CHCS Center for Health Care Strategies, Inc.

Advancing innovations in health care delivery for low-income Americans

Making the Business Case for CDC's 6|18 Interventions

January 28, 2019, 2:00 pm – 3:00 pm ET

Faulkner Consulting
Utah Department of Health
HCA Solutions, Inc.

Support provided by the Robert Wood Johnson Foundation

Questions?

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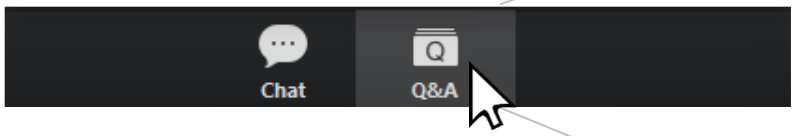

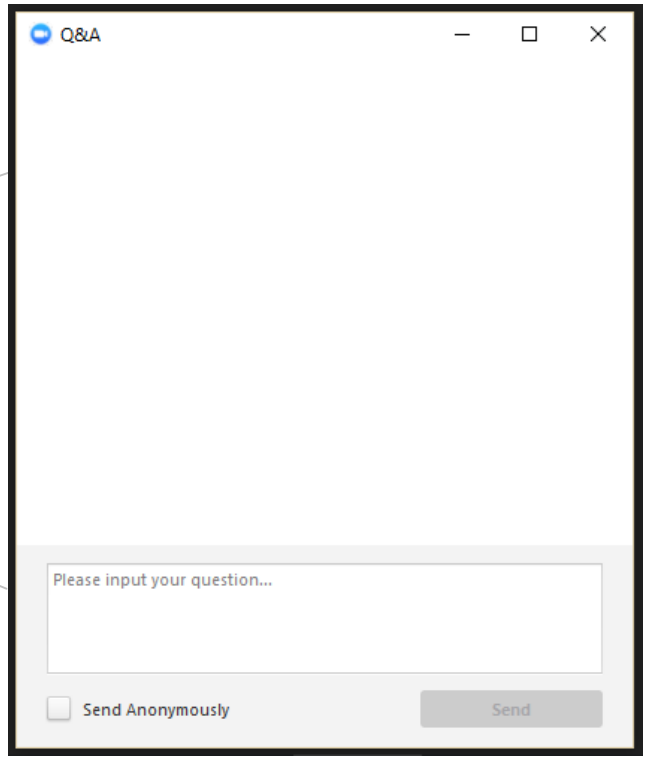

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Welcome & Introductions

Agenda

- Welcome and Introductions
  Shilpa Patel, CHCS
- Public Health and Medicaid: Making the Case for a Benefit Expansion or Change
  Tricia Leddy, Faulkner Consulting
- 6|18 Case Study: Utah
  Brittany Guerra, Asthma Program, Utah Department of Health
- How Actuaries Think: Medicaid Managed Care Organizations and New Programs
  Rebecca Owen, HCA Solutions, Inc.
- Moderated Q&A
  Shilpa Patel, CHCS

Meet Today's Presenters

Tricia Leddy,
Faulkner Consulting

Brittany Guerra,
Utah Department of Health

Rebecca Owen,
HCA Solutions, Inc.

Shilpa Patel,
Center for Health Care Strategies

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Public Health and Medicaid: Making the Case for a Benefit Expansion or Change

Tricia Leddy

Faulkner Consulting

What Case are You Making?

Determine if new state dollars are required

- Medicaid must pay for a portion of all new expenditures with state as well as federal dollars.
- Adding a new service which requires new state dollars, even just in year one, requires high level approval (sometimes legislature or Governor).
- Public Health can help Medicaid to make the case that the state investment will result in at least equal savings.
- Another alternative is to identify current state funds in Public Health which are supporting this service (or another service) which can be matched with federal Medicaid dollars, allowing Medicaid to add a new service with no new state dollars.

Steps for Gathering and Documenting Information

Identify the potential gains

- Access
- Quality
- Outcomes/health status
- Customer satisfaction
- Financial savings ("business case")
  - Medical
  - Administrative
- RI's Asthma Program: Described potential gains across all areas
- Can Public Health offer to collect data, analyze, and document gains and successes?

