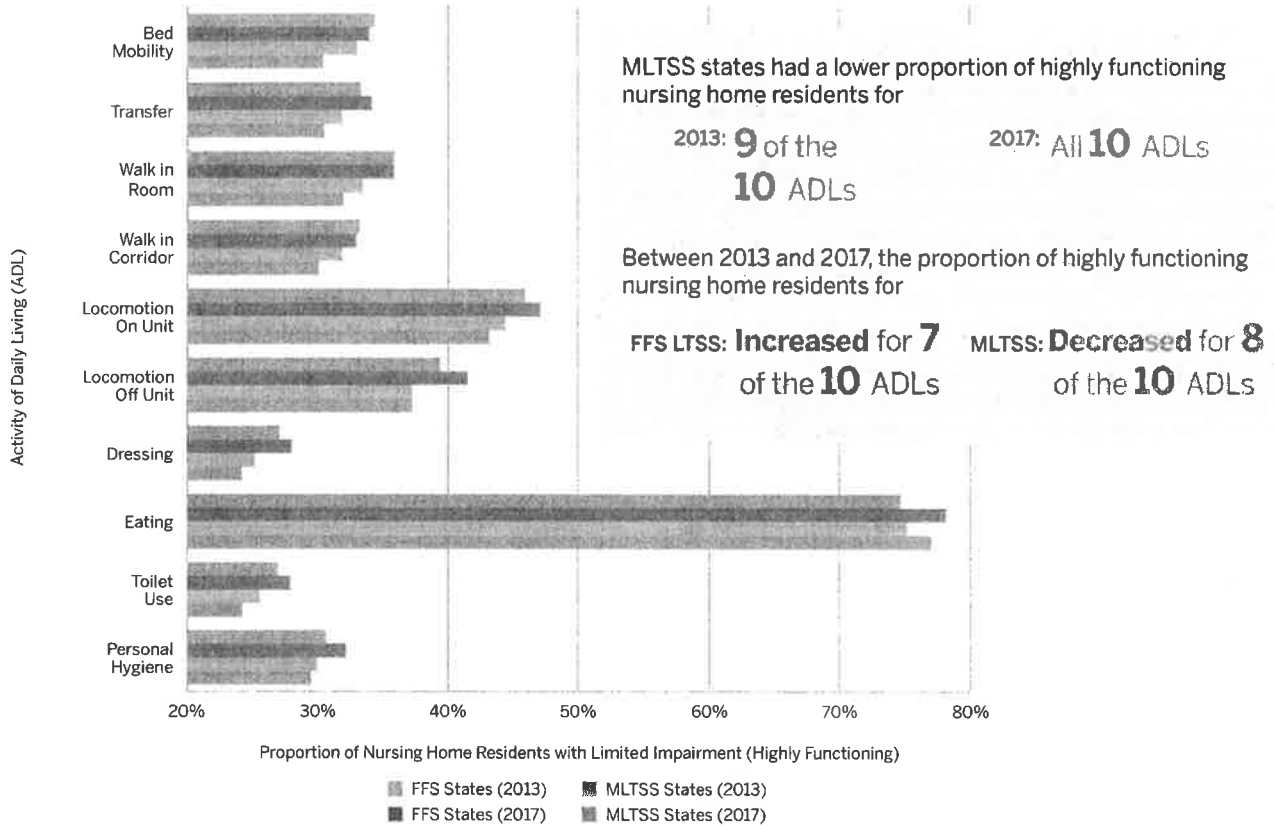
The number of nursing home residents per capita decreased at a faster rate in MLTSS states than in FFS LTSS states for all 65 and over age groups.

Low acuity members in nursing homes

Another indication of successful nursing home utilization reduction may be a high level of acuity of nursing home residents. MLTSS programs aim to provide HCBS to lower acuity (higher-functioning) members outside of an institutional setting. As low acuity members remain in the community longer or transition out of nursing homes, we would expect the remaining nursing home population to have higher acuity and more severe activities of daily living (ADL) impairments.

In the MDS data, nursing home residents are categorized as being independent, requiring supervision, requiring limited assistance, requiring extensive assistance, or as being totally dependent for each ADL. For simplicity, we categorized members into two levels of functional impairment: limited assistance (or less) and extensive assistance (or more). We then summarized the proportion of members in each state with limited impairment (highly functioning residents) for each ADL measured in the MDS. Figure 8 shows the proportion of nursing home residents requiring limited assistance or less for each ADL for 2013 and 2017, respectively. Figure 8 shows results separately for current MLTSS and current FFS LTSS states.

FIGURE 8: FUNCTIONAL STATUS OF NURSING HOME RESIDENTS (CY2013 VS. CY2017)



We also reviewed results on a state-by-state basis and classified states according to the number of ADL categories that showed an increased level of acuity (lower proportion of residents with limited impairment). The table in Figure 9 groups states based on the number of ADL categories with increased acuity between 2013 and 2017. Figure 9 illustrates the following:

- All five states that showed no improvement (same or increased proportion of residents with limited impairment) in any ADL categories are FFS LTSS states
- A majority of MLTSS states (19 of 23, or 83%) showed improvement in four or more ADL categories whereas a minority of FFS LTSS states (13 of 28 or 46%) showed improvement in four or more ADL categories
- States with long-standing MLTSS programs such as Arizona (seven ADL categories improved), New Mexico (five ADL categories improved), and Tennessee (nine ADL categories improved) continue to show improvement long after program implementation

FIGURE 9: CHANGE IN ACUITY OF NURSING HOME RESIDENTS (2013 - 2017)

NUMBER OF ADL CATEGORIES WITH INCREASED ACUITY	FFS LTSS STATES		MLTSS STATES	
	NUMBER	PERCENTAGE	NUMBER	PERCENTAGE
0	5	18%	0	0%
1-3	10	36%	4	17%
4-6	4	14%	10	43%
7-9	9	32%	8	35%
10	0	0%	1	4%

These findings suggest that the acuity level of nursing home residents in MLTSS states is increasing at a faster rate than the acuity level of nursing home residents in FFS LTSS states. The difference may be a result of MLTSS programs more effectively providing care for highly functioning members in the community rather than in the nursing home.

Conclusions and considerations

Each state will need to consider different priorities and potential obstacles before transitioning to MLTSS. Cost-effectiveness, quality of care, provision of care in the appropriate venue, staff burden during times of member transition, impact on nursing home reimbursement, and member choice are important considerations; not all of these items are easily quantifiable. We believe an in-depth, state-specific analysis of nursing home residents can assist with part of an MLTSS transition assessment. This analysis focused on general trends in summarized data. A more detailed, state-specific analysis could examine demographic trends in more detail, study ADL impairment on a patient basis rather than an aggregate basis, analyze nursing home readmission rates, and identify holes in the state's current level of HCBS delivery.

Likewise, any MCO considering contracting with a state to offer MLTSS coverage should study the state's current level of efficiency in order to understand what level of savings is achievable. Achievable savings should be compared to nursing home transition assumptions and managed care savings built into MLTSS capitation rates.

Our review of the MDS and ACS data, as outlined in this paper, considers one objective of MLTSS: providing LTSS care in the community rather than in nursing homes. Our analysis suggests that MLTSS states are outperforming FFS LTSS states on this objective. While it is not the only indicator of success, reducing nursing home usage through the provision of home and community-based care is extremely important to the financial viability of a Medicaid LTSS program.



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BACKGROUND

Medicaid commonly represents the largest expense in state budgets, and in 2017, Medicaid cost Mississippi and the federal government a combined \$6.06 billion.¹ Medicaid beneficiaries are particularly complex and vulnerable, needing a level of coordination of medical and social services that is not possible in a fee-for-service (FFS) environment. Managed care provides an opportunity to states to improve their Medicaid program and the experiences of beneficiaries, while facilitating innovation, program integrity, predictability, and reduced cost trend.

Recognizing the advantages of managed care, between 2005 and 2015, the number of states exclusively leveraging risk-based managed care contracts grew from 18 to 29, a 61% increase, and as of September 2016, 39 states offered Medicaid managed care in at least part of the state or for some populations.^{2,3} This movement has resulted in considerable cost savings for some states, with estimates of up to 20%.⁴ Additionally, managed care affords opportunities for providers and beneficiaries that are otherwise unachievable, such as robust care coordination, enhanced infrastructure, value-based incentives, and improved health outcomes (see **Exhibit 1** for additional opportunities provided by managed care).

Exhibit 1. Examples of Benefits of Medicaid Managed Care, by Stakeholder

STATE
<ul style="list-style-type: none"> • Provides budget stability over time and allows cost predictability • Limits state financial risk by allocating risk to managed care organizations (MCOs) through fixed payment structure (per member per month) • Facilitates accountability for quality care by shifting responsibility to MCOs rather than state management of activities across thousands of providers • Creates the potential to expand services and program eligibility as a result of cost savings • Allows for flexibility in service provision and encourages innovation among competing MCOs • Shifts program administration burdens such as network management, claims payment, and utilization management to MCOs and away from state
PROVIDER
<ul style="list-style-type: none"> • Allows an opportunity for value-based incentive payments through collaboration with MCOs to determine provider readiness for participation in different value-based arrangements • Creates a potential for enhanced infrastructure through MCO investments • Provides assistance and training for providers for things such as patient outreach, continuing medical education (CME), evidence based practices, and population health analytics • Affords innovations in service delivery that can help providers manage their patient panel (e.g., data tools)
BENEFICIARY
<ul style="list-style-type: none"> • Ensures coordination of care across primary, specialty, inpatient, and outpatient care providers,

¹ http://www.lbo.ms.gov/misc/FY18_BudgetBook/bbook18-br60.pdf

² Health Management Associates. *The Value Of Medicaid Managed Care*. December 9, 2015.

³ Kaiser Family Foundation. *Total Medicaid MCO Enrollment, September 2016*.

⁴ The Lewin Group. *Medicaid Managed Care Cost Savings – A Synthesis of 24 Studies*. March 2009.

which is not possible in FFS environments

- Requires that each beneficiary has an ongoing source of care appropriate to his or her needs
- Provides continuity of care for newly enrolled beneficiaries or individuals moving in and out of Medicaid/Medicaid managed care
- Delivers member services that beneficiaries otherwise would not have access to, such as guidance on benefits and coverage
- Provides assurance of an adequate provider network to meet beneficiary needs and guarantees out-of-network access if an MCO is unable to provide timely access using network providers
- Ensures that the scope of coverage for each service covered by an MCO is no less than that of the same service provided to Medicaid beneficiaries on a FFS basis
- Allows for additional benefits and services, as appropriate, beyond those offered through the State Plan

MANAGED CARE IN MISSISSIPPI

In 2011, Mississippi implemented Mississippi Coordinated Access Network (MississippiCAN), a statewide Medicaid managed care program targeting children and non-elderly adults. Individuals in institutional settings (such as a nursing facility), individuals dually eligible for Medicare and Medicaid, and waiver members currently are excluded from MississippiCAN.

Since the implementation of MississippiCAN, UnitedHealthcare Community Plan (UHC) has been proud to partner with the Division of Medicaid (DOM) to improve the health and quality of health care delivery. Below are a few highlights of our numerous programs and interventions:

- **Diabetic Members.** Eye exam screening rate improved by 66% and diabetes control levels improved by 31%.
- **Women's Health.** Breast cancer screening rates improved 56%; cervical cancer screening rates increased by 43%.
- **Pregnant Mothers.** Prenatal scores improved by 36% and postpartum rates improved by 83%.
- **Behavioral Health.** Follow-up visit with a provider after a mental health hospitalization rate improved by 51% for 7 days and 26% for 30 days.
- **EPSDT.** From 2012 to current, UHC members have experienced a 270% increase in pediatric wellness exams compliance.

Case Study: UnitedHealthcare Community Plan Strategies

UnitedHealthcare Community Plan's commitment to serving the state of Mississippi is evidenced through our nearly 500 employees in the State and our investment in local communities. We are focused on making healthcare simpler for our nearly 240,000 Medicaid members in the State and this attention to the member experience has helped us achieve an 82% positive member satisfaction rating in MSCAN and 88% in MSCHIP.

*In 2016 alone, the MSCAN program saved Mississippi **approximately \$240.3 million** compared with projected claims without care coordination. The program is estimated to **save another \$1.39 billion by 2021.***

(Internal UHC Analysis)

As part of our commitment to Mississippi, UnitedHealthcare consistently brings innovative solutions to the market, works with providers to deliver increased value to those we serve and the State, and invests in the community to help people live healthier lives.

Innovative Solutions

- Recognizing that health is more than what happens in the doctor's office, our care teams leverage tools such as **Healthify** to identify and connect members to resources in the community. Housing, financial support, transportation, food, and employment services rank among some of the most common resources sought by those we serve.
- UnitedHealthcare's **Baby Blocks** is a free, online, interactive incentive program to help pregnant women and new mothers with prenatal and well-baby care in Mississippi. The program enables users to receive email appointment alerts and wellness-related text messages, connect directly with maternity nurses, and earn rewards for keeping the appointments. Nearly 5,000 Mississippi women have successfully enrolled in our Baby Blocks program and 4,000 babies have been born. More than 1,800 babies have graduated from the full 15-month program.
- UnitedHealthcare implemented **Advocate4Me** in July 2016, a customer care approach that provides members with a single point of contact to address their various health needs. By calling the member service toll-free number, or using their preferred communication channel such as email, members are connected with an Advocate who provides them with end-to-end support, "owning" their request until it's resolved. Advocates can tap into a team of experts specializing in clinical care, emotional health, pharmacy, health care costs and medical plan benefits, to help each member navigate the health system and get the information he or she needs. This approach results in a simpler, more personalized and informed experience for the member. From July through December 2016, Advocate4Me assisted Mississippi members by engaging in over 1,400 conversations about gaps in care once members called for other reasons to provide actionable health education and further scheduled over 200 health care appointments.
- UnitedHealthcare's **KidsHealth Online Resource Center** has 200+ videos and 10,000+ pieces of written content for the web, ranging from condition-specific (e.g., asthma, diabetes, obesity, sickle cell) to wellness (e.g., nutrition, physical activity, safety, mental health). Information can be found to meet the needs by age, language, and learning style. During 2016, the KidsHealth Online Resource Center received over 5,000 visits and 15,053 page views. The top articles viewed were from the 1) Asthma Center, 2) Dealing with Addiction, 3) Allergies, 4) Nutrition & Fitness Center, 5) Flu Center, and 6) Kids Stay Safe Center.

*UnitedHealthcare has a team of **16 dedicated community health workers** in Mississippi who make home visits to members most in need of care support. We work face-to-face with members to identify and address underlying behavioral and social issues that may contribute to medical needs, and to ensure the member receives the right care at the right time with the right professional.*

Provider Collaboration

- Recognizing the importance of **value-based care**, and that not all providers are at the same readiness to accept risk, UnitedHealthcare offers a variety of value-based contracting strategies along a continuum. The foundation of this continuum is our new quality performance program that incentivizes providers to close gaps in care and ensure beneficiary needs are

addressed. This program includes technical, reporting, and administrative support to primary care practices to facilitate/expedite continuous improvement in their quality (HEDIS/CAHPS) performance. Currently, 95% of our members access care through providers participating in a value-based arrangement, and our goal is to reach 100% of membership by 2018.

