50-State Survey Data on Medicaid Managed Care Programs
Kaiser Family Foundation
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DIANE ROWLAND: Good morning, and welcome to the Barbara Jordan Conference Center and to this Kaiser briefing to release our 50 state survey data on Medicaid Managed Care Programs. I'm Diane Rowland, the Executive Vice President of the Kaiser Family Foundation and the Executive Director of our commission on Medicaid and the uninsured. And I'm very pleased to be having this briefing this morning.

You're probably use to— when you see Vern Smith and others up here, an annual update on some issue that we've been tracking and following for the many years of the Medicaid Commission. But today we're doing something that isn't an annual update, because it's been quite a while since we've been able to update you on some of the key characteristics of the Medicaid Managed Care Program in the 50 states.

So, I'm really especially pleased that we have this survey today, that we're able to have the participation of all 50 states and we want to really thank the Medicaid directors at this time with budget crunches and implementation of healthcare reform to really have stepped up and been able to give us the kind of in depth data that will be presented today.

Managed Care, as you know, is a growing part of the delivery of care for Medicaid beneficiaries throughout the country. We're seeing movement into new populations within the Medicaid program, in terms of the care they now receive through

managed care operations. We're seeing a diversity of approaches that the states are taking in the way in which they provide managed care services to their beneficiaries, so I think today's information will help shed some real light on how the managed care evolution and Medicaid is proceeding, and also to give you a lot of— in the report itself- descriptive data about how the states are performing.

I want to emphasize that this is not an evaluation of state managed care efforts, but instead a description of where we are today. But to help put some grounding on that, after Julia Paradise and Vern Smith present the key findings from a managed care report, we're going to turn to a panel of three Medicaid directors who can give us some insight into the world of on the ground implementation of managed care.

But our program today will begin with a presentation of the findings from Medicaid and Managed Care in 2010, highlights from our 50 state survey. It's co-authored by a great team, Julia Paradise, our Associate Director of our Kaiser Commission on Medicaid and the Uninsured will lead off with some key finding, followed by Vern Smith, the Managing Principal of Health Management Associates and his team, which includes Kathy Gifford, who's with us today as well.

Then we're going to turn to some of the perspectives from the ground from Craigan Gray, the Director of the Division of Medical Assistance in North Carolina's Department of Health

and Human Services; Jason Helgerson, the Medicaid Director in the Office of Health Insurance Programs in the New York State Department of Health; and Joe Vesowate, the Deputy Director of Managed Care Operations in the Medicaid and CHIP Division of Texas Health and Human Services Commission.

So, we'll begin by a national perspective and then we'll focus in on some of the realities on the ground. So, I'm going to turn to Julia to kick off the discussion.

JULIA PARADISE: Thanks, Diane, and good morning, everyone. Vern and I would also like to thank our co-authors, Kathy Gifford, who we're pleased to have join us this morning and Dyke Snipes. And I'd also like to thank Rachel Arguello, here at Kaiser for superb assistance with production of this report.

Of course as Diane said, we are— our whole team is very grateful to the Medicaid officials in every state and D.C. who somehow found the time— made the time to respond to our survey, we could not have done this without them.

So, I'm going to start with a little bit of background on our survey first. We surveyed states regarding their Medicaid Managed Care programs, operating as of October 2010. We asked about risk-based managed care organizations, or MCOs, and Primary Care Case Management, or PCCM, programs, both major forms of comprehensive managed care and Medicaid. We also asked about state contracts with prepaid health plans or PHPs

that provide a single type of benefit, such as behavioral health, or dental care or non-emergency transportation. This survey gathered detailed, descriptive information about many aspects of states managed care programs, as well as information on their quality initiatives, managed long-term care, managed care for dual eligible's and expectations related to health reform.

While Vern and I are going to present highlights from the survey that give the broad contours of Medicaid Managed Care, the report in the appendix tables contain a trove of state-by-state data that provide a more fine-grained picture of the distinctly different programs operating across the country.

In 2010, all but three states, Alaska, New Hampshire and Wyoming, had comprehensive managed care programs and Medicaid, 36 states had contracts with MCOs and 31 operated a primary care case management program. More states had both models of comprehensive managed care than just one or the other, and alongside their comprehensive managed care programs, half the states had contracts with prepaid plans for specific categories of service.

Consistent with the upward trend over the past couple of decades in both the number and share of Medicaid beneficiaries in managed care, our survey found that as of October of last year 35.5 million Medicaid beneficiaries, or

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about two-thirds of all Medicaid beneficiaries, were enrolled I a comprehensive arrangement.

As the shaded slices of the pie shoe, risk-based managed care dominated, accounting for over 26 million beneficiaries, or about three-quarters of beneficiaries in comprehensive managed care and half of Medicaid beneficiaries overall. PCCM accounted for the other quarter of beneficiaries in comprehensive managed care and about 16-percent of beneficiaries overall. This left just about a third of Medicaid beneficiaries remaining in traditional, fee-for-service for all or most of their care.

State variation is a hallmark of Medicaid, as many of you here know very well. And as you can see from this map there's considerable variation from state to state in the extent to which comprehensive managed care has taken hold. While in the U.S. overall and in the median state, 66-percent of beneficiaries are enrolled in such arrangements, in nine states concentrated in the center of the country, managed care penetration is 50-percent or less, while in another nine states 80-percent of beneficiaries or more are in comprehensive managed care.

Many states have long mandated managed care for most low income children, pregnant women and parents, but historically certain groups of beneficiaries with more complex needs have been exempt from mandatory managed care by federal

law or states have excluded them sometimes all together, sometimes offering enrollment on a voluntary basis. Barring out what others tracking Medicaid Managed Care have documented, our survey shows that many states are extending mandatory managed care to these higher need populations.

At least half the states reported some mandatory managed care for children with disabilities, children with special healthcare needs, and seniors and people with disabilities, not also eligible for Medicare. In addition, 25 states reported at least some mandatory managed care for individuals who are dually eligible for both Medicare and Medicaid.

Mandatory managed care in this context might refer to enrollment in a MCO or a PCCM program, or it might refer to enrollment in a prepaid plan for a specific type of service.

We are interested in the profile of health plan servicing Medicaid beneficiaries and from the survey we learned that close to two-thirds of Medicaid MCO enrollees are in plans that specialize in Medicaid. The others are in plans with a mix of Medicaid and commercially insured enrollees. For profit plans, now account for more than half of all Medicaid beneficiaries in MCOs, and publicly traded plans account for about four in ten.

Medicaid MCO enrollment is about evenly distributed between local and multi-state plans. How beneficiaries receive

information about their health plan options and how plan selection works, are important dimensions of state's Medicaid managed care programs. As states expansion managed care more broadly and as millions of adults new to Medicaid, many of them new to insurance all together, enter the managed care marketplace in 2014, marketing and consumer choice issues will matter on a larger scale and I'd like to highlight a couple of findings in this area.

First, three-quarters of states with MCOs reported that they allow plans to conduct outreach and marketing within federal rules, and a substantial majority of MCOs use an enrollment broker to provide plan information to beneficiaries and assist them in choosing a plan.

Second, there appears to be very great variation in states auto-assignment rates. The auto-assignment rate is the percentage of beneficiaries who do not choose a plan within the required timeframe and who are then automatically assigned to a health plan based on an algorithm established by the state. This auto-assignment, or default enrollment rate, can provide a useful signal of how well beneficiaries understand how managed care works and what their options are. Of the 36 states with MCOs, 26 provided us with their auto-assignment rates, which ranged from 3-percent all the way to 80-percent. Half the reporting states had rates of 20-percent or less, while four had rates exceeding 50-percent.

