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and Human Services*

*Maine People Living
Safe, Healthy and Productive Lives*

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Feasibility of Risk-based Contracting in the MaineCare Program

**Report from the Maine Department of Health and Human Services to the Maine
Legislature's Joint Standing Committee on Health and Human Services**

Submitted by:

The Department of Health and Human Services

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Executive Summary

The Maine Legislature directed the Department of Health and Human Services to study the feasibility of risk-based contracting in the MaineCare program and report its findings and recommendations. Risk-based contracting is an approach that pays contractors a set fee for a comprehensive set of services and holds the contractors accountable for the health of the MaineCare population over time.

The Department finds risk-based contracting in the MaineCare program to be both feasible and beneficial to members, and recommends that the approach be used to improve quality and reduce expenditure growth in the program. Following a one-year planning phase, the Department recommends enrolling most MaineCare beneficiaries into risk-based contracting arrangements over a three-year period. Feasibility assumes a willingness to invest in critical start up costs and infrastructure.

The Department assessed four critical feasibility factors, and made the following findings:

Contractor Capacity and Interest

The Department finds sufficient interest and capacity among potential contractors to proceed with more specific program development. The broad range of organizations responding, and the variety of risk arrangements proposed underscores that a risk-based MaineCare initiative will require substantial planning to refine a program model, and strong engagement of a potentially large number of interested contractors and subcontractors.

Stakeholder Engagement

Based on the RFI response and informal preliminary outreach, the Department finds that advocates, consumers, potential contractors and providers are willing to participate in stakeholder processes to ensure that any initiative will focus not only on slowing the growth of spending, but also on improving quality. To ensure a meaningful process, resources would need to be dedicated to engagement.

State Administrative Resources and Capacity

The Department finds its current administrative resources insufficient to perform the fiduciary and quality oversight functions inherent in risk-based Medicaid managed care. Feasibility depends on State government's ability and willingness to invest in start-up activities and make long-term commitments to adequate administration of the program.

Federal Authority

The Department finds it feasible to obtain federal permission to implement risk-based contracts in MaineCare, particularly if no expansion of the population is sought, thereby avoiding a Section 1115 waiver application.

In addition, the report addresses two other areas specified in the legislation, projected quality outcomes, and projected net savings.

Projected Impact on Quality and Health Outcomes

The Department finds that the impact of risk-based contracting on quality and health outcomes will be positive if the program places a strong emphasis on measuring quality and holding contractors accountable. Tying payment to quality is an important strategy that allocates resources according to performance.

Projected Net Savings

Risk-based contracting has been found to reduce the rate of growth in Medicaid programs elsewhere. With support from the Maine Health Access Foundation (MeHAF), the Department retained actuaries to project modest savings assumptions from the national experience to future MaineCare expenditures. The actuaries projected a range of savings from \$21 million per year to \$71 million per year (state and federal combined), depending on how the program is designed. These figures are net of any administrative costs paid to contractors. These savings do not count net start-up costs, projected at \$3.8 million in the first year.

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1. Background

A. Approach to Legislative Charge

This report is submitted to the Legislature pursuant to PL 2009, Chapter 213, Section PPPP-1:

Department of Health and Human Services; use of risk-based contracts within MaineCare. The Department of Health and Human Services shall investigate the feasibility of obtaining a waiver from the federal Centers for Medicare and Medicaid Services to establish a risk-based managed care contract for specific MaineCare populations or services. The department shall submit its findings and recommendations along with the projected net cost savings and the projected impact on quality of care and health outcomes to the Joint Standing Committee on Health and Human Services no later than April 1, 2010.

The Department identified four critical success factors to implementing risk-based Medicaid managed care (MMC), as follows:

- **Contractor capacity and interest.** Maine's previous attempt at risk-based MMC in the late 1990s ultimately failed for lack of sufficient interest among qualified contractors. In order to gauge whether or not interest among possible contractors is greater now, the Department issued a public Request for Information (RFI), the results of which are summarized in this report;
- **Stakeholder engagement.** Without exception, every state we consulted indicated that the participation of stakeholders (members, advocates, providers and contractors) is a critical success factor in planning and implementing Medicaid managed care programs;
- **State administrative resources and capacity.** We assessed the Department's current capacity to design, implement and manage risk-based contracts; and
- **Federal authority.** As specifically directed in the charge, we explored the various federal authorities under which states may operate risk-based Medicaid managed care programs.

In addition to determining feasibility, the charge directed the Department to address projected net savings, and impact on quality. With support from the Maine Health Access Foundation, the Department retained the Deloitte consulting firm to project net savings from various scenarios. We retained the Muskie School at USM to conduct a literature review to determine impact on quality and lessons learned from implementation in other states. We also held teleconferences with Medicaid officials in five states (Arizona, North Carolina, Vermont, Washington, and Wisconsin), selected to represent a range of program models and populations in managed care.