Steps for Gathering and Documenting Information

Gather evidence for success/savings

- Published research or reports
- Other state Medicaid programs
- Gather evidence on your own program
  - RI's Asthma Program gathered its own evidence on a CDC-funded asthma initiative: Defined initiative and tracked results and savings by population, including medium risk and high risk. Found significant improvements in utilization and savings in high risk.

Steps for Gathering and Documenting Information

Calculate the investment amount

- Calculate an investment amount that will result in savings
  - In RI, tailored proposed program to invest in enrollment of only higher risk members, where there was evidence that the program would result in positive outcomes and associated savings.
- This fiscal year; future years
- Magnitude: number of people, number of services, cost per service

Steps for Gathering and Documenting Information

Determine how savings will accrue

- True savings in an identifiable area of state expenditure
- "Cost avoidance" — what we would have spent without the new investment
  - In RI's asthma program, measured decreased utilization with vs. without asthma program. "Counts" avoided costs.

Steps for Gathering and Documenting Information

Determine where potential savings will accrue

- Medicaid budget? (best for business case)
  - Managed care health plan
    - In RI, potential savings accrue as lower PMPM costs/payments to health plan due to lower predicted hospital use.
  - Medicaid Fee-for-Service Program
- Another state program?
  - Cost of the current state program investment
  - Savings from the investment may decrease costs of another state program
  - Can savings be reinvested as the needed "state match"?
  - Society/education/corrections/ etc.

Determine Best Strategy *(may differ by state)*

- **Strategize your approach**
  - Need budget approval from governor or legislature?
    - Significant cost, change in covered benefits, visible change
  - If savings can accrue to the Medicaid budget, consider proposing change as a budget savings initiative
    - In RI, presented program investment as a budget savings initiative
  - Use data and information to make the best case for a new program investment that will at least "pay for itself"

Determine Best Strategy *(may differ by state)*

- **Need a contract change with health plans? (e.g., added benefit)**
  - Will there be a state and/or health plan savings from a health plan investment/savings?
    - Example: Adding postpartum family planning in RI's original 1115 waiver decrease births and associated public costs
    - If savings can be documented, the state can add dollars to PMPM for needed investment and decrease dollars to PMPM for promised savings, resulting in a net savings through net decrease in PMPM.

Determine Best Strategy *(may differ by state)*

- **Need a change in procedure with health plans?**
  - Partner with the plan — ask for their help in implementing the investment and tracking savings. Get them on the same side of the table to help solve the problem, focusing on improving care for members.
  - Document the access or quality issue and ask Medicaid to consider it for an upcoming EQRO focused issue.
  - Tell the plans WHAT you want to change and WHY (e.g., adding a service such as asthma home visiting, removing prior authorization, etc.), not HOW to implement the change.
    - In RI, it is up to the health plans to fully implement the required change.

Summary

- ***Get on the same side of the table!***
  - **Public health**
    - Can help Medicaid make the case by providing training, data gathering, reporting Medicaid's success.
  - **Medicaid**
    - Help Medicaid make the case to add a new expenditure by finding a reliable general revenue funding source or savings offset, especially in the first fiscal year.
  - **Health plans**
    - Get the plans involved in solving the problem
    - Solicit and consider Health Plan suggestions/ solutions

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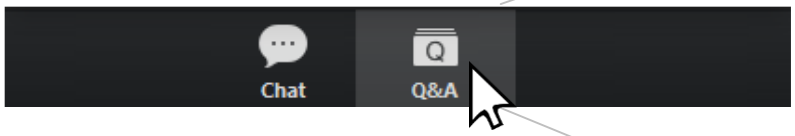