States pay MCOs on a capitation basis, that is a monthly per capita premium for each Medicaid enrollee. Three-quarters of states with MCOs set their capitation rates administratively using actuaries. However some set rates by negotiation or by competitive bid, and there are states that combine methods. Most states risk-adjust their rates for age and eligibility category, as well as gender and geography. And two-thirds of states also adjust for health status. Over half the states with MCOs base their payment in part on planned performance. Pay-for-performance most often takes the form of a capitation withhold, which states which plans can then earn back through performance or bonus payments to the plans.

And finally, we asked states whether they have a minimum medical loss ratio, or MLR, requirement for their plans. The MLR is the proportion of the capitation payment that a plan spends on clinical care, as opposed to administration, executive salaries, profits and so on. Only 11 states reported MLR requirements, ranging from 80-percent to 93-percent, and another three states plan to require an MLR in the future.

Although MCOs are considered comprehensive managed care, most states carve-out at least one acute care benefit from their MCO contracts, carve-out services are provided either on a fee-for-service basis or through a separate risk contract with a prepaid plan that specializes in those

services. As Figure 9 shows, dental and behavioral health services are the types of care states most often reported carving out. Interestingly, several states reported that they're carving some services, such as pharmacy, back in, or plan to do so.

Federal rules require that states insure that health plans servicing Medicaid beneficiaries have adequate provider networks and we asked states about their standards. States network adequacy standards are often defined in terms of provider to population ratios or distance or travel time maximums, and they typically vary by type of service and by urban versus rural area. Many, but not all the states with MCOs reported that beneficiaries enrolled in health plans sometimes experience access problems and in particular they sited dental care, mental health providers, and pediatric and other specialists as areas where some encounter difficulties. At the same time, although we did not ask states directly about accessing fee for service, it was most state officials' assessment that risk-based managed care improved access relative to traditional fee-for-service.

My last slide before I hand things off to Vern, focuses on findings related to PCCM programs. In these programs the state is in effect the managed care plan. The state generally contracts with primary care providers, or PCPs, to provide case management services to beneficiaries who select or sometimes

are assigned to them, and typically pays them a small monthly case management fee.

As with risk contracts, contracts with PCPs give states a tool for establishing standards and leveraging performance. And here what I would draw your attention to is the considerable number of PCCM states that require PCPs to participate in state quality initiatives that pay in part based on performance, and that have actively used PCCM as a platform for building more coordinated and highly integrated models of care. Thanks.

VERNON K. SMITH: Well, thank you, Julia, and Diane, and it's great to have a chance to be here on behalf of my former Medicaid Director, colleagues, co-authors, Kathy Gifford, who's here, and Dyke Snipes, who's in Florida, and with Julia and the assisting panel, which I'm really looking forward to as soon as I finish here very briefly.

One of the very interesting questions in the survey was the value that Medicaid directors placed on managed care. And what we heard from that question was that managed care really provides a vehicle for accountability and an organization structured to the delivery system, so that you can assure access. As Julia was just talking about, you can assure, measure, monitor, improve quality. You can achieve value, you can focus on specific public health population-based health objectives, and this is a very important set of values.

Well, how do states then achieve this quality improvement that they're seeking through managed care? Well, one of the ways is through accreditation of health plans. You don't have to have accredited health plans in order to do this, but accreditation really shows that the health plans that the state contracts with are interested in achieving standards that are greater than just those required for licensure, that they're also committed to quality and that they're prepared to be transparent in their quality measures. They're prepared to generate data and to report their actual performance on a wide range of quality measures, especially those that are important for Medicaid populations, which means measures related to child health, measures related for pregnant women, prenatal care, post partum care, screening for cancers and that sort of thing.

Now, all of the states with MCOs report these measures, about half the states with PCCMs also report these measures, and about a third of the states in the country report it for all of their populations, across fee for service PCCM, MCOs, whichever delivery system they contract with.

Now, what is it that states do with this information when they get it? Well, alright, here we go. So, three-fourths of the states prepare some kind of a quality report and this may be posted on the web or an actual paper copy report that you can take a look at. And you can see, you know, there is transparency here about how states are doing. One of the

interesting things is that 15 states prepare kind of a report card or a— I have here in my hand, the one that Michigan has, it's a consumer guide to Michigan health plans. And when a beneficiary is asked to make a choice of a health plan, they're able, in Michigan, to take a look and see for all 14 health plans in the state of Michigan, how those health plans perform on six different categories of measures, you know, how others— how the plan is rated in terms of getting care, how are they doing with child healthcare, how are they doing with women's healthcare, how are they doing in provided care for person's with chronic conditions like diabetes or asthma, or high blood pressure and whether they're accredited or not by an organization, such as NCQA.

States also with managed care have performance improvement projects, now these are required, every state does them that has risk-based capitated managed care. They focus on a wide range of things, again you see here where the health quality improvement priorities are for a state, and again you're gonna focus on the populations in Medicaid, improving birth outcomes, improving care for children, especially with sub-specialists, reducing inappropriate emergency room use, you'll see that one in a moment, that sort of thing. And all of these studies have to be evaluated and validated by independent, external, quality review organizations.

Now, when you look now at the special initiatives that states are able to do, again using the managed care organization structure that they have in their state, the most prevalent special quality initiative that states have been doing relates to reducing inappropriate use of the emergency room. States also are focusing on public health population based objectives, such as reducing obesity, and a good number of states, half the states, are focusing on reducing racial and ethnic disparities that may occur. But there are a wide range of things and states look at their own situation and find those things where it's most important for them to concentrate their efforts.

Now there are other efforts that are going on across the country relating to improving the care coordination through medical homes. Now, the term medical home has many different meanings when you talk about it within Medicaid. But 39 states, vast number of states, have some kind of a medical home initiative. This may be a formal patient centered medical home initiative, or it may be some other kind of initiative, but they're carried out through their PCCM or MCO programs. Now within the ACA there's a special option for health home for persons with chronic conditions and a lot of states are looking at this, because the ACA provides enhanced federal matching for care that's provided through these health homes for this population that’s particularly vulnerable. And it's 90-percent

federal matching for two years, so a lot of states are looking at it and I think we'll see some of that over the next year or so.

ACOs are also being developed across the country. Medicaid has a role to play in ACOs and many states are looking for how Medicaid will work with other payers in those organizations.

Now, a key focus of Medicaid programs across the country now is integrating and coordinating the care for persons who are both on Medicaid and Medicare and persons who are in long term care, populations with disabilities of one kind or another. Now, this is a particularly difficult area to have coordinated, integrated care. The concept is really pioneered by the PACE programs, beginning a number of years ago. These are programs for all inclusive care for the elderly. Many states have them, but they're all relatively small.

Now, here are a number of states, 10 or 11 states, that are pioneering a more organized structure of managed care for a long-term care population, some of these include long-term care only, some are integrated with a primary and acute care side as well, but these are pioneering states. And building from that now, there's an opportunity through the new authority and the ACA to integrate both the care and the funding for persons who are on Medicare and Medicaid. Some very exciting proposals are

under development now. Fifteen states received awards from CMS to develop their plans and other states— many, many states- are looking at this as well.

Now, within the ACA, we're expecting to see a large expansion in the number of people on Medicaid. One of the questions which has come up is: Does the current system have the capacity to serve these additional 16 million or more, depending on the estimate, people who will be coming into Medicaid, because of the expanded eligibility up to 133-percent of poverty. Well, when we asked this question in the spring, there was still a good deal of uncertainty about the development of exchanges, there still is, and states are very much in the middle of the process, but this gives an idea of how state Medicaid officials are looking at this.

And the first question was, within your managed care system now, is there capacity? Among the 36 states that contract with health plans, is there the capacity to serve the expected number of new eligible's that you see coming into Medicaid in your state? And of those 21 states that responded to that, 20 out of the 21 said, yes, they believe that their health plans had the capacity now to serve that population.