B. Medicaid Managed Care (MMC) History and Models

Very early state efforts at Medicaid managed care (MMC) can be traced back to the late 1960s (New York, 1967) and early 1970s (Michigan and California, 1972), but it was not until the late 1980s that large-scale programs emerged in a number of states (Hurley and Wallin, 1998). By then, managed care was growing rapidly among commercial populations, and a number of state Medicaid programs were drawn to the model for its potential to emphasize primary care and prevention, hold contractors accountable for outcomes across episodes of care, and increase budget predictability. MMC grew rapidly in the 1990s, and by 1998, national survey data showed for the first time that a majority of Medicaid beneficiaries were enrolled in some form of managed care (Kaye, 2005). The federal Balanced Budget Act of 1997 acknowledged the growth in MMC by amending the federal Medicaid statutes to allow managed care without waivers under certain conditions, while strengthening quality oversight requirements.

Growth since 2000 has been slower but steady. The Centers for Medicare and Medicaid Services (CMS) has reported that, as of June 30, 2008, over 70% of all Medicaid beneficiaries nationally (33.4 million out of 47.1 million) were enrolled in some form of managed care (Table 1-A). All states except two (Alaska and Wyoming) reported having some form of MMC in 2008. (Centers for Medicare and Medicaid Services, 2008a)

Table 1-A: Percent of Medicaid beneficiaries nationally who are enrolled in Medicaid managed care programs.

Year	% of Beneficiaries Nationally Who Are Enrolled in Medicaid Managed Care
2008	70.91%
2006	65.34%
2004	60.68%
2002	57.58%
2000	55.76%

Source: Centers for Medicare and Medicaid Services (2008b)

Although some states (Arizona and Oregon, for example) included all population groups very early in the development of their MMC programs, most began with children and parents (TANF and related groups), in part because they are more similar to commercial populations in terms of the type and cost of health care needed than older persons or persons with disabilities in SSI and related eligibility categories. Over time, increasing numbers of states have added SSI-related groups, and by 2002, more than 30 states included them in their programs (Table 1-B).

Table 1-B: Number of States including SSI-related Groups in MMC, 2002.

Group	Number of States
65 years and older	31
Children with Disabilities	38
Adults with Disabilities	36

Source: Kaye (2005)

C. Types of Medicaid Managed Care

The two major types of MMC are Primary Care Case Management (PCCM) and risk-based contracting. PCCM models pay primary care providers a small monthly fee to serve as the central manager of services for Medicaid members. The model is designed to increase access to primary care and decrease utilization of inappropriate hospital, emergency room and specialty care, but involves no financial risk. Claims continue to be paid on a fee-for-service basis to providers. MaineCare has had a PCCM program since 1998. Nearly 170,000 (60%) of MaineCare's 286,000 members are enrolled in a PCCM plan.

Patient-Centered Medical Home (PCMH) is an enhanced form of PCCM that is currently receiving much attention nationally. Like PCCM, the Patient-Centered Medical Home model is based on a primary care practice. Initiatives vary, but basic features include a team approach, care coordination, a long-term relationship between primary care provider and patient, and electronic medical records. Payment remains fee-for-service, and because expectations for coordination infrastructure are greater, the fee paid to the primary care practice is higher than what is paid in PCCM. MaineCare is participating in a multi-payer PCMH demonstration, in which about 21,000 MaineCare members are enrolled.

In risk-based MMC, Medicaid pays a set monthly amount, called a capitation, to a contractor, and the contractor is at financial risk to deliver a defined set of Medicaid services in exchange for the payment, whether or not the payment covers the actual cost of care in any given month. Risk-based contracts are population-based, which means that the total capitation payments made on behalf of the enrolled population are projected to be sufficient to finance care the the entire group.

Risk-based MMC includes full-risk programs, in which the contractor is at risk for all services, and partial-risk programs, in which the contractor bears some, but not all financial risk. Partial risk approaches include service carve-outs (in which some services remain fee-for-service) and risk sharing (in which losses are subject to stop-loss or other provisions that limit the risk).

Table 1-C compares PCCM (including Patient-Centered Medical Home) with risk-based Medicaid managed care.

Table 1-C. Characteristics of Medicaid Managed Care Approaches

	Primary Care Case Management (PCCM) and Patient-Centered Medical Home (PCMH)	Partial Risk	Full Risk
Contractor	A physician or other primary care provider	A provider-based organization or managed care organization	A managed care organization or other entity that can legally assume full financial risk
Contractor Role	Coordinate overall care	Coordinate overall care and assume some (but not all) financial risk	Coordinate overall care and assume full financial risk
Payments	Contractor receives an enhanced fee per member per month; claims are paid on a fee-for-service basis	Contractor receives a partial capitation for included services, or risk is mitigated by stop-loss or other mechanism	Contractor receives a full capitation for all services
Quality Approach	State works directly with primary care providers to impact quality indicators	State works with contractors, who in turn work with providers, to impact quality indicators	State works with contractors, who in turn work with providers, to impact quality indicators

In 2008, CMS reported 33.4 million beneficiaries enrolled in some form of MMC. Of these, 6.7 million, or 20%, were in PCCM programs. The remaining 80% were in full or partial risk programs. (Centers for Medicare and Medicaid Services, 2008a, 2008b). A majority of states operate both PCCM and risk-based MMC programs.