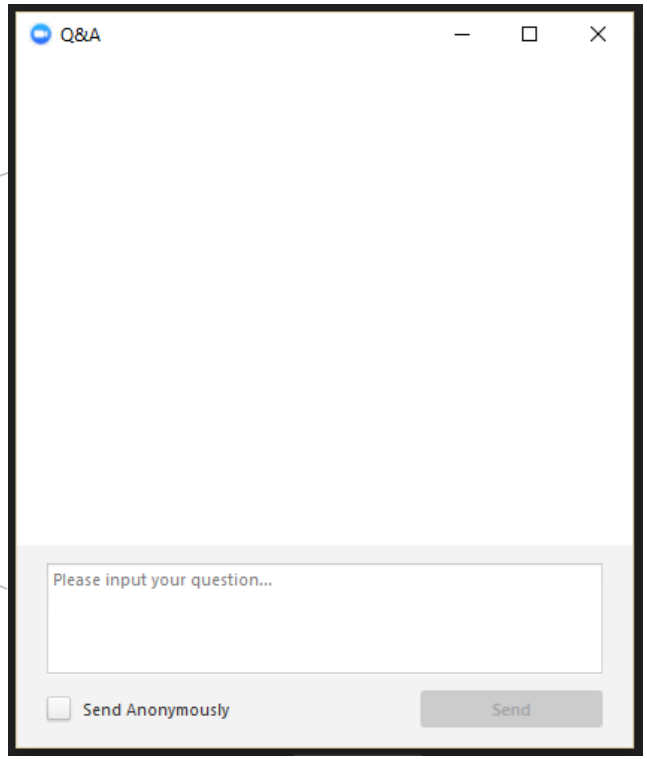

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Utah Asthma Program
6|18 Initiative 2017-2018 Cohort Outcomes and Benefits

Brittany Guerra, MPH
Health Program Specialist

January 28, 2019

Goal of joining 6|18

Seek expansion of the Utah Asthma Home Visiting Program (UAHVP) and sustainable reimbursement and coverage

- Show return on investment of UAHVP
- Explore multiple opportunities for funding
- Build better relationships between public health and Medicaid

Utah Asthma Home Visiting Program

Newly established home visiting program

- January 2016
- 2 Counties in Utah – funding by CDC grant
- Health Educators and Certified Asthma Educators
- CHW pilot in Salt Lake County
- 250 began, 205 completed

Preliminary Results

Improves Asthma Control and Quality of Life[3]

- **90%** of participants complete the program.[4]
- **80%** of participants had improved asthma control test scores from Visit 1 to Visit 3.
- **89%** of those who achieved control in the program reported having controlled asthma 12 months after the program.
- **75%** of participants started using their controller medication more by Visit 3.
- **68%** of participants reported increased confidence managing their asthma six months after the program.

Testimonial

"It used to be a way (of life) for our (daughter) to get sick…But after getting educated on her inhalers and having our home inspected, things changed.

We are happier! Plans happen, dates occur, friends play. Life is different."

-Mother in Utah County

Preliminary Results

Reduces Unwanted and Costly Events[3]

12 Months After Completing the Program

75% decline in average missed work days.

53% decline in average missed school days.

60% reduction in average unplanned doctor visits.

53% reduction in episodes requiring an oral systemic corticosteroid.

70% reduction in asthma-related ED visits.

82% reduction in asthma-related hospitalizations.

Preliminary Results

The Economic Case: Cost Savings and Return on Investment

Asthma is Common and Costly in Utah

- One in 12 Utah adults have asthma (8.3%).[6]
- One in 17 Utah kids have asthma (5.8%).[6]
- In Utah, about 48% of those with asthma are exposed to two or more triggers at home (i.e. dust or pets) and are more likely to miss school, work, and other usual activities.[7]
- Uncontrolled asthma in Utah is more prevalent among those with less education, low income, and those living in rural areas.[8]

There are on average **6,948**[9] Utah asthma-related ED visits a year.

