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Colorado Joint House and Senate Health and Human Services Committee

March 5, 2009

Attachment B

Aetna/Schaller Anderson Attendees

- Craig Bass – Regional Vice President
- Donna Checkett – Medicaid Business Development
- Linda Wertz - Consultant

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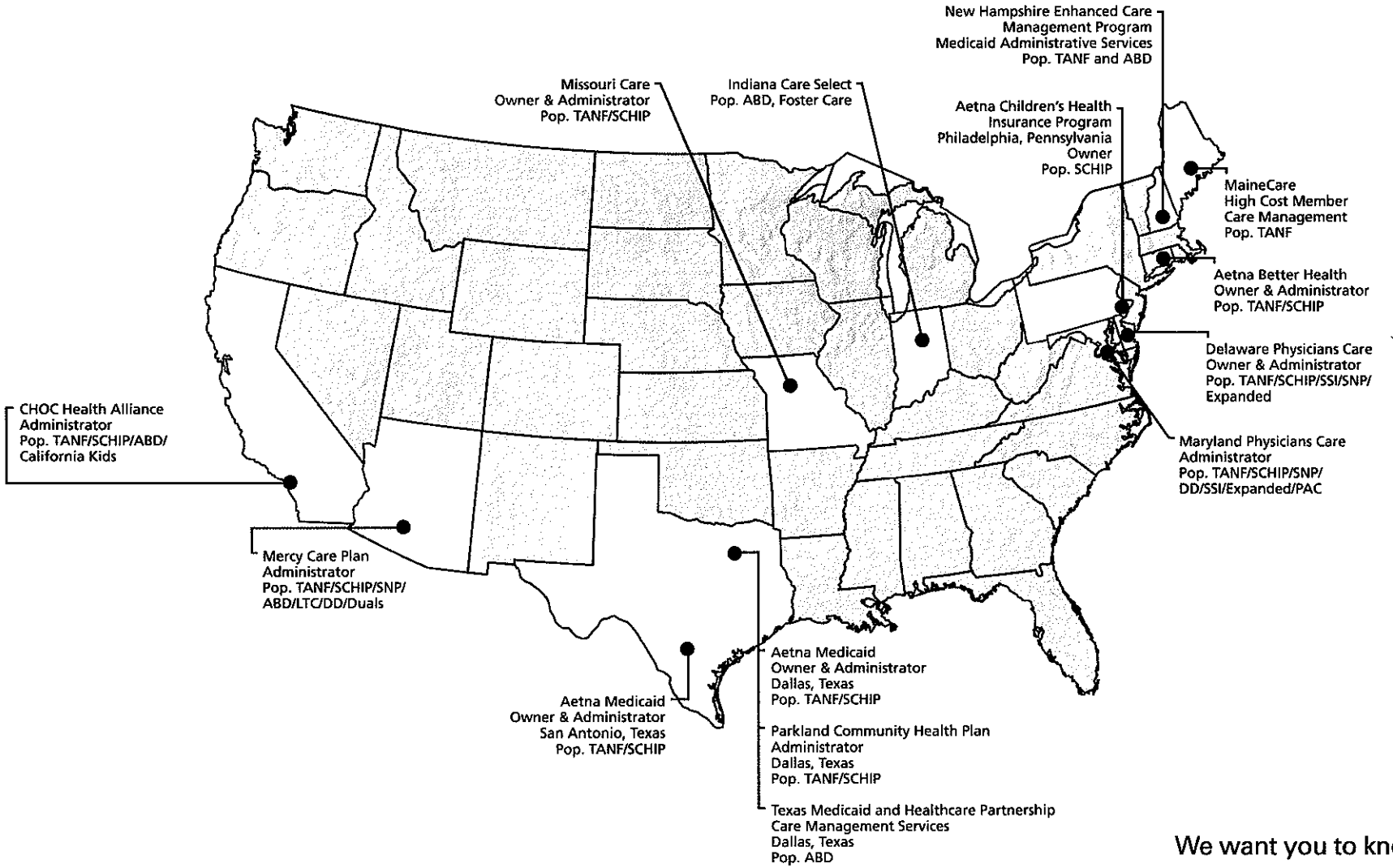
Aetna Medicaid Programs



