Exploring Opportunities for Medicaid Managed Care

Oct. 14, 2011
Overview

- About Amerigroup
- The Medicaid Landscape
- Health Care Reform and Effects on Medicaid Reimbursement
- Physician Collaboration and Innovation at Amerigroup
- Real Solutions for Medicaid Recipients: Long-Term Care Programs
About Amerigroup
Who We Are: Amerigroup*

- We coordinate health care services for approximately 2 million members in 11 states
- We meet the health care needs of financially vulnerable Americans, seniors and people with disabilities
- We serve those on Medicaid, Medicare and other publicly funded health care programs
- We offer 15 years of experience dedicated to government programs – more than any other publicly traded company
- We build strong community relationships and alliances to support our local health plans

*Amerigroup refers to Amerigroup Corporation and its subsidiary health plans
Who We Serve

- We focus on the conditions most prevalent among the populations we serve:
  - Moms and kids
  - Seniors
  - People with disabilities
- Accordingly, four areas are of particular interest:
  1. Prenatal care for pregnant women to ensure healthy babies
  2. Reduction and prevention of childhood obesity
  3. Home- and community-based services for independent living
  4. Provision of routine and nonemergent care in settings other than the emergency department
Who We Serve: Our Members

Amerigroup Member Population

<table>
<thead>
<tr>
<th>State</th>
<th>Amerigroup Membership 2Q11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Texas</td>
<td>593,000</td>
</tr>
<tr>
<td>Georgia</td>
<td>270,000</td>
</tr>
<tr>
<td>Florida</td>
<td>262,000</td>
</tr>
<tr>
<td>Maryland</td>
<td>207,000</td>
</tr>
<tr>
<td>Tennessee</td>
<td>205,000</td>
</tr>
<tr>
<td>New Jersey</td>
<td>133,000</td>
</tr>
<tr>
<td>New York</td>
<td>109,000</td>
</tr>
<tr>
<td>Nevada</td>
<td>86,000</td>
</tr>
<tr>
<td>Ohio</td>
<td>55,000</td>
</tr>
<tr>
<td>Virginia</td>
<td>40,000</td>
</tr>
<tr>
<td>New Mexico</td>
<td>22,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,982,000</strong></td>
</tr>
</tbody>
</table>

Source: Amerigroup Corporation
Who We Serve: Program Enrollment

**Amerigroup Member Population**

- **TANF**: 1,405,000
- **CHIP**: 266,000
- **SPD**: 216,000
- **Uninsured Adults**: 74,000
- **Medicare Advantage**: 21,000

**Total**: 1,982,000

**TANF** – Temporary Assistance for Needy Families  
**CHIP** – Children’s Health Insurance Program  
**SPD** – Seniors and People With Disabilities
The Medicaid Landscape
# Medicaid, CHIP and Other Health Spending Drive State Budgets

## General Fund Expenditures by Share of Total State Spending, Fiscal 2008

<table>
<thead>
<tr>
<th>Category</th>
<th>Expenditure Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transportation</td>
<td>0.7 percent</td>
</tr>
<tr>
<td>Corrections</td>
<td>7.2 percent</td>
</tr>
<tr>
<td>Medicaid</td>
<td>15.7 percent</td>
</tr>
<tr>
<td>Higher Education</td>
<td>11.5 percent</td>
</tr>
<tr>
<td>All Other*</td>
<td>27.1 percent</td>
</tr>
<tr>
<td>Public Assistance</td>
<td>1.9 percent</td>
</tr>
<tr>
<td>Elementary and Secondary Education</td>
<td>35.8 percent</td>
</tr>
</tbody>
</table>

*Denotes inclusion of the Children’s Health Insurance Program (CHIP), institutionalized care for people with disabilities, public health programs and employer contributions to health benefits.

