Evolving Health Care Payment: 'Big Changes' on the Horizon

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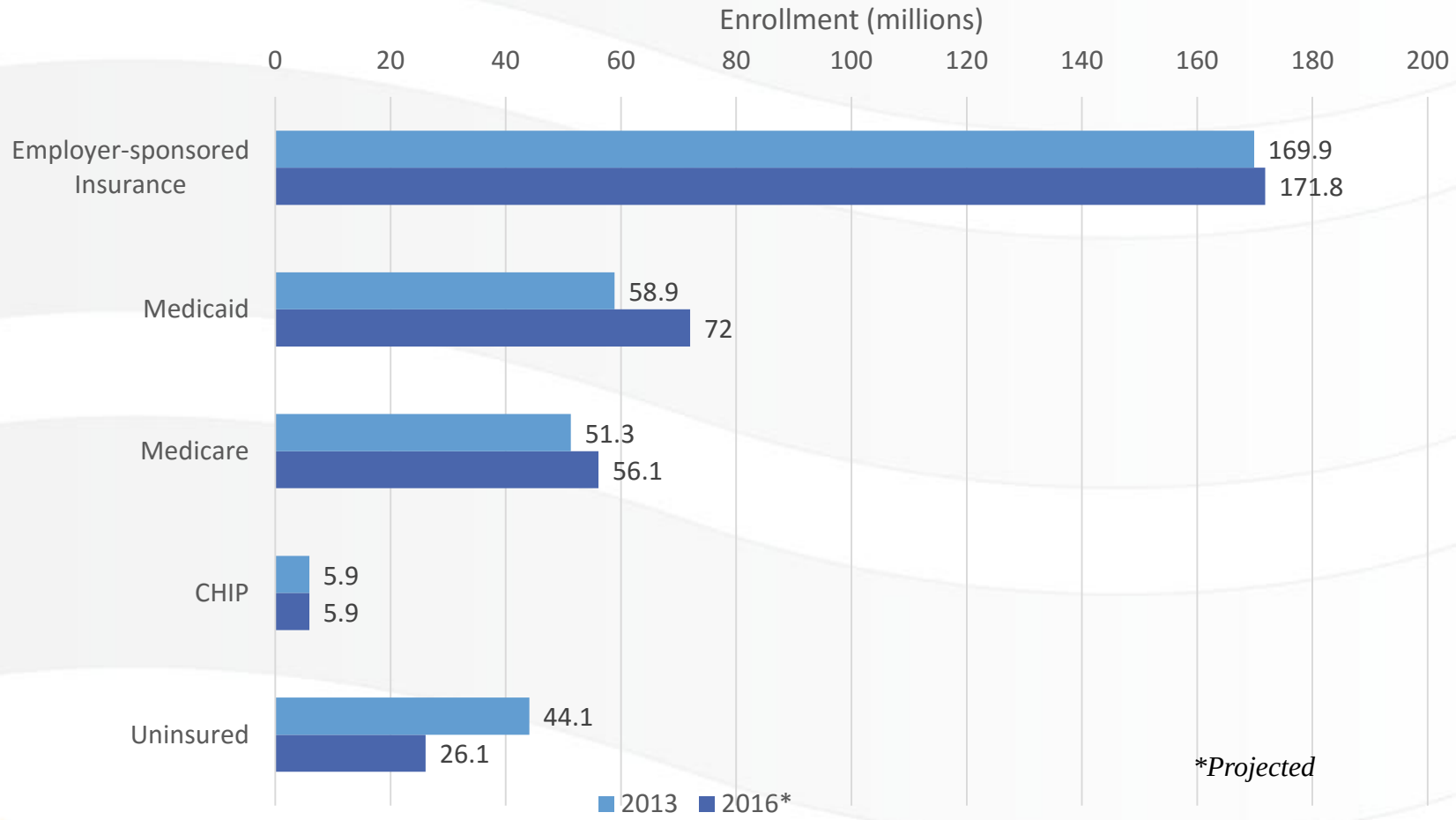
Vice President, Finance Policy

Focus Areas

- State
  - Medicaid Managed Care
    - Implementation
    - Issues and Concerns
    - Looking Ahead: Rates and Utilization
    - Oversight