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01/09

Overview of Schaller Anderson

- Established in 1986 by former directors of Arizona Medicaid (first statewide managed Medicaid program in the nation)
- Manage approximately 1.3 million Medicaid members with particular expertise in complex, chronic and long-term care
- Utilize managed care strategies and tools through a variety of models (capitation, non-risk MCOs, Enhanced PCCM, ASO services)
- Keys to our success – effectively integrating physical and behavioral health – clinical, operational and financial functions – to achieve higher quality health care outcomes
- Acquired by Aetna in 2007 as a wholly owned subsidiary

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Medicaid 2009

- Provides health and long-term care coverage for over 58.5 million people at a cost of $340 billion
  - 29.5 million children
  - 15 million adults in low-income families
  - 14 million elderly and disabled individuals
  - 8.8 million dual eligibles (40% of Medicaid spending)
  - 41% of all births
  - 1 million nursing home residents; 43% long term care services
  - 21% of total state spending in 2008
- Serves as the nation's de facto solution for uninsured, uninsurable and disabled populations
- Highly flexible and creative programs through waiver process

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Goals of Medicaid Managed Care

- Slow the rate of growth of the cost trend
- Improve access to care
- Improve and assure quality of care
- Establish and promote the use of a medical home

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Medicaid Managed Care

- 1980s: Arizona Health Care Cost Containment System (AHCCCS) is first and last state in nation to implement full capitation for all Medicaid beneficiaries. Other states follow lead with smaller programs.
- 1990s: Most states implement some version of managed care including Primary Care Case Management (PCCM) and capitation.
  - Primarily for low-income women and children
- 2000s: By the end of 2006, 48 states and District of Columbia had care delivery programs covering at least a portion of Medicaid recipients.
- Only two states (Alaska and Wyoming) do not have managed care programs. Seven states have PCCM programs only (ID, AL, AR, LA, ME, MT, SD). Eight other states have large (> 100K enrollees) PCCM programs in combination with MCOs

Models of Medicaid Managed Care

- Risk-based
  - MCO is paid a PMPM capitated payment and assumes some (partial-risk) or all (full-risk) of the financial risk for the delivery of a broad range of services.
  - 80% of Medicaid managed care enrollees receive services under this model
- Administrative Services Organization (ASO)
- Care Management
  - Vendor manages care but only administrative fees are at risk
  - States exploring this model for rural and disabled/elderly populations

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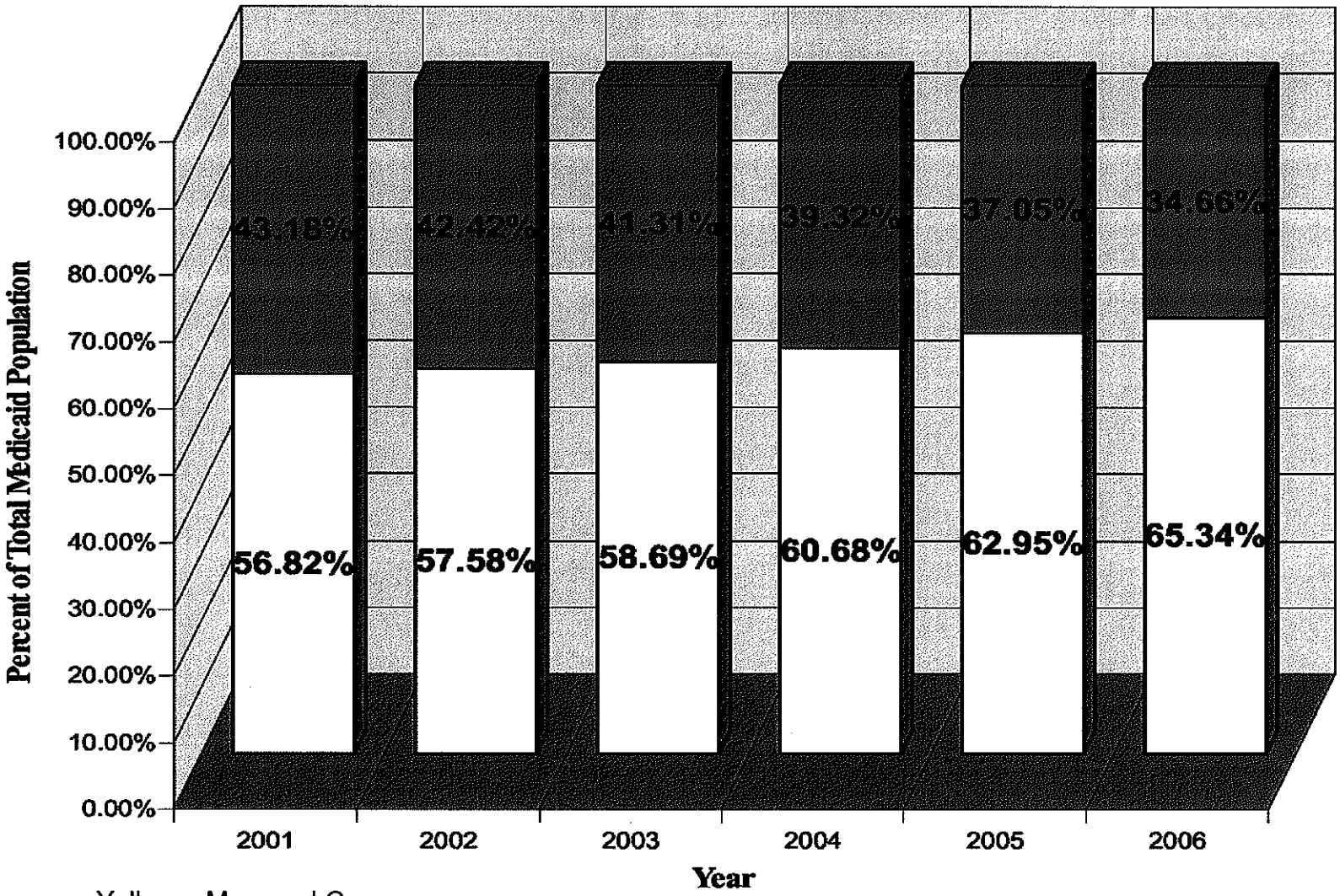
NATIONAL SUMMARY OF MEDICAID MANAGED CARE PROGRAMS AND ENROLLMENT

