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Presentation Overview

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- Medicaid Managed Care Market Overview
- State Approaches to Medicaid Managed Care
- Medicaid Managed Care: Key Considerations

Medicaid Managed Care Market Overview

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Managed Care is the Dominant Delivery Model

Since the 1980s, states have increasingly turned to managed care organizations to deliver services to Medicaid enrollees

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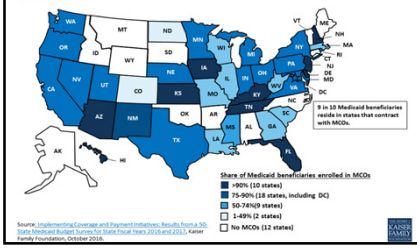
A large share of all Medicaid beneficiaries are enrolled in risk-based MCOs.



Source: Implementing Coverage and Payment Initiatives: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2016 and 2017, Kaiser Family Foundation, October 2016.

- The Medicaid program covers 1 in 5 Americans, more than 74 million children and adults
- 38 States and DC contract with Managed Care Organizations
- More than half of all Medicaid beneficiaries are enrolled in managed care
- All but 3 states have some form of managed care

States are Increasing Enrollment in Managed Care

States are adopting a variety of initiatives to enlarge the scope of managed care programs

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- Broader geographic reach of managed care
- Expanding Medicaid under the Affordable Care Act
- Moving more populations into managed care
- Mandating enrollment in managed care
- Increasing services delivered under managed care

Managed Long-Term Services and Supports

With rapidly changing demographics and limited options in private insurance and Medicare, Medicaid will continue to support a fast-growing need for LTSS

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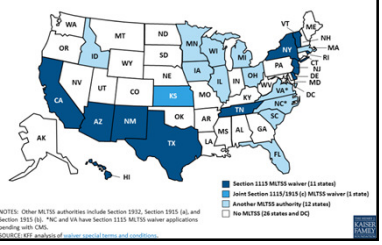
- Medicaid is the single, largest payer of Long-Term Services and Supports (LTSS), over $150 billion annually
- More states are moving long-term services and supports to managed care to improve care coordination and increase access to services
- As of last year, 22 states have comprehensive state-wide MLTSS, more than half were established since 2012

States with Capitated Medicaid MLTSS Programs, 2016



NOTES: Other MLTSS authorities include Section 1932, Section 1915 (a), and Section 1915 (b). *NC and VA have Section 1115 MLTSS waiver applications pending with CMS.
SOURCE: KFF analysis of waiver special terms and conditions.

Integration of Behavioral Health Services

While states have increased focus on the integration of physical and behavioral health, many behavioral health services remain "carved out" of managed care

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Increased Integration

- Approximately, 1 in 5 Medicaid beneficiaries have a behavioral health diagnosis and behavioral health services account for 26 percent of Medicaid spending
- In recent years, several states have carved Behavioral Health services into managed care, including Arizona and Texas
- Even in states that have preserved a carve-out, we are seeing a move to managed care like in Louisiana and Idaho
- 16 states currently integrate behavioral health services into managed care contracts, including mental health and substance use disorder treatment
- Congress has enacted several laws designed to improve access to mental health and substance use disorder services, most recently, the Mental Health Parity and Addiction Equity Act (MHPAEA), which applies to managed care

Value-Based Purchasing

States have recognized the need to increase value-based arrangements between a managed care organization and its provdier network

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Delivery System and Payment Reform

Managed Care Organization participation in value-based payment models, % of provider payments or multi-payer alignment initiatives

- Until recently, most states left value-based purchasing decisions up to the managed care organizations
- With the increased focus on multi-payer alignment and the need to move away from volume-driven fee-for-service payments, states are leveraging managed care contracts to encourage wider adoption
- Many states now are requiring MCOs to meet a certain percentage of provider payments, network providers or members covered by value-based arrangements
- Quality metrics and other performance measures vary significantly across states
- With the increased pressure to drive down costs, more states are exploring the adoption of additional payment and delivery reforms

Medicaid Managed Care Quality Measurement

States are evaluating opportunities to increase measurement and monitoring of performance and improve health outcomes across managed care programs

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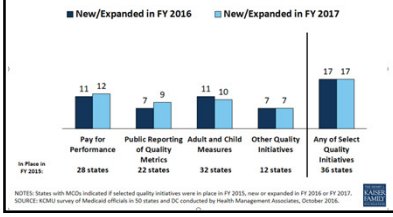
Select Medicaid Managed Care Quality Initiatives, FY 2015 – FY 2017



NOTES: States with MCOs indicated if selected quality initiatives were in place in FY 2015, new or expanded in FY 2016 or FY 2017.
SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2016.