D. Maine Policy and Program Context

MaineCare does not currently have risk-based contracting, but it does have several initiatives designed to better manage utilization of services, which is a key feature of any managed care approach. These include:

- A pharmacy benefits management program for all MaineCare members administered by Goold Health Services (GHS);

- A medical care management program for approximately 13,500 children and adults administered through a contract with Schaller Anderson (highest 10% of adults and 5% of children in terms of costs);
- A behavioral health utilization review program administered through a contract with APS Healthcare for inpatient and other mental health services;
- A primary care case management (PCCM) network covering 60% of MaineCare members which pays providers \$3.50 per member per month and an additional Physician Incentive Payment (PIP) for those who meet certain quality assurance standards.

In addition, MaineCare is participating in broader health reform efforts reflected in the State Health Plan. All of these are developing important infrastructure (financial incentives, utilization review, quality improvement) and building support for concepts (accountability, collaboration, alignment of incentives) that would advance the development of risk-based contracting going forward. These include:

- Maine's multi-payer Patient-Centered Medical Home (PCMH) pilot;
- The Maine Statewide Health Information Exchange (HealthInfoNet);
- Payment reform deliberations of the Advisory Council on Health System's Development, and efforts led by the Maine Health Management Coalition to develop payment reform pilots;
- Projects funded by the Maine Health Access Foundation to improve coordination of physical and mental health; and
- With Vermont, and in partnership with the University of Vermont Medical School and USM's Muskie School, a multi-year, multi-million dollar demonstration grant from the federal Centers for Medicare and Medicaid Services (CMS) to improve the quality of Medicaid services to children.

Maine's ongoing budget pressures create a more challenging context in which to launch a risk-based MMC effort. Although states do report achieving greater budget predictability and program value through MMC, they also note that significant planning time and resources are needed to create an effective program that will yield longer-term results.

2. National Experience with Risk-based Medicaid Managed Care

Although Maine operated a risk-based MMC program briefly in the late 1990s, no formal evaluation was conducted of the effort. We rely therefore on evaluation of programs in other states to learn implementation lessons and to project what the impact on quality could be in Maine, understanding that every state Medicaid program is highly unique.

A. Lessons Learned from Medicaid Managed Care Implementation

Many states now have mature MMC programs built over many years. Their experiences have been captured in a body of “lessons learned” literature, and despite the wide variety of program models operating in individual state and county contexts, there is a remarkable convergence of opinion among researchers and state officials about the key factors to implementing a successful MMC program:

- **Cultivate long term collaborative relationships** with contractors;
- **Measure performance**, which requires early attention to data gathering and analysis;
- **Engage stakeholders** early and continuously;
- **Build effective administrative infrastructure**; and
- **Adapt to local conditions.**

Each of these lessons is discussed briefly here.

Cultivate Long Term Collaborative Relationships

Several observers have noted that successful MMC programs reflect long-term collaborative partnerships between Medicaid agencies and contractors. (Hurley & McCue, 2000a, 2000b; Verdier & Hurley, 2004) Medicaid policy changes are common, and demands on the program cycle with the economy and political climate. A Medicaid managed care program that nurtures collaborative partnerships with contractors is best prepared to respond to future developments and to improve the program over time.

Measure Performance

MMC offers the opportunity to measure and manage performance, as a state Medicaid agency evolves from claims processor to value purchaser. Schneider et al. (2004) have observed that MMC’s ability to outperform FFS depends on Medicaid agencies’ ability to manage quality aggressively. Verdier and Hurley (2004) have noted that the specific focus of performance management may vary by state, but the collection and use of performance data is essential to program management, accountability of contractors and credibility with stakeholders. Fossett et al. (2000) argue that without a stable source of reliable, comparable data on all participating contractors, it is difficult to imagine a robust and credible system for tying payment to performance, or otherwise improving programs over time. Yet many states fail to develop good data early, and fall back to monitoring procedural requirements and complaints.

All of the program officials from other states who were consulted as part of this feasibility study reinforced the critical role of quality management. Agreeing on program improvement priorities and how they will be measured strengthens a collaborative approach, and helps sustain political support over time. Focusing on quality from the very beginning ensures that a program's goals are well understood by all parties, and creates a culture of performance.

Engage Stakeholders

Officials from MMC states emphasize the need to engage stakeholders in the design, development, implementation and oversight of MMC. Stakeholders include consumers, advocates, providers and contractors. Legislators are also key stakeholders whose early support is critical to long term program viability.

Barth (2007) has argued that building consumer support is particularly important and recommends multiple strategies, including public meetings, focus groups, advisory committees and quality oversight groups. Bella et al. (2006) cite Wisconsin's involvement of consumers in contract development as one key to the success of its managed care initiative for SSI-related groups, strengthening consumer buy-in and leading to the negotiation of several important contractual requirements to assure quality.