- In response to challenges experienced by providers as a result of enrollment growth and program changes, UHC implemented an enhanced issue intake and tracking procedure for providers, hired additional provider advocates to engage in field-based provider support, and in December 2015 introduced the **Provider Relationship Insight and Service (PRISM) Model**. PRISM includes dedicated human resources and state of the art information technology to conduct comprehensive issue management. This model supports provider resolution for all direct provider issues, including provider issues received via DOM.
- During Q4 2016, UHC deployed the **Care Provider Early Warning System (CP-EWS)**, a diagnostic tool that uses data collection and analysis to monitor in real-time the health of claims and provide early warning when adverse issues threaten provider payments. CP-EWS tracks claim performance, monitors for outliers, and provides proactive alerts to trending denials, fluctuations in claims receipts by provider, and cash flow interruptions. This new capability provides dramatically expanded insight into additional areas that can improve provider satisfaction with regard to the claim payment experience. CP-EWS was specifically designed to identify issues in a manner that leads to rapid investigation, provider communication, and corrective actions in a greatly abbreviated identification-to-resolution cycle time.
- UHC introduced a new **Provider Resolution & Express Decision (Code RED) Team** in March of 2017. The Code RED team was designed to quickly address provider issues in an environment that promotes open dialogue. Code RED engages the provider to resolve issues/concerns in real-time or discuss business or administrative practices that the provider may need to alter. The provider is able to communicate directly with subject matter experts to explain the issue, identify resolution plans, and agree on next steps and timeline. There also is an ability to perform provider group roster management to review data for all practicing providers and immediately identify any gaps needing correction. Code RED has three options: 1) a virtual visit with computer screen-sharing capabilities, 2) a face-to-face visit at the provider's office or other mutually agreed upon location, or 3) an appointment in our local office in Ridgeland, MS.

Community Investment

- UHC's **Farm to Fork Initiative** provides free farm-fresh vegetables to members in poverty-stricken, food desert designated locations. With distribution sites across the State, members and their families can reap the benefits of healthy eating and establish healthy habits for life. Between May and September 2016, we served approximately 4,946 members in 18 communities across the State. Over 22.5 tons of free produce and 9,892 health literature materials were distributed to members during this same time period.
- The UHC Mississippi plan has **donated more than 100 computers** to organizations around the State to assist students with technology and research skills and adults with accessing information on healthcare, employment, education, and social services.

-
- Children from low-income and low-education households are three-times more likely to suffer from obesity, which is a leading risk factor for diabetes, heart disease and many cancers.⁵ In response, UnitedHealthcare launched **Kicks for Kids** in Mississippi, an incentive initiative that offers kids ages 6-16 Nike gift cards for completing their wellness exams by the end of the year. As of December 2016, the initiative had produced approximately 821 Kicks for Kids eligible CHIP claims.
 - In December 2016, UHC delivered 150 **NERF ENERGY Game Kits** to the Boys & Girls Clubs of Central Mississippi. The Game Kits include an activity tracker, a soccer ball, and a mobile game. As children participate in physical activity, they earn "energy points" that are tracked by the activity band and these points turn into screen time to play the mobile game on a smartphone or tablet.

CONCLUSION

States have leveraged managed care for their Medicaid population for more than 40 years, with rapid growth in managed care programs in recent years. As of 2014, more than 55 million, or 77%, of Medicaid beneficiaries were enrolled in some type of managed care across the country.⁶ As discussed in this paper, managed care provides an opportunity to states to improve their Medicaid program and the experiences of beneficiaries, while facilitating innovation, program integrity, predictability, and reduced cost trend. Our national experience provides a unique perspective for us to support Mississippi as it considers system enhancements and transformation. We look forward to the opportunity to answer any questions about the value of managed care or support any other research necessary to support the goals of Mississippi.

⁵ America's Health Rankings®, an annual comprehensive assessment of the nation's health on a state-by-state basis.

⁶ Kaiser Family Foundation. Total Medicaid Managed Care Enrollment, 2014.

FINDINGS

Tab N



DEMONSTRATING THE VALUE OF MEDICAID MLTSS PROGRAMS



MLTSS
INSTITUTE
Where Policy and
Practice Meet



CHCS Center for
Health Care Strategies, Inc.

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Leah Smith, MSW, CHCS

The NASUAD **MLTSS Institute** was established in 2016 in order to drive improvements in key MLTSS policy areas, facilitate sharing and learning among states, and provide direct and intensive technical assistance to states and health plans. The work of the Institute will result in expanded agency capacity, greater innovation at the state level, and state/federal engagement on MLTSS policy.

The **National Association of States United for Aging and Disabilities (NASUAD)** represents the nation's 56 state and territorial agencies on aging and disabilities and supports visionary state leadership, the advancement of state systems innovation, and the articulation of national policies that support home and community based services for older adults and individuals with disabilities.

The **Center for Health Care Strategies (CHCS)** is a nonprofit policy center dedicated to improving the health of low-income Americans. It works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve beneficiaries of publicly financed care, especially those with complex, high-cost needs.

DEMONSTRATING THE VALUE OF MEDICAID MLTSS PROGRAMS



**MLTSS
INSTITUTE**

**Where Policy and
Practice Meet**



NASUAD
National Association of States
United for Aging and Disabilities

CHCS Center for
Health Care Strategies, Inc.

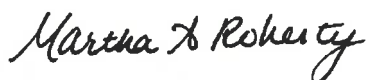
THE MLTSS INSTITUTE

Managed long-term services and supports (MLTSS) is a growing trend across the country. States seeking to modernize and improve their long-term services and supports systems continue to turn to managed care plans to help them achieve their goals. Operating an efficient and effective MLTSS program requires thoughtful program design, capable health plan partners, strong state oversight, and appropriate accountability mechanisms. NASUAD has been deeply engaged in providing technical expertise and assistance to our member states as they plan, design, implement, and evaluate their MLTSS programs. In fact, NASUAD is uniquely positioned to assist our members because we can:

- Arrange and facilitate peer-to-peer information exchange and mentoring relationships among the states using existing infrastructure and practices;
- Readily reach key, high-level state MLTSS decision-makers and serve as a trusted and secure medium for vetting challenges and preliminary, innovative MLTSS concepts; and
- Deliver solid, reliable technical assistance tailored to state officials and their key staff.

However, our Board of Directors recognized that staff capacity to provide technical assistance was outstripping the states' demand for it. This recognition led to the creation of the MLTSS Institute in 2016. The MLTSS Institute is intended to drive improvements in key MLTSS policy issues, facilitate sharing and learning among states, and provide direct and intensive technical assistance to states and health plans. The work of the Institute will result in expanded agency capacity, greater innovation at the state level, and state/federal engagement on MLTSS policy. Creating opportunities for thoughtful policy development, meaningful state interaction, and more effective use of limited state resources is critical to the maturation and success of MLTSS programs.

I am deeply grateful to our visionary Board of Directors, state long-term services and supports leaders, and thought leaders at national health plans who understand that well-managed and high quality MLTSS programs benefit us all, and are willing to invest their time and resources to that end.



Martha Roherty, Executive Director
NASUAD

EXECUTIVE SUMMARY

States are increasingly implementing comprehensive Medicaid managed long-term services and supports (MLTSS) programs, but there is limited evidence of their value. To help fill this gap, this report presents results of a survey of states with MLTSS programs. The twelve states responding to the survey—Arizona, Florida, Iowa, Kansas, Massachusetts, Minnesota, New Jersey, New Mexico, Rhode Island, Tennessee, Texas, and Virginia—account for more than half of the states operating MLTSS programs. States were asked about their goals in implementing MLTSS programs, what progress they had made in attaining those goals, and if they faced any challenges collecting data to document progress—

- **Rebalancing Medicaid LTSS Spending.** A key goal for all states was rebalancing Medicaid long-term services and supports spending toward home- and community-based settings and providing more options for people to live in and receive services in the community. Many states have specific rebalancing targets, as well as financial incentives for MLTSS plans to meet them. Eight states reported that they were making progress toward their rebalancing goals, which aligns with national trends in MLTSS rebalancing.
- **Improving Member Experience, Quality of Life, and Health Outcomes.** All states wanted to improve consumer health and satisfaction/quality of life. While it can be challenging to attribute improvements in health outcomes solely to MLTSS programs, seven states reported improved consumer health. Nine states said that they collect data on quality of life, and 10 states collect data on consumer and family satisfaction. Among states reporting outcomes, MLTSS consumers had improved quality of life and high levels of satisfaction. One challenge highlighted by states was that fielding the surveys used to collect these data is time and labor-intensive.
- **Reducing Waiver Waiting Lists and Increasing Access to Services.** MLTSS programs may reduce or eliminate waiting lists for waiver services. Six states said they wanted to reduce waiting lists, while others focused on increasing access to services. Some states successfully eliminated waiting lists, while other states addressed waiting lists by prioritizing applicants by level of need. Some states reinvested savings achieved through implementing MLTSS to decrease the number of people on waiting lists.
- **Increasing Budget Predictability and Managing Costs.** MLTSS programs' use of capitated payments can help improve budget predictability. The programs also have the potential to achieve savings by: rebalancing LTSS spending; managing service use; and avoiding unnecessary hospitalizations or institutional placements. Five states identified Medicaid cost containment as a goal and seven states identified budget predictability as a goal. While states report they are “bending the cost curve,” inadequate data are a barrier to states' ability to demonstrate these outcomes.

This survey provided compelling examples demonstrating that states are meeting their MLTSS program goals, but it underscores the importance of expanding the scope and amount of data collected on program impacts. Health plan contracts with strong data reporting and performance monitoring requirements are important tools for states to build stakeholder support and demonstrate program viability over time.



INTRODUCTION

Since the 1970's, state Medicaid agencies have contracted with managed care organizations (MCOs) to coordinate and manage care for Medicaid consumers. Managed care is a delivery system whereby the state Medicaid agency contracts with an MCO to provide Medicaid benefits to consumers. States pay each MCO a fixed—also known as capitated—per-member, per-month payment for each Medicaid consumer enrolled in that MCO's health plan. These arrangements are risk-based, meaning that if the MCO does a poor job of keeping the consumer healthy and incurs expenses above and beyond what the MCO is paid, the MCO does not get any more funds from the state. Similarly, if the MCO keeps consumers healthy and manages service utilization appropriately, it may keep some or all savings from the amount paid by the state.

More recently, however, states have looked to MCOs to provide and coordinate services for more complex populations, such as those requiring long-term services and supports (LTSS). These include a broad array of medical and social services that aid older adults and individuals with chronic illnesses and significant disabilities to perform activities of daily living (ADLs)—such as bathing, eating, and toileting—as well as instrumental activities of daily living (IADLs)—such as medication management, budgeting, and transportation. LTSS are delivered in a variety of care settings, which generally fall under two broad categories: institutional (nursing facilities or intermediate care facilities); and community-based (in the home or community settings, such as adult day services).

States are increasingly implementing comprehensive Medicaid managed long-term services and supports (MLTSS) programs in order to better manage care for consumers using LTSS, increase access to community-based care, improve member satisfaction and health outcomes, and improve budget predictability. However, no two MLTSS programs are exactly alike. Despite states' increasing adoption of MLTSS, to date, few studies on the value of MLTSS programs have been conducted. Additionally, states are mindful of the fact that they will need to carefully monitor the quality of the care provided by the MCOs to these vulnerable consumers. This report aims to partially fill the gap in evidence, as well as highlight promising practices and insights from leading states in the hope of spurring further interest and additional research on MLTSS and its attendant opportunities and risks.

METHODOLOGY

NASUAD partnered with the Center for Health Care Strategies to research and write this report. Its conclusions are based on a NASUAD survey of states with MLTSS programs, the purpose of which was to elicit state perspectives on MLTSS; identify promising practices and innovative initiatives; and gather examples for states that are in the process of developing, or thinking of implementing an MLTSS program. The states surveyed include both those with long-standing MLTSS programs and those with new programs. The survey was sent to the following 19 states:

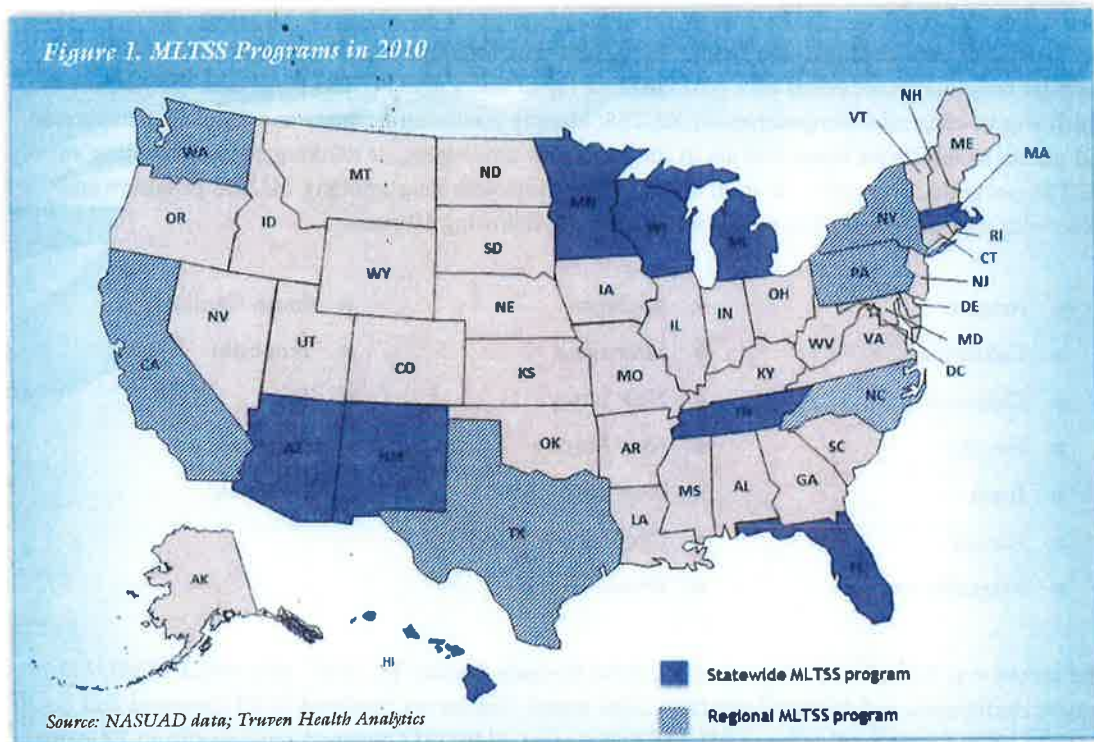
- Arizona
- California
- Delaware
- Florida
- Iowa
- Kansas
- Massachusetts
- Michigan
- Minnesota
- New Jersey
- New Mexico
- New York
- Ohio
- Rhode Island
- South Carolina
- Tennessee
- Texas
- Virginia
- Wisconsin

The survey was fielded from December 22, 2016 through January 31, 2017, after which NASUAD sought clarification and further detail from some states. The survey consisted of 37 questions and touched upon a variety of different MLTSS policy areas. NASUAD obtained responses from 12 states (Arizona, Florida, Iowa, Kansas, Massachusetts, Minnesota, New Jersey, New Mexico, Rhode Island, Tennessee, Texas, and Virginia), which account for more than half of the states operating MLTSS programs. Additional information from published literature and other reports was used to frame and supplement the states' responses.