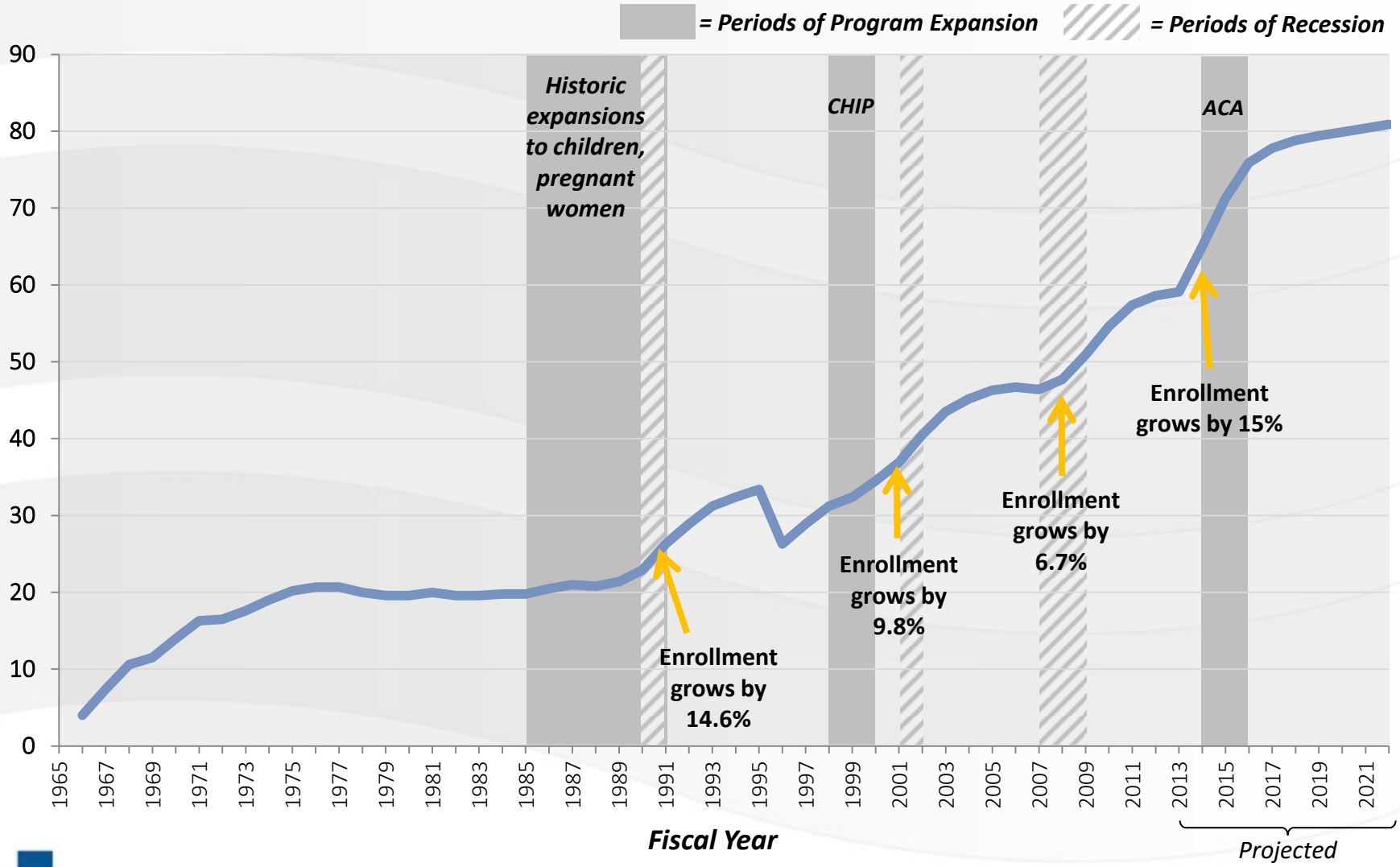
Medicaid Trends

Medicaid's Role is Strong and Growing



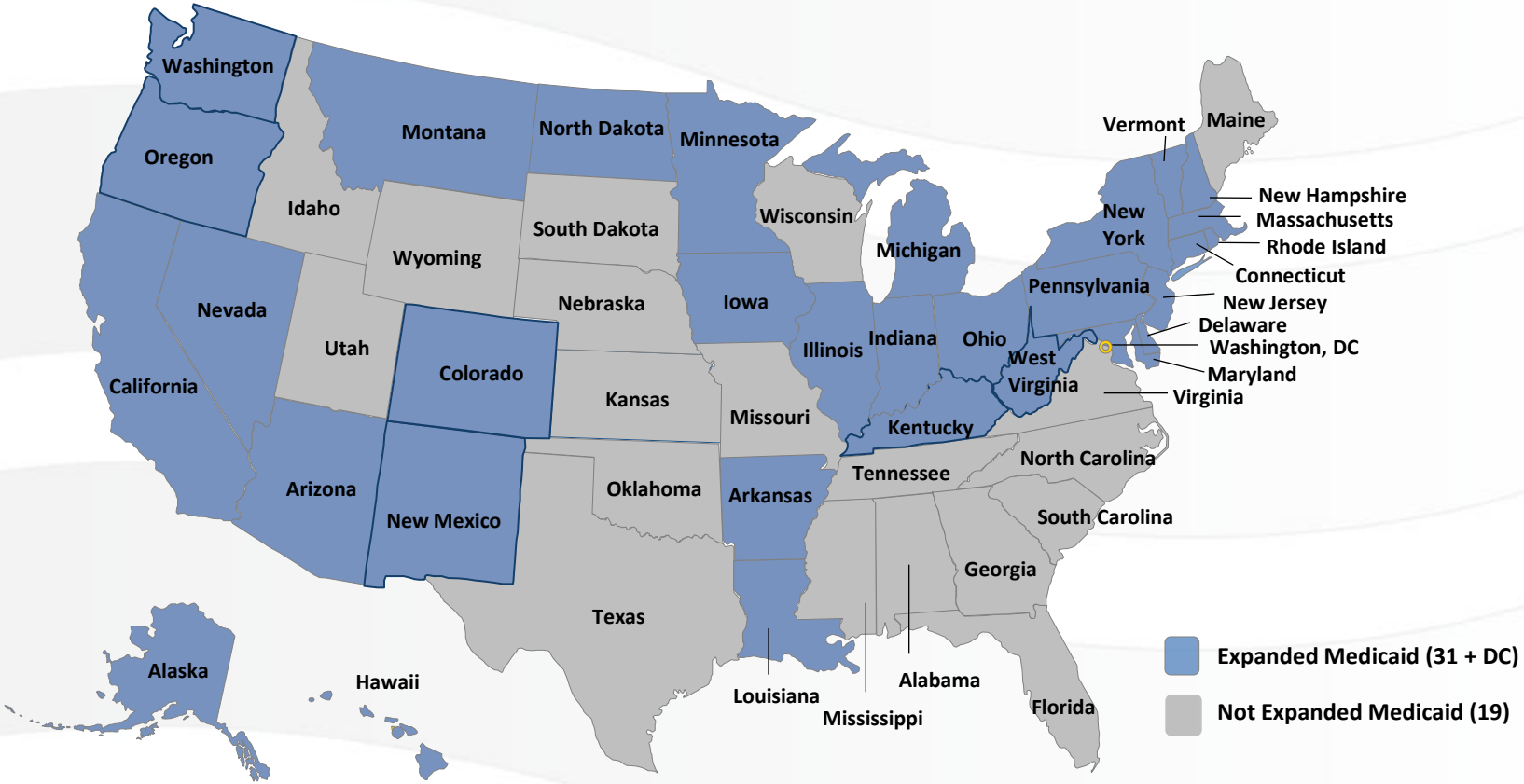
Note: Individuals reporting multiple sources of coverage are reflected in each respective category. Medicaid enrollment includes individuals receiving partial benefits. Source: Centers for Medicare & Medicaid Services (CMS), Office of the Actuary, National Health Statistics Group, Source: Manatt

Steady Growth in Medicaid Enrollment



***Source**: OACT 2012 and 2013 Actuarial Reports*
http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Downloads/medicaid-actuarial-report-2013.pdf
US Business Cycle Expansions and Contractions, National Bureau of Economic Research

31 States Plus DC Have Expanded Medicaid…So Far

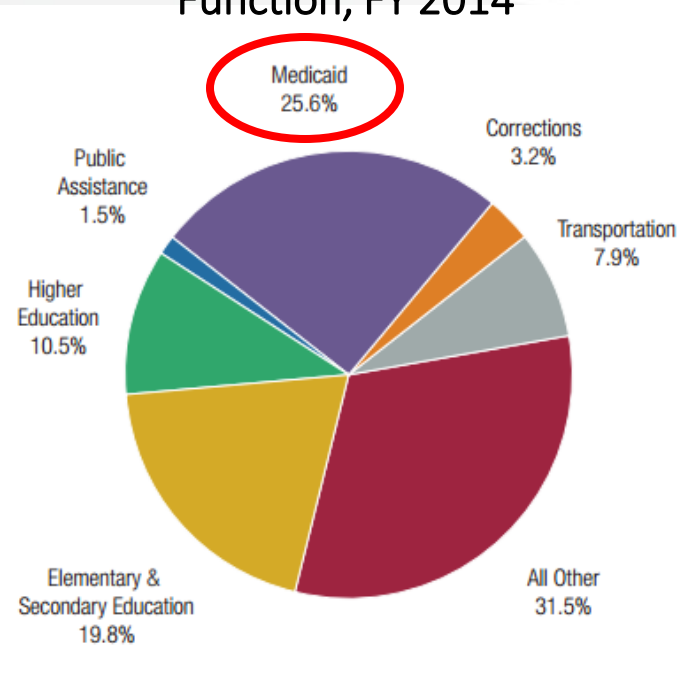


Medicaid expansion decisions as of January 2016. Arizona has submitted a waiver request to move to an alternative expansion approach. Coverage under Louisiana's expansion is targeted to begin on July 1, 2016. Source: Manatt