Build Effective Administrative Infrastructure

One of the greatest misconceptions about MMC is that it relieves the state of program management responsibilities. MMC changes the role a state Medicaid agency plays, and offers new opportunities to promote quality, but strong management of program contractors is essential to achieving goals. States with little or no prior experience with MMC need to recruit or build skill sets necessary to operate in a fundamentally different program environment from claims processing and bill paying. Having these new competencies are key to promoting purchaser-plan collaboration and establishing credibility with stakeholders. (Hurley & McCue, 2000a)

In order for value-based purchasing to be more than just rhetoric, a state agency must become a sophisticated and prudent purchaser of care, which includes specifying contract language, designing benefits, monitoring quality and managing performance. (Landon et al., 1998)

Many states that implemented MMC came to realize they needed better data from their contractors and greater data infrastructure, including in-house expertise on data management and analysis. (Bella et al., 2006) State officials consulted for this feasibility study recommended building in adequate ramp-up time of a year or more for relatively simple program models, and longer for innovative designs for special population groups.

Adapt to Local Conditions

All MMC programs operate in unique state environments and rely on local providers, and the most successful programs are designed to take advantage of local conditions. The major features of successful risk-based MMC (emphasis on performance, flexible benefits, financial incentives) are constant across states, but the specific program features (types of contractors,

degree of risk, geographic reach) vary with state characteristics. For example, Wisconsin has used counties and groups of counties as its contractors in Family Care. That approach was feasible because counties already played a significant role in the delivery of health and social services in that state. The model is not likely to work in Maine, where counties do not currently have a Medicaid role. Hurley & McCue (2000a) put it this way: Medicaid managed care...“can only be understood by appreciating the political, economic, and social variability across and within states...emulation must be undertaken with considerable caution.”

One of the significant local factors in Maine is its rural character. Traditional models of managed care rely on population density to spread risk and adequate supply of providers to create competitive market forces. A risk-based contracting approach might be viable in southern Maine’s population centers, but may need to be combined with primary care case management, patient-centered medical home, or other fee-for-service strategies in more rural areas .

B. Health and Quality Outcomes of Risk-based Medicaid Managed Care Programs

To assess the impact of risk-based Medicaid managed care on outcomes, the Department commissioned the USM Muskie School to conduct a review of the literature on Medicaid managed care nationally. The review is included as [Appendix A](#), and summarized here.

Very few studies were found that address member health outcomes, such as morbidity or mortality. Most of the Medicaid managed care literature addresses utilization outcomes. In some instances, a change in utilization is considered an indicator of good quality. Examples are increases in childhood immunization and decreases in preventable admissions to hospitals. Other changes in utilization are desired because they promote cost-effectiveness and are generally preferred by consumers. Examples are decreases in institutional care and increases in home- and community-based care.

The literature assessing the impact of risk-based Medicaid managed care is mixed to favorable. Most access and utilization studies reviewed were favorable. Risk-based Medicaid managed care increases the likelihood of having a usual source of care, and reduces the use of emergency departments and admissions to hospitals. It has been associated with smoking cessation among pregnant women, and with greater likelihood of receiving prenatal care, well-child care and childhood immunizations. Among those who use long term services and supports, risk-based managed care has been associated with reduced use of nursing home care, and increased use of home- and community-based services.

A smaller number of studies report adverse outcomes, including increases in emergency department use and fewer pre-natal visits in the early stages of pregnancy. At least one study associated negative impact with program implementation problems that included difficulties transferring member information from the Medicaid agency to contractors, resulting in service delays.

Impact most often reported in the literature—increases in preventive and ambulatory care, and decreases in institutional care—are consistent with what policymakers want Medicaid managed care to achieve. Because most Medicaid managed care initiatives reflect the unique characteristics of the programs in which they operate, caution must be taken in projecting those outcomes in Maine. Nonetheless, the preponderance of studies from other states suggests that risk-based Medicaid managed care can improve access and quality, particularly when implementation is planned carefully, and a strong quality management program is in place.

See [Appendix A](#) for the full literature review conducted for this feasibility study.

3. Projected Net Cost Impact

The Legislative charge directed the Department to include in this report “the projected net cost savings” of implementing risk-based contracting in MaineCare. A review of national studies and CMS policy provides a common approach to calculating net cost savings:

- CMS requires a state’s Medicaid managed care program to be cost-effective in comparison to the state’s Medicaid fee-for-service program. Cost savings, therefore, are measured relative to what a state would have spent in fee-for-service for a comparable population of beneficiaries;
- CMS also requires that managed care rates be actuarially sound. In general, this means that actuaries use cost experience from the most recent period available to calculate future managed care rates;
- In setting managed care rates, actuaries calculate a discount from fee-for-service claims experience, based on the traditional ways in which managed care saves money: improving access to primary and preventive care; promoting health; managing complex care; negotiating discounts with providers in return for volume (which is more likely in urban areas than in rural areas); and reducing inpatient and other expensive forms of care by providing more community-based care whenever appropriate; and
- Savings are partially off-set by the administrative costs of the managed care organizations, which are built into their rates.