When asked whether the Medicaid officials thought that the Medicaid health plans were interested and participated in the exchange? Of the 18 states responding with a yes or a no, 13 said yes. So, this is just an indication, I swear it is,

but a good deal still of uncertainty, as you can see on this issue.

Now, will the state require Medicaid health plans to participate in the exchange? It's a policy option being considered and, in terms of whether the state was considering it, eight states indicated that yes, they thought the state would be considering it, but again it's not a decision, it's just an indication of where states may be thinking. And similarly, in the development of the exchange, because there's, you know, this concern about continuity of care, as people move between, because of their incomes from year to year, between the exchange and Medicaid, and to minimize the discontinuity that might occur if a plan or if an individual had to change plans, change networks, you know, well plans in the exchange have to participate in Medicaid and a number of states, seven in this survey, said, yes, they thought they might consider that, but again these are decisions not yet made, they're indications of how things might proceed in the future.

So, just to kind of wrap up, what we see here is the prospect for an accelerated amount of activity in managed care in Medicaid. The reasons are pretty clear. The state budget pressures, fiscal pressures, are expected to continue, state Medicaid programs are looking more toward including the populations that are more vulnerable into Medicaid managed care, those persons with disabilities and the dual eligibles.

There will be this expansion in the number of people on Medicaid, and of course there's a good deal of interest. So, there is a prospect for a large expansion of Medicaid and the prospect for health plans of an increase in enrollment. With that, why don't I wrap up and I'm looking very much to the discussion from the Medicaid directors. Thank you.

DIANE ROWLAND: Thank you, Julia and Vern, for presenting what are just the tip of the iceberg of the very many statistics and finding that you will find in the report. We've heard a lot of information and I'm sure most of you are still absorbing that. So, we thought it would be helpful now to see how it works on the ground and to have three states share with us their experiences with managed care and their plans. And I'm gonna start by asking Jason Helgerson, from the State of New York, to kick off the discussion, and then we'll go down the row.

JASON HELGERSON: Great, thank you. And I found that very interested, as well, to hear about what all the other states are doing. But, to give you a little context about what managed care means in New York, I think I have to give a little context about what the Medicaid program in the State of New York looks like.

New York actually has the largest Medicaid program in the country from a budgetary standpoint, our annual budget is $53 billion. We serve roughly 5 million New Yorkers, about 25-

percent of the state's population is enrolled in the Medicaid program at any time. The program— New York has a proud, progressive tradition of offering extensive healthcare safety net. We have, in essence, entitlement level of coverage for anyone living below the poverty line, whether you're a parent, a child, or a childless adult. And through CHIP and other expansions, we cover parents to higher levels, and then have an initiative where we, in essence, provide access to virtually any child in the state, that includes legal immigrants are also covered in our state.

In the case of New York and managed care, we have a two decade history with managed care, one of the first states in the country to expand. Like a lot of states, we started in voluntary programs and progressed into mandatory programs. In our case, our mandatory Medicaid managed care programs function under an 1115 waiver with CMS, but also, like a number of states, while we made rapid progress, particularly in the 90s into the 2000s, in terms of the percent of people enrolled in the program, we basically got to a point where we had sort of moved many of the lower cost, less challenged populations into managed care. And for a variety of reasons, we did not go to populations that were more complex, had higher costs, and higher needs.

In addition, we also carved out certain services, particularly for people who have the most complex behavioral

health needs, for instance, their behavioral health services were provided on a fee-for-service basis. And that's really where the state has been for a number of years, sort of a half-way point to real managed care for the entire population, but really not going into, you know, those higher cost areas. That really has all changed in the last few months, Governor Cuomo was elected back in November, took office in January. And one of the things that he wanted to get his arms wrapped around was the real budgetary challenge that the Medicaid program has put on the State of New York. The costs in that program have been growing very rapidly and, in particular, in certain areas that have been in the fee-for-service program, we've seen amazing cost growth.

For instance, over the last five years, fee-for-service, non-institutional, long-term care services, so those are primarily home health related services,we've seen that budget double over five years. But yet the number of people served in that program is actually declined. So, on a per-person basis, more than a 100-percent growth. And, you know, there's a number of reasons for that, not all of them problematic, but it is clearly that has really been in our view, in the governor’s view, it was really a major challenge, was that this sort of uncontrolled, unregulated, entitlement-level of coverage in certain areas was really what was driving the challenges in the Medicaid program. And, so, to address

that he created what's called a Medicaid redesign team, which was a group of 27 stake holders, representing a wide array of interests, both in health care and then even beyond, and legislators are well, to basically try to come up with a plan. Unfortunately, that team was only given two months to develop a plan, although as I've said before, sometimes a really bad budget and a limited amount of time can actually be to your advantage in terms of getting substantive reforms. Because, what came out of that two-month process were 73 distinct proposals, of which a expansion of managed care, or as we are now calling it care management, was one of the primary reforms to come out of that process. And, basically, what the Medicaid redesign team, and it's now the law in the State of New York, has basically put the state on a three-year glide path to ending fee-for-service in our state.

In addition to that, just getting out of the fee-for-service business, in our view is not enough. We actually want to evolve the managed care program and actually try to get, and what I think Vern and others have mentioned is that one of the more exciting things out of the Affordable Care Act, is really to effectively get our arms around the dual eligible population, to get that population into fully integrated care. We've had a number of small programs, probably more than most states have had over the years, but those programs really have not grown to sufficient size. We've got 700,000 duals in the

State of New York, they drive roughly 36-percent, they represent 36-percent of the total Medicaid budget for those 700,000 people. They're 48-percent of the Medicare expenditure in the State of New York and, what we're very interested in, is a new discussion with the federal government about how we can use care management and unique forms of care management to effectively coordinate the needs of that population and help ensure that we get them, both cost effective care and improve their health outcomes.

I think that, basically if I were to describe our overall approach to Medicaid redesign, I'd say that basically what New York is betting is that better care management will actually bend the cost curve. And our hope, is that by implementing a wide array of strategies, including mandatory managed care in some of the areas that have been exempt from it in the path, including also patient-centered medial homes, health homes, we're moving aggressively in all of these areas, because our view is that uncoordinated care is more expensive and we've got a lot of uncoordinated care in New York, and we think that we have an opportunity here, that if we get our arms around that and do a better job, particularly with the sickest, most challenged populations in the state, that we can save money and get better outcomes.

You know, I get asked all the time, does managed care save money? It's a very good question. Yes it can if— I

believe- if done right. If not done right, it can actually cost you more money. I think that there's been a variety of studies over the time that's shown mixed results in terms of that. But, our belief is that it's a lot better than uncoordinated fee-for-service, at least based on our own experiences in New York. So, I think we're bullish about the future, we're excited that we have now the statutory framework to move forward. There's a lot of work that needs to be done. Some of these populations that have been in fee-for-service are very complex. We're going to need new models from new partners in this "care management for all" strategy. We're going to need to get partners who've been with us, who've been managing portions of the benefit in the past, to really step up and look to expand to a more fully integrated model.

What I like about the situation in New York is we have a wide array already of providers of managed care that we work with today. We have your— as it was mentioned, we have for-profits, we have non-profits, we have provider-owned integrated systems. We have a wide array of different entities, which I actually think in the long run, will allow for more consumer choice, allow for different models to basically compete against each other, but at the same time we're still going to need more partners, particularly in certain— more rural parts of our state. But I do— I am overall bullish on managed care.

And then I guess I'll conclude my remarks here by just saying, in terms of what I see as the really— the care management or managed care, depending on your vernacular, what's the value proposition? And I think my view it's sort of a six-point value proposition. First— and it's not guaranteed that managed care gets you this, but I think if it's done well it can.

