MEDICAID REFORM WAIVER STAKEHOLDERS MEETINGS: Highlights for Advocates

Following passage of SB180 Medicaid Reform (comprehensive Medicaid payment and delivery system reform designed to limit cost growth while improving health outcomes), Utah Medicaid Director Michael Hales and SB180 sponsor Sen. Dan Liljenquist agreed to convene 7 weekly meetings to obtain input from stakeholders on the Medicaid 1115 waiver portion of SB180.

Following are meeting highlights from a mostly UHPP or consumer advocacy perspective.

As soon as the waiver proposal is released for public comment on June 1, it will be important to track stakeholders’ mostly positive input to make sure it is reflected in the waiver proposal. Also, please join us at the June 1 Monthly Meeting (at Department of Health, Cannon Health Building, Room 125, 1460 W 288 N in Salt Lake City) with Michael Hales. Michael will walk us through the new waiver proposal, to be released that same day, and take your questions. Then advocates and UMP partners will gather again (after the DWS portion of Monthly Meeting) at 3:30 pm that same afternoon to strategize for the public testimony forum scheduled at the Department of Health (also room 125) on June 9 4:00-6:00 PM. All of these meetings take place in room 125 of Cannon Bldg.

March 30, 2011/Meeting 1
Topic: Overview

Attendees: Michael Hales (Director of Health Care Financing, UT Dept of Health), Sen. Liljenquist, Rep. Sanpei, Shanie Scott & Judi Hilman (UHPP), Sheila Walsh-McDonald (SLCAP), Gail Rapp (Director, Bureau of Managed Care), Lincoln Nehring & Barb Munos (Voices for Utah Children), Dave Gessel (UHA), Barb Visocchi, Gordon Crabtree (U of U Hospitals & Clinics), Michele McOmber (UMA), Paul Munen, Brian Monsen (Molina Healthcare), Vicki Wilson, Russ Elbel (Healthy U), Alan Prus (AUCH), Lisa Nichols (Midtown Community Health Center), Todd, Jess Gomez, Jim Murray (SelectHealth), Russell Frandsen (Legislative Fiscal Analyst), Cathy Dupont (Leg Research & General Counsel), Kolbi Young (CHIP), Kirsten Stewart (SL Tribune, off record), John Corliss, Blake Anderson, Emma Chacon (UT Dept of Health).

Status Quo of Medicaid Managed Care
Along Wasatch Front, there are 3 different managed care arrangements...

1) Molina HealthCare: on a full risk, capitated basis, which gives Molina incentives to cost-effectively manage care. How it works: state look at 2 years of claims data; Milliman (actuarial firm) then analyzes. Rates based on amount per client are then negotiated w/Molina.

2) Healthy U at U of U: this managed care arrangement is called “pre-paid ambulatory health plan” because U of U pays claims on ambulatory services; state pays inpatient claims.

3) SelectHealth is an example of a “primary care case management” contract: the state contracts w/SH for access to provider network, but state pays all claims.

All 3 types of plans are acceptable as managed care in eyes of CMS. The problem is that they are all different, which makes it difficult to compare the plans on quality and health outcomes

Purpose of Broader SB180 Process ...

- Providers today are focused on chasing down payments, but Medicaid as payer is tapped out! Objective of moving to capitation is to make the rate of Medicaid spending more stable; goal is to shrink rate of growth from current 11% to 8% or less.
- The first step is to transition managed care plans to full risk basis—like Molina today. These arrangements will then evolve to “accountable care.” Plans will be accountable for clinical outcomes of beneficiaries. All parts of the system will have incentives to deliver care in most cost-effective manner possible. “To get this right, we must have bundled payments...all the way down the value chain” (Sen. L)
- Our goal is to set up an environment where you all (provider stakeholders) can succeed and patients can get the care they need. “We will be in a collective eco-system together” (Rep. S)
• If we succeed w/transition to ACO, etc. will be in better position to handle the huge Medicaid expansions of 2014 (Michael Hales)

Narrower Purpose of Waiver
• May need a waiver from CMS to dedicate some portion of hospital assessment proceeds to managed care (Rep. S). This gets us closer to ACO infrastructure where we are all partnering together.
• Depending on how designed (carrots vs. sticks), healthy behavior incentives may need a waiver.

Provider Perspectives

Molina's Muench:
This is positive, will bring consistency to managed care. Will work best if get incentives aligned on providers' end.