TRENDS IN MLTSS PROGRAMS

Growth in MLTSS Programs over Time

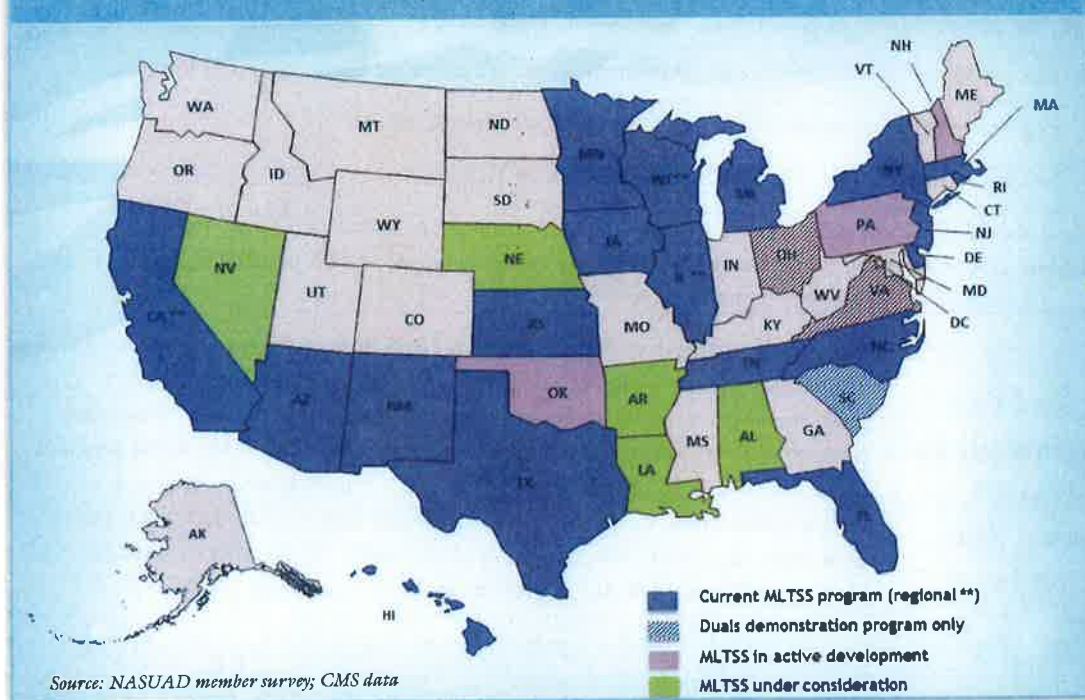
In 1989, Arizona was the first state to have a Section 1115 waiver approved by the Centers for Medicare & Medicaid Services (CMS) to implement MLTSS.¹ Over the next 15 years, MLTSS program development was spotty. However, between 2004 and 2010, the number of MLTSS programs increased from eight to 15 (see Figure 1).



Today, there are 19 states operating MLTSS programs (see Figure 2). Another three states operate MLTSS only within the confines of a Financial Alignment Initiative demonstration, which coordinates care and aligns benefits for individuals eligible for both Medicare and Medicaid (known as dually eligible beneficiaries).² Five states (New Hampshire, Ohio, Oklahoma, Pennsylvania and Virginia) were developing new or significantly modifying existing MLTSS programs in early 2017, and five more are exploring the possibility of doing so. States have implemented MLTSS using various Medicaid waiver authorities, including: Section 1115, 1915(b), 1915(a), 1915(c), and 1932(a) waivers; Financial Alignment Initiative demonstrations; and other concurrent authorities.

Four of the five states with MLTSS program development underway intend to use a 1915(b)/(c) combination waiver for their MLTSS programs; Virginia is pursuing Section 1115 authority. North Carolina also has a pending Section 1115 waiver with CMS that will, if approved, alter its current limited MLTSS program and change its operating authority for MLTSS. For more information on states' MLTSS program waivers, see the Appendix.

Figure 2. MLTSS Programs in 2017



Populations Included in MLTSS Programs

The most vulnerable populations are generally enrolled in MLTSS programs in order to provide the benefits of care coordination.³ Older adults are the most commonly included population, followed by individuals with physical disabilities. Some states also enroll children with disabilities, dually eligible beneficiaries, individuals with traumatic brain injuries (TBI), and those with intellectual/developmental disabilities (I/DD). Individuals with I/DD have typically been the last population to be enrolled in MLTSS programs; as state agencies and MCOs gain further experience with effectively coordinating care and gaining stakeholder support, this trend is expected to continue. States are also increasingly including persons with behavioral health conditions into MLTSS programs, as they seek to better integrate physical and behavioral health services.

Benefit Integration

States take different approaches to providing benefits under MLTSS programs. The most common approach is to provide a comprehensive benefits package to the populations enrolled. That type of benefits package permits a consumer to access acute/primary care, LTSS, and behavioral health services from one MCO. Such an approach can allow an MCO to serve the whole person and build provider networks that address all the needs of its consumers.

Other states provide only LTSS benefits in their MLTSS programs, which means that consumers get acute/primary care or behavioral health services from another MCO or from the state's traditional fee-for-service program. This program design choice can be driven by:

- The expansion of MLTSS after an established acute care managed care program is in place;
- Legislative or gubernatorial directives for separate programs; and/or
- Interest in contracting with MCOs that specialize in LTSS.

Among the 22 MLTSS programs currently in operation, 70 percent include Medicaid primary and acute care, more than 80 percent include nursing facility services, and 85 percent incorporate Medicaid home and community based services (HCBS).

Some states have used their Section 1115 demonstrations to provide limited HCBS benefits to consumers that otherwise would not be eligible for LTSS.

Michigan and North Carolina approach LTSS differently than most states, in that they operate long-standing, statewide, county-based, capitated programs that include only behavioral health and I/DD services. Programs can even vary within one state, as in the case of California's Medicaid program Medi-Cal, where LTSS is integrated into MCOs in only seven counties. Furthermore, some states, including Delaware, Hawaii, Rhode Island, and Tennessee have used their Section 1115 demonstration authority to provide a more limited set of HCBS to individuals at risk of needing LTSS.⁴

States' MLTSS Goals

States responding to the survey had several goals in implementing their MLTSS programs (see Figure 3). They included rebalancing Medicaid spending from institutional settings toward home- and community-based care and improving consumer health and satisfaction. Some states also identified reducing Medicaid HCBS waiver waiting lists, increasing budget predictability, and containing costs as program goals.

Figure 3. States' MLTSS Program Goals

- Rebalancing Medicaid LTSS spending
- Increasing budget predictability
- Improving consumer health and satisfaction
- Containing costs
- Reducing Medicaid HCBS waiver waiting lists

Many states see the goals of MLTSS programs as being interconnected. For example, reductions or elimination of waiting lists can help shift Medicaid LTSS spending toward HCBS, and serving more people in the community can improve consumer experience and health outcomes. Improved health outcomes can then, in turn, reduce costs.

Each of these goals for states' MLTSS programs and their reported progress in meeting those goals is examined below. Challenges that states face regarding data collection to support these goals are also discussed. While many states reported examples of ongoing data collection, monitoring and evaluation in key program areas, a significant opportunity exists to improve information collected about MLTSS program outcomes. For example, more data are needed around the impact of MLTSS programs on consumer or family satisfaction, consumers' quality of life and physical health outcomes, and cost effectiveness. States are challenged in this effort because they often have:

- limited systemic information to benchmark their fee-for-service LTSS programs;
- limited staff resources to collect and analyze data; and
- difficulty attributing program outcomes solely to the MLTSS program when it is part of comprehensive state Medicaid or integration efforts.

Rebalancing Medicaid LTSS Spending

Goals. Rebalancing Medicaid LTSS spending toward home- and community-based care and providing more options for individuals to live in and receive services in the community—if that is consistent with an individual's goals and desires—is a key goal of MLTSS programs in all of the states responding to the survey.

Many of the states surveyed have established specific rebalancing targets, as well as financial incentives for MLTSS plans to meet them. States often structure MLTSS payment rates to encourage MCOs to use HCBS instead of nursing facility services. For example, Florida's goal is to have no more than 35 percent of consumers in its statewide Medicaid Managed Care Long-term Care program residing in nursing facilities. To that end, it developed a method to adjust health plan payments annually to provide incentives for them to meet rebalancing targets.^{5,6} The state pays a blended rate, assuming a specific mix of consumers in nursing facilities and in the community, as well as a 'transition' target. If the MCOs meet or exceed those targets, they benefit financially; if they don't, they lose money.⁷

States expect that successfully rebalancing LTSS toward HCBS will help to support other MLTSS program goals, including improving quality of life, expanding access to HCBS services, and reducing costs. New Mexico views this shift as supporting the person-centered goals of its Centennial Care program and improving consumers' quality of life.⁸ Rebalancing is also a key objective for TennCare CHOICES, which has goals of serving more people with its already existing LTSS funds, and creating a more sustainable program.⁹ Lastly, Rhode Island's goal is to spend half of its Medicaid long-term care dollars on nursing facility care and half on HCBS. As of February 2017, Rhode Island is spending 79 percent of Medicaid dollars on institutional care.^{10,11} The state plans to accomplish its rebalancing goals through several healthy aging initiatives, including building age-friendly communities, enhancing community living and respite supports, strengthening the Executive Office of Health and Human Services and Medicaid interventions, and creating value-based payment opportunities and system transformation through partnerships with industry.¹²

Progress to Date. Eight states (Arizona, Florida, Kansas, Massachusetts, Minnesota, New Jersey, New Mexico, and Tennessee) reported that MLTSS has promoted rebalancing the LTSS delivery system, which aligns with national trends in MLTSS rebalancing.¹³ Nationally, the percentage of LTSS

spending on HCBS increased each year since 1995.¹⁴ Fiscal year 2013 was the first year that HCBS accounted for just over half of LTSS spending in the United States. Between 2013 and 2014, the percentage of Medicaid LTSS funds spent on HCBS increased from 51 percent to 53 percent.¹⁵ Beginning in 2016, CMS required states to report the estimated percentage of MLTSS dollars spent on institutional care and HCBS,¹⁶ so that specific MLTSS rebalancing expenditure data would become more readily available.

“In Arizona, given our historical perspective, we consider MLTSS to be an important tool to support the rebalancing of institutional and HCBS spending, and, in turn, provide greater access to HCBS options.”

—Arizona survey respondent

While it would be an overreach to attribute the increase in HCBS spending solely to the increased use of MLTSS, it is reasonable to suggest that MLTSS contributed to this trend.

Survey responses provided specific examples of success in states’ rebalancing efforts. After 25 years of incrementally adjusting HCBS targets, Arizona reported that 86 percent of its MLTSS consumers are in community settings and 68 percent are living in their own homes. Tennessee began its MLTSS program, TennCare CHOICES, with only 17 percent of Medicaid consumers receiving services in community settings.¹⁷ As of August 2015, fully 44 percent are living in community settings. Likewise, New Mexico by 2015 had reduced the percentage of Medicaid consumers residing in nursing facilities from nearly 19 percent to 14 percent.¹⁸ Since its MLTSS program was implemented, Florida has had a 12 percent decrease in the number of Medicaid consumers receiving care in nursing facilities.¹⁹

In a study comparing consumers in Massachusetts’ Senior Care Options MLTSS program to a control group of Medicaid consumers who received LTSS through the fee-for-service system, enrollees in Senior Care Options had a 16 percent lower risk of long-stay nursing facility admission, as well as a 23 percent lower rate of nursing facility entry risk at the end-of-life.²⁰ New Jersey reported that it analyzed enrollment and living arrangement data to monitor MCOs’ abilities to make appropriate nursing facility placements. As of December 2016, approximately two-thirds of the state’s MLTSS consumers were receiving HCBS services, and its nursing facility population had decreased by about 1,000 since program implementation in 2014.²¹

Improving Member Experience, Quality of Life, and Health Outcomes

Goals. Most states view MLTSS as an opportunity to create a more seamless experience of care for consumers, which should improve their quality of life. Through care coordination requirements and an enhanced array of services, MLTSS programs can bridge silos that consumers must navigate, improving their health and satisfaction. Improving health outcomes—managing chronic conditions and avoiding potentially preventable hospital admissions or emergency department visits—is a fundamental goal for MLTSS programs. One of the primary drawbacks of traditional fee-for-service programs is the bifurcation of acute care services and long term services and supports—each of which has an impact on the other. The improvement of health outcomes may be more likely when a program includes all services—physical health, behavioral health, and LTSS—under one MCO. All of the states surveyed indicated that improving consumer health, as well as consumers’ satisfaction and/or quality of life was a primary goal for MLTSS implementation.

Satisfaction with the MLTSS program as a whole often depends on the extent to which consumers feel that their managed care plans consider and address their needs and make them feel engaged and supported. For example, many MLTSS programs strive to achieve person-centeredness in service planning and delivery, underscoring the importance of helping consumers live the fullest life possible by meeting their goals and needs. Many states have sought extensive feedback from consumers, families, and other stakeholders to inform necessary adjustments to program operations and policies and improve quality outcomes to help meet this goal. Early engagement during MLTSS program development and implementation, as well as ongoing engagement during the span of the program, is an important tool to monitor program success.

Many states view care coordination as a key driver of MLTSS programs' ability to improve consumer experience and their quality of life. All MLTSS programs have requirements for care coordinators, often nurses or social workers, to assist consumers in coordinating the full array of services offered through the program.

Progress to Date. MLTSS program features such as a dedicated care coordinator, better support for family caregivers, higher likelihood of community residence, the ability to live in the setting of one's choice, and improved connection to the community can all have positive effects on consumer health and well-being. However, determining the effects of a particular feature on consumer outcomes may be difficult to separate from other variables. In addition, it can be challenging to attribute these improvements solely to MLTSS programs where several Medicaid delivery system initiatives may have been implemented at the same time in a state. However, several states have made progress in assessing certain outcomes.

Seven states (Arizona, Florida, Kansas, New Jersey, Massachusetts, Minnesota, and Tennessee) reported that their MLTSS programs improved the physical health of consumers enrolled. States have demonstrated improved health outcomes through a variety of tools, including consumer surveys and quality measures derived from managed care encounter data.²² Florida reported that in a survey it developed for its MLTSS program enrollees, nearly 60 percent of respondents said their overall health improved since their enrollment. Other states measure outcomes using data on health care utilization and preventable high-cost events. Between 2013 and 2014, Texas saw modest decreases in potentially preventable hospital admissions and readmissions rates in its STAR+PLUS program.²³ The U.S. Department of Health and Human Services' Assistant Secretary for Planning and Evaluation released a study in March 2016 comparing the outcomes of consumers from 2010 to 2012 in the Minnesota Senior Health Options (MSHO) program with similar individuals outside of the program.²⁴ The study found that consumers in the MSHO program were 48 percent less likely to have a hospital stay, and those who were hospitalized had 26 percent fewer stays overall. Additionally, MSHO consumers were also 13 percent more likely to receive HCBS and were 6 percent less likely to have an outpatient emergency department visit—of those who did visit the outpatient emergency department, 38 percent had fewer subsequent visits. Through the Kansas KanCare program, primary care physician visits increased by 80 percent, “costly hospital stays” decreased by 29 percent, and emergency department use decreased by seven percent.²⁵ Non-emergency transportation use was also up 56 percent, an indication that KanCare consumers might have been attending more appointments with providers.²⁶

“A successful MLTSS program will think about care planning beyond traditional support services.”