Medicaid Accounts for a Large Share of State Budgets

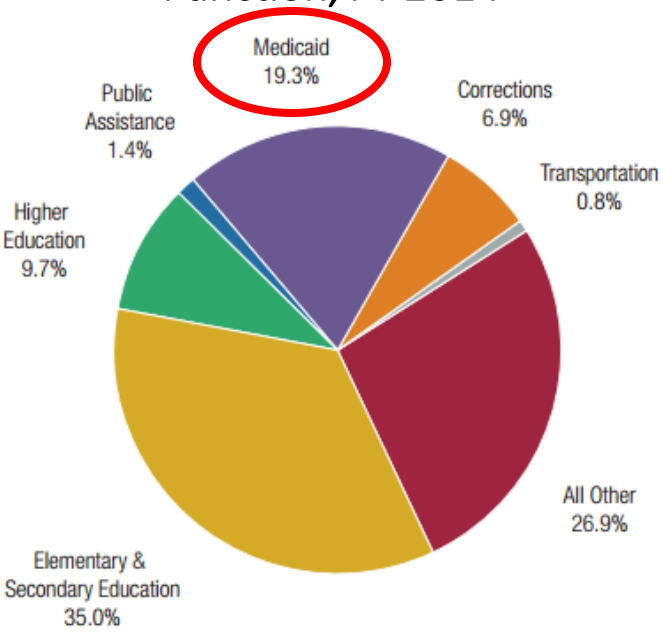
- **Total expenditures on Medicaid are rising; impact on State General Funds varies**

Total State Expenditures by Function, FY 2014



Medicaid expenditures expected to increase by 15% in FY15

Total General Fund Expenditures by Function, FY 2014



State general funds Medicaid expenditures expected to increase by 4.8 % in FY15

Source: National Association of State Budget Officers State Expenditure Report/Manatt

Medicaid Managed Care

Iowa Health Link

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Implementation

- April 1
  - 560,000 Iowans distributed among 3 MCOs.
    - Amerigroup, AmeriHealth-Caritas, United

Branstad says it's been 'relative smooth' transition to Medicaid privatization

APRIL 4, 2016 BY O. KAY HENDERSON

Last Friday, about 3,000 calls were made to the state "call center" created to help figure out benefits for Iowa Medicaid patients and the health care professionals who treat them.

Friday was the day Iowa's 560,000 Medicaid patients were switched to a private managed care system. Governor Terry Branstad describes the transition as "smooth.

"Nothing of this magnitude is going to be totally glitch-free," Branstad says. "But the reports I've been geting is that it's relative smooth and, you know, there are all kinds of opportunities for

Governor Terry Branstad.

Recent Editorials

Editorial: A 'smooth' Medicaid transition, governor?

The Des Moines Register

Frustration, confusion linger in Medicaid transition

THE COURIER

Siouxland providers ready; patients wary of Medicaid change

Sioux City Journal

Highlighted Issues and Concerns

Ongoing Issues and Concerns

- Medicaid as secondary payer
- Prior Authorization
- Utilization Management
- Claims Processing
- Utilization Reductions
- Rural Health Clinic Reimbursement
- Critical Access Hospital Reimbursement
- Timely Filing
- Denials and Appeals
- ID numbers
- Crossover Claims
- Network/Out-of-Network Status

Eligibility Verification

- Eligibility and Verification Information System (ELVS)
- ELVS Call-In
  - No Enrollment required
  - One member check at a time
- ELVS web portal
  - Enrollment required through the Electronic Data Interchange Support Services (EDISS).
  - Allows multiple member checks
  - Login ID and password may be obtained through EDISS
- Informational Letter 1650-MC

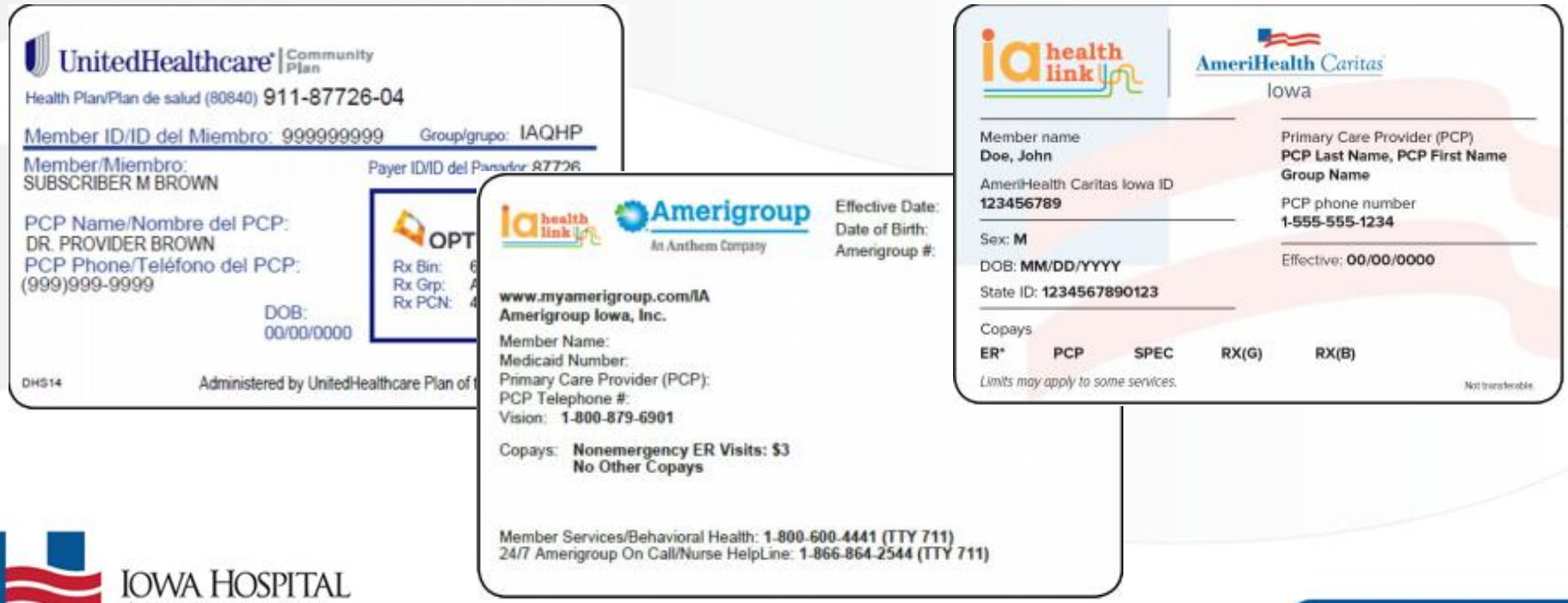
Cards and ID Numbers

Amerigroup = "Medicaid number."