Total Annual Medicaid Population Distribution by Year: Managed Care v. Other as of June 30, 2006



•Yellow = Managed Care
• Blue = Fee for Service

Source: CMS

Aetna/Schaller Anderson Care Management Contracts

- Maine, New Hampshire, Indiana, and Texas
- Populations include ABD, Seriously Mentally Ill, TANF/SCHIP
- Predictive modeling identifies high risk recipients through medical, behavioral and pharmacy claims
- Health Risk Questionnaire collects self-reported member information

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Care Management Programs; Common Elements

- Medical Home and assigned PCP for each member
- Predictive Modeling and Risk Stratification used to create care plans. Get members the right care at the right place, on time
- Full range of clinical care management tools
- State retains medical claims risk
- We put administrative fees at risk if certain quality and operational benchmarks are not met

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Early Observations of our Care Management Programs

- Success Factors:
  - Transparent planning process involving providers and advocates
  - Mandatory enrollment into a program/plan with PCP assignment
  - Six month minimum ramp-up time
  - Use of full range of clinical care management tools is critical
  - Limit number of carve-outs

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Early Observations of our Care Management Programs

We have learned:

- Many members have significant behavioral health needs which impact their physical health needs; requires effective coordination
- Need a standardized health risk assessment for self reported data
- Use of Predictive Modeling tool is critical to identify high risk members and target interventions
- Provider Engagement
  - State must financially incentivize providers to participate in the care management process, preferably with payment for both outcomes and care coordination

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Early Observations of our Care Management Programs: Cost Savings

- Cost savings much harder to quantify than capitation
- Changes in quality and access harder to measure and possibly harder to achieve
- 12-18 months before can begin to measure savings
- "Baseline management" challenge
- Reasonableness and clarity in contract is critical and fair

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Care Delivery Essentials

- Medical home for all members
- 24 hour access at best place of service
- All claims, authorizations, lab, BH, pharmacy data are integrated
- Quality monitoring and measurement are working
- Utilization and care management: A seamless integration as members move from low risk to high risk status, from ambulatory to inpatient settings and back
- Member and provider profiles and care plans are accessible
- Provider Engagement

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Conclusion

- Care management programs can work but are not simply managed care substitutes
- Transparent process before RFP is critical to get the best and most innovative thoughts and ideas
- Thank you for your time!
- Discussion

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