- Most states that contract with managed care organizations adopt quality measures for annual reporting
- States are increasingly incorporating withhold provisions into managed care contracts
- More states are also adopting quality measures for long-term services and supports
- The new Medicaid Managed Care Rule requires states to adopt a comprehensive quality strategy as well as a quality rating system

State Approaches to Medicaid Managed Care

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State Approaches to Medicaid Managed Care

While most States transition to managed care for similar reasons, program design and administration often reflect Medicaid program history and the needs of local communities

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- States transition to Medicaid Managed Care for a variety of factors. Three prominent reasons include:
  - greater budget predictability,
  - improved care coordination for recipients, and
  - reduced program costs,
- The ability to leverage managed care contracts to drive program improvements is another key factor
- With complex populations driving program costs, states continue to explore innovative approaches to leverage managed care for these populations, even in states transitioning to managed care for the first time
- The New Medicaid Managed Care Rule preserves states' flexibility in administering their Medicaid Managed Care Programs while driving greater alignment, promoting consumer engagement and access, and improving quality

Focus State: Arizona

Arizona is considered a leader in behavioral-physical health integration and was an early adopter of value-based payments

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- Arizona has nearly all of its Medicaid beneficiaries in managed care through the Arizona Acute Care Program (AACP) and two distinct MLTSS programs to provide services to members with physical and developmental disabilities
- The state's focus on integration required a new approach to evaluating policies holistically
- Arizona set value-based payment targets for AACP to reach its maximum target of 50% in 2018 and the Arizona Long Term Care Service Elderly/Physically Disabled Program to reach 50% in 2019.
- A leader in LTSS, Arizona now requires plans that want to serve Medicaid to also have a D-SNP. This includes extensive outreach/education campaigns to make sure members are aware of their options.
- An early adopter of VBP, the state intends to apply the VBP target to D-SNPs too and signaled intent to apply withholds to MLTSS

Focus State: Indiana

While Indiana was a mature managed care market, the transition to a new model highlighted the need for robust consumer engagement

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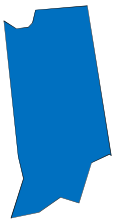

- Under the leadership of then Governor, now Vice President Pence, Indiana implemented HIP 2.0 to align Medicaid with standard provisions found in commercial health plans within a consumer-driven design
- Key components include:
  - Premiums
  - Six-month "lockout" period for members who do not make POWER account contributions
  - Co-pays of up to $25 for repeated nonemergency use of the emergency department
- As part of the initial evaluation of HIP 2.0 several issues surfaced that highlight the need for more effective consumer engagement and outreach:
  - About 1/3 of individuals declared conditionally enrolled never enrolled
  - Most individuals in HIP Plus did not know they had a POWER account and those who did, only 19 percent checked their balance monthly

Focus State: Iowa

Moving into year 2, most view Iowa's transition to Medicaid Managed Care as a success despite continued challenges

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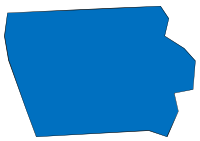

- Iowa launched its Medicaid Managed Care program in April of last year, transitioning close to 600,000 Medicaid recipients to Managed Care
- Iowa Health Link integrates physical, behavioral and long-term care into one managed care program
- The transition experienced challenges related to provider payments, provider networks and capitation rates
- The legislature, concerned about robust monitoring and oversight of MCOs, established a new legislative committee to provide oversight to the program and requires the Department of Health Services (DHS) to convene monthly stakeholder meetings
- As part of its monitoring and oversight efforts, DHS collects and publishes data from MCOs in across key program areas

Focus State: Kentucky

Kentucky's transition to Medicaid Managed Care in 2011 often serves as a cautionary tale for other states making the transition

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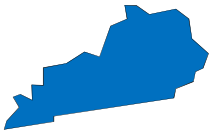

- Kentucky experienced several key challenges during the transition related to continuity of services, transition period, contract oversight and timely payment
- While the initial transition period was challenging, the state was able to significantly turn things around by the second year
- Kentucky also pursued Medicaid expansion under the Affordable Care Act and in contrast to its transition to Managed Care, was seen as one of the most successful implementations
- Now a more mature program, Kentucky is looking to align Medicaid more closely with commercial insurance. The state submitted an 1115 Waiver renewal request to CMS that is awaiting approval. The Waiver contains several key features similar to Indiana such as premiums, a 6-month lock out period and work requirements.

Medicaid Managed Care: Key Considerations

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Key Considerations: Program Implementation

Whether a state is a mature Medicaid Managed Care market or newly transitioning to Medicaid Managed Care, successful program implementation depends on a variety of factors

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- Most states experience challenges transitioning to managed care or implementing new programs, with some experiencing greater challenges than others
- Even with differences in program structures and strategies to improve health outcomes and reduce costs, managed care programs align on success factors for a smooth transition
- These factors are key whether you are transitioning to managed care for the first time or implementing a new program
- Priority areas include stakeholder engagement, transition planning, rate development, program monitoring and oversight, change management and systems readiness

Key Considerations: Program Administration

Leading Medicaid Manage Care States are taking a more prescriptive and rigorous approach to program administration

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- Governance model that supports clear lines of accountability and an organizational design that aligns roles across the organization and supports synergies
- A seamless member experience and training to ensure culturally competent customer service that is tailored to the unique characteristics and needs of the population at the local level
- A strong program model with a focus on behavioral and physical health integration, long-term services and supports and a commitment to establishing strong linkages with community organizations to address social service needs
- Investments in information technology and analytics for improved program monitoring and oversight
- A compliance culture with ongoing training on program requirements and regulations