AmeriHealth-Caritas = "State ID."

United = Medicaid ID as the MCO ID referred to on the card as "Member ID."

IA Health Link members will need to keep their Iowa Medicaid Eligibility Card. **Members will need to present both cards when receiving services.**



Prior Authorization

May 1

- Prior Authorization Policies Effective

April 1 – June 30

- All existing prior authorizations will be honored.
- Providers will be able to establish new authorizations following the policies of the member's selected MCO.

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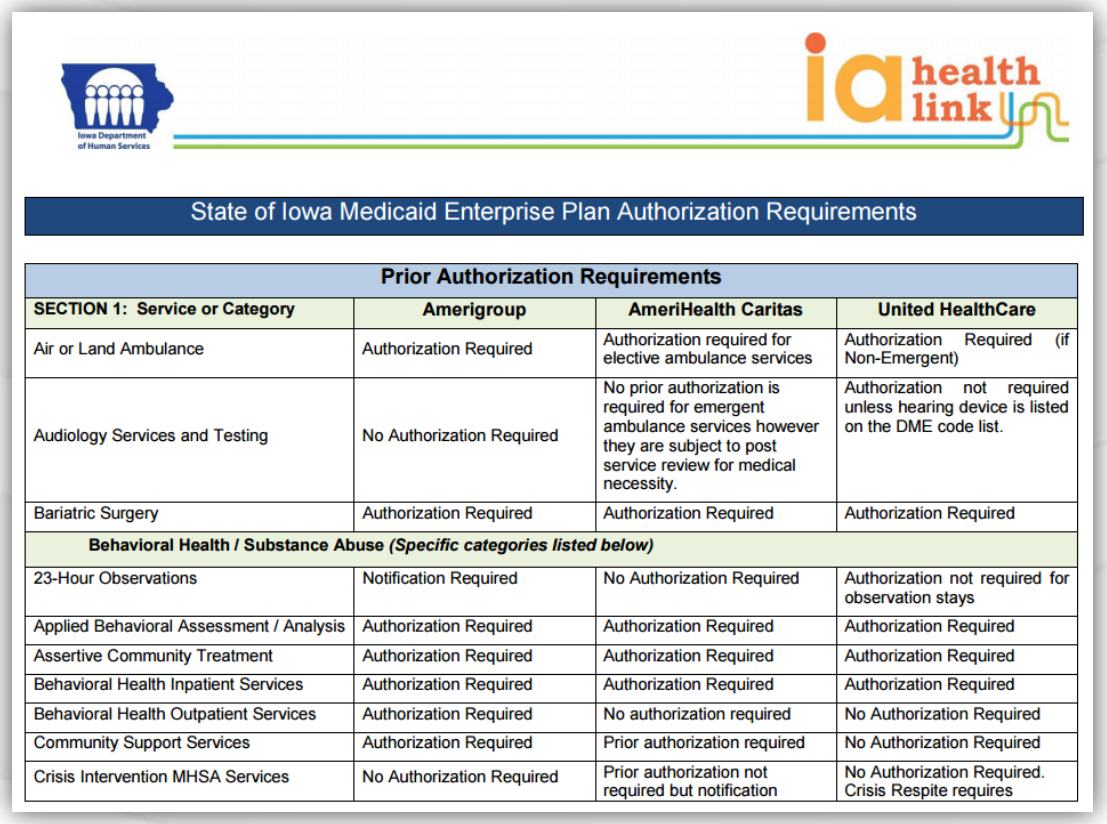
Prior Authorization Guide

Review carefully and note differences between plans.

- Download and print the PA requirements by plan.



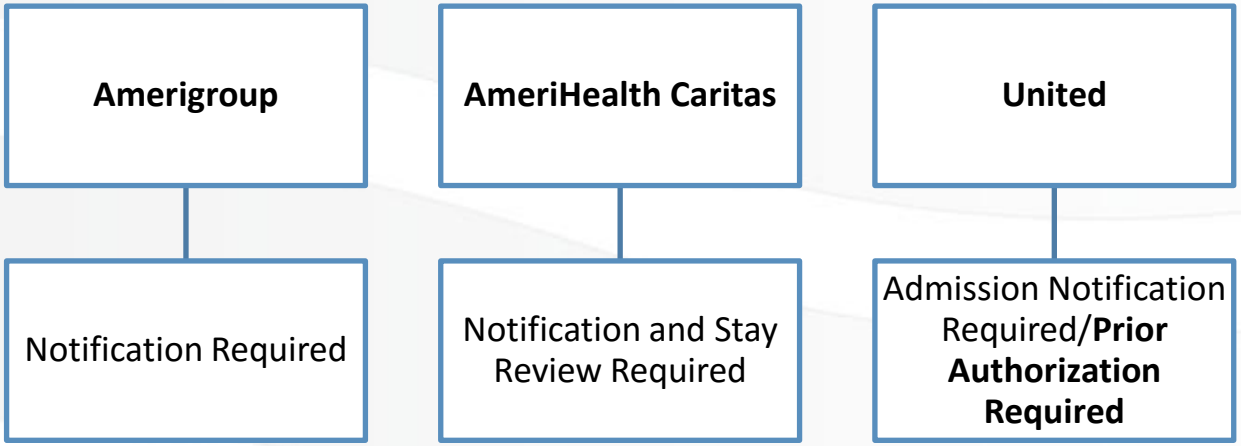
State of Iowa Medicaid Enterprise Plan Authorization Requirements