U of U Hospital & Health System’s Gordon Crabtree:
• Supplemental Payments and DSH (Disproportionate Share Hospital) payments and Graduate Medical Education$ are critical for our ability to serve uninsured/as a teaching hospital; we have a unique claim on these an payment ratios between state, U of U & Feds have not been updated
• We’re all for deliver system reform, but if we have so many uninsured at our door, will run into difficulty

UMA’s Michele McOmber: if we are accepting more risk, we will need to be paid accordingly

UHA’s Dave Gessel:
• assessments should stay with the provider category where originated
• All interests must have stake in the process, must give a little—including patients.
• Patients need financial incentives to pursue healthy behaviors, seek care in right time/place

Discussion Topics (shown in bold) with Stakeholder or State Official Comments

Pharmacy (Rx) Benefits & Purchasing & relationship to state’s PDL (preferred drug list)...
• Now Rx benefit is carved out. Under new managed care or ACO arrangement since ACA (federal health reform), managed care plans will be able to negotiate directly for better Rx pricing (Hales,& Sen. L)
• Post- ACA, managed care will have their own P & T committee to interface with state’s P & T (Hales)
• But the statute is not clear on these relationships (Cathy Dupont of Leg Research)

On integration of mental health care and long term care (and duals) in ACO transition...
Many stakeholders asked about these populations. These areas will be pulled in to the ACO transition—but later; will start w/low hanging fruit (Sen. L).

On medical home work going on now in Utah & relationship to proposed changes...
Sen. L & Rep. S: We want to encourage innovations like Dr. Chuck Norlin’s Utah Pediatric Partnership to Improve Healthcare Quality.

Rainy Day Fund (Stabilization Fund) and what will protect it, given that similar $s were raided in the past...
• We can’t bind the Leg—all we can do is put Medicaid at the top of priority list for the fund (Sen. L)
• ...and “keep the pressure on” to reserve this fund for Medicaid (Rep. S)

NCQA Standards on ACOs or Accountable Care Organizations (UHPP post hoc: see model ACOs like Intermountain initial skeptical response) include the following:
1. There must be a sufficient number of primary care practitioners
2. Clients must have ways to give feedback
3. Must measure outcomes at every point in the transition
When released in July, 2011, we will use them probably and adopt some of our own besides (Sen. L)

**Healthy Behavior Incentives**

- Health plans will create their own carrots (Hales) –as opposed to sticks.
- Patients need $ incentives to pursue healthy behaviors or seek care in right time & place (Gessel, UHA)
- As we learned from PCN, affordability is a key factor in compliance (Sheila)
- We may want to use optional benefits or health club memberships as carrots (Molina’s Muench).
- WV ran into trouble when providers had too much pressure to simply sign the form [saying that patient was engaging in healthy behavior, even when not]. Hales asks for ideas on healthy behavior incentives.
- CMS is not likely to approve incentives that limit or segment access to Medicaid optional services—see [guidance for the Medicaid Incentives for Prevention of Chronic Diseases grant](Hilman, UHPP)

**April 6, 2011/Meeting 2 (Provider Focus) Topic: Integrating Pharmacy Benefit into the New ACO**

Discussion focused on how the state will integrate pharmacy payments into the bundled capitated rate schedule, as required by SB180. The DOH will request historical data from providers and managed care to better set the new bundled payment rates. The primary concern of the meeting focused on the exemptions of mental health medications on Utah’s current PDL. Managed care plans and providers feel that there will be a substantial crossover with these clients. Managed care stated that as much as 80% of their clients will need mental health services which they receive through their primary care providers. The inability to integrate mental health medications into the new payment system could be a serious problem and one that needs a closer look by the group. At this point, DOH cannot strategize effectively regarding mental health medications as the state would need a statutory/legislative change for this to happen.

The state will be negotiating with the ACO's so they will have no financial risk with the inclusion of pharmacy costs into the new rates, but rolling this benefit in to reform will be critical to incentivize providers to utilize cheaper more effective drugs. The state may look into a tiered payment program regarding drug classifications.

The group feels that the entire drug formulary should be included in the PDL, but as stated above, DOH has no control of this without legislative authority. Managed care stated that they were not interested in assuming the risk for mental health clients until these changes are made to the PDL. Managed care stated that they would prefer to utilize their own PDL, P&T Committees, and DUR board rather than the state’s.

Process moving forward for inclusion of pharmacy benefits into the new payment structure:

- Gather historical pharmaceutical claims data
- Include specific regulations into the plan
- Review aggregated PM/PM rates based on client category to adjust rate to include pharmacy
- Step therapy will be allowed within the new ACOs
- DOH will provide claim data to enable plans to review aggregate pool of pharmacy risks
- DOH is required to remain budget neutral under federal regulations
- Out-of-network payments will have a set rate under a new fee schedule

ACO’s will be receiving rebates instead of the state under the new reforms. DOH will utilize rebate data to figure these savings into the capitated payments, or they may utilize allowances for the rebates. All of this will be included in the contract negotiations with the ACOs. DOH is unsure whether they are able to share contract information with the plans and will discuss this with CMS.