—Tennessee survey respondent

Eleven states (Arizona, Florida, Iowa, Kansas, Minnesota, New Jersey, New Mexico, Rhode Island, Tennessee, Texas, and Virginia) use consumer and/or family surveys to collect information on consumer and family satisfaction with the MLTSS program. Nine of these states also collect information on the quality of life of consumers participating in their MLTSS programs. Figure 4 below displays the different tools that states are using to assess quality of life and/or satisfaction.

Figure 4. Tools States Use to Collect Data on MLTSS Consumer Quality of Life and Satisfaction

<i>State</i>	<i>Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey</i>	<i>National Core Indicators—Aging & Disabilities (NCI-AD™)</i>	<i>State-Developed Tools</i>	<i>HCBS Experience of Care Survey*</i>
Arizona				✓
Florida			✓	
Iowa			✓	
Kansas		✓		
Minnesota		✓		
New Jersey		✓		
New Mexico	✓			
Rhode Island	✓			
Tennessee		✓		
Texas		✓		
Virginia			✓	

** The HCBS Experience of Care survey has been added to the CAHPS family of surveys and is now known as CAHPS HCBS*

Florida noted 77 percent of respondents to its state survey reported an improved quality of life since joining an MLTSS plan. In Texas, consumers receiving MLTSS services reported that having HCBS gave them a sense of independence and personal space that was important for their quality of life. In Virginia, consumers in the state’s Commonwealth Coordinated Care demonstration program were asked to comment on the one thing they liked or disliked most about their care coordinator. The 291 comments received were overwhelmingly positive and indicated that respondents were particularly pleased with care coordinators’ helpfulness, compassion, friendliness, ability to listen, efficiency, responsiveness, politeness, information, and communication style.²⁷ New Jersey, Tennessee, and Texas are using information gleaned from the NCI-AD™ survey to implement quality improvement activities for their MCOs.

While some states find value in reviewing family and member satisfaction annually, other states find “real-time” or regular check-ins with consumers and families on their care experiences to be important for guiding program modification on a more rapid cycle. Among other methods, Tennessee uses computer tablets to gather point-of-service consumer satisfaction during visits with the care coordinator.²⁸ New York also frequently assesses consumer satisfaction with its MLTSS program.²⁹

Challenges in Collecting Quality of Life Data. One of the most valid and reliable ways to assess quality of life outcomes for MLTSS programs is to survey consumers and their caregivers (as appropriate). However, in-person or phone surveys are time and labor-intensive. States have limited capacity to conduct and oversee data collection efforts across the scope of questions needed to cover all aspects of the MLTSS program. New Jersey reported that data collection by state and local staff is labor-intensive. Texas reported that its expansive geography was a challenge because survey contractors must travel extensively to complete in-person surveys, making data collection time- and resource-intensive. Another state noted lack of funding as the reason why it does not collect satisfaction data from individuals and families. Because quality of life outcomes are so important to assessing the success of an MLTSS program, continued effort must be made to make the collection of this data less burdensome and timelier. States should also look for other ways to measure satisfaction and quality outcomes—for example, the National Quality Forum’s recently released framework for HCBS quality measurement.³⁰

Reducing Waiver Waiting Lists and Increasing Access to Services

Goals. When there is a greater demand for HCBS services than there are existing 1915(c) waiver slots, some states maintain waiting lists for services. In 2015, there were over 600,000 individuals on HCBS waiver waiting lists in 35 states.³¹ MLTSS programs may reduce or eliminate waiting lists, which, in turn, would result in increased access to LTSS. Six states (Florida, Iowa, Kansas, New Jersey, New Mexico, and Tennessee) indicated that a reduction in waiting lists for LTSS was a goal for their MLTSS programs. Tennessee also identified increasing care options and expanding access so that more people can receive care in the community as a related key objective.³² Other states focused on increasing access to HCBS options, the preferred service setting for most consumers.

Progress to Date. Some states leverage their MLTSS program to eliminate waiting lists, while other states have addressed waiting lists by prioritizing applicants by level of need. Tennessee has eliminated waiting lists for TennCare CHOICES consumers who qualify for a nursing home level of care, and, through its Section 1115 demonstration, it also provides individuals needing a lower level of care with a narrower package of services to prevent or delay transitions to nursing homes.^{33,34} Other states reported that they reinvested savings achieved through managed care implementation to decrease the number of people on waiting lists. For example, in 2014, Florida invested \$12.6 million to enroll wait-listed individuals with the most critical needs into its MLTSS program.³⁵

For some states, in addition to reducing or eliminating wait lists, increasing access can mean expanding the array of services available under an MLTSS program. From 2013 to 2014, all seven MCOs in Florida’s MLTSS program offered between five to 12 expanded benefits (i.e., vision services, non-medical transportation, and hearing evaluations).³⁶ All seven plans provided support for nursing facility transitions, dental services, and over-the-counter medications as expanded services. In certain circumstances, Tennessee also allows its MCOs to provide “Cost-Effective Alternative” services, if they provide a less expensive alternative to a Medicaid service and prevent an individual from developing a condition that would require more costly treatment in the future, such as institutionalization.³⁷ Examples of Cost-Effective Alternative services include a transition allowance (i.e., up to \$2,000 to establish a community residence when transitioning from a nursing facility, including rent/utility deposits, household furnishings, items, etc.) and HCBS (e.g., attendant care) in excess of a defined benefit limit.³⁸ Budget constraints have made providing a comprehensive dental benefit challenging in Massachusetts’ fee-for-service system, but MCOs in its Senior Care Options program have filled this gap by providing dental services not covered by MassHealth.³⁹

Many Medicaid agencies work with MCOs and sister state agencies to address challenges with access to services. Transportation services to medical appointments can make it easier for individuals with chronic conditions to remain living in their home, and consumers frequently identify this benefit as highly valuable.⁴⁰ Several states increased access to services by providing expanded transportation options. For example, Massachusetts MCOs participating in the Senior Care Options program can directly coordinate and pay for transportation services for medical appointments, which minimizes the burden often associated with managing these services under the fee-for-service system. Other states have focused on expanding provider recruitment and other related activities in underserved areas. New Jersey strives to increase access to services and critical providers, especially for those in underserved areas, in different ways. The state uses financial incentives to encourage providers to serve these areas and plans to incorporate more evidence-based telehealth technologies and programs, like Project ECHO (Extension for Community Healthcare Outcomes), into the service delivery system.⁴¹ New Mexico also uses Project ECHO in its Centennial Care program.

Increasing Budget Predictability and Managing Costs

Goals. MLTSS programs can improve budget predictability for states simply because MCOs are paid a monthly capitation rate for all covered services. Seven states (Florida, Iowa, Kansas, Massachusetts, New Jersey, Rhode Island, and Tennessee) identified budget predictability as a goal for MLTSS implementation.

MLTSS programs also have the potential to achieve savings by: rebalancing LTSS spending to provide more HCBS; managing service utilization; and using care coordination to avoid unnecessary inpatient or institutional placements. Five states (Florida, Iowa, New Jersey, New Mexico, and Virginia) identified Medicaid cost containment as a goal for MLTSS implementation. Virginia believes that

the features of Commonwealth Coordinated Care Plus, its soon-to-be-launched MLTSS program, will also reduce costs over time.⁴² In Florida, quality and efficiency are goals of the state's MLTSS program, while transitions from institutions to HCBS are also viewed as opportunities to achieve savings.^{43,44} To emphasize this point, Florida estimated that without the nursing facility-to-community transitions facilitated by its MLTSS program, Medicaid LTSS might potentially have cost the state an additional \$284 million in 2014-2015, \$432 million in 2015-2016, and \$200 million per year each year thereafter.⁴⁵

Tennessee describes managed care as a set of principles that can improve coordination, quality, and cost-effectiveness of care for vulnerable populations, and views quality and cost as "inextricably linked."⁴⁶ Similarly, one of the goals for KanCare

is to "control Medicaid costs by emphasizing health, wellness, prevention, and early detection, as well as integration and coordination of care."⁴⁷ Kansas believes that by requiring MCOs to meet certain outcomes and performance goals and tying these to financial incentives, quality will improve and costs will decrease.⁴⁸

Progress to Date. Seven states (Florida, Iowa, Massachusetts, New Jersey, New Mexico, Rhode

"It's important to have realistic expectations for the MLTSS program. The initial focus must be on ensuring that members get high-quality services and providers are paid. Trying to achieve savings too quickly can shift the focus away from these non-negotiables."

—Tennessee survey respondent

Island, and Tennessee) reported collecting data to demonstrate “bending the cost curve” or reducing the rate of growth in Medicaid expenditures. Checking for cost neutrality (e.g., waiver program costs are less than or equal to the cost of institutional programs for the same population enrolled in an HCBS waiver), analyzing Medicaid expenditures (including encounter and enrollment data), and measuring nursing facility diversion rates were the most noted methods used to monitor program sustainability and cost effectiveness.

Florida reported that shifting to a capitated, risk-adjusted MLTSS program enhanced the predictability and management of its MLTSS program.⁴⁹ In addition, its MLTSS program met five percent savings targets established by the legislature during the first three-month period of statewide implementation in 2013 and 2014.⁵⁰ Massachusetts also reported meeting its goal of budget predictability for its “otherwise volatile and high-cost populations” enrolled in the Senior Care Options.⁵¹

To decrease administrative burden, states may also restructure their Medicaid agencies and streamline some responsibilities that are delegated to MCOs. Three states (Florida, Massachusetts, and Texas) reported that implementing MLTSS decreased administrative burden in their Medicaid programs. However, as Tennessee recognized, it is important to note that successfully implementing managed care and achieving program goals requires a significant investment in monitoring and oversight capabilities, shifting the state’s infrastructure to “manage” managed care.⁵² This includes continuous involvement of state leadership in program management and oversight, and having a robust strategy for overseeing MCO performance and accountability.

Challenges in Documenting Financial Outcomes. Ensuring program sustainability and cost effectiveness are important MLTSS program goals; however, inadequate data have been a barrier to states’ ability to demonstrate these outcomes. MLTSS programs generally do not operate independently, but rather are part of a broader Medicaid or integrated care initiative in the state. Therefore, attributing cost effectiveness solely to the efforts of the MLTSS program can be challenging. For example, Texas MLTSS is part of a larger program that integrates MLTSS and acute care services to provide consumers with comprehensive care. The savings achieved through the integrated program have been evaluated, but not in terms of the specific impact of MLTSS. Texas intends to evaluate the impact of the managed care implementation of the Community First Choice option once sufficient data are available. New Jersey noted that because they rely on self-reported data from its MCOs, the data may not always be reliable. In addition, states do not often collect baseline measurements across several cost and quality indicators prior to an MLTSS program launch. Moreover, they do not often have solid cost projections for their fee-for-service programs against which they can compare their MLTSS programs. This makes it almost impossible to reliably make “pre—post” comparisons. Tennessee did monitor relevant targets prior to TennCare CHOICES implementation to establish a baseline and later demonstrate program outcomes. States considering new or expanded MLTSS programs should consider investing resources in establishing baselines from their current program, as it is critical to provide post-implementation comparisons, which are often demanded by stakeholders.

“Florida has seen a 12 percent decrease in the number of consumers receiving services in nursing facilities, a decrease that can be attributed to the MLTSS program and payment incentives to ensure consumers receive care in the least restrictive setting. The MLTSS program has resulted in cost savings to the state and better budget predictability—an important factor in serving a growing aging population.”

—Florida survey respondent

CONCLUSION

This report reviewed several state goals for implementing MLTSS programs, including: rebalancing Medicaid LTSS spending; improving consumer experience, quality of life and health outcomes;

More data are needed around the impact of MLTSS programs on consumer or family satisfaction, consumers' quality of life and physical health outcomes, and cost effectiveness.


reducing wait lists and improving access to services; and increasing budget predictability; and managing costs. Several states provided compelling examples demonstrating that they are meeting these goals. At the same time, their work underscores the importance of expanding the scope and amount of data collected and the need to continue strengthening efforts to monitor the performance of MLTSS plans, in order to assure the best outcomes for their consumers.

States reported lessons learned related to the challenge of better demonstrating program value, including the necessity for standardized quality measures across MLTSS programs to assess person-centeredness and outcomes, as well as better monitoring of managed care performance as an essential obligation. Other take-aways included:

- Collecting and analyzing encounter data and other programmatic data is challenging;
- Developing an oversight structure for MLTSS programs is complex; and
- To achieve a smooth transition from a fee-for-service system, dedicate more staff resources and refine existing staffing strategies for MLTSS implementation and oversight.

One recommended solution for states is to collect baseline measures on consumers' health status, as well as other program variables like cost and service utilization, in order to tie outcome measures to these benchmarks:

- State legislatures request information regarding MLTSS program sustainability. States listed a variety of data and reporting measures (e.g., LTSS rebalancing, program sustainability and cost savings, improved health outcomes, and nursing facility diversion) that were helpful in addressing legislative inquiries.
- Stakeholders have concerns about network adequacy and provider payment rates. States noted significant stakeholder pushback when transitioning from fee-for-service models to managed care. A primary concern was MCOs' perceived use of a "medical model" rather than a person-centered approach to the full range of LTSS needed by consumers to lead a meaningful and engaged life. Assessing access and consumer satisfaction pre- and post-implementation could be valuable in addressing stakeholder concerns.
- Stakeholders voice concerns about service reductions or appeals and grievances. Building a track record of strong consumer education and post-enrollment support (e.g., MLTSS ombudsman programs) can mitigate those concerns.



Another solution for states is to ensure that MCO contract requirements correlate to program goals and facilitate the collection of additional data to demonstrate the value of the program to stakeholders with various concerns and interests. States will find that strong contracting requirements and performance monitoring are important tools for reassuring stakeholders, building their support, and demonstrating program viability over time.

Technical Assistance Available for States

Operating an efficient and effective MLTSS program requires a thoughtful program design, capable health plan partners, strong state oversight, and appropriate accountability mechanisms. A recent study concluded that these factors vary considerably from state to state.⁵³ NASUAD created the MLTSS Institute to capitalize on its capacity to deliver solid, reliable technical assistance tailored to each state's program and needs. NASUAD staff are available to assist states with any number of activities, including: stakeholder engagement, quality measurement, value-based purchasing, contract management, and collaboration with health plan partners and other contractors.

NASUAD created the MLTSS Institute to capitalize on its capacity to deliver solid, reliable technical assistance tailored to each state's program and needs.