First, that it gets better care coordination, which should improve quality and lower cost. Next, it allows you to align incentives within the healthcare delivery system, and potentially, especially with integrated delivery systems that you can partner with and hopefully get better outcomes and lower cost. It allows for improved access. I've seen— and this is the second state in which I've been the Medicaid Director, so I've seen that actually it can increase access and allow those managed care entities to pay higher than fee-for-service rates in markets where it's necessary to ensure that sub-specialists and other providers are available. It gives increased flexibility, managed care plans can fund services, provide social services, other supports that the Medicaid-fee-for service program can't pay for. And I think that's something that's sometimes lost, is that the managed care plans have opportunities that fee-for-service does not.

Fifth is local and regional flexibility. New York is a large and very diverse state. The Bronx is very different than

Buffalo, to say the least, and so the healthcare solution in the Bronx is going to be very different than the healthcare solution in Buffalo. And by partnering with local managed care organizations and partnership with the provider communities, I think can lead to a lot of local, regional innovation, which I think is a good thing and I'm a big believer that one size fits all solutions in states diverse as New York are not going to work very successfully.

And then finally, which I think is also obvious to most of you, is risk reduction. By going to capitation, or near capitation or capitation-like payment systems, the state is able to, in essence, insure greater— you have a better sense of what your actual budget is going to be, which for those of us, particularly myself who now manages under a statutory spending cap on the— for the state share and the Medicaid program, first of its kind in the country. Certainty is a nice thing to have, I wish I had more of it, but I think that it is another potential value that managed care provides to states.

DIANE ROWLAND: Thank you, Jason. Now, I'll go south to Dr. Gray in North Carolina.

CRAIGAN GRAY: Thank you. North Carolina is the home of the medical home. Community care of North Carolina started about 15 years ago. It's a 501(c)(3)corporation, owned by the primary care physicians of North Carolina, started by them 10

to 15 years ago. And it's gradually grown to a 14-network group across the entire state, all 100 counties.

Informatics is the key to North Carolina's success with the PCCM model. The informatics center is centrally located in a organization owned by the primary care doctors of North Carolina, where all the information, Medicaid claims data, is collected and used for a quality initiative. But the North Carolina program distinguishes itself a little differently from other states, in the fact that— that CCNC Community Care was started by physicians at the local level, particularly and specifically started by pediatricians and then growing to include family doctors and general internists. And even now, as the demand is required, it's moving into other areas, involving specialists, particularly psychiatrists, with our combined care model, with mental health and physical health together in the same location, cross-location and co-location.

Additionally, the obstetricians have joined in our pregnancy home model, which I'll talk about just briefly in a moment. And thirdly, our radiologists are beginning to join as well, because of the image management system that we imposed across the straight. They want to have a very intimate part and collective and collaborative part of that, they are joining CCNC as well, that's Carolina, Carolina Community Care.

Now, just like any young kid, any young child, there's growth that has to take place. You have to let down the pants

every now and then and take the cuffs off. You have to widen the waste a little bit and, even occasionally, have to buy a new pair of britches, CCNC is no different. The budget demands of this year and the last two years have been very, very strenuous, and there's been tremendous changes in clinical practice that need to be incorporated into our care management process. For example, over the last two years, North Carolina has removed $1.6 billion out of a program, a $12.5 billion program. And this year, because of continued budget constraints within the state, we are charged with taking out another billion. You can do the math, $2.6 billion over three years. We now have a little less than a $10 billion program. So, this change is really pushing North Carolina Medicaid significantly. And quite frankly, we are unembarrassed about using the power of the Medicaid program to improve the quality and the standard of care across the state of North Carolina, that's the vision.

So, as we discuss this matter across the state, we're convinced that CCNC, Community Care, needs to mature even more. Specifically, I'm talking about taking a fee-for-service program, with a pmpm, and adding some incentives to drive the quality issue even farther. This is based upon outcome metrics, pharmacy, for example, is being pushed to fill more generic prescriptions on the basis of tiered reimbursement

program, favoring the generic process, so really pushing that initiative.

But in addition that, we're also adding value-added programs, specifically those programs which are quality outcome driven metric-led programs. An example of that, just one example is the pregnancy home model, which is a value-added program. North Carolina does not get good marks in the management of pregnancy, even though we have some of the finest and nationwide recognized institutions across the nation, including Duke and UNC, others. We have four medical schools in our state. But this is an incentivized program, where we're using clinical, outcome-driven metrics, to improve that process. We'll pay you a little more obstetricians, but it's a quid pro quo arrangement, mm-hmm, we give, we get. It's all part of the deal. It's data driven, it's claims driven, and another unique thing about CCNC, it's surveillance driven. Not surveillance like private-eye type, but surveillance in terms of in office chart review.

Last year we – through CCNC looked at over 20,000 medical records to see that we were getting where we wanted to get. And, in fact, it's been shows and the literature has shown that surveillance-driven, quality outcome metrics are far more accurate and far more direct, and far more personalized than just simple data driven material.

So, that speaks to the seriousness of the quality initiative. Well, okay, where does this go, where does the PCCM model go from here? Well, I've talked about it being a turbocharged PCCM hybrid and, indeed it is, because mental health is being included into the process. The informatics center that is owned by CCNC, by Community Care, has included our mental health providers across the state, so they have access to the physical medicine pieces of an individual's healthcare. And, indeed, through a change in the law, we made mental health information available to the primary care physician through the CCNC Informatics Center. That is a big step.

Now, substance abuse still is not available as freely, because of some federal law, maybe that will be changed in the future as well. Because, indeed, if substance abuse is a health issue, then primary care physicians, or any physicians looking after an individual patient, needs that information to provide the comprehensive care to achieve our overall quality objectives. So, we— what interests you to know, that this model is well developed and is on a pathway to continued success, sufficiently enough to— to attract the attention of several large, local, industrial associations within our state, one pharmaceutical and one high-tech industry within our state is engaging CCNC, our local care partners, our community care

partners, our PCCM model, in the state to take care of their patients.

And, additionally, Blue Cross and Blue Shield that manages our state health plan, has also engaged CCNC to manage the state health plan population. That's our state employees, me, the teachers, and other state employees. Though, this is truly engaging the power of the Medicaid program to improve the standard of care across the state. This involves duals, it involves the ABD population, which are enrolled in the community care medical home model.

The future looks bright. The future looks difficult. We'll get there.

DIANE ROWLAND: Thank you. And now we'll move on to— we'll go a little west and still south to Texas.

JOE VESOWATE: Good morning. Thank you for allowing me to come and comment on the report and tell you about what Texas is doing in Medicaid managed care, which is quite a lot.

Actually, before I get there, I want to make a couple of comments about the report and I won't reiterate some of the things that Jason and Craigan have said, I think Jason summarized the advantages of managed care as a model and also some of the challenges that we face. And Craigan focused on the importance of metrics, because it's well known that what you measure is what organizations will react to, and, in Texas that's no different. Also, that Medicaid is such a large payer

and such a large component of the healthcare system that we can shape behavior to some extent and what we expect does make a big difference in how healthcare is delivered, not just for Medicaid patients, but for all patients.

But first to the report, I was pleased, perhaps gratified, to see that Texas finds itself in the group of states that is doing, for the attributes, that are what most states are doing. So, if you have a high percentage of states doing something, Texas finds itself in that group. And especially when it comes to certain initiatives at the ground level, such as reducing, encouraging the reduction of ER utilization through special programs, focusing on disease management programs for the chronically ill. To make sure that penetration into the healthcare system is minimized, because of effective, preventative and primary care, focus on behavioral health and coordination, which I would like to emphasize again, because what we find is that, the more you identify the populations that need those services and react effectively to that need, in addition to their physical need, the savings are dramatic. We see very high cost for a very small percentage of that population.