In 2014, total Utah asthma-related ED visits cost **$28.1 million.**[10]

The Program Saves Money[3,11]

Number of Participants[12]	82
Program Cost per Participant	$353.83
Average Asthma ED Visit Cost[13]	$1,815.73
% Decrease in Total ED Visits	70%
For Every $1 Invested:	**$3.31 saved**

Supporting Partners

- 6|18 internal workgroup and coordination with Medicaid representatives
- Funded local health departments and legal departments
- Data stewards – Utah Office of Health Care Statistics and Medicaid
- TA providers and Reviewers of analysis and factsheets/talking points/reports

What We Did

- Quality Improvement/EQRO and exploring relationship between MCOs and UDOH
- Fee for Service CPT codes
  - Medical Care Advisory Committee to Medicaid Presentation June 2018
- State Block Grant Funding through Medicaid
  - Need approval by legislature in 2019

Still Looking Into:

- Match outcomes in MCO claims data
- Individual contracts with MCOs (MATCH model)
- Pay for Success
- Additional grant funding from CDC

Useful Resources from 6|18

- Infrastructure and upper leadership support
- In person meetings and peer to peer calls
  - Relationship building
- Connected us to national expertise
  - In-depth and one-on-one discussion of how others did their work
  - Reviewed our work: factsheets, analysis, talking points, reports
  - EQRO analysis from national partner

THANK YOU!

Brittany Guerra, bguerra@Utah.gov, 801-538-6894

Health.Utah.gov/asthma

@UtahAsthma

@UtahDepOfHealth

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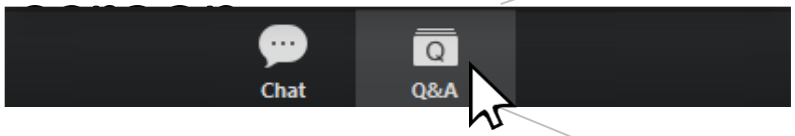

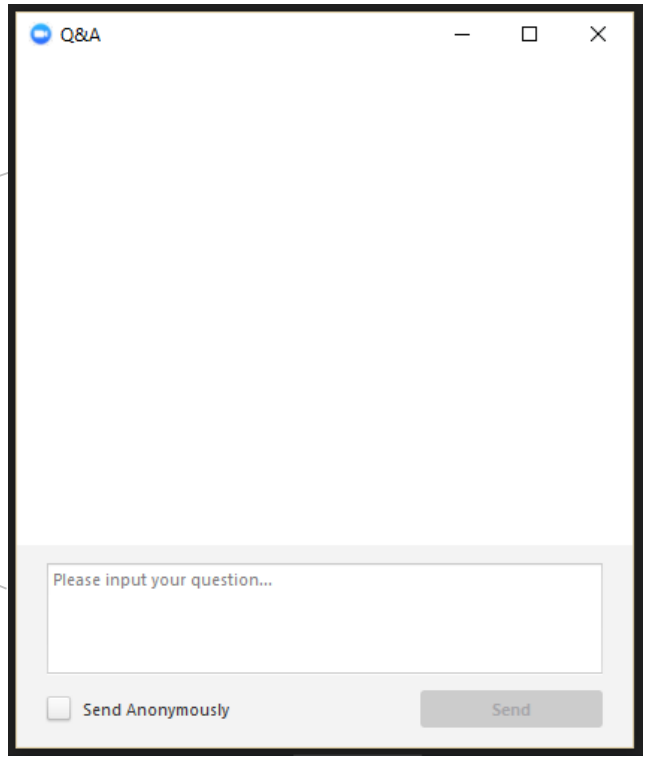

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How Actuaries Think: Medicaid Managed Care Organizations Incorporating New Programs

Rebecca Owen, FSA FCA, MAAA

January 28, 2019

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Notes before we begin

- This presentation is at a high level and does not intend to be exhaustive.
- Every situation requires careful attention to the specifics at hand.
- Medicaid Managed Care Manual released two years ago is 1,425 pages long. (!)
- Actuarial Standard of Practice: Medicaid Managed Care Capitation Rate Development and Certification.
- Medicaid Managed Care Rate Setting Guide.

Six topics MCO plan actuaries think about – Actuarial Soundness!

- Medicaid Managed Care rates need to cover all the cost of care (with some exceptions).
- Types of changes that are being proposed to the benefits for beneficiaries.
- Looking at expected costs of an added benefit or a care intervention means asking questions:
  - How does my population compare?
  - How does my delivery system compare?
  - What is the nature of my company?
  - What if the predictions are not accurate?