State Budgets Continue to Feel Recession’s Impact

Largest State Budget Shortfalls on Record

<table>
<thead>
<tr>
<th>Year</th>
<th>Total State Budget Shortfall (in Billions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>-$40</td>
</tr>
<tr>
<td>2003</td>
<td>-$75</td>
</tr>
<tr>
<td>2004</td>
<td>-$80</td>
</tr>
<tr>
<td>2005</td>
<td>-$45</td>
</tr>
<tr>
<td>2009</td>
<td>-$110</td>
</tr>
<tr>
<td>2010</td>
<td>-$130*</td>
</tr>
<tr>
<td>2011</td>
<td>-$103*</td>
</tr>
<tr>
<td>2012</td>
<td>-$191</td>
</tr>
<tr>
<td>2013</td>
<td>-$46**</td>
</tr>
</tbody>
</table>

* Denotes reported to date ** Denotes preliminary estimate

Source: Elizabeth McNichol, Phil Oliff and Nicholas Johnson, the Center for Budget and Policy Priorities, “States Continue to Feel Recession’s Impact” (June 17, 2011). Figures are compiled using a Center for Budget and Policy Priorities survey, which was revised in January 2011.
Benefits of Medicaid Privatization

- Increases Access to Care
  Managed care increases access to primary care and use of preventive services through mechanisms that increase access while lowering costs

- Yields Cost Savings
  By collaborating with doctors, hospitals and other health care providers to ensure beneficiaries receive proactive health services and supports, managed care reduces the incidence of acute episodes of care, improves the quality of life and yields savings to state Medicaid programs

- Achieves Quality Improvements Through Accountability
  Managed care achieves quality improvements by adhering to quality standards and monitoring procedures. No comparable standards or procedures are required in Fee-For-Service (FFS) arrangements

Sources: Kaiser, Feb. 2010; U.S. Department of Health and Human Services, April 2005
State Budget Savings Through Medicaid Managed Care

- Medicaid managed care can save up to 20 percent

- The Supplemental Security Income (SSI) population represents the largest opportunities for cost savings through care coordination and access

- Programs with the largest savings impact include those that reduce inpatient utilization through an emphasis on care coordination and medication management

Examples of State Budget Savings Through Medicaid Managed Care

- A May 2011 Lewin Group study of the Pennsylvania HealthChoices managed care program showed savings of $2.1-$2.9 billion in Medicaid savings compared to its FFS and ACCESS Plan.

- The Hilltop Institute analyzed New Mexico’s Coordination of Long-Term Services (CoLTS) program and projected that the state is expected to spend $108.6 million less than without the CoLTS program from inception through 2012.

Sources:
- CoLTS A-2 Cost Effect, New Mexico’s 2010 1915(b) waiver renewal, Appendix D.
  Analysis by the Hilltop Institute at the University of Maryland.
State Budget Savings through Medicaid Managed Care (cont’d.)

- Texas Health and Human Services Commission projected in its 2012-2013 budget request a savings of $601 million in general revenue and $1.2 billion in all funds for expanding Medicaid managed care.

- Florida’s managed Long-Term Care (LTC) Diversion program avoided approximately $294 million in costs that would have been paid if all eligible enrollees were served in a nursing home instead of in the community.

Sources:
Texas Health and Human Services Commission Budget Request 2012-2013, page 14
Department of Elder Affairs, State of Florida, Long-Term Care Community Diversion Pilot Project, Legislative Report, December 2007-2008, page 10
Health Care Reform and Key Effects on Medicaid Reimbursement
Reimbursement

- Primary Care Physicians (PCPs) at 100 percent of Medicare
  - Begins 2013 and fully funded by federal matching dollars for two years
  - How will states implement this?
  - What happens after 2014?

- Code Editing Logic
  - Primarily code bundling and maximum units
  - National Correct Coding Initiative (NCCI) now mandatory for all state Medicaid programs
  - Most states mandating that managed Medicaid follow NCCI, as well
  - States previously used: none, NCCI, third-party vendor logic
  - Bottom line: code editing will largely resemble Medicare edits
Reimbursement - Recovery Audit Contractors (RACs)

- **What are they?**
  - Third-party auditors selected by CMS to audit for improper Medicare claims payment (currently four nationally)
  - Contractors use their own software logic to identify possible overpayments, request medical records and audit for over- and under-payments
  - RACs were legislated in 2003, became a Medicare demonstration program in 2005 and a permanent program in 2007

- **Potential for Change**
  - Patient Protection and Affordable Care Act requires states to engage RAC auditors for Medicaid claims, as well
  - Each state is in the process of deciding how to implement RAC (New Hampshire has chosen Goold Health Systems as its RAC)
Collaboration and Innovation
Why Provider Collaboration?