Prior Authorization Requirements			
SECTION 1: Service or Category	**Amerigroup**	**AmeriHealth Caritas**	**United HealthCare**
Air or Land Ambulance	Authorization Required	Authorization required for elective ambulance services	Authorization Required (if Non-Emergent)
Audiology Services and Testing	No Authorization Required	No prior authorization is required for emergent ambulance services however they are subject to post service review for medical necessity.	Authorization not required unless hearing device is listed on the DME code list.
Bariatric Surgery	Authorization Required	Authorization Required	Authorization Required
Behavioral Health / Substance Abuse *(Specific categories listed below)*			
23-Hour Observations	Notification Required	No Authorization Required	Authorization not required for observation stays
Applied Behavioral Assessment / Analysis	Authorization Required	Authorization Required	Authorization Required
Assertive Community Treatment	Authorization Required	Authorization Required	Authorization Required
Behavioral Health Inpatient Services	Authorization Required	Authorization Required	Authorization Required
Behavioral Health Outpatient Services	Authorization Required	No authorization required	No Authorization Required
Community Support Services	Authorization Required	Prior authorization required	No Authorization Required
Crisis Intervention MHSA Services	No Authorization Required	Prior authorization not required but notification	No Authorization Required. Crisis Respite requires

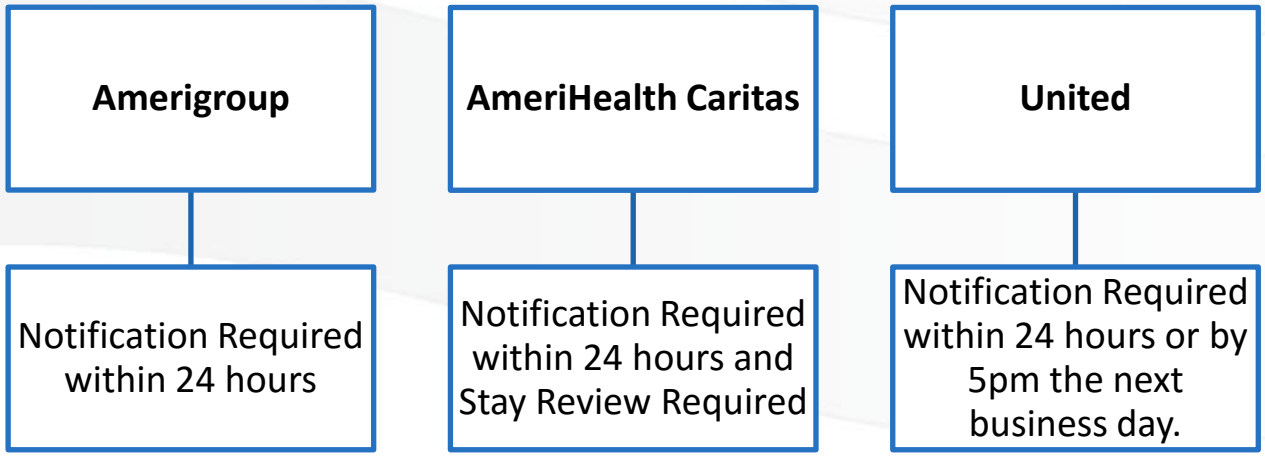
Link

Variances: Prior Auth/Notification

Non-Emergent Inpatient Admissions



Emergent Inpatient Admissions



Variances: Prior Auth/Notification

Observation

Amerigroup	AmeriHealth Caritas	United
Notification Required	Authorization NOT required for 48-hour Observation	No Authorization required for observation stays

Prior Auth/Notification

Newborn Delivery

Amerigroup	AmeriHealth Caritas	United
Notification required within 24 hours of delivery. Completion of Newborn Notification of Delivery Form is required.	Notification required within 24 hours of delivery	Prior Authorization is not required. Call/fax: date of birth, birth weight, gender, delivery type, gestational age

Appeals

Amerigroup	AmeriHealth Caritas	United
Provider disputes must be submitted within 120 days of receipt of remittance	The appeal outcome will be communicated to the Provider within thirty (30) days of receipt of the appeal from the provider.	30 days from the notice of decision

Out-of-Network Providers

Non-Emergency Services

- Provider accepts to treat an out-of-network patient.
  - Prior authorization required for ***all*** services
  - Receive a 90% out-of-network rate
  - Balance billing not allowed.
- Provider does not accept to treat an out-of-network patient.

Emergency Services

- Not limited to in-network providers.*
- No prior authorization required.
- Medical screening examination covered*
  - 90% payment rate
  - Balance billing not allowed

*42 CFR 438.114

** as defined by the Emergency Medical Treatment and Active Labor Act (EMTALA) regulations

Impact of Fee-for-Service vs. Capitation

Capitation Rates and Utilization, Provider Rates and Reductions

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- Capitation is a fixed amount of money per patient per month paid in advance to Managed Care Organizations
- Rates are set initially for 18 months. (January 1, 2016 – June 30, 2017)
- Capitation rates are developed using historical costs and average utilization of services
- Capitation rates are adjusted in advance based on the expected impact of managed care
  - Utilization reductions