A recent synthesis of 24 Medicaid managed care cost studies from other states concludes that Medicaid managed care does reduce the rate of expenditure growth. (Lewin Group, 2009) Lewin reviewed cost studies conducted by states, independent assessors and academic researchers and came to the following conclusions:

- Nationally, net savings range from .5% to 20%;
- Savings are generally greater with SSI-related eligible populations than with parents and children in TANF and other eligibility groups;
- Savings are generally greater in urban areas than in rural areas;
- Savings are greater in risk-based models than in primary care case management (PCCM) models;
- Savings tend to increase over time as states gain experience and recover initial investments; and
- Savings derive primarily from reducing inpatient use.

Maine Projections

With support from the Maine Health Access Foundation (MeHAF), the Department engaged actuaries at Deloitte Consulting to calculate net cost savings of a risk-based MaineCare managed care initiative. The legislative charge directed the Department to study feasibility “for specific MaineCare populations or services” but did not indicate which populations or services,

so the Department instructed Deloitte to be broadly inclusive of populations and services, with two exceptions:

- Persons receiving services through Maine’s MR Waiver (home- and community-based services for persons with mental retardation) were not included in the analysis. Although this group should be considered for future phases of managed care development, the complexities associated with their specialized services would require significant planning, reducing the feasibility of including this group in the short-term;
- Dually eligible beneficiaries (those who have both MaineCare and Medicare) were also excluded. This has the effect of excluding most beneficiaries who are 65 and older, and a portion of younger beneficiaries who have Medicare by virtue of disability. Again, this group should be considered for future phases, but dual eligibility introduces many complexities for rate setting, provider network development, contractor qualifications and federal authority.

Consistent with the national experience, Deloitte assumed lower savings for TANF than for SSI-eligible populations, and lower savings in rural areas than in urban parts of Maine. Table 3-A shows the savings factors used in the analysis.

Table 3-A: Savings Factors Used to Project Net Cost Savings in Maine

Managed Care Program Location	Managed Care Savings Factor	
	Parents and Children	Older Persons and Persons with Disabilities (SSI)
Urban Counties	8% - 12%	10% - 14%
Rural Counties	6% - 8%	8% - 10%

Urban: Androscoggin, Cumberland, Kennebec, Penobscot, Sagadahoc, and York.

Rural: All other counties.

Deloitte also needed to make assumptions about participation levels. Mandatory programs generally save more because more beneficiaries are enrolled. Mandatory programs are the norm nationally for TANF and related populations. States are split when it comes to enrolling SSI-eligible populations, with some including them in mandatory programs and others in voluntary programs.

The decision about whether or not to make a program mandatory is related to how rural a state is. In general, to make a program mandatory, CMS requires a state to offer beneficiaries a choice of at least two managed care plans. Low numbers of beneficiaries and providers in rural areas can make it difficult for two competing plans to be viable. Therefore, many states make managed care mandatory in urban areas but not in rural areas. Taking this into consideration, Deloitte produced 4 different savings scenarios, combining various mandatory/voluntary

assumptions. The results range from a low savings estimate of \$21 million per year to a high of \$71 million per year, as shown in Table 3-B. All figures are state and federal funds combined.

Table 3-B: Estimated Net MaineCare Savings from Various Scenarios.

Savings Scenario	Parents and Children Urban	Parents and Children Rural	Older Persons and Persons with Disabilities (SSI) Urban	Older Persons and Persons with Disabilities (SSI) Rural	Estimated Annual Net Savings (\$ million)⁽¹⁾
Scenario 1	Mandatory	Mandatory	Mandatory	Mandatory	\$33 - \$71
Scenario 2	Mandatory	Mandatory	Mandatory	Voluntary	\$30 - \$66
Scenario 3	Mandatory	Mandatory	Voluntary	Voluntary	\$24 - \$55
Scenario 4	Mandatory	Voluntary	Voluntary	Voluntary	\$21 - \$47

¹ Based on FY 2008 dollars, state and federal combined. Estimates do not account for claim cost trend rates, possible rate cuts, or start up costs. Savings assume enrollment of all groups except dually eligible (for Medicare) and members of MR waiver.

Urban Counties: Androscoggin, Cumberland, Kennebec, Penobscot, Sagadahoc and York.

Rural Counties: All other counties.

As reported in the previous section, a key success factor identified in numerous studies of Medicaid managed care is a state’s ability to develop and maintain the infrastructure needed to design and oversee an effective program. Table 3-C presents estimates of these costs, which would need to be netted out of any of the savings scenarios in Table 3-B. Note that first year costs are higher, since most tasks have an initial development cost, followed by lower update or maintenance costs in subsequent years. With the exception of the enrollment broker, all costs link directly to CMS requirements for designing and operating a Medicaid managed care program. (A state could choose to perform enrollment as a state function rather than use an enrollment broker contractor, though there would still be a cost associated with the function.)

Given the reality of start-up costs, and considering Lewin’s national findings that savings tend to increase over time as states gain operational expertise, Maine would be prudent to estimate relatively low net savings in the first year of operation.