APPENDIX: STATE MLTSS PROGRAMS

State	Managed Care Authority Used	Populations Enrolled					Covered Benefits	
		Seniors	PD	DEB	I/DD	BH	Comprehensive	Other
Arizona ⁱ	1115	✓	✓	✓	✓		✓	
California	1115; FAI	✓	✓	✓			✓ (DEB only)	LTSS
Delaware	1115	✓	✓				✓	
Florida	1915(b)/(c)	✓	✓					LTSS
Hawaii	1115	✓	✓	✓			✓	
Iowa	1915(b)	✓	✓		✓		✓	
Illinois	1915(b); FAI	✓	✓	✓			✓	
Kansas	1115	✓	✓	✓	✓		✓	
Massachusetts	1915(a); FAI	✓		✓			✓	
Michigan	1915(b); FAI			✓	✓	✓	✓ (DEB only)	LTSS; BH
Minnesota	1915(a); 1915(b)	✓		✓			✓	
New Jersey	1115	✓	✓	✓			✓	
New Mexico	1115	✓	✓	✓			✓	
New York	1115; FAI	✓	✓	✓	✓		✓ (DEB only)	LTSS
North Carolina	1915(b)				✓	✓		LTSS; BH
Ohio	FAI			✓			✓	
Rhode Island	1115; FAI	✓	✓	✓			✓	
South Carolina	FAI			✓			✓	
Tennessee	1115	✓	✓	✓	✓		✓	
Texas ⁱⁱ	1115; FAI	✓	✓	✓	✓		✓	
Virginia ⁱⁱⁱ	FAI			✓			✓	
Wisconsin	1915(b); 1932(a)	✓	✓	✓	✓		✓ (DEB only)	LTSS

Source: NASUAD data; CMS Managed Care Profiles (<https://www.medicaid.gov/medicaid/managed-care/state-profiles/index.html>)

Key

Authority

- 1115—Section 1115 demonstration
- 1915(a)—Voluntary managed care program
- 1915(b)—1915(b) managed care waiver
- 1932—State plan amendment for managed care
- FAI—Financial Alignment Initiative demonstration

Populations

- PD—Persons with physical disabilities
- DEB—Dually eligible beneficiaries
- I/DD—Persons with intellectual/developmental disabilities
- BH—Persons with mental health and/or substance use disorders

Benefits

- Comprehensive—full range of acute/primary/LTSS/behavioral health services
- LTSS—Nursing facility services as well as home and community based services only

- ⁱ Arizona enrolls beneficiaries dually eligible for Medicare and Medicaid in its ALTCS program, although “dually eligible” is not one of the program’s enrollment categories.
- ⁱⁱ Texas I/DD population receiving I/DD HCBS 1915(c) waiver services or residing in an ICE/IID receive only acute services through MCOs.
- ⁱⁱⁱ Virginia intends to terminate its FAI in December 2017 and instead implement a broader MLTSS program to include both dually eligible and non-dually eligible.

ENDNOTES

- ¹ Arizona has always provided LTSS through a managed care delivery system, and so never transitioned from fee-for-service to MLTSS.
- ² States taking part in the Financial Alignment Initiative: CA, CO, IL, MA, MI, NY, OH, RI, SC, TX, VA and WA. For more information see: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsInCareCoordination.html>.
- ³ States also can use many other strategies to coordinate care—and integrate benefits—for the dually eligible population. Many MLTSS programs include Medicare primary and acute care services for these consumers. States may integrate Medicare and Medicaid services through Financial Alignment Initiative demonstrations, aligned Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) and Medicaid MCOs, and Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs) among other initiatives.
- ⁴ M. Watts, M.B. Musumeci, and P. Ubri. Medicaid Section 1115 Managed Long-Term Services and Supports Waivers: A Survey of Enrollment, Spending, and Program Policies. Kaiser Family Foundation. January 2017. Available at: <http://files.kff.org/attachment/Report-Medicaid-Section-1115-Managed-Long-Term-Services-and-Supports-Waivers>.
- ⁵ B. Kidder. “Statewide Medicaid Managed Care Program.” Agency for Health Care Administration presentation to Florida House Health and Human Services Committee, January 10, 2017. Available at: http://ahca.myflorida.com/medicaid/recent_presentations/House_Health_Human_Services_Med_101_2017-01-10.pdf.
- ⁶ As of July 2016, 46,805 MLTSS consumers in Florida lived in HCBS settings, while 42,161 lived in nursing facility settings. Source: Ibid.
- ⁷ B. Kidder. “Florida Medicaid: Managed Care Rate Setting.” Agency for Health Care Administration presentation to Florida House Health Care Appropriations Subcommittee, January 11, 2017. Available at: http://ahca.myflorida.com/medicaid/recent_presentations/House_Health_Care_Appropriations_Subcommittee_Managed_Care_Rate_Setting_2017-01-11.pdf.
- ⁸ New Mexico Human Services. *Centennial Care 1115 Waiver Renewal Subcommittee Long-Term Care Brief*. December 2016. Available at: <http://www.hsd.state.nm.us/uploads/files/Long%20Term%20Care%20Brief%20-%20Waiver%20Renewal%20Committee%20Dec%202016%202016.pdf>.
- ⁹ P. Killingsworth. “State of Tennessee Managed Long Term Services and Supports.” Presentation during Wisconsin Managed Care Discussions. November 2015.
- ¹⁰ As of February 2017, Rhode Island spent 79 percent of its Medicaid long-term care dollars on institutional care and 21 percent on HCBS. “Healthy Aging in the Community: Rebalancing Long-Term Care in Rhode Island.” Rhode Island Executive Office of Health and Human Services presentation to the Rhode Island Lt. Governor’s Long Term Care Coordinating Council, February 2017.
- ¹¹ Rhode Island Executive Office of Health and Human Services. *State Annual Report on Long-Term Care System Reform and Rebalancing*. April 6, 2016. Available at: http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Reports/LTSS_Reform_Rebalancing_April2016.pdf.
- ¹² Rhode Island Executive Office of Health and Human Services, op. cit.
- ¹³ Twelve states responded to the survey AZ, FL, IA, KS, MA, MN, NJ, NM, RI, TN, TX, and VA; however, some states did not respond to each question.
- ¹⁴ S. Eiken, K. Sredl, B. Burwell, and P. Saucier. *Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2014: Managed LTSS Reached 15 Percent of LTSS Spending*. Truven Health Analytics. April 2016. Available at: <https://www.medicare.gov/medicaid/ltss/downloads/ltss-expenditures-2014.pdf>.
- ¹⁵ Ibid.
- ¹⁶ Ibid.
- ¹⁷ Killingsworth, op. cit.
- ¹⁸ “Centennial Care Next Phase.” New Mexico Human Services Department presentation to 1115 Waiver Renewal Subcommittee, December 16, 2016. Available at: <http://www.hsd.state.nm.us/uploads/files/Presentation%20-%20Dec%202016%202016%20Waiver%20Renewal%20Committee.pdf>.
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- ²⁰ Health Management Associates. *Value Assessment of the Senior Care Options (SCO) Program*. July 2015. Available at: http://www.mahp.com/unify-files/HMAFinalSCOWhitePaper_2015_07_21.pdf.
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- ²² Health Management Associates, op cit.
- ²³ The Institute for Child Health Policy, University of Florida. *Texas Medicaid Managed Care and Children's Health Insurance Program: External Quality Review Organization Summary of Activities and Trends in Healthcare Quality*. January 2016. Available at: <https://bhs.texas.gov/sites/bhs/files/egro-2015-summary-of-full-report-activities-and-trends-in-healthcare-quality.pdf>.
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- ²⁶ Ibid.
- ²⁷ A. Cuellar, G. Gimm, and C. Gresenz. *A Survey of EDCD Waiver Participants who were Enrolled in the Commonwealth Coordinated Care (CCC) Program for Dual-Eligibles*. George Mason University Department of Health Administration and Policy. September 2016. Available at: http://www.dmas.virginia.gov/Content_atcbs/altc/CCC_Tel_Mail_Survey%20Findings_Enrollees_16-9-2.pdf.
- ²⁸ Killingsworth, op. cit.
- ²⁹ New York State Department of Health. *2015 Managed Long-Term Care Report*. 2015. Available at: http://www.health.ny.gov/health_care/managed_care/mltc/pdf/mltc_report_2015.pdf.
- ³⁰ National Quality Forum. *Quality in Home and Community-Based Services to Support Community Living: Addressing Gaps in Performance Measurement*. September 2016. Available at: http://www.qualityforum.org/Publications/2016/09/Quality_in_Home_and_Community-Based_Services_to_Support_Community_Living__Addressing_Gaps_in_Performance_Measurement.aspx.
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- ³³ Ibid.
- ³⁴ TennCare Division of Health Care Finance & Administration. "To Qualify for CHOICES." Available at: <http://www.tn.gov/tenncare/article/to-qualify-for-choices>.
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- ³⁶ Florida State University. *Independent Assessment of the Florida Statewide Medicaid Managed Care Long-Term Care Program. Final Report for Program Year 2013-2014*. January 2016. Available at: http://abca.myflorida.com/medicaid/Policy_and_Quality/Quality/performance_evaluation/MER/Archive/med168/docs/Independent_Assessment_FL_SMMC_LTC_Program-Final_Report_2013-14.pdf.
- ³⁷ Bureau of TennCare, Health Care Finance & Administration. *TennCare Policy Manual*. Policy No: BEN 08-001. December 2014. Available at: <https://www.tn.gov/assets/entities/tenncare/attachments/ben08001.pdf>.
- ³⁸ Ibid.
- ³⁹ Health Management Associates, op cit.
- ⁴⁰ Health Management Associates, op. cit.
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- ⁴³ B. Kidder. "Florida Medicaid: Managed Care Rate Setting," op. cit.
- ⁴⁴ B. Kidder. "Medicaid Long-term Care Program," op. cit.
- ⁴⁵ Ibid.
- ⁴⁶ Killingsworth, op. cit.
- ⁴⁷ Kansas Department of Health and Environment, Division of Health Care Finance. "KanCare Final Evaluation Design." March 2015. Available at: <https://www.kanccare.ks.gov/docs/default-source/policies-and-reports/quality-measurement/kanccare-final-evaluation-design-march-2015.pdf?sfvrsn=2>.
- ⁴⁸ Ibid.
- ⁴⁹ B. Kidder. "Statewide Medicaid Managed Care Program," op. cit.
- ⁵⁰ Florida State University, op. cit.
- ⁵¹ Health Management Associates, op. cit.
- ⁵² Killingsworth, op. cit.
- ⁵³ AARP Public Policy Institute. *Keeping Watch: Building State Capacity to Oversee Medicaid Managed Long-Term Services and Supports*. July 2012. Available at <http://www.nasuad.org/sites/nasuad/files/keeping-watch-building-state-capacity-to-oversee-medicare-managed-ltss-AARP-ppi-health.pdf>.



National Association of States United for Aging and Disabilities

1201 15th Street NW, Suite 350 • Washington, DC 20005
Phone: 202-898-2578 • www.nasuad.org

FINDINGS

Tab 0



MISSISSIPPI HOSPITAL ASSOCIATION

November 12, 2018

Kevin S. Cook
CEO
University of Mississippi Hospitals and Health System
2500 North State Street
Jackson, MS 39216-4500

Re: Commission on Expanding Medicaid Managed Care

Dear Mr. Cook,

On behalf of the membership of the Mississippi Hospital Association, we ask that you please include this letter and its attachments into the record of the above referenced commission. As the hospital representative on the Commission, we appreciate you voicing the concerns of the industry and ensuring that the concerns of hospitals are heard.

As you know, hospitals have experienced significant challenges regarding the current managed care program. Recently, at a meeting of the Rural Health Alliance (“RHA”), members expressed concerns regarding the lack of uniform credentialing between the managed care plans and the Division of Medicaid as required by Mississippi Code Section 43-13-117. We ask that the plans comply with current state law regarding credentialing. RHA and other members continue to experience significant denials and delays in payments – denials which are often overturned and delays which are not the fault of the hospital. One large health system prepared a description of its issues with the managed care companies. That information is attached herewith. You’ll note that the number of payment errors from the Division of Medicaid (1) pales in comparison to the number of errors from Magnolia (7) and United (5). Similarly, the average time to resolve these errors was one month for Medicaid, 3.4 months for United and 11 months for Magnolia. The Committee should comprehensively study the timeliness and accuracy of payments made by the MCOs as compared to those claims paid under fee for service Medicaid. The impact of these delays and denials on a hospital’s cash flow can be substantial.

Finally, there have been no findings or audits to determine the savings attributable to the managed care programs or the benefits of the program. Specifically, Mississippi Code Section 43-13-117 requires an audit to determine how much money has been by the MCOs as a result of improved health outcomes. A comprehensive audit on all of the statutorily required elements should precede any recommendations

regarding the expansion of the managed care program. From filings made by the two Medicaid managed care organizations with the Mississippi Insurance Department, the difference between premiums earned and losses incurred from calendar year 2013 through calendar year 2017 is \$978,963,956. Arguably, this represents the administrative payments made to the plans. It could be argued that unless the plans have saved more than they have been paid in administrative fees, the program has not truly saved any money.

The timeline to report the Commission's recommendations and findings was always aggressive, but was made worse by the fact that the Commission did not meet within 45 days of the effective date of the statute as the law required. Given such hurdles, it is virtually impossible for the Commission to obtain enough information over a two month period to digest and examine a program that has spent tens of billions of dollars over the last eight years and covered hundreds of thousands of beneficiaries.

Again, thank you for representing hospitals on this Commission. Should you or the Commission have any questions or require specific information regarding hospitals, please do not hesitate to contact me.

Sincerely,

A handwritten signature in blue ink that reads "Timothy H. Moore". The signature is written in a cursive style with a large initial 'T'.

Timothy H. Moore
President / CEO

Attachment

Medicaid and MS Can payer error resolution timeframes

Payer	Error/project	Months for Resolution
Medicaid	Medicaid - 2018 new CPT codes	1
MS Can Magnolia	Magnolia surgical under-payments	4
MS Can Magnolia	Magnolia 2016 newborns	22
MS Can Magnolia	Magnolia IP Rehab - 2016-17 claims	23
MS Can Magnolia	Cenpatico Magnolia - routing rev 204 claims incorrectly	16
MS Can Magnolia	MS Can Magnolia - 2018 new CPT codes	7
MS Can Magnolia	MS Can Magnolia - pending claims (new CPT's)	3
MS Can Magnolia	MS Can Magnolia - rev code 450 denials	2
MS Can UHC	MS Can UHC - 2017 CPT codes	5
MS Can UHC	MS Can UHC - CO-256 denials	2
MS Can UHC	MS Can UHC - 2018 new CPT codes	4
MS Can UHC	MS Can UHC - CPT 80307	5
MS Can UHC	MS Can UHC - CO-256 retractions	1

95

Payer	# of Errors	Total Months for Resolution	Average Months for Resolution
Medicaid	1	1	1
MS Can Magnolia	7	77	11.00
MS Can UHC	5	17	3.4
Grand Total	13	95	7.31

FINDINGS

Tab P

Mississippi Pharmacists Association

www.mspharm.org

341 Edgewood Terrace Dr., Jackson, MS 39206

P: 601.981.0116 F: 601.981.0451

Dear Chairman Wiggins and Commission members,

The Mississippi Pharmacists Association (MPhA) represents all areas of pharmacy practice, including health-system, academia, chain, independent, technicians and students. Not only is MPhA opposed to adding any other categories of eligibility to Managed Care in MS, MPhA is in favor of carving out pharmacy services for all Medicaid beneficiaries.

In 2011, the Mississippi Division of Medicaid (DOM) Office of Pharmacy had the foresight to make the managed care pharmacy benefits program a 'pass-through model' rather than a 'spread-pricing model'. DOM determines the Preferred Drug List for fee for service (FFS) as well as the plans. Additionally, rebates belong to Medicaid rather than the plans, and reimbursement for pharmacy services is the same as for Medicaid FFS.