The encouragement of medical homes, that's a requirement in our contracts, and we're seeing some very aggressive moment in that area to ensure that patients have

coordinate care, test results, lab results, therapies, are all integrated into a treatment plan that helps the individual.

And finally, the addition of significant quality incentives, encouraging our managed care organizations to focus on quality. As you all know, I'm sure, managed care has moved from what was primarily a program to control fiscal risk to one that today really focuses on care coordination and health outcomes, access to preventative and primary care to reduce costs to the state and ultimately to the tax payer.

But all that's happening at the local level inside of some bigger system changes. Texas has been a managed care state, in one form or another in some part of the state, since the early 90s, with a pilot program that began in the Travis County, the Austin area known as Lone star, where Texans of course are nothing, if not self-effacing. Today we call it STAR, the State of Texas Access Reform, program that serves primarily pregnant women, children, and low-income families, provides what we call in Texas, a state plan, the basic Medicaid benefits, acute Medicaid benefits.

In addition to that, that program has expanded so that, effective on March 1, 2012, that program will be in all parts of the state, urban and rural areas. So, I can tell you today, that the report points out to the fact that, because of the percentage of people in managed care, it is the model, in Texas it is the model.

In addition to that, we have a program called STAR Plus, which is a program that combines acute and long-term care services for the aged, blind, and disabled population, also effective March 1. 2012, that program will expand from the major urban areas of the state to include the Rio Grande Valley, the Lubbock area and the El Paso area, so other than the rural counties in Texas, you will see that integrated system for the aged, blind, and disabled in all parts of the state, and it will encompass most of the population.

So, the future in Texas is managed care, we certainly have challenges ahead of us. A couple of points I want to make about that, the report— executive summary focuses on some of the areas that states need to be concerned about, capitation being adequate, networks being adequate, access to a state, like Texas with large geographic areas and varying levels of infrastructure creates some challenges. It focuses on transition from PCCM or fee-for-service to managed care and I would tell you that being on the ground and having to make that happen, you can't focus enough on that. It's complex, it's a change for people, it's a change for communities, and so the report speaks to that importance, and we certainly echo that. The takeaways that I have from the report clearly, other than the fact that managed care is growing as a model, and I think it will continue to grow, because of the budget pressures, the access need, population growth.

I saw today downstairs while waiting to come in on the TV, C-SPAN interview was occurring and one of the blurbs at the bottom said that Medicaid enrollment has increased by 6 million lives in this country since the recession began. So, clearly growth is outpacing infrastructure and states are going to have to response. Care coordination is the corner stone, others have said that, the report makes that clear. Again, it's no longer about fiscal control, it's about coordinating care and the end will take care of itself. Services are being carved in, if you can— if that's even a word. We are adding the pharmacy benefit to our managed care program in Texas, that's about a $4 billion spend over a two year periods, that's quite a lot. We have gone to a capitated dental program for children. We serve about 2.7 million children through dental managed care, beginning in March 1, 2012.

The next frontier as we see it, is how are we going to coordinate care for the dual eligibles? A lot of discussion, as you know, and you've heard is that CMS is looking at flexibility for states. Texas is moving in that direction, looking at what's possible and what will work. Clearly, Medicaid programs that do provide effective long-term care do say the Medicare budget, dollars, and we believe that states should have the opportunity to have some flexibility and some opportunity, to work within appropriate guidelines, to manage that at the state level. So going forward, finally, where do

quality and cost meet? You hear a lot about the intersection of the quality and cost chasm.

And I think to summarize, you do get what you inspect, not what you expect. And so it will be important for us as a state to look at what's happening in terms of the on the ground delivery, not just how well it's happening, but what the real cost drivers are, find ways to measure those and get a balance.

With that I'll stop and take any questions.

DIANE ROWLAND: Thank you very much. So, you've been presented with a lot of statistics and now you've shared, with our panel, the experiences of three states, so it's time for you to pose your questions to the report authors that are here, Julia and Vern, and to our representatives of Medicaid on the ground. If you would please raise your hand, they'll try to get a mic to you and please identify yourself as you ask your question. Let's start in the front.

JASON RIKEHARD: Oh, hi, can you hear me? John Rikehard with CQ, curious in the states where you have increased access from managed care, to what extent is the trade off higher spending?

DIANE ROWLAND: Jason, you want to take that one?

JASON HELGERSON: I guess the question is that, so in terms of expanded access to managed care or?

JASON RIKEHARD: Well, actually— sorry, what I meant was to the extent that managed care is increasing access to

care generally, to what degree is the trade-off higher spending, I mean do you have to pay more to bring in more doctors.

JASON HELGERSON: Right, I think that in a sense it's kind of— that's another design parameter that's at the state's decision. Obviously, you'd need to maintain adequate capitation and to the extent to which— the manner in which states use different approaches to determining what their capitated rates would be, the extent to which plans over time increase payments in certain areas and that leads to higher payments and, therefore, higher rates can lead to higher costs. That said that, in at least the experience in New York is that where we've seen higher rates in managed care, as opposed to fee for service was actually in primary care, which we think is actually a good thing and that is actually has potential to lower costs, because that means that more people have access to primary care.

The other area that we have— I think we are putting, investing more dollars, well it's true North Carolina's home of medical home, New York has probably invested more money in patient centered medical homes in New York State, in the sense that we have in essence a bonus payment for payment for physicians who meet NCQA accreditation standards. We now have 820,000 New York Medicaid patients who are utilizing patient centered medical homes, most of them are enrolled in health

plans and we're doing evaluation right now that looks at the outcomes for those members to see that extra investment payments, millions of dollars going out the door. Are we seeing a return on investment? So, I think it's definitely something where it depends on how states proceed. We think it's a value proposition worth making, but I think you have to continually evaluate your strategy.

DIANE ROWLAND: And Dr. Gray?

CRAIGAN GRAY: Thank you. Please realize that Jason has 5 million people in his program, we have 9.5 million people in the entire state of North Carolina. It's alright, nothing could be finer than to be in Carolina in the morning. I want to add a little bit to the question about using managed care, does it really cost more money. In fact, look at the pregnancy home model of which we anticipate, by improving the standard of care within the state then we— and pay doctors more for the level of service that they provide, and by their meeting the quality outcome driven metrics that we have imposed upon this process, and actually they did it, we didn't. We asked them to pick four, they did.

We anticipate, in the first year, of this program, that includes start up costs and all the programic changes, including IT, we'll be $1 million positive at the end of the second year, as this continues to ramp up, we'll be $18 million positive, and the third year goes even beyond that, something

like $36 million positive. But that does not even measure the collateral benefit that we receive from this program by getting healthier kids on the ground, if you please, that doesn't even measure that. The later costs that Medicaid would undoubtedly bear of these kids that would be impaired by being very low birth weight, those costs are avoided and we're not even measuring that at this point.

DIANE ROWLAND: Thank you. Next question. In front.

DOUG TRAPP: Hi, I'm Doug Trapp, with American Medical News. Quick question, there was a question in the survey about the ability to handle the new enrollees starting in a couple of years, in 2014, could you guys explain what your views are in your state, if you can handle that and why or why not?

JASON HELGERSON: I guess I could start. We do believe that there is sufficient capacity to handle the new enrollees, actually the impact of health reform in New York, because we already cover so many of these people already, will not be as great as it will be in other states. So we feel we have sufficient capacity.

CRAIGAN GRAY: In North Carolina, we'll give you a marginal answer on that, because, indeed we anticipate with healthcare reform, to be between five and 700,000 new participants. And what we really are concerned about is not the 133ers, and that is the group that received that specialized benefit, graded benefit up to 133-percent, 138-

percent of federal poverty, but what we really worry about is the woodwork effect. The woodwork effect are those people who are currently eligible for Medicaid who have dropped out, and by the way we have about a 20-percent dropout rate per year, when those people are mandated to come back onto Medicaid, we worry about them and our ability to pay for them and the ability of the care team to manage them.