Table 3-C. Development and Operational Costs (total state and federal combined)

Tasks	Performed By	FY 11	FY 12	FY 13
Engage Stakeholders	Department and Contractors	\$500K	\$100K	\$100K
Define Operational Model	Department and Contractors	\$500K	\$300K	\$300K
Develop and Submit Waivers and/or State Plan Amendments	Department and Contractors	\$500K	\$100K	\$100K
Develop RFP and Evaluate Responses	Department and Contractors	\$500K		
Develop Rates	Contracted Actuaries	\$750K	\$250K	\$250K
Update Information Systems	Contractors	\$1M	\$200K	\$200K
Develop Quality Management System, External Quality Review Organization (EQRO)	Department and Contractor	\$400K	\$350K	\$350K
Select Enrollment Broker	Contractor	\$250K	\$100K	\$100K
Develop and Manage Contract	Department	\$250K	\$200K	\$200K
Total		\$4.65M	\$1.6M	\$1.6M
Reallocation of existing contract and staffing resources, FY 11		(\$850k)		
Net new needs, FY 11		\$3.8M		

4. Department Findings: Feasibility in Maine

Through an extensive review of national experience, the Department identified 4 major factors impacting feasibility:

- *Contractor capacity and interest;*
- *Stakeholder engagement;*
- *State administrative resources and capacity; and*
- *Federal authority.*

This section addresses our findings for each factor.

A. Contractor Capacity and Interest

Maine's previous attempt at Medicaid risk-based contracting in the late 1990s resulted in only one qualified bidder (NYLCare). Following an initial contract period marked by low enrollment, the contract was not renewed. Given this history, the Department decided to issue a Request for Information (RFI) to gauge whether or not health plans, provider systems and others would be able and willing to partner with MaineCare in risk-based arrangements.

On December 21, 2009, the RFI was published on the Department's website, and 92 insurers, providers and related organizations were asked specifically to respond. More than 50 organizations were represented at a public informational meeting held on January 14, and 22 organizations responded by the deadline of February 1. A summary of responses is included as [Appendix B](#). Most of the responses were well prepared and provide good information to guide the Department should it proceed with program design and implementation.

FINDING: The Department finds sufficient interest and capacity among potential contractors to proceed with more specific program development. The broad range of organizations responding, and the variety of risk arrangements proposed underscores that a risk-based MaineCare initiative will require substantial planning to refine a program model, and strong engagement of a potentially large number of interested contractors and subcontractors.

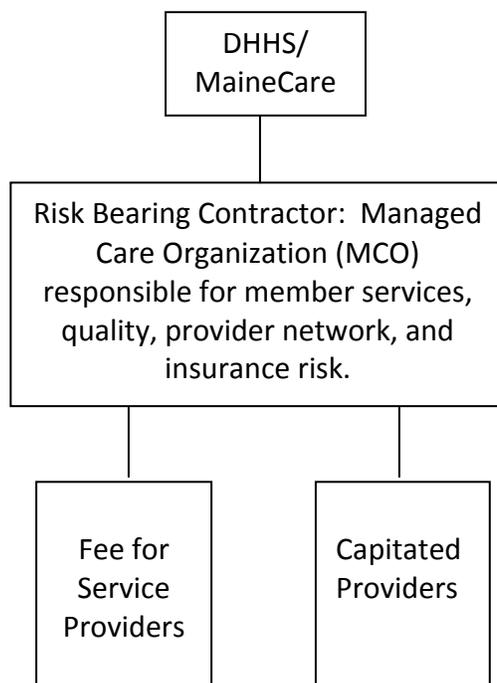
Nine national organizations responded. Six of these organizations have the capacity to assume financial risk. Among these organizations, AmeriGroup, Centene, Wellcare and Wellpoint indicate the capacity to provide a risk-based managed care program on a state-wide basis. Two organizations offer more limited capacity; AmeriHealth can provide risk-based managed care in a limited service area and ValueOptions' capacity is limited to behavioral health services. All six organizations indicate that their approach would be one of contracting with local hospitals, doctors and other providers to provide MaineCare services.

The remaining three national organizations have the capacity to provide focused management services to either MaineCare or a Managed Care Organization (MCO) engaged by MaineCare. While these organizations may link their reimbursement to identified performance measures,

these organizations did not offer to enter into full risk contracts. APS Health Care currently provides managed behavioral health services for select MaineCare members, and Schaller Anderson manages a broad array of services for certain high-cost members with complex care needs. Beacon Health Services also has the capacity to provide managed care services for MaineCare members utilizing behavioral services.