Rates

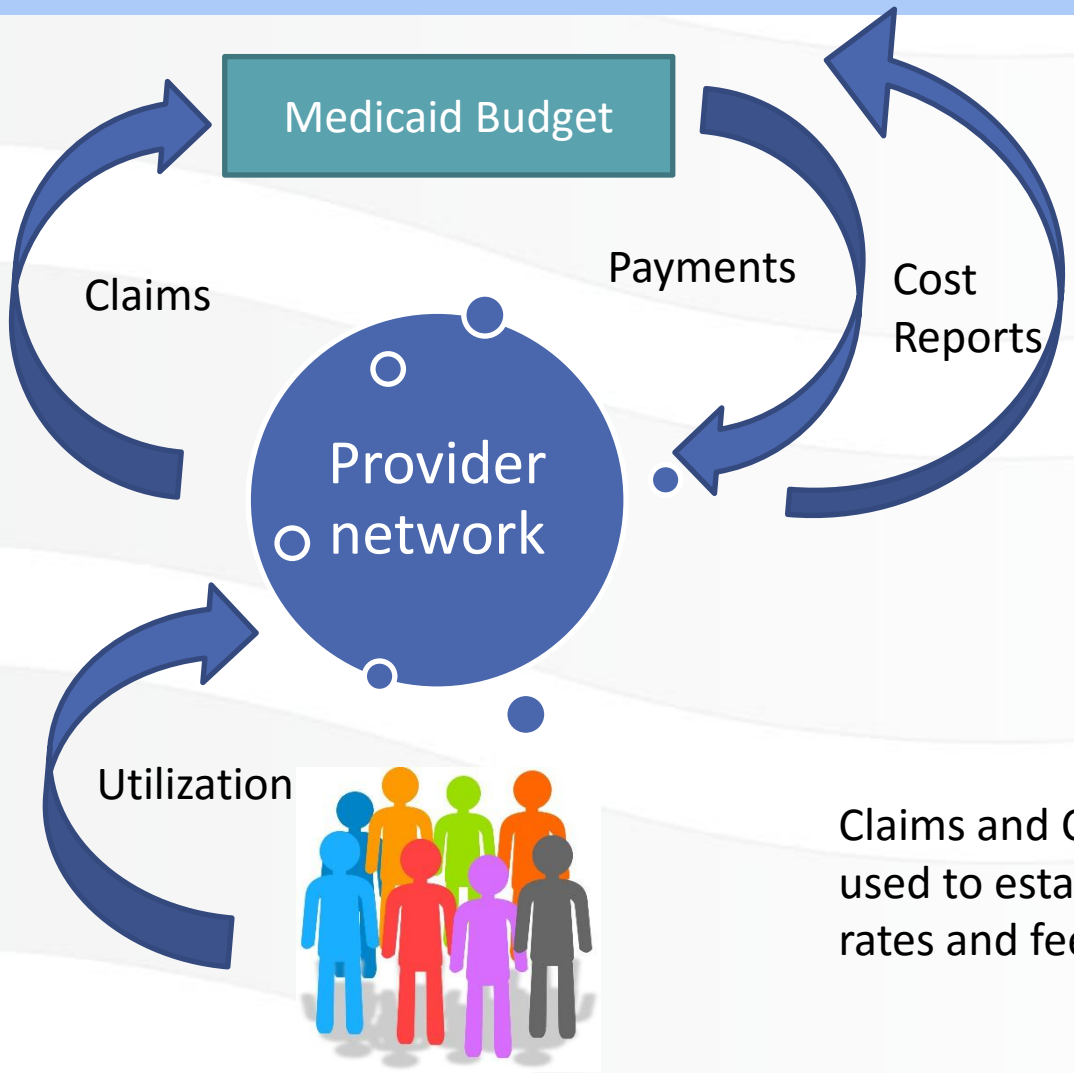
FFS

- **Fee-For-Service**
- Per Service/Provider
- **Provider Specific** Rates/Fee Schedules
- Established by department/Legislature
- Rate rebasing
- Applied uniformly
  - By provider type

Capitation

- **Fee-For-Patient**
- Per Capita
- **Member category** specific rates
- Established by actuaries
- No Rate Rebasing/Negotiated
- Applied individually
  - By patient rate bands

FFS



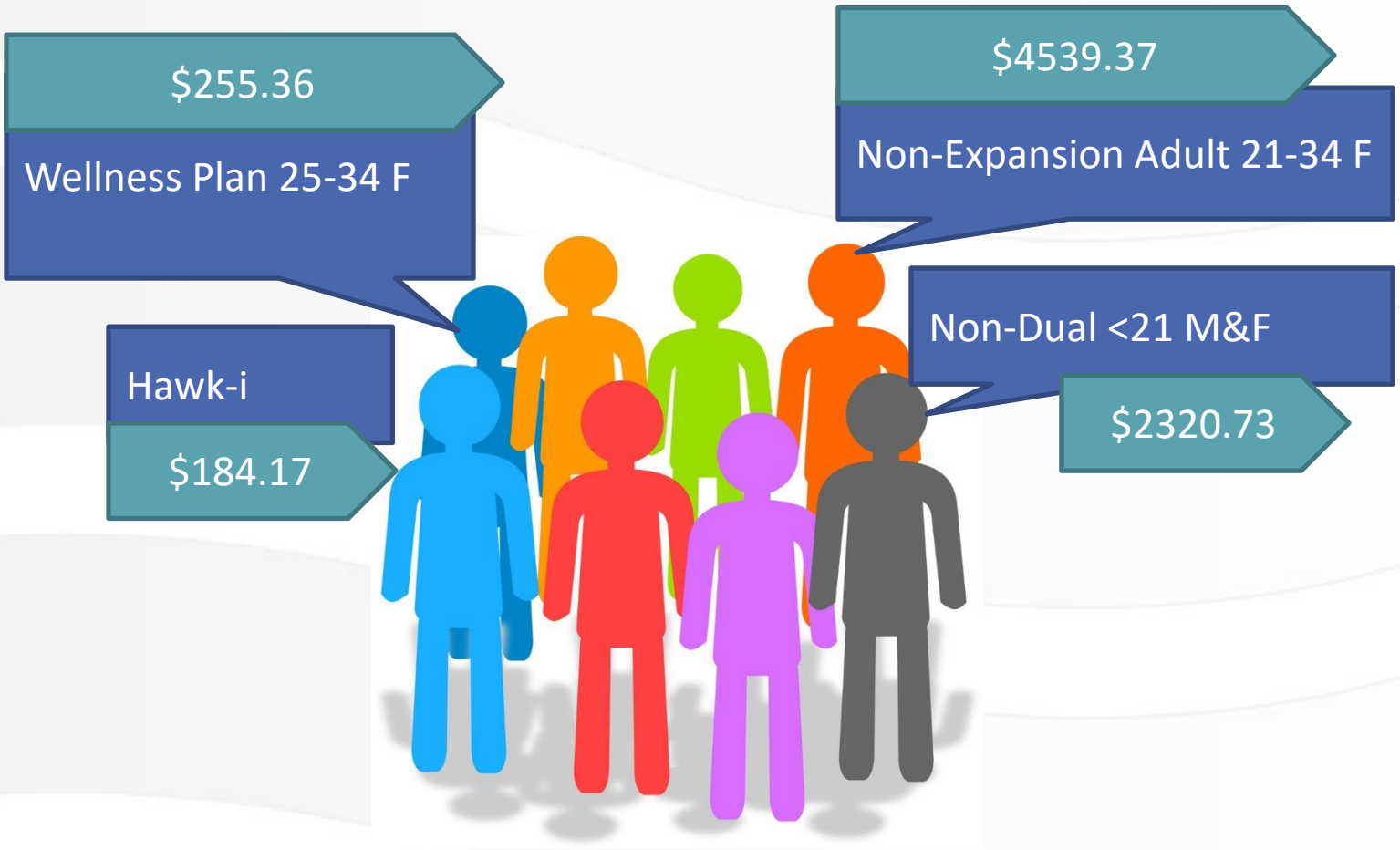
Claims and Cost Reports used to establish provider rates and fee schedules.

