

**MINUTES OF THE EXECUTIVE COMMITTEE OF THE
ALABAMA MEDICAID ADVISORY COMMISSION
NOVEMBER 14, 2012
GORDON PERSONS AUDITORIUM**

Members Present

Donald E. Williamson, M.D., Chair
Mr. Frank Brown
Mr. Jim Carnes
Mr. Danny Cottrell
Dr. Marquita F. Davis

Mr. Stan Hammock
Senator Greg Reed
George "Buddy" Smith, Jr., M.D.
Mr. Mike Warren
Representative Greg Wren

Welcome by Dr. Williamson

Dr. Williamson welcomed the group and stated it was highly likely that Alabama would move to managed care in 2014, whether commercial managed care or community managed care. The change is necessary due to Alabama's current system being fragmented, there being too much hospital and emergency room utilization, and Alabama not having the appropriate incentives to ensure coordination of care. There were fundamental issues around the payment system, which was focused on paying for utilization, with the result being incentivized utilization. There were discussions regarding moving from a per diem to a diagnosis related group (DRG) model and ultimately looking at capitation. The revenue system would also require a fundamental revision. Alabama built a hospital funding system on certified public expenditures (CPEs), which were neither transparent nor simple and created an opportunity for future significant liability. Alabama would need to move from CPEs to something that would be understandable and transparent.

The Governor stated yesterday that he would not expand Medicaid under the current program; it would not be rational to add thousands more new people to a broken system.

Presentation by Manatt

Manatt, a consulting firm hired by the Alabama Hospital Association to work on health system reform from the hospitals' perspective, presented their perspective on how Alabama could begin transforming its healthcare system.

In summary, Manatt proposed putting all existing Medicaid beneficiaries into one single system, providing the existing three or four primary care networks with new tools and better data to manage care, and changing them from fee for service payment to capitated payment. Over time, the networks would evolve from non risk bearing entities to risk bearing entities so that they became community-based managed care entities

coordinating care for individuals. A new payment model, followed by a global cap, would be imposed.

To obtain the maximum benefit of this design, physicians, hospitals, pharmacy services, nursing home services, home health services, and the entire spectrum of Medicaid services would be coordinated by the community-based entities.

Manatt's proposal would be done in phases and would take two years for implementation.

Presentation of Commercial Managed Care Plans

United Healthcare presented information on commercial managed care plans. The presentation was a collaborative effort with feedback provided by Amerigroup, Amerihealth Mercy, Centene Corporation, HealthSpring, Meridian Health Plan, Viva Health, and Wellcare.

This proposal recommended restructuring the provider financing/payment model to allow Alabama to benefit from managed care savings by implementing a managed care organization-based capitated Medicaid program. The system should cover all populations and all services. At least three plans should be selected in a competitive process to provide member choice and create a competitive environment to drive health plan performance and reduce complexity for providers and state agencies. In addition, managed care organizations recommended that preference be given to entities that bid on a statewide basis with extra points in the scoring process.

The model could be built to Alabama's specifications and would take 12 to 24 months for implementation.

Tennessee, Texas, Kansas, New Mexico, New York, and New Jersey are implementing the model that was recommended for Alabama.

Discussion

In response to questions posed by Committee members, the managed care representatives provided the following additional observations:

Given Alabama's history of no real deep base of managed care, it may be reasonable to begin with a less ambitious integration as a first step, realizing less money would be saved, with an ultimate step being the addition of other populations at a later date - - if Alabama contemplated going in this direction.

The managed care approach, which would not be implemented overnight and would be implemented in phases, would be a paradigm shift not only for providers but also for the Medicaid Agency. The role of the Medicaid Agency would change fundamentally whether commercial managed care or community-based managed care was selected.

If Alabama shifted risk and capitated an entity, the Medicaid Agency would move from paying bills to managing data and from performing the work to managing the companies that performed the work.

Either type of transformation of the Medicaid system would likely require an 1115 waiver; however, the waiver would be structured and written differently depending upon the type of managed care chosen.

The managed care companies proposed a commercial managed care plan that would be a turnkey operation built to Alabama's specifications rather than a community-based managed care plan that Alabama would have to grow and develop. The trade off would be that the commercial managed care organization would be paid the return investment whereas if Alabama developed the community-based managed care plan, those dollars would be saved by the state.

The commercial managed care organizations asserted that they would not restrict access and would offer the benefits that the state required as part of Medicaid, and therefore, they would not be allowed to eliminate certain benefits. They also could not pay providers less than Medicaid required them to pay providers and often times would pay providers more. Commercial managed care organizations would do profit sharing either by pay for performance or a shared savings model.

A key difference between patient care networks and managed care organizations is that patient care networks would not bear the risk that a managed care organization would bear. If patient care networks had a loss, the state would be responsible. Additionally, managed care organizations would provide more holistic case management whereas patient care networks would be more siloed to what would be of most interest to a particular group of providers.

The managed care companies assumed this model would be actuarially sound if Alabama changed the way it paid hospitals.

In response to questions posed by Committee members, Manatt provided the following additional observations:

Community-based managed care and commercial managed care increasingly demonstrated the kind of results important to Alabama. Commercial managed care is present around the country and succeeded in producing budgetary savings for states. In a number of states, it also significantly disenfranchised the provider communities creating, in certain situations, pockets of access vacuums as well as significant excessive or incremental costs to providers. The fundamental economics of the program would have to be addressed. The principles of managed care organizations have merit but the approach to implementing them would be challenging.

Alabama's Medicaid system is bare bones and the notion of shifting risk would be attractive on one hand and yet if it were simply a game of squeezing providers in a

relatively low cost per beneficiary world, it would be a no win proposition after a short period of time.

If the decision to change to commercial managed care was made in January 2013, implementation would not occur until June 2014. If community-based managed care were selected, it would be 2014 before the networks could be set up and functioning and it would be 2016 and 2017 before Alabama would be sharing risk.

Closing Comments and Next Meeting Date

The Executive Committee was not prepared to make a recommendation to the Commission at the conclusion of the meeting.

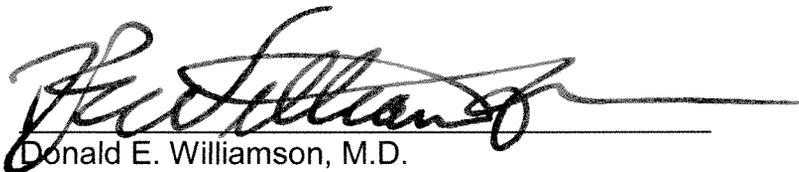
The next meeting of the Executive Committee will be held on Wednesday, November 28, at 2 p.m.

Dr. Williamson stated that he and Dr. Nancy Dunlap would obtain more information regarding the 1115 waiver since the waiver would be required, regardless of the direction that would be taken. Dr. Williamson indicated he would also follow-up with the actuary on information regarding how Wyoming's 1115 waiver was received by the Centers for Medicare and Medicaid Services.

At the next meeting, the Executive Committee will hear from state Medicaid programs that are in both models so the Executive Committee can make a recommendation to the Commission at the next meeting on December 7.

Information regarding DRG transformation may also be available for discussion at the next meeting.

There being no further business, the meeting was adjourned.



Donald E. Williamson, M.D.
State Health Officer
Chair, Alabama Medicaid Advisory Commission