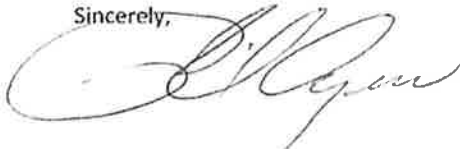
In 2017, West Virginia carved out the pharmacy benefits from their managed care program and are projecting a \$38 million annual savings. The findings of a June 2018 audit encouraged Ohio Medicaid officials to move to a pass-through model for their managed care pharmacy benefits program. This audit found that in 2017, Ohio managed care pharmacy benefit managers (PBMs) billed the state \$223 million more than what the PBMs paid to the dispensing pharmacies. Mississippi has never allowed a PBM to run the Medicaid pharmacy program. These examples serve as evidence to the reason why we should not allow the PBMs the authority.

Nationally, pharmacies are facing many challenges, including but not limited to pricing, availabilities, limited networks and insurance obstacles. DOM's Office of Pharmacy has consistently been a valuable resource to provide assistance for the Medicaid beneficiary populations, and providers. The office of Pharmacy handles all aspects of the Medicaid pharmacy benefits within our state. An example of an innovative program is the Complex Pharmacy Care Program (CPCP), started in October 2016, designed to manage complex disease states and beneficiaries. In a little over the the first year of implantation the CPCP, aimed at ensuring the effective/appropriate use of complex expensive medications, has saved the state \$4.6 million. With 65% of the Medicaid beneficiary population enrolled in managed care, the state will not realize the full potential of programs savings such as the CPCP. We need more beneficiaries in the CPCP to see the full potential.

MPhA members state that there are problems with the managed care companies' pharmacy programs. Problems include, but not limited to, timely payments, pharmacy reimbursement error, burdensome and unfair pharmacy audits, forcing beneficiaries to use the managed care mail-order program, unreadiness for claims processing changes, and requiring specialty prescriptions to be dispensed by Managed Care owned specialty pharmacies and/or out of state pharmacies when there are in state pharmacies that can dispense said medications.

The MPhA membership and I are appreciative of this opportunity to express our concerns.

Sincerely,



Phil Ayers, PharmD, BCNSP, FASHP
MPhA Interim Executive Director



FINDINGS

Tab Q

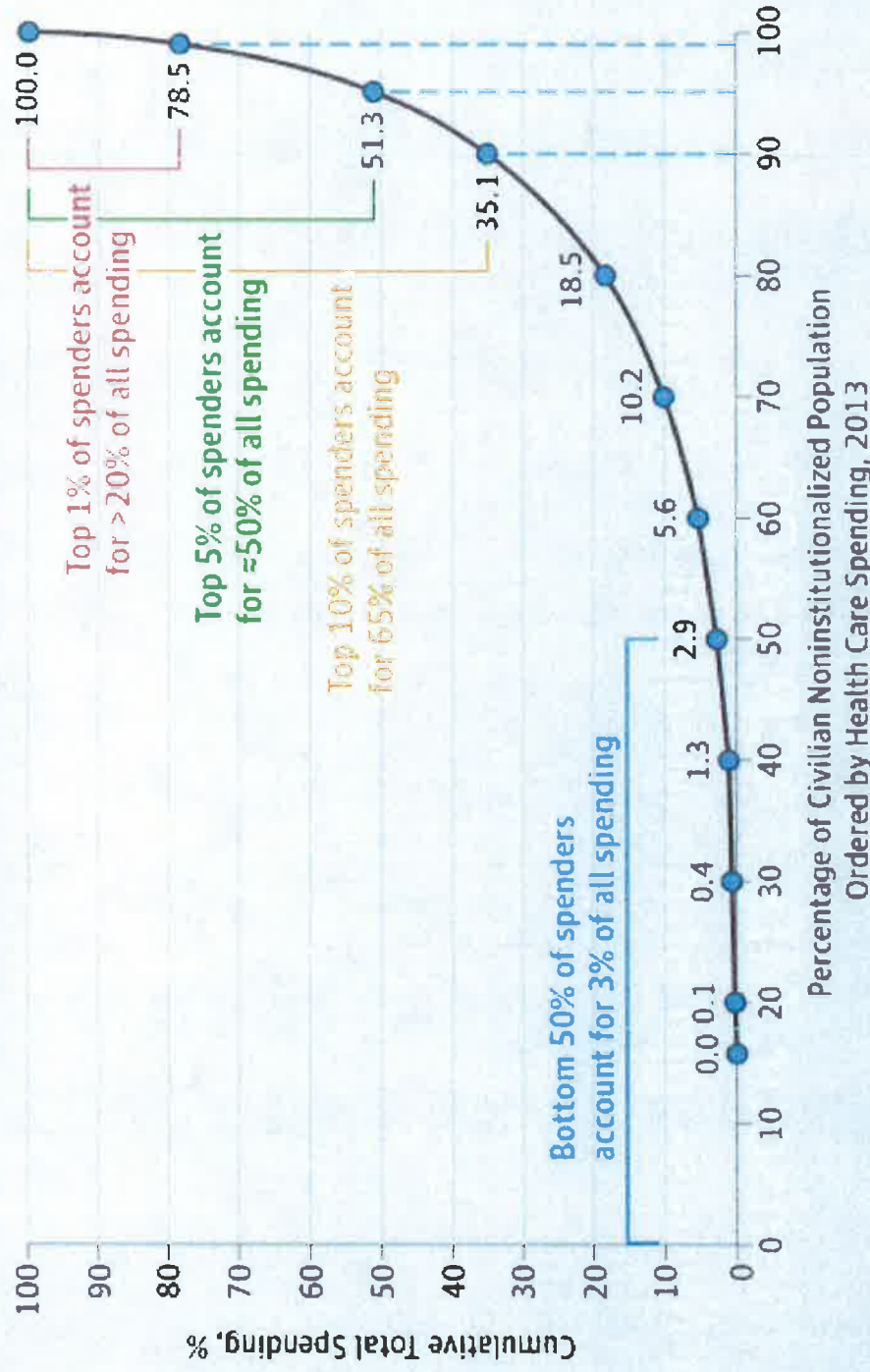
Michael Mansour, MD, FACP, FACC
President Mississippi State Medical Association



80-20 Rule of Healthcare Economics

Uwe Reinhardt, JAMA 2016

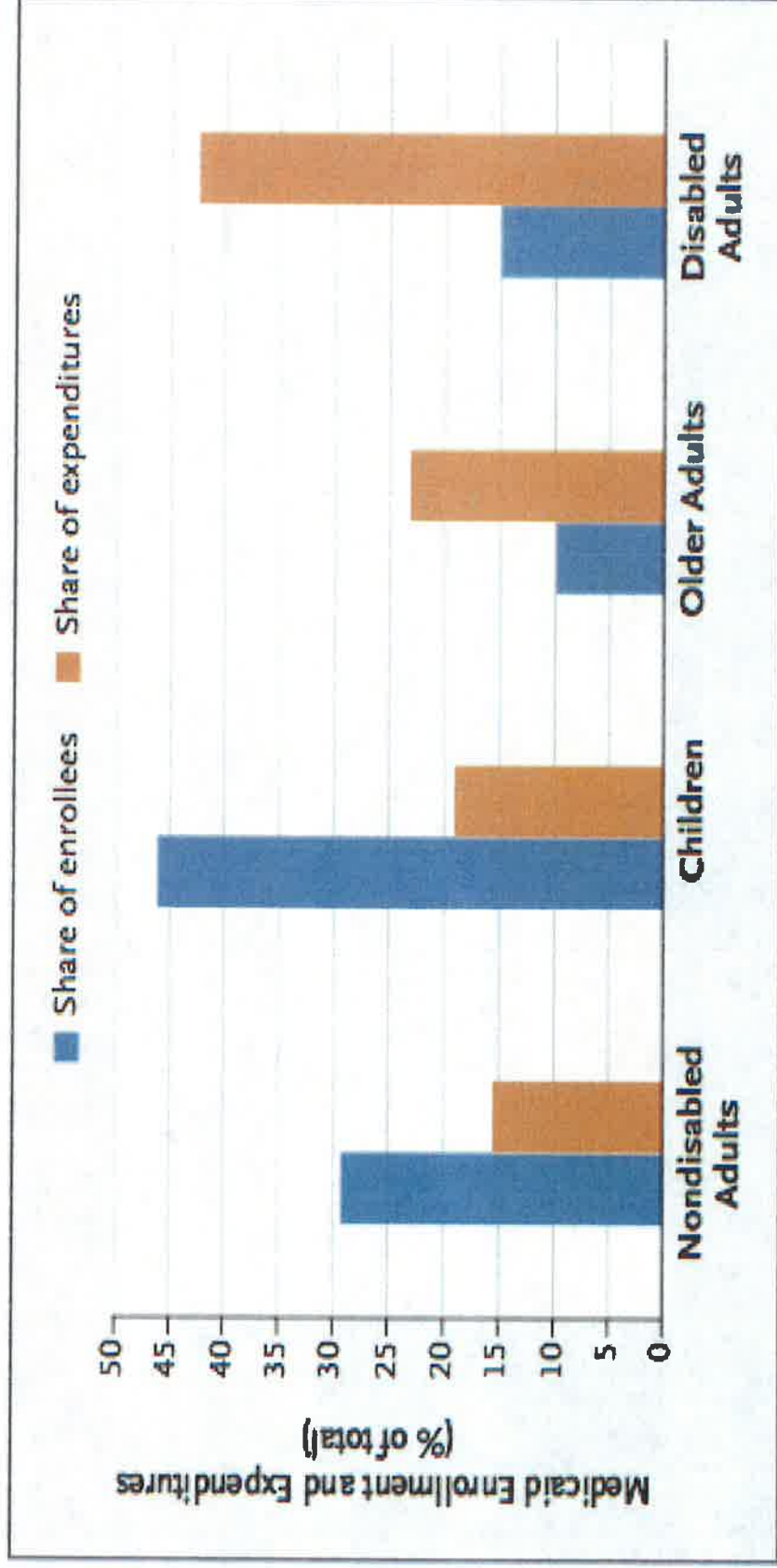
Concentration of Health Spending Among Highest Spenders



Source: National Institute for Health Care Management Foundation analysis of data from the 2013 Medical Expenditure Panel Survey

Controlling the Cost of Medicaid

NEJM 377:3:201-203



Medicaid Enrollment and Expenditures, by Eligibility Group, Fiscal Year 2013.

Data are from MACStats: Medicaid and CHIP Data Book (December 2016) (www.macpac.gov/publication/macstats-medicaid-and-chip-data-book-2).

Determinants of Health and Well Being

10% Healthcare

20% Social/Environmental

30% Genetics

40% Individual Behavior

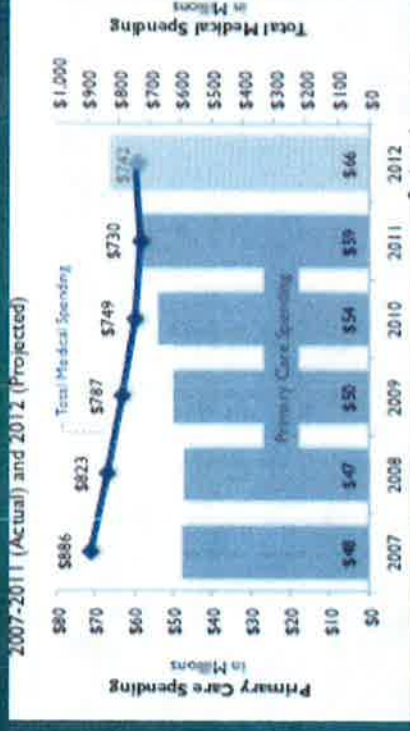


GOALS for Addressing Non-communicable Diseases & Social Determinants of Health

- 1. Decrease Illness**
- 2. Improve Access**
- 3. Limit Cost**



Primary Care Spending as Percent of Total Health Spending (Rhode Island)



- Primary Care Spending Increased 23%
- Total Spending Decreased 18%

Office of Health Insurance Commissioner State of Rhode Island September 2012



Public Health Spending

Every 10% increase in spending

= 1%-7% decrease in deaths (over 13 yrs.)

3.2 % Cardiovascular Disease

- 
- Infant Mortality
 - Diabetes • Cancer

Hypertension Consequence & Cost

Major Contributing Factor

- 54% of Strokes
- 47% of Coronary Artery Disease
- 13.5% of all Deaths Worldwide

**Cost Equals 10%
of Total Healthcare Expenditures**



Diabetes Occurrence & Cost

- ▶ **30 million Diabetic Americans**
- ▶ **84 million Pre-Diabetics**

Estimated Cost of Diagnosed Diabetes

- ▶ **2012 \$245 Billion**
- ▶ **2017 \$327 Billion (Increased 26%)**
- ▶ **2017 per capita expenditures**
- ▶ **\$10,060 men, \$9,110 women**

Diabetes Medical Expenditures

TOTAL MEDICAL COST

- 30% Hospital Inpatient Care
- 30% Rx to Treat Diabetes Complications
- 15% Anti-Diabetic Medications
- 13% Physician Office Visits



Consequences of Inadequate Diabetes Management

Patients with No Health Insurance

60% fewer physician office visits

52% fewer prescriptions

168% more Emergency Room Visits



**5% Reduction in Prevalence
of Diabetes & Hypertension**

SAVINGS MISSISSIPPI

\$92 million in first 2 years

\$275 million over 5 years

Tobacco Use & Costs in Mississippi

23% of Mississippians Use Tobacco

Tobacco-related Illness

- ▶ \$1.2 billion direct medical costs
- ▶ \$320 million annual Medicaid costs
 - ▶ Ban Smoking in indoor public places
decreases heart attacks 13-17%
 - ▶ Tobacco Users Fee \$1.50/pack
would reduce smoke-related illness



Telehealth

- ▶ Allows management of chronic disease by remote monitoring
- ▶ Saves costs from complications of chronic disease that lead to increased hospitalizations

Population Health Management

1. Keeps patients healthier.
2. Reduces Costs .

4 Recommendations

1. Web-based portal to determine what screenings are needed.
2. Promote covered wellness screenings, encourage providers.
3. Reimburse primary care preventive screenings at 100% Medicare.
4. Evaluate MCOs based on preventive wellness screenings.

FINDINGS

Tab R

Medicaid commonly represents the largest expense in state budgets, and in 2017, Medicaid cost Mississippi and the federal government a combined \$6.06 billion.¹

Medicaid beneficiaries are particularly complex and vulnerable, and require a level of coordination of medical and social services that is not possible in a fragmented fee-for-service (FFS) environment.

Managed care provides an opportunity to states to improve their Medicaid program and the experiences of beneficiaries, while facilitating innovation, program integrity, predictability, and reduced cost trend.

Additionally, managed care affords opportunities for providers and beneficiaries that are otherwise unachievable, such as robust care coordination, enhanced infrastructure, increased access to HCBS services, value-based incentives, and improved health outcomes.

We recommend DOM include the following populations in MSCAN to allow more beneficiaries to receive whole-person, coordinated care, while reducing the State's Medicaid costs.

- *Dually Eligible Individuals*: Individuals dually eligible for Medicare and Medicaid are a vulnerable population, making up 21% of Mississippi's Medicaid population and 35% of the State's Medicaid costs.² Currently these individuals are served through a number of coordinators resulting in a considerable amount of care fragmentation, potential redundancy in services, poorer health outcomes, and financial cost shifting across their various payers.
- *LTSS Individuals*: Mississippi Medicaid spends nearly \$1.6 billion per year on LTSS with greater than \$1.1 billion spent in institutional settings.³ By transitioning to managed LTSS within MSCAN and shifting the risk for this population to COOs, this will ensure more holistic care for this population and support the State in its transition into home and community-based settings, while saving the Medicaid program money on this expensive population.