- Fundamental core belief that physicians ultimately control cost and quality
- Create a new value proposition, built on aligned incentives that pay for outcomes not volume
- Initially engaged with our PCPs targeting the right practices that allow us to have collaborative relationships in each market
Patient-Centered Medical Homes

- Deployment of practice coaches and medical directors into key PCP offices

- Innovative relationship entered into with TransforMED (American Academy of Family Physicians subsidiary)
  - Co-facilitation model: allows third-party access to office processes where direct-payer involvement would be inappropriate
  - Rollout in selected markets in 2011, 30 PCP sites are included
Patient-Centered Medical Homes (cont’d.)

- Actionable Information Sharing
  - Medical Home Reporting Package
    - Quality results, care gaps
    - Identifies emergency room, hospital and specialist visits
    - Medication adherence
    - Detailed analysis of medical costs by PCP

- Capability to distribute data to providers through multiple channels (paper, secure email, website, direct to Electronic Health Records (EHRs))

- Capability to receive data from provider EHR systems
## Collaboration Continuum

<table>
<thead>
<tr>
<th></th>
<th>Level of Collaboration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Low</td>
</tr>
<tr>
<td>Nature of Provider Relationship</td>
<td>Traditional contracted network participant</td>
</tr>
<tr>
<td>Financial Arrangement</td>
<td>Reimbursed on a FFS volume basis</td>
</tr>
<tr>
<td>Information Sharing</td>
<td>Mailed provider profiling and basic quality reporting</td>
</tr>
</tbody>
</table>
## Patient-Centered Medical Home Program

### Key Elements

**Patient-Centered Medical Home (PCMH) Program**

- Devoted medical leadership and medical practice consultant resources
- Amerigroup ↔ PCMH aligned objectives
- Formalized collaborative practice coaching
- Use of evidence-based strategies for performance improvement
- Focused work on the comprehensive set of defined elements for PCMH
- Reporting specific to practice site that is:
  - Focused on both quality and cost
  - Includes actionable data elements

### Aligned Objectives

- Unit cost and utilization management
- Quality improvement
- Member and provider satisfaction
- Health plan customer satisfaction
## Largest Medical Home Pilots

<table>
<thead>
<tr>
<th>Pilot</th>
<th>State</th>
<th>Start Year</th>
<th>Physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Cross Blue Shield – Michigan</td>
<td>MI</td>
<td>2008</td>
<td>8,147</td>
</tr>
<tr>
<td>Penn. Chronic Care Initiative</td>
<td>PA</td>
<td>2008</td>
<td>780</td>
</tr>
<tr>
<td>Washington PCMH Collaborative</td>
<td>WA</td>
<td>2009</td>
<td>755</td>
</tr>
<tr>
<td>I-3 PCMH Academic Collaborative</td>
<td>NC/SC</td>
<td>2009</td>
<td>753</td>
</tr>
<tr>
<td>Hudson Valley Pay-for-Performance/Medical Home</td>
<td>NY</td>
<td>2008</td>
<td>500</td>
</tr>
<tr>
<td>Louisiana Health Care Quality Forum</td>
<td>LA</td>
<td>2007</td>
<td>500</td>
</tr>
<tr>
<td>Amerigroup Corporation</td>
<td>Multi*</td>
<td>2009</td>
<td>381</td>
</tr>
<tr>
<td>Greater New Orleans PCP Access Grant</td>
<td>LA</td>
<td>2007</td>
<td>324</td>
</tr>
<tr>
<td>Colorado Family Medicine PCMH</td>
<td>CO</td>
<td>2008</td>
<td>320</td>
</tr>
<tr>
<td>CIGNA/Dartmouth-Hitchcock PCMH</td>
<td>NH</td>
<td>2008</td>
<td>253</td>
</tr>
</tbody>
</table>