As part of our process we worked with the local institute of medicine, North Carolina IOM, and have been looking at new models of care and our workforce, and we will have to make some changes, even though, currently, we have a 90-percent overlap with commercial— our networks, our CCN networks have a 90-percent overlap with commercial carriers. So, we're pretty well covered in terms of access. We just don't know where all these— this 700,000 of new people are going to go, and that may cause an access issue.

DIANE ROWLAND: And, Joe, I know Texas is gonna have a lot of new eligibles.

JOE VESOWATE: We will, and I think for us we have currently 19 managed care organizations across the state that do business in Texas with the Medicaid program. So, we think because we have a competitive business environment and several players in the markets, in fact, in some of our larger areas, such as Houston can have as many as five managed care organizations, providing services, that the key for us is

having those competitive relationships, good business environment and the right number of MCOs, so that we are— capacity can be absorbed. People are served today and in many of large urban areas, provider-based plans, hospital-based plans who are owned or operated by the hospital district exists today, so in some form or fashion people are being served and the key for us is to make sure that the business relationships we have are sufficient to meet the need.

DIANE ROWLAND: Thank you.

JILL WECHSLER: Hi, I'm Jill Wechsler, with Managed Healthcare Executive magazine. Some Republicans, and perhaps others, have suggested that the Medicaid managed care would improve by eliminating the rule that you have to have at least two managed care organizations serving any market, and also modifying the federal waiver process. And I'm wondering what you think about that?

JASON HELGERSON: You know, honestly, my experience, this is my second state. I was in Wisconsin before I became the Medicaid Director in New York in January. I guess, in my experience, because there's a rule exception clause that allows you to operate with a single managed care entity in very rural areas, that, at least my experience, has found that it really hasn't been a huge barrier. That said, particularly for some of the special populations.

It's going to be a challenge for us over the next three years to basically recruit people who are capable and in managed long term care, for instance, and some of those areas to get that, whether eliminating the two plan limit. I mean, our vision for this is choice. We want to have members be able to choose a plan that best meets their needs and have a variety of different choices. So, I guess, in a sense that, you know, I think that's certainly not something that we're advocating for.

DIANE ROWLAND: Okay, [inaudible] next.

RUTH LUBIC: My name is Ruth Lubic. I'm a nurse midwife working here in the district in a low-income area to see if the disparities of the African American people can be reduced. And, in fact, we have been able to reduce them significantly, saving a lot of money using the IOM proxies for the cost of preterm birth for example, which we reduced by two-thirds. In 2006, we saved more money for the system than our operating budget, but, the for-profit managed care company that oversaw our payments, refused to give us more half our charges, so we had to go out and raise half the budget, in spite of this. And I'm just wondering whether of any you gentlemen find that you're looking at the for-profit managed care companies in terms of how much profit they're making and whether there's any attempt to contain that profit at the expense of the providers out there in the low-income areas making a difference for them?

MALE SPEAKER: You start on that one.

CRAIGAN GRAY: Well, I answer this question in the context of being a board certified obstetrician/gynecologist. And, indeed, the primary author of the pregnancy home model in North Carolina, which indeed gave more money to providers, but, on the other hand, I want more from them, in terms of their product. It sounds like you are headed in the right direction. North Carolina does not have a for-profit managed care company. We have the PCCM model.

Now, you would say doesn't community care, your MCO, hmm, yes, but only whisper those words in the presence of North Carolina doctors, but, our intent— our intent is to move that to more of a care management company, to do just that. So, from our state's perspective, we are willing to share the profits, if you please, from good care with the people who are providing the good care and likewise, keep those benefits from people— from providers who do not provide good care.

JOE VESOWATE: I will tell you in Texas, the report pointed out which states have a medical loss ratio requirement. We do not— we have a cap on profit. We call it the experience rebate program. We receive very detailed financial reports from our managed care organizations. We require audits, verifications of those numbers. We compare the claims records, the payment records and the encounter data, to the amounts reported on the financial reports to ensure that they are

accurate and complete, so in Texas, we also have a cap on administrative expenses and we have very clear definitions of what is allowed as an administrative expense. So we work under the concept that, we will not hold you to a certain medical loss ratio, provided that you deliver the care appropriately and you acquire the right outcomes, however, if you report profit above a certain level the state will recover that and we will adjust your capitation to actual expense according, so while Dr. Gray answered from the perspective of a physician, I must tell you I'm answering it from the perspective of a certified public accountant.

CAROL O'SHAUGHNESSY: Hi, I'm Carol O'Shaughnessy, with the National Health Policy Forum, and thank you for the report. I was at a meeting yesterday, where a CMS official said, eventually in the next number of years fee-for-service will disappear from Medicaid. But I have a question about the elderly disabled and quality of long-term care. Many applications apparently coming into CMS to have managed care for long-term services and supports, and, I wondered if you could talk a little bit about quality metrics for long-term services and supports in your various states or I don't know if the study addressed that, because we're still struggling with quality measures for home and community based services, even though the 1915(c) waiver has been around since 1981, CMS has, in the last 5 or 8 years, has begun to look at quality metrics

for those services. And given that that's the largest part of the expenditures, I wonder if you could comment on that?

JASON HELGERSON: Sure, that's an excellent point. It's an area where I, you know, in New York we've been very focused, we have a very extensive performance measurement and we put a large percentage of capitation payments, one of the largest in the country at risk, based on actual performance by plans, but that aggressive approach has not extended into the managed long term care area until now, and we actually have working right now, a stake holder group that is focused on, what are the metrics that the state should use for managed long term care? And then, out of that, will then be an opportunity to then implement a pay-for-performance initiative to reward the plans, because that is the big fear.

The big fear is that, in mixing of the question we heard earlier, that you'll bring in these insurance companies, big insurance companies who will profit and that it will lead to poor quality care. And I think that, you know, managed care, it's a tool, but it's how you utilize the tool, and I think that in order to utilize it effectively, you have to structure a contractual relationship that provides the right financial incentives and has the right checks in the system, to ensure you're getting the outcomes you want. But a key thing in long term care, is how you measure those outcomes, and that's one of the things that we're grappling with right now,

is that we move to mandatory managed long term care goes into effect beginning in April of 2012.

And so, what we're gearing up for is that move, which includes identifying very specific performance measures that we're going to hold the plans accountable for.

DIANE ROWLAND: Okay.

SCOTT GREEN: My name is Scott Green. I work at Bank of America Merrill Lynch in New York. Blue Cross Blue Shield plans have expressed an interest to expand their presence in Medicaid with the view that they're well-positioned to handle members who might navigate between Medicaid and exchanges in 2014. But over the last year or so they have not been as successful in competing for RFPs, so in Louisiana Blue Cross Blue Shield of Louisiana decided not to bid, because it didn't think it could win an adequate return and in Texas, Healthcare Service Corp didn't win much business at all.

And I think why, I see one of the questions in your survey that only eight out of the 27 states are thinking about requiring MCOs to participate in exchanges. So, I guess my question is, why aren't states thinking about requiring the MCOs and Medicaid to participate in exchanges, and if and when they do will that impact the competitive position of Blues to win Medicaid business or is there some reason why they might not be as efficient?

JASON HELGERSON: Interesting question, I think there's a number of insurers who traditionally have been managed care organizations those that traditionally have played only in the commercial business who are now trying to take a look and see what position they may want to play in Medicaid managed care and then also in Medicare managed care. And, I think one of the challenges— and, you know, in New York we have a unique situation where we have a wide array. We have four-profit— non-profits, you know, provider-owned. And, when I've read analysts, Wall Street analysts, reviews of our managed care market in New York, usually what's highlighted is that it's already a fairly saturated market, so there's a lot of players already on the ground.