As of 2015, Mississippi had less than 31% of its total LTSS spending in HCBS, compared with a national average of 55% and a state high of 82% (Oregon).⁴

Furthermore, in 2017 median nursing facility costs in Mississippi are estimated to be nearly \$80 thousand per person, while HCBS home health aide and adult day health care costs are estimated at \$41 thousand and \$11 thousand, respectively.⁵

Because of the enrollment thresholds listed in Mississippi Code, carving additional populations into MSCAN likely will require a statutory change.⁶

¹ http://www.lbo.ms.gov/misc/FY18_BudgetBook/bbook18-br60.pdf

² CMS Medicare-Medicaid Enrollee State Profiles, Mississippi, FY2011. Published 9/26/16.

³ Truven Health Analytics. Medicaid Expenditures for Long Term Services and Supports (LTSS) in FY2015.

⁴ Truven Health Analytics. Medicaid Expenditures for Long-Term Services and Supports in FY2015.

⁵ Genworth Cost of Care Survey, 2017.

⁶ 43.13.117(H) (1); Managed care programs... shall be limited to the greater of (i) forty-five percent (45%) of the total enrollment of Medicaid beneficiaries, or (ii) the categories of beneficiaries participating in the program as of January

**Medicaid Managed Long-Term Services and Supports (MLTSS)
Resources regarding Program Efficacy – December 2016
– Service Utilization – Beneficiary Satisfaction – Provider Experience – Innovations –**

Service Utilization

Delaware Diamond State Health Plan Plus and Tennessee Choices Program

- In both Delaware and Tennessee, the implementation of MLTSS programs has led to the increased use of participant-directed service models by LTSS participants.¹

Texas STAR+PLUS

- In a focused study of Texas STAR+PLUS Supplemental Security Income (SSI) beneficiaries who received adult day health or personal assistance services, Aydede (2003) found that STAR+PLUS members had shorter hospital lengths of stay, fewer emergency room visits, and much lower health care costs overall than a comparison group of SSI beneficiaries who were not enrolled in a managed care plan.²
- Specific Health Plan Experience:
 - 22% reduction in inpatient admissions
 - 38% reduction in emergency room use

New Mexico Centennial Care

- Key Utilization/Cost per unit Statistics.³

Long Term Services and Supports: Medicaid Only – Nursing Facility Level of Care				
Service Grouping	Utilization (per 1,000 Members)		Cost per Unit	
	4/1/2014 to 3/31/2015	4/1/2015 to 3/31/2016	4/1/2014 to 3/31/2015	4/1/2015 to 3/31/2016
Inpatient Admissions	361.4	335.6	\$ 16,575	\$ 18,213
Inpatient Days	2,360.2	2,227.0	\$ 2,538	\$ 2,744
Personal Care Services/hour)	915,917.3	812,989.4	\$ 15	\$ 15
Pharmacy Scripts	45,048.2	42,892.6	\$ 67	\$ 79

Long Term Services and Supports: Self Directed Population (Dual and Medicaid Only)				
Service Grouping	Utilization (per 1,000 Members)		Cost per Unit	
	4/1/2014 to 3/31/2015	4/1/2015 to 3/31/2016	4/1/2014 to 3/31/2015	4/1/2015 to 3/31/2016
Inpatient Admissions	265.7	220.7	\$ 8,108	\$ 8,865
Inpatient Days	1,588.8	1,590.2	\$ 1,356	\$ 1,230
Personal Care Services/hour)	200.9	95.0	\$ 9	\$ 11
Pharmacy Scripts	355,919.4	332,458.5	\$ 115	\$ 110

¹ Kasten, J., Saucier, P., Burwell, B. *How Have Long-Term Services and Supports Providers Fared in the Transition of Medicaid Managed Care? A Study of Three States.* Truven Health Analytics prepared for Office of Disability, Aging and Long-Term Care Policy Office of the Assistant Secretary for Planning and Evaluation. U.S. Department of Health and Human Services. December 9, 2013.

² *Medicaid Managed Care.* Issue brief no. IB79. AARP, n.d. Web. <http://assets.aarp.org/rgcenter/il/ib79_mmltc.pdf>

³ Centennial Care Waiver Demonstration Section 1115 Quarterly Report. New Mexico Human Services Department. September 7, 2016

Beneficiary Satisfaction

New York Managed Long Term Care

- 84% of respondents rated their health plan as good or excellent.⁹
- 90% would recommend their plan to a friend.¹⁰
- 86% rated their care manager and home health aide/personal care aide as good or excellent.¹¹

Florida Agency for health Care Administration

- Long-Term Care Enrollee satisfaction survey shows high satisfaction with care and improvement in overall health and quality of life
 - 77.4% of respondents reported that their quality of life had improved since enrolling in their long-term care plan¹²
 - 79.7% of respondents rated their health plan an 8, 9 or 10.¹³
 - 83.4% of respondents reported it usually or always easy to get in contact with their case manager.¹⁴
 - 84.4% of respondents reported their case manager an 8, 9 or 10.¹⁵
 - 59.5% of respondents reported their overall health had improved since enrolling in their LTC plan.¹⁶
- Specific Health Plan Experience based on the 2016 Florida Long-Term Care Enrollee Satisfaction Survey:
 - 73.4% of respondents reported that their quality of life had improved since enrolling in their long-term care plan
 - 80.9% of respondents rated the health plan 8, 9 or 10
 - 85.0% of respondents reported it usually and always easy to get in contact with their care manger
 - 85.0% of respondents reported their case manager an 8, 9 or 10
 - 59.0% of respondents reported their overall health had improved since enrolling in their LTC plan

Texas STAR+PLUS

- Specific Health Plan Experience based on 2016 LTSS Satisfaction Survey:
 - 83.6% of respondents rated the health plan 8, 9 or 10
 - 90.7% of respondents rated their health plan highly
 - 98.5% of respondents plan to continue membership in Specific Health Plan

Arizona Long Term Care System

- Specific Health Plan Experience based on 2016 LTSS Satisfaction Survey:
 - 84.5% of respondents rated the health plan 8, 9 or 10
 - 94.0% of respondents rated their health plan highly

⁹ New York State Department of Health 2014 Managed Long Term Care Report.
www.health.ny.gov/health_care/managed_care/mltc/pdf/mltc_report_2014.pdf

¹⁰ New York State Department of Health 2012 Managed Long Term Care Report.
www.health.ny.gov/health_care/managed_care/mltc/pdf/mltc_report_2014.pdf

¹¹ Ibid

¹² Florida Agency for Healthcare Administration - Quality and Performance Snapshot 3/1/2016
http://www.fdhc.state.fl.us/medicaid/statewide_mc/index.shtml

¹³ Florida Agency for Healthcare Administration - Quality and Performance Snapshot 3/1/2016
http://www.fdhc.state.fl.us/medicaid/statewide_mc/index.shtml

¹⁴ Ibid

¹⁵ Ibid

¹⁶ Ibid

TennCare/Tennessee CHOICES

- Tennessee has demonstrated an 88% improvement in quality scores and boasts a 2012 consumer satisfaction score of 93%.¹⁷

Provider Experience

- Virtually all traditional HCBS providers were offered contracts to participate in MCO networks when MLTSS was initially implemented.¹⁸
- In Tennessee, Delaware and Minnesota MLTSS programs – all are pursuing payment reform in partnership with MCOs and providers.¹⁹
- The implementation of MLTSS programs has resulted in an increase in demand for and supply of HCBS, and contributed to reduced demand for nursing home services in Tennessee, Delaware and Minnesota.²⁰
- While the demand for Medicaid nursing home days has declined, nursing home providers had generally adapted by seeking other revenue sources.²¹

Innovations

- Delegation of case management to care systems. Care managers with large primary care clinics are assuming responsibility for case management of members who already use the system for primary care.²²
- MCOs make community grants.²³
- Stimulating supply of needed services.²⁴
- Improving the Electronic Visit Verification system.²⁵
- Workforce development.²⁶

¹⁷ Tennessee's Health Care Finance and Administration FY 2014 Budget Presentation.

¹⁸ Kasten, J., Saucier, P., Burwell, B. *How Have Long-Term Services and Supports Providers Fared in the Transition of Medicaid Managed Care? A Study of Three States*. Truven Health Analytics prepared for Office of Disability, Aging and Long-Term Care Policy Office of the Assistant Secretary for Planning and Evaluation. U.S. Department of Health and Human Services. December 9, 2013.

¹⁹ Ibid

²⁰ Ibid

²¹ Ibid

²² Ibid

²³ Ibid

²⁴ Ibid

²⁵ Ibid

²⁶ Ibid

Arizona Long Term Care System

- As of September 2015, 86% of the ALCTS Program members lived outside of institutions and in the community.⁴
- Specific Health Plan Experience:
 - As of September 2015, 74% of its ALCTS Program members lived in the community

Florida Statewide Medicaid Managed Care – Long-Term Care Program

- The goal is to have no more than 35% of the state’s long-term care enrollees in nursing facilities. Progress in the last year has been realized – as of July 2014 47% of members lived in the community; as of 7/1/2015 50% of members lived in the community⁵

TennCare/Tennessee CHOICES

- Before implementation of Tennessee CHOICES, the nursing facility placement rate was 83%, and 17% of individuals were served through HCBS. As of February 2016, 57.2% % were in a nursing facility and 42.8% were served through HCBS.⁶
- In 2010, when the program was first enacted, about 17% of long-term services and supports recipients received services in HCBS settings. By August 2013, the percentage of LTSS recipients living in the community increased to 39.7%. Over this three year period, the HCBS population increased by 161% from 4,861 to 12,692, while the number of Medicaid recipients in nursing facilities declined by 17%.⁷
- State experienced a 32-day reduction in average nursing facility length of stay during first year of the program.⁸
- Specific Health Plan Experience:
 - Onsite assessments and development of in-home and community-based support services reduced utilization of youth residential treatment facilities. 34.8% of youth and adults receiving onsite assessment/care coordination prior to the authorization of residential treatment services were maintained at home with support services rather than being admitted to residential care.
 - 4.8% reduction in clinical management of acute care inpatient utilization (2010-2011).
 - 9.6% reduction in behavioral health inpatient utilization (2010-2011).
 - 30% diversion rate to a lower level of care for behavioral health.
 - Decrease of 0.74 emergency room visits per member as a result of emergency department diversion initiative that placed a social worker in the emergency room.

⁴ Arizona Health Care Cost Containment System – Arizona Long Term Care System Annual HCBS Report CY 2015 (10/1/2014 – 9/30/2015. March 2016

⁵ Florida Agency for Healthcare Administration - Quality and Performance Snapshot 3/1/2016

http://www.fdhc.state.fl.us/medicaid/statewide_mc/index.shtml

⁶ LTSS Governor’s Dash Board Graphs, <https://www.tn.gov/tenncare/topic/ltss-governors-dashboard-graphs>

⁷ http://medicaiddirectors.org/sites/medicaiddirectors.org/files/public/trends_in_medicaid_long_term_services_and_supports.pdf.

⁸ <http://aspe.hhs.gov/daltcp/reports/2013/3LTSStrans.shtml>

⁸ Ibid

CONSENSUS
RECOMMENDATIONS

Tab A

Tab A. The Commission recommends for consideration and final determination by the Legislature that the Division of Medicaid study and implement a pilot program regarding an alternative managed care payment model for Children with Complex Medical Conditions (CMC) receiving services from the University of Mississippi Medical Center (UMMC). The managed care payment model would establish a pediatric organization to function as an integrated pediatric network with a capitation agreement with managed care entities, which would redirect funding to provide Medicaid services to the CMC population consisting of children with significant chronic conditions in two or more body systems or a single dominant chronic condition, pursuant to guidelines developed by the Children's Hospital Association under a partnership contract and not require any additional funding from the State General Fund.

**CONSENSUS
RECOMMENDATIONS**

Tab B

Tab B. The Commission recommends for consideration and final determination by the Legislature that the Division of Medicaid study the feasibility of implementing a pilot program to provide an alternative managed care payment model for individuals with behavioral health issues receiving services from a regional mental health/intellectual disability commission established under 41-19-33 located in the State of Mississippi. The managed care payment model would establish an organization to function as an integrated behavioral health care network with a capitation agreement with managed care entities, which would redirect funding to provide Medicaid services to the behavioral health population under a partnership contract and not require any additional funding from the State General Fund.

The pilot program would be a collaboration between Regional Mental Health Program(s) established under 41-19-33, MCO(s), the Division of Medicaid and other health care provider(s) in Mississippi. The proposal is to study the feasibility of a pilot program that integrates primary health and behavioral health care services under the same umbrella with a capitated rate and the associated financial, medical and behavioral health benefits that can be achieved. The intent of the "Integrated Care Pilot Program" will be to address the significant behavioral and primary health care issues that currently exist within the affected population and to show improved health and well-being outcomes while reducing cost within the Medicaid program.

If a pilot program is deemed feasible, a report of findings and recommendations shall be prepared for the 2020 Regular Session.

CONSENSUS
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Tab C

Tab C. The Commission recommends for consideration and final determination by the Legislature that the responsibilities of the Mississippi Commission on Expanding Medicaid Managed Care be transferred to and become a permanent function of the Medical Care Advisory Committee within the Division of Medicaid in order to continue monitoring the feasibility of including additional categories of Medicaid-eligible beneficiaries and otherwise revising the Medicaid Managed Care payment program.

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Tab A

CEMMC Draft Recommendations - Drew Snyder

1. Continue to study the possibility of adding additional populations into a managed care model, but don't pursue changes in 2019.
2. Paragraph(H) of Miss. Code Ann. 43-13-117, which authorizes to DOM to use managed care organizations, accountable care organizations, and provider-sponsored plans, needs to be deleted from code section and moved to a different or new code section.
3. Delete the requirement in current 43-13-117(H) that managed care companies must reimburse at no less than normal fee-for-service reimbursement rate. This language discourages two-sided risk-sharing arrangements and other innovative approaches. Alternatively, DOM should revise normal fee-for-service reimbursement rates to be more in line with peer states like Alabama.
4. Remove population limitations on managed care and ACO populations. Language unintentionally limits ACO arrangements with fee-for-service population.
5. Continue to examine MCO care coordination and cost avoidance efforts in MississippiCAN, particularly related to care coordination and impact on taxpayers.
6. Continue legislative education opportunities about the Medicaid fee-for-service programs. Learning more about the role of Planning and Development Districts and Department of Rehabilitation Services in case management of waiver populations would be useful.
7. The Division of Medicaid should evaluate reimbursement rates and outcome data for nursing facilities compared to other southeastern states and report those findings to Legislature.
8. Tie future reimbursement to quality, value, and outcomes. If Legislature wants to set parameters on provider reimbursement, it should apply reimbursement ceilings instead of reimbursement floors.
9. Remove 5% assessment in 43-13-117. It's confusing, unfair to certain providers, and unnecessary (DOM can change reimbursement methodology through state plan to reflect legislative intent).
10. DOM should continue to work with managed care entities to get more detail into MCO administrative expenditures.
11. Improve oversight and training of managed care program integrity units.
12. Seek flexibility from CMS to incorporate price into procurements for managed care contracts.
13. DOM should stop tying the managed care companies to the DOM administrative code and should do more to allow the managed care to manage.
14. DOM should work with the two nursing home associations on a quality-based reimbursement component.
15. Continue to focus efforts on rebalancing between home and community based services
16. The Division of Medicaid should incorporate withhold arrangements into existing MSCAN and CHIP contracts where capitation payments are withheld if certain deliverables aren't met.
17. Oppose any efforts to have any willing provider-type mandates in Medicaid. The MCOs should take a more active role in network management by disenrolling chronically underperforming providers. In doing so, MCOs should make known to network providers what the expectations for performance are, clearly define the metrics used by the MCO to assess performance, and frequently communicate with underperforming providers to allow more improvement.
18. Work with plans on common policies that can reduce a provider's administrative burden. The ongoing effort to centralize credentialing is one example.
19. Authorize Division to engage in selective contracting with providers for areas with access to care issues.
20. Avoid policies that essentially make managed care into third-party administrator that pays claim and follow the same policies of fee-for-service Medicaid. That's an inefficient model.