Rate Bands

Medicaid Member Categories

Children 0-59 days M&F
Children 60-364 days M&F
Children 1-4 M&F
Children 5-14 M&F
Children 15-20 F
Children 15-20 M
Non-Expansion Adults 21-34 F
Non-Expansion Adults 21-34 M
Non-Expansion Adults 35-49 F
Non-Expansion Adults 35-49 M
Non-Expansion Adults 50+ M&F
Pregnant Women
Hawk-i
TANF Maternity Case Rate
Pregnant Women Maternity Case Rate
Wellness Plan 19-24 F (Medically Exempt)
Wellness Plan 19-24 M (Medically Exempt)
Wellness Plan 25-34 F (Medically Exempt)
Wellness Plan 25-34 M (Medically Exempt)
Wellness Plan 35-49 F (Medically Exempt)
Wellness Plan 35-49 M (Medically Exempt)
Wellness Plan 50+ M &F (Medically Exempt)
Wellness Plan 19-24 F (Non-Medically Exempt)
Wellness Plan 19-24 M (Non-Medically Exempt)
Wellness Plan 25-34 F (Non-Medically Exempt)
Wellness Plan 25-34 M (Non-Medically Exempt)
Wellness Plan 35-49 F (Non-Medically Exempt)
Wellness Plan 35-49 M (Non-Medically Exempt)
Wellness Plan 50+ M&F (Non-Medically Exempt)
Family Planning Waiver
ABD Non-Dual <21 M&F
ABD Non-Dual 21+ M&F
Breast and Cervical Cancer
Residential Care Facility
Dual Eligible 0-64 M&F
Dual Eligible 65+ M&F
Custodial Care Nursing Facility 65+
Hospice 65+
Elderly HCBS Waiver
LTSS blended with actual membership mix
LTSS blended with 3.25% rebalanced membership
Custodial Care Nursing Facility <65
Hospice <65
Non-Dual Skilled Nursing Facility
Dual HCBS Waivers: PD; H&D
Non-Dual HCBS Waivers: PD; H&D; AIDS
Brain Injury HCBS Waiver
LTSS blended with actual membership mix
LTSS blended with 2.25% rebalanced membership
ICF/MR
State Resource Center
Intellectual Disability HCBS Waiver
LTSS blended with actual membership mix
LTSS blended with 1.0% rebalanced membership
Children in a Psychiatric Mental Institute (PMIC)
Children's Mental Health HCBS Waiver
LTSS blended with actual membership mix
LTSS blended with 3.0% rebalanced membership

Population


$255.36
Wellness Plan 25-34 F
$4539.37
Non-Expansion Adult 21-34 F
Hawk-i
$184.17
Non-Dual <21 M&F
$2320.73