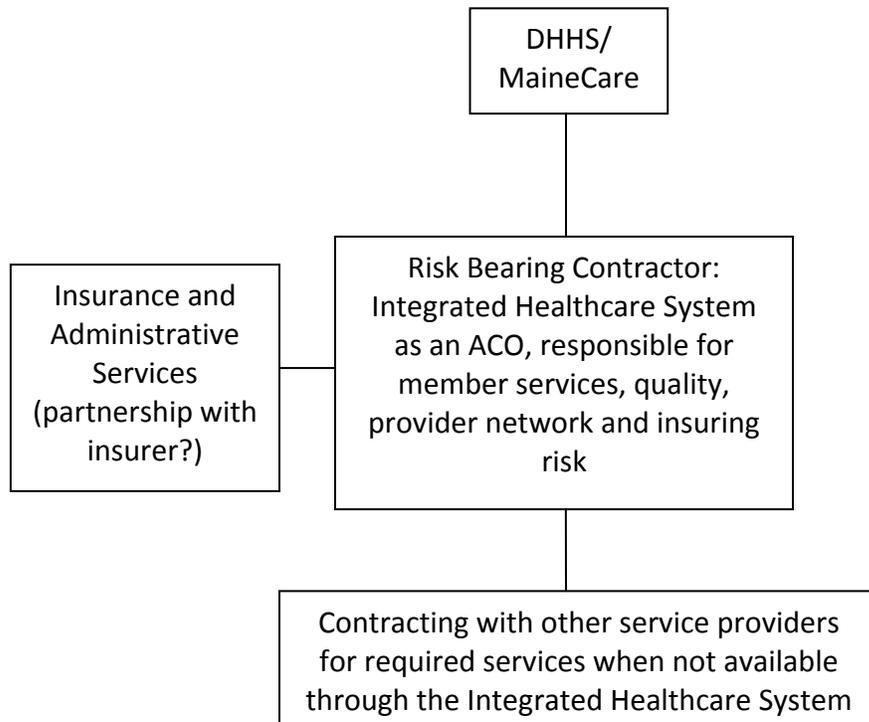
In Maine, the risk-based managed care programs proposed by these organizations would likely be based on an MCO (Managed Care Organization) platform. Organizationally, this approach is shown in Figure 1.

Figure 1: Managed Care Organization (MCO) Model



In contrast to the above approach which has been implemented in a number of states, there has been recent and growing interest in Maine and nationally in Accountable Care Organizations (ACOs). This approach could be based in a health care system which assumes clinical responsibility for an identified population (i.e., MaineCare members) through a risk-based payment arrangement. The critical difference in this approach is that the provider organization has established a direct contractual arrangement with MaineCare, rather than contracting with an intermediary MCO. (see Figure 2). Some health reform policymakers are promoting the ACO approach as a structure that more formally and efficiently engages providers around the delivery of cost effective, quality care. While these advocates point to very successful examples of the ACO model (e.g., Geisinger Clinic and Cleveland Clinic), this concept is relatively new and has not been extensively implemented. A key question is whether such an organization could bear risk directly, or whether it would need to partner with an insurer to do so. Efforts are underway in Maine to test this concept in Payment Reform pilot projects.

Figure 2: Accountable Care Organization Model



Two integrated health care systems expressed an interest in working with the State in developing an ACO for MaineCare. The OneMaine Health Collaborative would create a statewide effort through the combined resources of Eastern Maine Healthcare Systems, MaineGeneral Health and MaineHealth. OneMaine provided few details but expressed interest in further engagement of the State on this initiative. A second system, Central and Western Maine PHO, offered a more detailed concept for an initiative covering 6 counties.

Five other hospitals responded individually to the RFI and indicated capacity and interest in providing institutional as well as professional services to an identified managed care organization with which the State contracts. Within their respective service area, these institutions often provide or can arrange to provide a broad array of services, and have varying capacity to enter into risk-based reimbursement arrangements with contracting MCOs.

Five RFI respondents provide very specialized services, including community support services for persons with disabilities (Alpha One), general home care, hospice and community based services (Androscoggin Home Care and Hospice, and SeniorsPlus), behavioral health services (ISS of Maine) and primary care services (Maine Primary Care Associates). These organizations

represent an array of necessary resources for which an identified MCO or ACO is likely to contract.

Finally, the U Mass Medical School responded to the RFI. This organization offers no capacity around the requested financing and managed care services but instead offers policy and program development consultation to Medicaid programs.

B. Stakeholder Engagement

As reported earlier, one of the key lessons learned from other states is that early and ongoing engagement of stakeholders is critical to the success of Medicaid managed care (MMC) efforts. Risk-based contracting alters many aspects of how care is provided and received, how payments are made, how quality is measured, and the role played by the state Medicaid agency. Beneficiaries, advocates, providers and contractors must all be involved to ensure the smoothest possible transition. Legislators and other political leaders must be briefed frequently. All stakeholders must be involved in identifying clear goals for a MMC effort, and agree on how progress will be measured.

In reviewing waiver proposals, State Medicaid Plan amendments and risk contracts, the Centers for Medicare and Medicaid Services (CMS) look for evidence of substantial consultation with stakeholders. If Maine moves forward with this initiative, the Department will need to demonstrate that it has mounted a substantial effort in this regard.

FINDING: Based on the RFI response and informal preliminary outreach, the Department finds that advocates, consumers, potential contractors and providers are willing to participate in stakeholder processes to ensure that any initiative will focus not only on slowing the growth of spending, but also on improving quality. To ensure a meaningful process, resources would need to be dedicated to engagement.

If an initiative is launched, the Department will consult initially with its MaineCare Advisory Committee (MAC) and its Providers' Advisory Group (PAG) to seek their help in crafting a stakeholder process that builds on existing structures, expanding on them as necessary to ensure input across a range of interested parties.