A lot of the players, as I said, are provider-based who have maybe some advantages in terms of recruiting members, because they're both provider and insurer. So, I think the challenge you're going to have as a company sort of sitting on the outside looking in, how do you get into the market? There's entry costs associated with moving into a managed care, Medicaid managed care, you have to build a network, you have to invest, you know, and usually probably the best way to do that is in a state where you have the competitive procurement process. And so I know, Texas has a competitive procurement process. I think California's moving forward with a DBD population of a competitive procurement process. We have not

used competitive process in New York for many years. There's strengths and weaknesses to the competitive process, but I think that that's going to be a challenge, because plans that have been on the outside, might now wish they had made a decision years ago enter and they may find it a little bit more challenging they might have originally thought.

DIANE ROWLAND: And Vern?

VERNON K. SMITH: Yeah, and if I could just add quickly to that. I wouldn't focus on— I heard you say only eight, I think if you look at the numbers that we had there, of the 10 states that were prepared to express an opinion, eight out of 10 said that they were considering the option of requiring plans in Medicaid to participate in the exchange and a similar number who had reached a point, but you know, that question was asked a few months ago a lot of development is happening.

The key point here is that states, whether they're on Medicaid programs or people in charge of developing the exchange are really focused on some of the information which has come available earlier this year, about the extent to which people move back and forth across that 133-percent line. And there is a lot of interest in making sure that people aren't force to change plans, are not forced to change providers when they make that transition, either from the exchange to Medicaid or from Medicaid to an exchange kind of situation. So, I think you'll see people looking at this, and that's really what the

question was, looking at how they can minimize the impact of that movement back and forth across that eligibility line.

DIANE ROWLAND: And, Joe, since there was a reference to Texas.

JOE VESOWATE: I just wanted to make a point that you are correct that Blue Cross Blue Shield was awarded a contract in the Travis County area, and it is not insignificant. These are large markets relatively speaking, because Texas is a big state, but also would point out as Jason made some great points about saturation and maturity. And Texas also added three other managed care organizations this last procurement, so it is competitive and we look for competitive balance in all areas. It's not as if Blue Cross Blue Shield was not the only organization that did enter. So, you have to look at that as well I think.

DIANE ROWLAND: Okay.

MARY ELLE CREST: Hi, I'm Mary Elle Crest [misspelled?] from Avalere Health. This question is for Joe in Texas. You mentioned that Texas is carving drugs back into MCO contracts and I was under the impression that the legislation also required MCOs to completely adhere to the state's PDL. I was wondering, what were the factors that went into that policy decision and what do you think the implications of that policy are? Thank you.

JOE VESOWATE: Well, I can only speak broadly. Our vendor drug program has managed a lot of the details, but you may be aware that Medicaid programs receive rebates on drugs based on where they're placed in the PDL. So, the drug benefit was carved back in and Texas legislature considered a lot of discussion and took a lot of input on this. When the decision was made, there were two options at the time, allow managed care organization to have their own formulary and PDL or adhere to the one that the state had in place. Texas decided that the correct move at this time was to adhere to the PDL and formulary in place. It certainly is less of a change for the pharmacies that provide— that dispense the medication and, at the same time allowing the drug benefit to be carved back in. So, I think it was a matter of making the right move at the right level at this time.

MEG MURRAY: Hi, I'm Meg Murray and I represent the Safety Net Health Plans, which there are a lot in Texas and New York. And the thing that I was most struck with from the report was the level of quality oversight of managed care compared to the fee for service program and Vern you said, I think almost every state that does managed care requires HEDIS and CAHPS and EQRO and all of that, but only 30-percent of the fee-for-service states do. And so I was curious for the state Medicaid directors, would you support a requirement that the

fee-for-service programs be held to the same quality standards as the managed care programs that you run?

CRAIGAN GRAY: Well, in fact in North Carolina, the fee-for-service programs are held to those same standards and actually comparing ourselves to Tennessee, Georgia, Oklahoma, our fee-for-service care management system is as good as, if not better than any of those states who are under managed care, quite surprising, but good.

VERNON K. SMITH: And Craigan, I know this from, you know, talking to you otherwise, but of all the states in the country that have a PCCM program, how many of them are prepared to submit quality data to NCQA?

CRAIGAN GRAY: Well, I don't know the answer to that question, except North Carolina.

VERNON K. SMITH: Which is the only state.

CRAIGAN GRAY: Yeah.

DIANE ROWLAND: Okay, here.

PEGGY BAILEY: Hi, I'm Peggy Bailey with the Corporation for Supportive Housing and I had a question for the Medicaid Directors around integrated care with behavioral health and primary care. You each mentioned that in an environment where there's MCOs and BHOs, I just was wondering if you could talk a little bit about that. I know I followed New York in that conversation a lot during the Medicaid

Redesign Team, so I just wanted to hear a little bit more about how you're navigating that as your trying to integrate care?

JASON HELGERSON: Sure, what was mentioned is that we've had an interesting eight months on the issue of behavioral health. As I mentioned in my opening comments, history in New York was that, for the people who had the most significant behavioral health needs, it was a carved out fee-for-service system, it had been for a long time. When we started the Medicaid redesign process, we put out two proposals, one was to almost like straw dogs to get some reaction from folks, but one of them was to carve the benefit entirely in to the existing managed care contracts, another one was to carve it out. What ended up happening through that debate was that, for the first time in anybody's memory the behavioral health community in the State of New York came together around a proposal.

Okay, we understand you want to move to managed care, we just want to do it through behavioral health organizations to basically do it, it's carved out, stand alone benefit, but do it within eventually a fully capitated environment. That has since then, even evolved further and now, what people are beginning to realize is, maybe this care management thing isn't all bad if we do it the right way, because of the flexibility, the potential for providers to share in savings from doing a better job of managing care and now we're getting to the idea

that people are talking about special needs plans, SNPs, that focus on those people with the significant, persistent mental illness, which to us is a very interesting and exciting idea, particularly in dense urban markets, like New York City, where we already have special needs plans that focus on people with AIDS and HIV, for instance, that we think that we have some unique opportunities, because of— particularly in the city where we can have a unique set of providers step forward as it is happening in the AIDS/HIV world to actually be managed care organizations unlike any other in the country, where they are highly specialized in dealing with these patients, but they are providing a full integration of services. So, they provide the acute, the long term, as well as the behavioral health services, and we think that that's probably going to be the future, particularly for our chronically mental ill.

CHRISTINA LENORE: Good morning, my name is Christina Lenore [misspelled?], I'm with Levitt Partners. I have two related questions about medications, prescription drugs. There's a lot of talk about carving the programs back in and I'm wondering if there's any desire to carve out particular types of drugs, mental health drugs or specialty drugs, which are very costly. And the challenge to manage and related to managing all medications, I'm wondering what states, there was some mentions in the report of adherence, a little bit of medication management, some states are pretty progressive in

that area, but there wasn't a lot of mention in the report, so I'm wondering what else is going on around using pharmacists to provide clinical services for medication management.

CRAIGAN GRAY: Again, North Carolina's experience is a little different, yes, we are in terms of specialized therapies, that's also a program being managed and mental health drugs are being managed through a registry. Mental health drugs are very potent medications, particularly atypical anti-psychotics, they're very potent and they're being used for a wide variety of diagnosis' unrelated to the original researched and approved diagnosis. But it's interesting to note, that within each network for North Carolina there is one or two located pharm Ds, pharmacists, super pharmacists, that are in the program that evaluate those people who are on multiple drug therapy.

So that's— it's being managed on a local level, in terms of drug utilization or over utilization. And to really achieve significant savings and beyond that folks, it's not just the savings, it's better healthcare when people are taking two or three beta blockers or another variety of hypertensive medication or if they're taking a couple of mental health drugs that compound the problem. So, it's better care as a result of careful pharmacy management.