- notes by Shanie
UHPP was not able to attend this meeting.

This was more of a free form discussion, with the community health centers weighing in on how they do their cost sharing, how much they charge. I was ready with tons of articles on the importance of the right balance for cost sharing and what the law/regulations actually say, but the legislators didn’t want to go in a prescriptive mode. They (the Legislators) were interested in having the health plans do a more market-based approach, recognizing that they will be competing to get families and individuals into their plans, that each plan would be required to have a published co-pay fee schedule and beneficiaries could choose the plan that best suited their needs and circumstances. All the plans were interested in a refundable co-pay if ER visits turn out to be appropriate. There was also discussion of having triage in the ER for inappropriate primary care cases, referring them to the nearest clinic if it was open. Depending on what the health plans come up with, I am not at all certain what CMS might say.

--notes & reflections by Sheila Walsh-McDonald (SLCAP)

A strong contingent (mainly health plans) felt there was not enough flexibility in both the amount and where cost sharing is permitted to drive behavior. There was also a discussion about whether premiums were an appropriate tool (to influence behavior). This led to discussion about the experience of CHIP premiums, the problem with churning, and the need to keep people enrolled in order to allow plans to truly manage care (this is where the issue of 12-month continuous eligibility was brought up).

- additions by Lincoln Nehring, Voices for UT Children

April 20, 2011/Meeting 4 (Provider Focus)  Topic: Capitated Rate Setting and Data Requirements

This meeting focused on the creation and stabilization of a capitated (a set or fixed payment rate to managed care or MCO plans designed to strengthen incentives to manage care effectively and limit wasteful spending) for the new bundled payment system. The focus for the immediate future will be to understand what portion of this structural change will need waiver approval from CMS—and what portion will not. Currently, Molina is the only managed care system in Utah that is already utilizing a bundled capitated rate agreement with the state. The future ACO’s will be able to analyze these current rates while looking to their own historic fee-for-service rates to set their new capitated rates.

Key points moving forward:

1. The state will need to adjust rates early and more frequently than the historic norms, as the interested stakeholders gather historical data to ensure accurate rate setting.
2. The starting point for this process will be with CMS as they provide further guidance to the state regarding data for treatment codes.
3. Initially the process may impose a normal fee schedule with a capitated rate balance.

The state actuaries have recommended...

1. The rate setting will be set on a 1 year diagnostic code (risk adjusted factors);
2. 6 months into FY12 the state will update the rates based on additional data.

A key factor in success of the new rate system will be weighing the balance of setting rates twice in one year. Without enough data, this can create administrative burdens. Also, due to the counties selected to participate in reform, the risk should be stable until the 2014 Medicaid expansions, although at that time the rates will need to be reanalyzed and adjusted to accommodate the new enrollees. The state will maintain the current process of
an annual enrollment period, which will not allow clients to shift plans outside of this time, keeping enrollment and rates stable.

.notes by Shanie

April 27, 2011/Meeting 5 (Client Focus) Topic: Client Incentives for Healthy Behavior

This discussion focused on the creation of a new healthy behaviors incentive program. UHPP’s Shanie presented information on several state examples as well as successful clinical studies to support a successful program. One promising model is Wisconsin’s Badger Care Plus program. The main features include:

- the only way to address rising costs in the long term is to help individuals get and stay healthy
- Implemented in January of 2008
- Requested 5 health plans to submit grant proposals for incentive programs. Their results will be evaluated to pinpoint best practices.
- Through these pilot programs Wisconsin hopes to identify creative, evidence based approaches to healthy behavior.

Voices for Utah Children’s Barb Muños has also been gathering information regarding state programs. Both Florida and Idaho’s incentives programs have successful features that might be replicated in Utah. The findings of state programs as well as clinical studies show that the state should implement the following steps to achieve success:

1. States should assess consumer awareness and understanding of the program to ensure that they have sufficient understanding to make healthy lifestyle changes and benefit from the program—focus groups might help.
2. Provide varied, targeted and easy-to-understand, culturally and linguistically accessible educational materials and approaches.
3. Develop connections with program partners, and addressing systemic barriers which will be critical components to program success.

Federal Grant Opportunity

Section 4108 (Incentives for Prevention of Chronic Diseases in Medicaid) of the 2010 Patient Protection and Affordable Care Act (PPACA) requires that the Secretary of the Department of Health and Human Services (DHHS) provide grants to states in order to implement initiatives that involve providing incentives to Medicaid beneficiaries to participate in health improvement programs. The state has submitted an LOI (Letter of Interest) for this grant focused on the creation of healthy behaviors incentives programs. This grant will be given to 10 states for a total of 100 million dollars. The state of Utah is currently drafting the grant proposal for this program.