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Tab B

Commission on Expanding Medicaid Managed Care: Managed Care Industry View

Michelle Bentzien-Purrington Vice President Molina Healthcare
November 13, 2018

Study Commission Objectives

1. Review the program's financial metrics
2. Review the program's product offerings
3. Review the program's impact on insurance premiums for individuals and small businesses
4. ***Make recommendations for future managed care program modifications***
5. Determine whether the expansion of the Medicaid managed care program may endanger the access to care by vulnerable patients
6. Review the financial feasibility and health outcomes of populations health management
7. Make recommendations regarding a pilot program to evaluate an alternative managed care payment model for medically complex children

Current Medicaid Populations Not Covered by Managed Care

Nursing Facility

Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IDD)

Assisted Living Waiver

Elderly and Disabled Waiver

Intellectual Disabilities/Developmental Disabilities Waiver

Independent Living Waiver

Traumatic Brain Injury/Spinal Cord Injury Waiver

Healthier Mississippi Waiver

Family Planning Waiver

Dual Eligibles

Review of Highlighted Population

LONG TERM SERVICES AND SUPPORTS

Long Term Services and Supports

- Services and supports used by individuals of all ages with functional limitations and chronic illnesses who need assistance with daily activities
- Assistance with one or more Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs)
 - ADLs: Self-care activities (bathing, dressing, etc.)
 - IADLs: Routine activities (shopping, housework, etc.)
- LTSS include, but are not limited, Nursing Facility long-term care, adult daycare programs, home health, personal care services, transportation, supported employment, meals, environmental modifications and assistance from a family caregiver
- Can be provided in multiple settings: Institutions (Nursing Facilities, Intermediate Care Facilities) or Home and Community-Based settings (home, assisted living facility, etc.)
- 90% of LTSS population in the community rely on unpaid help

Managed Long Term Services and Supports

Managed Long Term Services and Supports (MLTSS) is a model to deliver LTSS in a person-centered way to achieve state goals that typically include:¹

- Improving coordination and integration for those using LTSS
- Increasing access to community-based care
- Improving member satisfaction and health outcomes
- Improving budget predictability

Figure 2.1: Prevalence of MLTSS in 2004, 2012, and 2017



¹Dobson, C., Gibbs, S., Mosey, A., and Smith, L. (2017). Demonstrating the Value of Medicaid MLTSS Programs. NASUAD and CHCS. Available at: <http://www.chcs.org/media/FINAL-Demonstrating-the-Value-of-MLTSS-5-12-17.pdf>

State Goals for MLTSS Programs

Improving Member Experience, Quality of Life, Health Outcomes	Rebalancing MLTSS Spending	Reducing Waiver Wait Lists and Increasing Access to Services	Increasing Budget Predictability and Managing Costs
<ul style="list-style-type: none"> Consumer feedback mechanisms and high customer ratings Improved health outcomes demonstrated through quality measures and outcomes 	<ul style="list-style-type: none"> More people living in community settings Nursing home transition prevented or delayed Home and Community-Based Services (HCBS) spend now more than long-term care institutional spend 	<ul style="list-style-type: none"> Non-emergent transportation Innovative programs and collaborations Community collaborations 	<ul style="list-style-type: none"> Program costs reduced Quality-based incentives Administrative simplification and efficiencies

Source: Dobson, C., Gibbs, S., Mosey, A., and Smith, L. (2017). Demonstrating the Value of Medicaid MLTSS Programs. NASUAD and CHCS

Expanding Beyond a Medical Model

Stakeholder engagement, integration and coordination are keys to success

Sociological

+

Psychological

+

Biological

Health

Non-MLTSS	Staffing	Providers	Community	Administration
<ul style="list-style-type: none"> Breaks in eligibility Epidemic care Pregnancy Larger support system at clinic visits 	<ul style="list-style-type: none"> Case management Health education & wellness Telephonic support 	<ul style="list-style-type: none"> Traditional medical & behavioral health providers Primary care, OB/Gyn, pediatrics 	<ul style="list-style-type: none"> Faith-based organizations United Way Schools 	<ul style="list-style-type: none"> Insurance Commission Medicaid Agency Traditional eligibility, rates, reporting Clinical-oriented value proposition
<ul style="list-style-type: none"> More continuous eligibility Chronic, complex care Social determinants of health 	<ul style="list-style-type: none"> Complex care coordination Social workers Community Connectors Face to face visits and telephonic support Advanced finance & data analytic 	<ul style="list-style-type: none"> Atypical providers MCBS/LTC Community based providers (CILs, AAA) Population specific specialists 	<ul style="list-style-type: none"> Population centered organizations (CILs, AAAs, ADRGs, ANCs) HUD 	<ul style="list-style-type: none"> Dept. of Aging & Disability Local Authorities Complex eligibility, data feeds, rates and reporting Real time change in condition & setting of care Holistic value proposition

Improving Lives



"I know I can trust her and go to her and she takes the time to assess my needs to provide exactly what I want. It's a great support system."

-MLTSS Medicare-Medicaid member



From "I'm dying here emotionally" to "I'm so excited about going to work. It's part-time but just to be useful."

-MLTSS Member

True Stories: [Shauna](#), [Carol](#), [Diane](#), [Cliff](#), [Ruth](#), [Vickie](#)

Innovative Partnerships and Collaborations

- Nursing Facility Collaboration and Innovation
 - Advisory Committees that are partnerships and deliver results
 - Value-based contracting
 - Administrative simplification
 - Improved outcomes
- Caregiver Training and Support
 - Improved caregiver satisfaction
 - Reduced healthcare utilization
- Housing Collaborations
 - Improved integration, coordination
 - Reduced healthcare utilization (emergency department, inpatient, and pharmacy)

"Molina has spent the extra time and the extra money to reach out to us."

"It's nice to know you have people behind you that also have the patient's best interest at heart."

-MLTSS providers

[Link to Managed Care and Nursing Facility Collaboration Video](#)

Recommendations

We recommend expansion of the MSCAN program to include all current and currently excluded populations. Expansion of the program would result in:

- Budget predictability
- Long term cost savings to the State
- Increased premium tax revenue for the state
- Reduced administrative burden
- Higher quality of care for the impacted beneficiaries
- Additional community based care for the long term care populations

Contact Information and Questions



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Tab C

MEMORANDUM

To: Chairman Brice Wiggins and Members of the Commission on Expanding Medicaid Managed Care
From: Aaron Sisk, President and CEO, Magnolia Health
Re: Findings of Fact and Recommendations
Date: November 13, 2018

1. Review the program's financial metrics:

- Please see reports submitted to the Commission by the Mississippi Division of Medicaid (MSDOM).

2. Review the program's product offerings:

- Please see reports submitted to the Commission by the MSDOM.

3. Review the program's impact on insurance premiums for individuals and small businesses:

- No evidence was presented to the Commission identifying any direct impact on insurance premiums for individuals and small business caused by the Mississippi Coordinated Access Network (MSCAN) and Magnolia submits that the MSCAN and MS Medicaid programs have no direct impact on health insurance premium rates for individual and small group business.

4. Make recommendations for future managed care program modifications:

- We recommend expansion of the MSCAN program to include all current and currently excluded populations. Expansion of the program would result in budget predictability, long term cost savings to the State, increased premium tax revenue for the state, reduced administrative burden and a clearer operational role for the MSDOM, better care for the impacted beneficiaries and more community based care for the long term care populations.
- Please see the attached independent studies from Milliman and NASUAD (trade association of state aging and disabilities directors) analyzing the value of Managed LTSS (Long Term Care). Findings from the two studies are summarized as follows:
 - o Key findings from Milliman paper (based on review of MDS nursing home data):
 - The number of nursing home residents per capita decreased at a faster rate in MLTSS states than in fee-for-services LTSS states for all 65 and over age groups.
 - The acuity level of nursing home residents in MLTSS states is increasing at a faster rate than the acuity level of nursing home residents in FFS LTSS states, which may be a result of MLTSS states more effectively providing care for highly functioning members in the community rather than in the nursing home.
 - o Key findings from the NASUAD paper (based on survey of 12 states who have implemented MLTSS):
 - Eight states reported that they were making progress toward their rebalancing goals of increasing the percentage of members receiving LTSS in the community
 - o For example, since implementing MLTSS, TN moved from 17% of LTSS recipients receiving services in the community to 44%
 - Among states reporting outcomes, MLTSS consumers had improved quality of life and high levels of satisfaction.
 - o For example, Florida noted 77 percent of respondents to its state survey reported an improved quality of life since joining an MLTSS plan

- Arizona, Florida, Kansas, New Jersey, Massachusetts, Minnesota, and Tennessee reported that their MLTSS programs improved the physical health of consumers enrolled
 - MLTSS states have reduced or eliminated waiting lists for waivers.
 - In 2014, Florida invested \$12.6 million to enroll wait-listed individuals with the most critical needs into its MLTSS program
- It may be of value for DOM to engage Milliman to conduct a study regarding the impact of transitioning our Long Term Care populations into Managed Care.
 - If the Legislature is unable to add LTSS then we recommend adding the Healthier Mississippi Waiver, Family Planning Waiver, and Dual Eligible populations.
 - We recommend that the statutory language requiring that the MSCAN Managed Care Organizations reimburse providers at a rate that is not less than the Medicaid Fee Schedule be removed or amended in order to allow the Managed Care companies the flexibility to negotiate more robust quality and risk based contracts with providers. This change would bring Mississippi in line with the majority of managed care programs in the nation.
- 5. Determine whether the expansion of the Medicaid managed care program may endanger the access to care by vulnerable patients:**
- No evidence was presented to the Commission demonstrating that the expansion of the Medicaid managed care program may endanger the access to care by vulnerable patients. Magnolia currently has a robust provider network that is more than sufficient to absorb an expansion of the program. No vulnerable patients would be negatively impacted by access to care issues as a result of MSCAN expansion.
- 6. Review the financial feasibility and health outcomes of populations health management as specifically provided in paragraph (2) above:**
- See one-page report previously submitted to the Commission from Magnolia Health outlining our care management program and some of the initiatives that we have in place.
 - Care Management and population health are the cornerstone of managed care and, because they are not available through traditional fee for service Medicaid, would provide a value add to current and future Medicaid beneficiaries should the MSCAN program be expanded.
 - Care Management delivers savings through one on one health care education and by identifying and addressing social determinants of health.
 - We are piloting Telehealth options to augment our traditional Care Management activities in order to increase effectiveness.
- 7. Make recommendations regarding a pilot program to evaluate an alternative manage care payment model for medically complex children:**
- We support this effort by UMMC and believe this can be accomplished contractually between the MCOs and a hospital system and does not require a legislative action or mandate.
 - Should the legislature decide to mandate a pilot program then we ask that the managed care companies be excluded from the mandate and that the program be set up as a waiver that is separate and distinct from the managed care program. Should the pilot be used as a comparison to the effectiveness of the MSCAN program then we ask that it be subject to the same or substantially similar contractual, administrative and statutory requirements.

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Tab D



MISSISSIPPI INDEPENDENT PHARMACIES ASSOCIATION

November 13, 2018

Chairman Wiggins and Committee Members,

The Mississippi Independent Pharmacies Association (MIPA) is made up of the local independent pharmacies located across Mississippi. MIPA members are on the frontline of healthcare and sometimes are the easily accessed healthcare provider in their area. Not only are we opposed to adding any other categories of eligibility to Managed Care in Mississippi, MIPA is in favor of carving out pharmacy services for all Medicaid beneficiaries.

In 2011 the Mississippi Division of Medicaid (DOM), in accordance with legislation from the Mississippi Legislature, entered into contracts with managed care companies in the hope of saving money and having budget predictably over the DOM budget. It is unknown at this time if the managed care program is really saving the State money or not.

In 2011, DOM's Office of Pharmacy had the foresight to make the managed care pharmacy benefits program a 'pass-through model' rather than a 'spread-pricing model'. DOM determines the Preferred Drug List for fee for service (FFS) as well as the plans. Additionally, rebates belong to DOM rather than the plans, and reimbursement for pharmacy services is the same as for Medicaid FFS.

In 2017, West Virginia carved out the pharmacy benefits managed care program in 2017 and they are projecting a \$30 million annual savings. The findings of a June 2018 audit encouraged the Ohio Medicaid officials to move to a pass-through model for their managed care pharmacy benefits program. This audit found that in 2017, Ohio managed care pharmacy benefit managers (PBMs) billed the state \$223 million more than what the PBMs paid to the dispensing pharmacies. Mississippi has never allowed a PBM to run the Medicaid pharmacy program and these examples serve as evidence to the reason why we should not allow the PBMs the authority.

Nationally, pharmacies are facing many challenges such as pricing, availabilities, limited networks and insurance obstacles. DOM's Office of Pharmacy has consistently been a valuable resource to provide assistance for the Medicaid beneficiary population and providers. The DOM Office of Pharmacy handles all aspects of the Medicaid pharmacy benefits within our state. An example of an innovative program is the Complex Pharmacy Care Program (CPCP), started in October 2016, designed to manage complex disease states and beneficiaries. In a little over the first year of implantation the CPCP, which is aimed at ensuring the effective use of complex expensive medications, has already saved the state \$4.6 million. With 65% of the Medicaid beneficiary population enrolled in managed care the state will not witness the full potential of program savings from the CPCP. We need more beneficiaries in the CPCP to see the full potential.

MIPA members state that there are problems with the managed care companies' pharmacy programs. Problems include, but are not limited to, timely payment, pharmacy reimbursement error, unfair and burdensome audits, forcing beneficiaries to use the managed care mail-order program, unreadiness for claims processing changes, and requiring specialty prescriptions to be dispensed by managed care owned specialty pharmacies and/or out of state pharmacies when there are in state pharmacies that can dispense said medication.

A few years ago, mental health was included in the managed care program. It is our concern that long-term care will be the next provider to be included in managed care. About 90% of the residents in the traditional nursing home receive their pharmacy benefits through Medicare Part D. Local and Long Term Care pharmacists work with nursing home staff, and physicians to assure that patients can get their medications through the Part D plans. Adding another layer with managed care for Medicaid only LTC patients will make this challenging for this vulnerable patient population.

In closing, my membership and I are appreciative of this forum to express our concerns.

Sincerely,

A handwritten signature in cursive script, appearing to read "Robert Hugh Dozier".

Robert Hugh Dozier

Executive Director