PMPM

Amerigroup

United

AmeriHealth -Caritas

Provider Networks

Amerigroup

$$$$$$$$$

United

$$$$$$$$$

AmeriHealth - Caritas

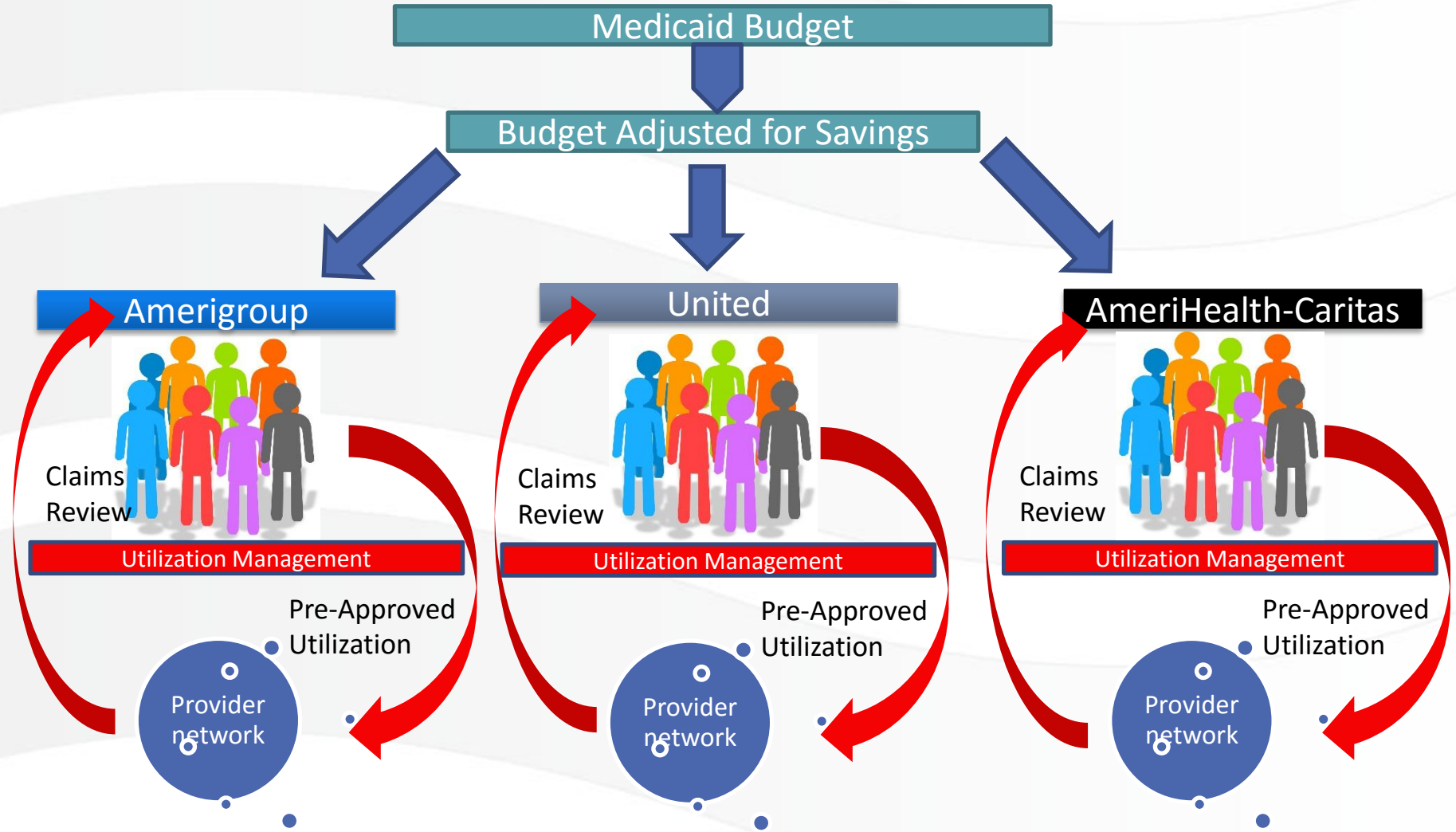
$$$$$$$$$

Provider network

Provider network

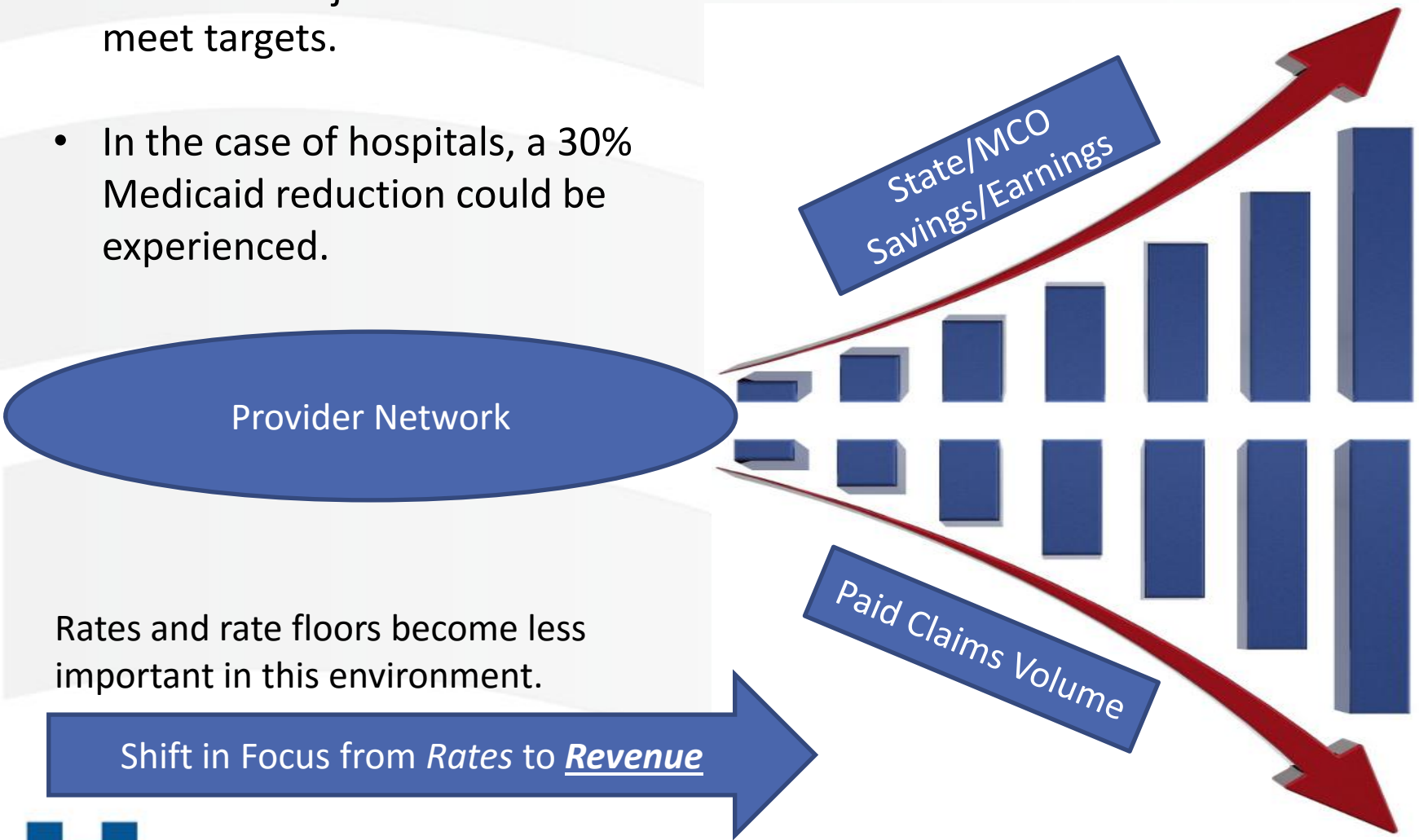
Provider network

Capitation


Medicaid Budget
Budget Adjusted for Savings
Amerigroup
Claims Review
Utilization Management
Pre-Approved Utilization
Provider network
United
Claims Review
Utilization Management
Pre-Approved Utilization
Provider network
AmeriHealth-Caritas
Claims Review
Utilization Management
Pre-Approved Utilization
Provider network

PMPM Calculations

- MCOs will adjust utilization to meet targets.
- In the case of hospitals, a 30% Medicaid reduction could be experienced.



Rates and rate floors become less important in this environment.

Shift in Focus from *Rates* to ***Revenue***

Impact

- Capitation rates were developed with pre-calculated reductions to utilization.
  - Savings to state are immediate.
  - Results in less money to pay providers than before.
  - Utilization will be managed to reach/exceed cost targets.
  - Payment rates will also be managed.
- Demand for service is not likely to decrease
  - Reimbursed utilization will decrease.
  - Revenues will decrease
  - Uncompensated care likely to increase

Oversight

Managed Care Oversight

Included in HHS Appropriations bill

- Governor Can Line-Item Veto

Included:

- Set Hospital Payment Rates Floors at Rates in Effect as of June 30, 2016.
- Requires Data Reporting by MCOs to State

Not included:

- Cost settlement for CAHs
- 365 day claim submission (now at 180 days)

Oversight

Information must be published on IA Health Link Website

Annual summaries to DHS from:

- DHS Council
- MAAC
- Ombudsman

Continuation of Health Policy committee

- 10 Legislative Members
- Meets 2x Annually
- Makes Recommendations

Continuation of monthly stakeholder meetings throughout 2017

Data Reporting -Consumer Protection

- Member enrollment and disenrollment
- Grievances and appeals (member): timely resolution and number
- Call center information
- Prior Authorizations (% and timely processing)
- Provider Network Adequacy (gaps in network)
- Case management ratios
- HCBS waiver #s and waiting list #s
- Level of care assessments (# and timeliness)

Data Reporting MCOs

Claims processing

- Percentage of claims paid, denied, disputed
- 10 most common reasons for denials
- Timely adjudication
- Encounter data (timeliness, completeness, accuracy)
- VBP (% of members covered by VBP)
- Financial Information (Cap rates, MLR, admin loss ratio, underwriting ratio, program cost savings)
- Utilization by DRG, APC, and total claims volume
- Value Added services and utilization
- Claims paid by provider type

Data Reporting MCOs

Health outcomes

- HEDIS performance
- VIS performance
- Consumer assessment of health care providers and systems performance
- Consumer satisfaction survey

Utilization Information

- Inpatient hospital admissions and potential preventative admissions
- Readmissions
- Outpatient visits
- ED visits and potential preventative ED visits

Data Reporting MCOs

- Fraud, waste and abuse identified by MCO
- Enrollment and payment info. (eligibility and 3rd party liability)
- MCO financial reserves
- Insurance Division Report
- External quality reviews submitted to GA and governor
- Accreditation evaluation report from NCQA

Federal Medicaid Managed Care Rules

- Final Rule Released
- Major provisions
  - Beneficiary support and information
  - Enrollment and disenrollment
  - Provider network adequacy and access to care
  - Managed long-term services and supports
  - Appeals
  - Capitation rate-setting
  - Quality of care
  - State monitoring
  - Program integrity

- Final rule will determine what aspects of Iowa's plan will need to be restructured to comply with these new federal requirements.

Next Steps…

IHA Engagement

- Medicaid Payment Policy Workgroup
  - 1st Meeting April 12
    - 80+ Iowa Hospital Representatives
    - Iowa Medicaid
    - MCOs
- Technical Advisory Group
  - Subset of Policy Workgroup
  - MCOs