.notes by Shanie

May 4, 2011/Meeting 6 Topic: Provider Assessment and UPL* Preservation

Hospital Assessment

This meeting was focused specifically on the hospital assessments as well a teaching hospital payments (UPL or Upper Payment Limit* payments) and how reform will affect these payments. Hospital representatives asked how can the state preserve the current hospital assessments as reform moves forward? The DOH feels that as long as the state uses the current dollar amount as part of the total Medicaid payments to hospitals, these rates should remain stable. An ACO would contract with hospitals directly to negotiate these rates.
Hospitals are still concerned that the reimbursement rates be set carefully as the current hospital taxes are quite high. They are concerned that the health plans may not have the same incentives as hospitals by virtue of their liability for the tax.

Graduate Medical Education Payments (GME)

Unlike hospital assessments, GME payments are much more flexible for the state to integrate into teaching hospitals. CMS has stated that Utah cannot direct payments to ACO’s BUT they are able to direct specific payments to teaching hospitals. As well, the state has been directed by CMS that they will have flexibility with DISH (Retroactive Medicaid, Uninsured) payments. The state would like to keep supplemental payments separate from the bundled payments to the ACO’s initially; Representative Sanpei feels that this should be temporary.

-May 11, 2011/Final Meeting 6 (Client Focus) Topic: Quality=Q Measurement-

Michael Hales and Rep. Dean Sanpei clarified that Utah Medicaid ACO Q standards and measures will need to evolve as Q standards for accountable care organizations will be a moving target for as long as it takes the NCQA (National Commission on Quality Assurance) to finalize their draft standards.

Michael: as we look at the rate development structure, this will need to align with the /Q measures. As we move into this area, we will also need to look at historical expenditure data as well. Then we will use encounter data to move forward, accounting for risk differentials. We need to have something in place now to begin the transition to accountable care; then we can build on these standards. Michael agreed to UHPP’s request to formalize a Q panel to help develop more permanent standards. Lots of heads nodded in interest-

Rep. Sanpei: need to pick from existing measures, don’t re-invent wheel. CMS will like that we are having panel (answer to Sanpei from Hales).

Julie Day: lots of overlap w/meaningful use. It’s not just about measurement and transparency but also and just as critically it’s about a new structure for health care delivery. For example, if reporting for diabetes, it’s not just about measuring their progress but about tracking and managing their care through the system. CMS wants to see way more than just Q measuring.

Lincoln of Voices handed out draft recommendations for quality standards—these will be posted shortly.

Korey C, now of HealthInsight: there is a P.R. patient acceptance angle here we should look at. This is not just managed care in drag, like one consumer said.

Hales: At the end of the day the Q standards must measure overall health and how the care received was helpful to that end.

Jason (former Medicaid Director of TX, now helping out at Voices and UHPP): the ACO concept is still new to CMS. It is fair to say CMS will expect to see that MCOs have capacity to do this—that’s the accreditation piece. CMS wants to see readiness review as a first step. Once you get past the capacity issue, you must show (meaningful use). From there the community needs to see what the DOH does with these data.

Kim Wirthlin (University of Utah Hospitals & Health Sciences): the hardest thing is to actually evaluate the Q of care received. 30% of value-based purchasing is patients’ experience. The other 70% is on clinical outcomes. We must puzzle this out now in the inpatient context and next in outpatient setting.
**Next steps for the Stakeholder Process**

- Waiver draft will be posted on June 1 State Bulletin (Dept of Admin Rules): [http://www.rules.utah.gov/publicat/bulletin.htm](http://www.rules.utah.gov/publicat/bulletin.htm)
- June 7 MCAC public hearing
- June 9 General Public hearing (both in room 125)

*notes by Judi*

*Upper Payment Limit or UPL funds play a critical role in supporting public safety net hospitals and medical schools, both of which serve a disproportionate number of uninsured patients (U of U in Utah). In a [2006 report](http://www.lewin.com/content/publications/UPL.pdf), the Lewin Group characterizes the status of UPL funds in efforts to modernize or reform Medicaid managed care as follows:

*Expanding Medicaid managed care enrollment has the potential to slow the growth of Medicaid costs, lead to more efficient service delivery, and promote high quality integrated systems of care. The potential benefits of managed care have led many States to consider expansions in capitated Medicaid programs to the extent that they are consistent with state health care policy goals and specific market and political conditions. However, current Medicaid hospital reimbursement calculations only include fee-for-service Medicaid utilization, which places significant barriers to expanded use of capitated Medicaid managed care contracting in some states. The practical result of this dilemma is that states considering expanding Medicaid managed care must balance any potential benefits against the risk of losing substantial Federal Upper Payment Limit (UPL).*

See their paper: [http://www.lewin.com/content/publications/UPL.pdf](http://www.lewin.com/content/publications/UPL.pdf)