C. State Administrative Resources and Capacity

As previously reported, a key lesson learned nationally is that states with little or no prior experience with MMC need to recruit or build skill sets necessary to operate in a fundamentally different program environment from claims processing and bill paying. Having these new competencies is key to promoting purchaser-plan collaboration and establishing credibility with stakeholders. (Hurley & McCue, 2000a) MaineCare has little existing infrastructure to design and implement a major risk-based program. Although it has relationships with consulting organizations and academic institutions that would be beneficial, the Department would need

to develop specialized capacity within State government to make risk-based contracting feasible.

FINDING: The Department finds its current administrative resources insufficient to perform the fiduciary and quality oversight functions inherent in risk-based Medicaid managed care. Feasibility depends on State government's ability and willingness to invest in start-up activities and make long-term commitments to adequate administration of the program.

The key functions necessary to design and implement a program were summarized earlier in Table 3-C. While many of those functions can be performed in part by consultants, State government should focus on building internal capacity in a few key areas. One is contract development and management. For this function, the state should actively recruit a person with significant managed care experience. A second is quality management. To ensure value, the State must define and monitor quality indicators, and hold contractors accountable for performance. If this function is not adequately addressed from the start, the State will not know if it is improving value, and will have difficulty holding contractors accountable.

D. Federal Authority

The Legislative charge specifically asked the Department to investigate the “feasibility of obtaining a waiver from the federal Centers for Medicare and Medicaid Services” to implement risk-based contracting.

We analyzed federal authority for risk-based contracting. The federal Balanced Budget Act of 1997 made it far simpler for states to implement risk-based contracting in Medicaid. All population groups may be enrolled voluntarily into risk-based arrangements with adoption of a Medicaid State Plan Amendment. No waivers are necessary. The proposed State Plan Amendment and contract are reviewed by CMS to ensure that federal requirements regarding quality, rate setting and service delivery are met, and a program may be implemented. Parents and children may be enrolled in a mandatory program with a State Plan Amendment, as long as beneficiaries are offered a choice of at least 2 plans in urban areas, and a choice of at least two primary care providers in rural areas.

Authority to enroll other groups is more complex. SSI and related eligibility groups may also be enrolled in mandatory programs with a State Plan Amendment, with the following exceptions: persons dually eligible for Medicaid and Medicare, children with special needs, and Indians. For those groups, special provisions apply.

Dually eligible members and special needs children may not be enrolled in mandatory programs without a Section 1915(b) or 1115 waiver. Indians may be required to enroll only if the MMC plan or PCCM program is an Indian Health Service entity, a tribally operated health program, or an urban Indian health program.

Section 1915(b) waivers generally take less time for approval and carry less risk to the State (in terms of federal financial participation), making them the preferred option. A section 1115 waiver is necessary if expanding the covered population, as with Maine’s current non-categorical waiver. If Maine chooses to include long-term services and supports in its initiative, existing Section 1915(c) home- and community-based waivers can be used concurrently with managed care authority to ensure that current HCBS financial eligibility rules can continue to be applied in a managed care arrangement.

FINDING: The Department finds it feasible to obtain federal permission to implement risk-based contracts in MaineCare, particularly if no expansion of the population is sought, thereby avoiding a Section 1115 waiver application.

Federal authority options are summarized in Table 4-A.

Table 4-A: Federal Authority for Risk-Based Contracting in Medicaid

Eligibility Group	Needed for Voluntary Enrollment	Needed for Mandatory Enrollment (with choice of 2 plans)
Parents and Children	State Plan Amendment	State Plan Amendment
SSI, excluding dually eligible for Medicare, special needs children and Indians	State Plan Amendment	State Plan Amendment
Dually eligible or special needs child	State Plan Amendment	Section 1915(b) waiver or Section 1115 waiver
SSI, with long-term services and supports included	Existing Section 1915(c) waiver, concurrent with above	Existing Section 1915(c) waiver, concurrent with above

5. Recommendations

1. The Department recommends development of a substantial risk-based Medicaid managed care program with a strong emphasis on quality. The goal of the program would be to improve value for all stakeholders by enhancing quality and reducing the growth rate in spending.
2. Planning, including a strong stakeholder engagement process, should begin immediately. Implementation should be phased in as follows:

July 1, 2010 to June 30, 2011	July 1, 2011 to June 30, 2012	July 1, 2012 to June 30, 2013	July 1, 2013 to June 30, 2014
Planning	Mandatory Enrollment for Parents and Children Voluntary Enrollment for persons with Acquired Brain Injury	Mandatory enrollment for SSI-eligible groups, except for dually eligible and MR waiver members Voluntary enrollment for Indians	Voluntary enrollment for dually eligible and MR waiver members Include long-term services and supports.

3. MaineCare should seek full risk arrangements through a Request-for-Proposal process. Both managed care organizations (MCOs) and accountable care organizations (ACOs) should be encouraged to bid, as long as they can bear risk directly or through partnerships with others.
4. The State should invest in adequate start-up costs to ensure strong stakeholder engagement, a robust quality management platform, and strong value-based purchasing capacity.

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