Source: Patient Centered Primary Care Collaboration

[www.pcpcc.net](http://www.pcpcc.net)
Technology Innovations Benefitting Members and Physicians

- Mobile, field-based service coordinators
- In-home needs assessments, including:
  - Functional status, goals and health risks
  - Environmental factors
  - Family and social supports
- Coordination with physicians and other providers
  - Your “eyes and ears” in the home
- Meeting patients in the home, office and hospital
Real Solutions for Medicaid Recipients: LTC Programs
Duals Account for 40 Percent of Medicaid Spending

Medicaid Enrollment
- Adults: 25%
- Children: 50%
- Other Seniors and People with Disabilities: 25%

Medicaid Spending
- Long-Term Care: 28%
- Non-Dual Spending: 60%
- Medicare Acute Premiums: 4%
- Prescribed Drugs: 0.4%
- Other Acute: 2%

Total = $58 Million
Total = $300 Billion

Source: Kaiser Commission on Medicaid and the Uninsured, Henry J. Kaiser Family Foundation, “Top 5 Things to Know About Medicaid” (February 2011)
What is Coordinated LTC?

- Coordinated LTC programs can enroll:
  - People eligible for LTC that can safely live in the community if they are provided support services at home
  - People who receive LTC services in a nursing facility or require that level of care
  - People with both Medicaid and Medicare benefits who do not currently require LTC services but meet eligibility criteria

- Who does not get enrolled?
  - People with serious or persistent mental health conditions
  - People with developmental disabilities who are permanently institutionalized
  - People who opt out of coordinated LTC and choose to stay in the existing FFS program
Real Stories, Real Results: At 102, Member Goes Home Again

- Amerigroup Texas member, Maudie, was having difficulty with the transition from her home to a nursing facility.
- Late in 2009, her daughter referred her to the STAR+PLUS program and the benefits it offered.
- Case Manager Karen Frazier assessed Maudie’s needs, Coordinator Easter Negron set her up with food and clothing, and Case Manager Meredith Green coordinated Maudie’s equipment needs.
- The Amerigroup team effort helped Maudie return home in March 2010.
LTC Quality Outcomes

- Empowerment of seniors and people with disabilities to live independent and healthy lives
- Self-directed guidance of services provided by members
- Caregiver support
- Single point of contact to help them navigate complex systems
- Early identification of additional service needs, thus preventing acute conditions and hospitalizations
- Lower cost of services for states and taxpayers
LTC Options Cost Comparison

- Nursing home: ~$80,000/yr
- Assisted living: ~$39,000/yr
- Home with support: ~$24,000/yr

FFS vs. Coordinated Care

Expected Coordinated Care Savings

- Year 1: $1.74B (FFS), $1.70B (Coordinated Care)
- Year 2: $2.80B (FFS), $2.68B (Coordinated Care)
- Year 3: $4.01B (FFS), $3.74B (Coordinated Care)

Expected cost under current FFS system: $1B, $2B, $3B, $4B, $5B
Expected cost under coordinated care: $1B, $2B, $3B, $4B, $5B
Amerigroup LTC Programs

- Texas STAR+PLUS
  - 471 individuals diverted from entering a nursing home in 2009
  - $123 million has been saved – $92 per member per month
- Florida’s Nursing Home Diversion Program
  - Transitioned 123 individuals from nursing homes back to the community
- TennCare CHOICES in LTC
  - More than 633 potential members have been screened, 400 enrollments submitted and 252 enrollments approved for LTC services
Amerigroup LTC Programs (cont’d.)

- New York’s Managed LTC Plan
  - Statewide program enrollment has grown by approximately 20 percent per year

- New Mexico Coordination of Long-Term Services (CoLTS)
  - Between 2008 and 2012, the state is expected to save $108.6 million from the CoLTS program
Summary

- Medicaid continues to expand in terms of the eligible population and the cost per individual
- Managed Medicaid’s ability to lower cost and improve quality metrics presents an opportunity for states at a time during which budget deficits are the norm
- The increasing complexity of Medicaid enrollees and the health care system in general presents an opportunity for Medicaid payers, physicians and providers to collaborate to improve access to quality care, reduce administrative burden and reduce costs