DIANE ROWLAND: Okay, question back here.

FEMALE SPEAKER: Oh, over here, [inaudible].

LAURA SUMMER: Thank you. Hi, I'm Laura Summer from Georgetown University. And I'm interested in having some of you respond to a question about the intersection between expanding managed care for populations that have been receiving long term services and supports and some of the initiatives that states have been developing over the past couple of decades to provide consumer direction, more consumer direction for example, and to make the transition from institutions to community based care?

JOE VESOWATE: Hi, Laura. I think we've actually spoken before about this.

LAURA SUMMER: Yeah, and thank you for all your input.

JOE VESOWATE: Uh-huh, it's a great question. We're interested in this in Texas. The STAR Plus program, as I mentioned is a 1915(b)(c) combination program, that combines acute and long term care. The key component of STAR Plus is a process called service coordination. An individual that's properly credentialed is responsible for coordinating the care for those individuals and also for assessing an individual, advising them on consumer directed opportunities.

It's a requirement and we found that in the managed care programs, that the update for the consumer directed services component is higher actually than in the fee-for-service or other programs. But I think it's critical that you realize that long-term care is not acute care. And what we

have found is that the way that, that system works is different than the way that the acute care system works and we do have to make sure that the MCOs that operate that program understand two things. That within the 1915(b)(c) waiver the importance is flexibility, to make sure that the individual remains active in their community as quality of life. And we've typically measured that through the CAHPS survey.

We've asked individuals, you know, how they're doing, how do you feel about service coordination, are you pleased with your doctor, and we get high response rates, satisfaction rates, for those individuals that do avail themselves. But the question was asked earlier about how do you really measure affect and long term care, and I think that's something that we are working as well with the stakeholder group to develop metrics that are a little more hard-hitting, looking at nursing facility placements and what the rates of matriculation in or out are, avoidance of hospitalization for individuals in the community.

It was hard to bring people together and manage the group at a size that was effective for us and we started with a very large group of measures, but we've managed to cut that down to seven or eight. Final recommendations will be coming out to our leadership team and we will implement those in our 2012 contracts. So, I think this is an area where you have start really looking, HEDIS is acute and, you know, we've done

a real good job of that. We've used the CAHPs survey, but I think we have to look at measures of effect in long term care and we're doing that, just to make sure that we know, not just what the member says, but what we see in the data as well.

DIANE ROWLAND: Okay, one question back here.

LYNDA HONBERG: Hi, Linda Homberg from the Maternal and Child Health Bureau, and first, Dr. Gray, thank you for pointing out that the medical home was started with pediatricians, a fact that a number of people don't know. My question is on access to pediatric specialists, which we hear from our families is increasinglya problem is more children with disabilities and children with special healthcare needs are moved to Medicaid managed care. What you will be doing—all of you will be doing, to improve access?

JASON HELGERSON: Well, I think as I mentioned one of the things that I think is a strength of the managed care program over fee-for-service is the ability that where shortages exist, or where it's particularly challenging from an access standpoint, managed care plans have flexibility to basically meet our network requirements. I mean that's one of the key challenges, states have to have is, you know, the broader your network requirements, the higher your capitation payment has to be, so that's a natural trade off, but I think it does give you that flexibility, particularly in those sub markets where, you know, in some of those pediatric

specialties, in particular, there just aren't going to be that many providers, particularly in rural areas. So, I think that, you know, there are opportunities within that.

I would say that, you know, I often hear about access problems in managed care, but I think that, um, you know, because of historically low rates in Medicaid, for providers, particularly for independent physicians, it's— you have big access problems in fee-for-service and— and so, that's what I say is a potential big advantage of managed care if it's done right is that you can actually ensure better access if you structure your contracts appropriately.

DIANE ROWLAND: Okay, one more questions, two more, okay, one, two.

FEMALE SPEAKER: Hi— oh sorry, go ahead.

DIANE ROWLAND: I said, one, two, one.

FEMALE SPEAKER: You can go first.

DIANE MCCOMB: Okay, Diane Macomb with the Delmarva Foundation. This question is for Jason Helgerson. I understand that New York is pursuing an 1115 waiver for people with intellectual disabilities and that it is a separate 1115 waiver. And I'm curious what your thoughts are on why it is not an integrated population with the rest of your health care system for long term services and supports and what challenges you see in implementing that waiver? Thanks.

JASON HELGERSON: Yes, developmental disabilities and the services provided to that population in New York are, to say the least, unique in the sense that we have probably the most comprehensive infrastructure for serving people with developmental disabilities in the— and I would say, argue, in the nation. And the financial structure that has supported that system is basically financially at risk, given the way we've historically financed it. So, the reason for us keeping the— that issue separate is primarily a financial one. That said, we do believe that moving to a care management strategy is consistent. There will similar approaches for the roughly 100,000 people who do have developmental disabilities in the state.

So we are moving to care management, we do want to have more fully integrated care management, but we have to go from an environment where, I'll give you an example, is that we rely heavily on state employees to manage the system. So, in the State of New York we have roughly 25,000 state employees who basically man the various service locations that meet the needs of this population. So, it's a very— there's a very, very long history to this program in the state, so it's going to take us a while longer for that particular population to get to where we want to get to, but we're hopeful over a five year waiver timeline, we'll be able to, in essence, get to pretty close to a fully integrated care management for that population.

DIANE ROWLAND: And a question here.

MARY MOSQUERA: Yes, I'm Mary Mosquera from Healthcare Finance News and my question is for any of those who can answer it. I was wondering how health plans, managed care plans in your state, or in states that you've heard of, are going to ramp up their infrastructure to meet the massive amounts of new people who will be on Medicare? I know in New York, you said you wouldn't be handling that much more, but in North Carolina some would be coming back, and it seems that health plans will have to— whether it's clinical, administrative, financial, there's going to be a lot of infrastructure that's needed. And I was wondering what you've heard so far that health plans are doing there?

CRAIGAN GRAY: One thing that's happening in North Carolina is, both through the sub specialties, the family doctors and even pediatricians being involved to have the— each individual who has a license to care for patients to operate at the highest level that that license will allow. So, that's one way we're doing that. We're looking at other models of care which include changing the paradigm, it happens in the primary care office, group visits, telemedicine is a project that we're putting into place to manage those people with chronic illnesses.

We have a pilot in Rowan County which has been very successful and it reduced emergency room visits in a high level

population, specifically those with diabetes and congestive heart failure, almost by 48-percent, so it's significant. Using— and it's not just a forever kind of thing, it's a teaching tool as well, so we are, you know, finding, fixing and educating the population to be able to managed chronic disease better. So, that's— that's one way we're doing that, which will indeed reduce the chatter coming through the primary care office for those— for management of chronic disease.

DIANE ROWLAND: Thank you. Well, we have had a rich discussion here. For those who are also wondering what happened with the number of uninsured, as the Census Bureau released its data today. It's up nearly a million to 49.9, which some of you may say, but that's less than last year, because the Census Bureau, as it does to foil us, has revised last year's estimate down to 49 million, so the new number is 49.9. It's a million increase over last year, but the number for last year is different than every number you've ever seen.

But that shows you why it's important to continue to track and to monitor, and to have data on what's going on. I think today you saw the real importance of having care management, replacing the words managed care, because I think really the states are going is for care coordination and care management for very difficult populations. And I think this report and the discussion today will hopefully give you some insight into issues to follow and ways in which the healthcare

system for Medicaid beneficiaries is being reformed. And I want to thank again our report authors and also especially our panel who came here to join us today and to provide some great insights into how they are managing the programs in their states. And thank you all for attending and for participating always in these briefings. Thank you very much.

[END RECORDING]

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.