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Medicaid Managed Care Rates need to cover all the cost of care (with some exceptions).

- First some jargon….
  - PMPM, Capitation Rate, Carve Out, Carve In
- What the rates cover:
  - Claims Costs
  - Administration
  - Margin
- Adjustments
  - Program
  - Geography
  - Age/Gender
  - Risk Score

Types of changes that are being proposed – program and interventions

- Beneficiaries
  - Add a benefit
  - Change a benefit
- Provider Changes
  - Change a delivery method
  - Change provider payments
- Plan Changes
  - Administration
  - Care management

How does my population compare?

- Demographics
- Geography
- Socio-economic Factors
- Cultural Preferences
- Disease Prevalence
- Ability and Willingness to Change
- Other battles capturing attention and energy

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How does delivery system compare?

- Types of Delivery Systems
- Network Structure
- Payment Methods
- Access to Care
- Current Programs in Place
- Time to Program Maturity
- Provider Incentives
- Pharmacy

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What is the nature of my company?

- Small or Big?
- Regional or National?
- Provider Owned?
- Many Lines or Only Medicaid?
- Profit vs Not-for-profit?
- Aligned with Mission?
- Already Part of the Strategic Plan?
- Capacity and Capability?

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What if the predictions are not accurate?

- How much premium is at risk?
- How many changes are there in this plan year?
- Do risks offset or do they compound?
- What other risks are evolving?
- What if the political situation changes?
- How will this be monitored?
- Next year vs this year…

Details and links

- ASOP 49 http://www.actuarialstandardsboard.org/asops/medicaid-managed-care-capitation-rate-development-and-certification/
- Medicaid.gov https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-site.html
- Medicaid Rule https://www.federalregister.gov/articles/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered
- Medicaid Managed Care Rate Setting Guide https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/2016-medicaid-rate-guide.pdf

Thank You For Your Time

Rebecca Owen
rebecca.owen@hcasolutions.com

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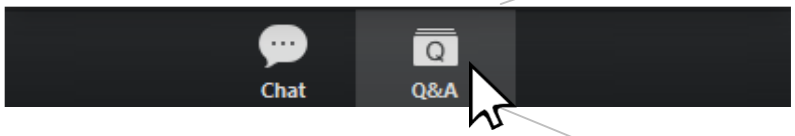

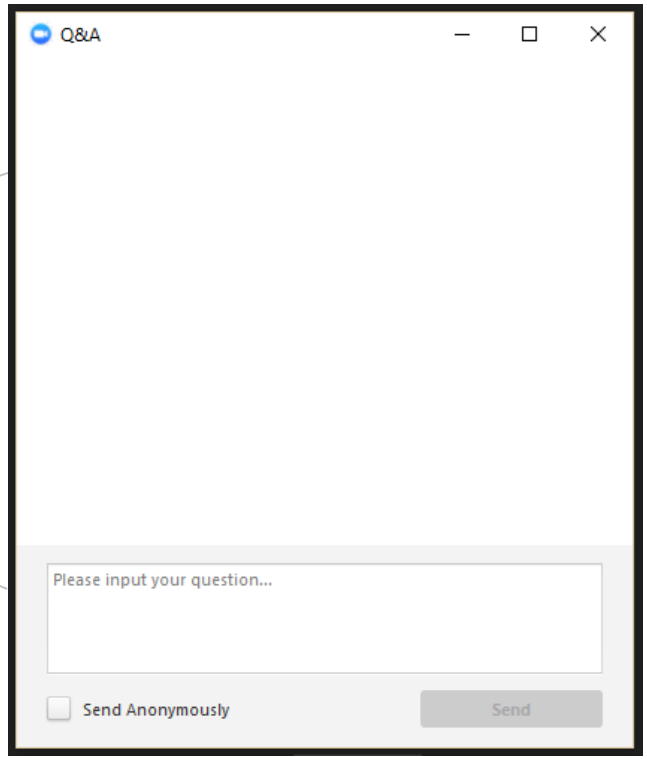

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