Federal and State Legislative Update

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Federal Issue Update

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SGR Fix

SGR Formula Permanently Repealed

- $200 Billion (10 Years)
- Higher cost-sharing for high income Medicare beneficiaries
- Deductibles for supplemental Medicare plans
- Scheduled 2018 hospital rate increase of 3.2% partially implemented over 6 years
- Caps post-acute 2018 market basket to 1%
- $141 Billion Unfunded

SGR Fix:

Includes:

- 2-year extension of low volume and Medicare Dependent Hospital payments
- 2-year extension of ambulance add-ons
- 2-year extension of therapy cap exception
- 2-year extension of CHIP

SGR Fix:

Did Not Include:

- Fix for 96-hour rule
- Correction of direct supervision of outpatient therapeutic services policy
- Extension of Rural Community Hospital Demonstration
- RAC reforms

But Avoided-

- Site-neutral cuts or CAH payment changes as pay-fors
- Cuts to bad debt
- Cuts to GME
- ICD-10 implementation delay

Two-Midnight/Short Stay Policy

IHA/AHA submitted comments on:

- A new short-stay payment methodology
- Opposition to the two-midnight policy

Not addressed in IPPS Final Rule

MedPAC recommended complete removal of two-midnight policy and RAC reforms in April

Enforcement delay expires ***May 1, 2015***

6-Month extension of probe and educate contained in SGR fix

State Issue Update

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Hospital Operations

Payment for Prisoner Treatment (HF 528)	• Clarifies Existing Code Responsibilities • Clarifies Exchange of Custody
CANDOR – Adverse Outcome Discussions (SF 426)	• Allows for Candid Conversations • Agreed to by Medical Community, Trial Lawyers
Polysomnographer Licensing (HF 203)	• Prevents Dual Licensure for RTs • May Increase Overall Licensure Fees 120%
Iowa Health Information Network (HF 381)	• Movement to private sector in 2016 • IHA opposes mandatory use, fees
AARP CARE Legislation (SF 465)	• Being debated in states throughout nation • Hospitals would train caregivers upon discharge

Medicaid Rebasing

Core Message: Fund Hospital Medicaid Rebasing at $6.5 Million

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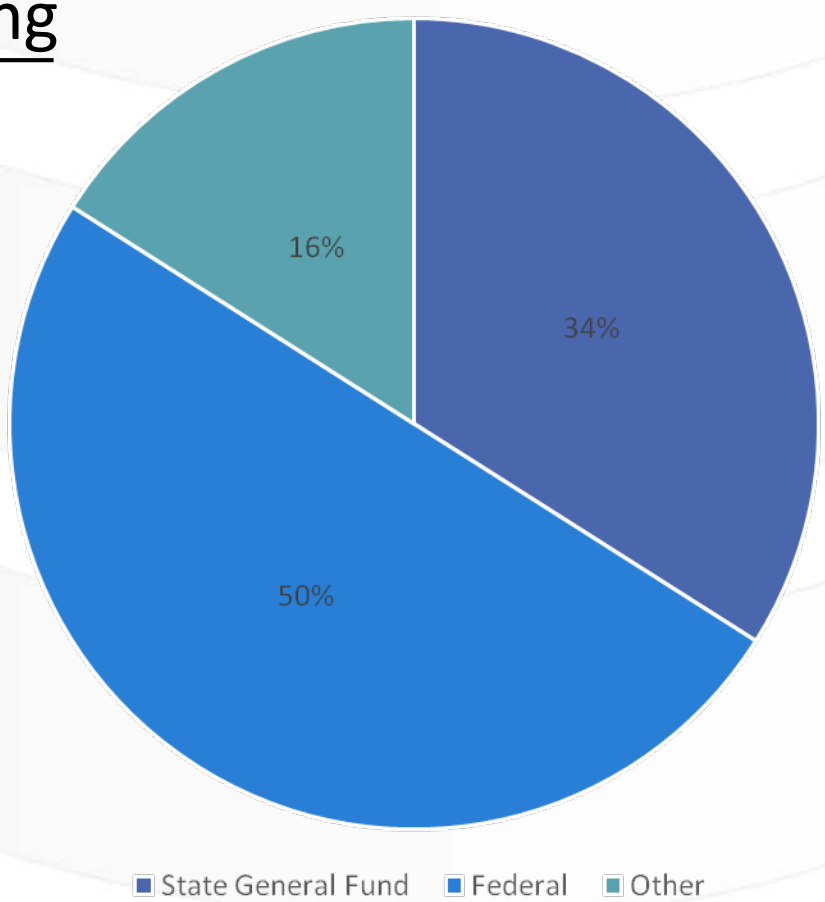
SFY 2016 DHS Budget Proposal

$2.05 Billion – State Funding

\+ $2.06 Billion – Federal Funding

$4.11 Billion Total Request

14% increase ($171 million) in State Funding from FY 2015



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Medicaid Budget Request

SFY15 - SFY17 Revenue and Expenditure Estimates

SFY15 – SFY17 Budget Assumptions			
	SFY15	SFY16	SFY17
State Revenue	$1,499,448,072	$1,497,025,377	$1,497,025,377
State Expenditures	$1,547,988,682	$1,667,802,212	$1,753,148,419
Ending Balance	($48,540,610)	($170,776,835)	($256,123,042)

- Note: Budget estimates will change due to publication of the final FY 2016 FMAP.

SFY16 Medicaid Request

SFY16 Request	$170.8M
SFY15 Unfunded Need	$48.5M
FMAP Changes	$73.4M
State Revenue Changes	$2.4M
Growth (Enrollment, Costs, Etc…)	**$46.5M**
Projected SFY15 Spending	$1,548M
Projected SFY16 Growth	$46.5M
Percent Change	3.0%

Rebasing

Hospital Rebasing

- Occurs Every 3 Years
- Postponed From 2015
- $6.5 Million State Cost

Home Health "Rebasing"

- Increases Tied to Medicare (LUPA)
- Promised in 2013
- $3.9 Million State Cost

Nursing Home Rebasing

- Occurs Every 2 Years
- Increases Bed Tax
- $32 Million State Cost

Related Issues

Governor Included Rebasing in FY 2016 Budget Proposal

- However, Governor also included moving Iowa Medicaid to managed care (saving $100 million annually)
- Likely means this would be last opportunity for rebasing/payment increases
- Unknown relationship with ACO development, Hospital Provider Assessment, etc.

Medicaid Managed Care

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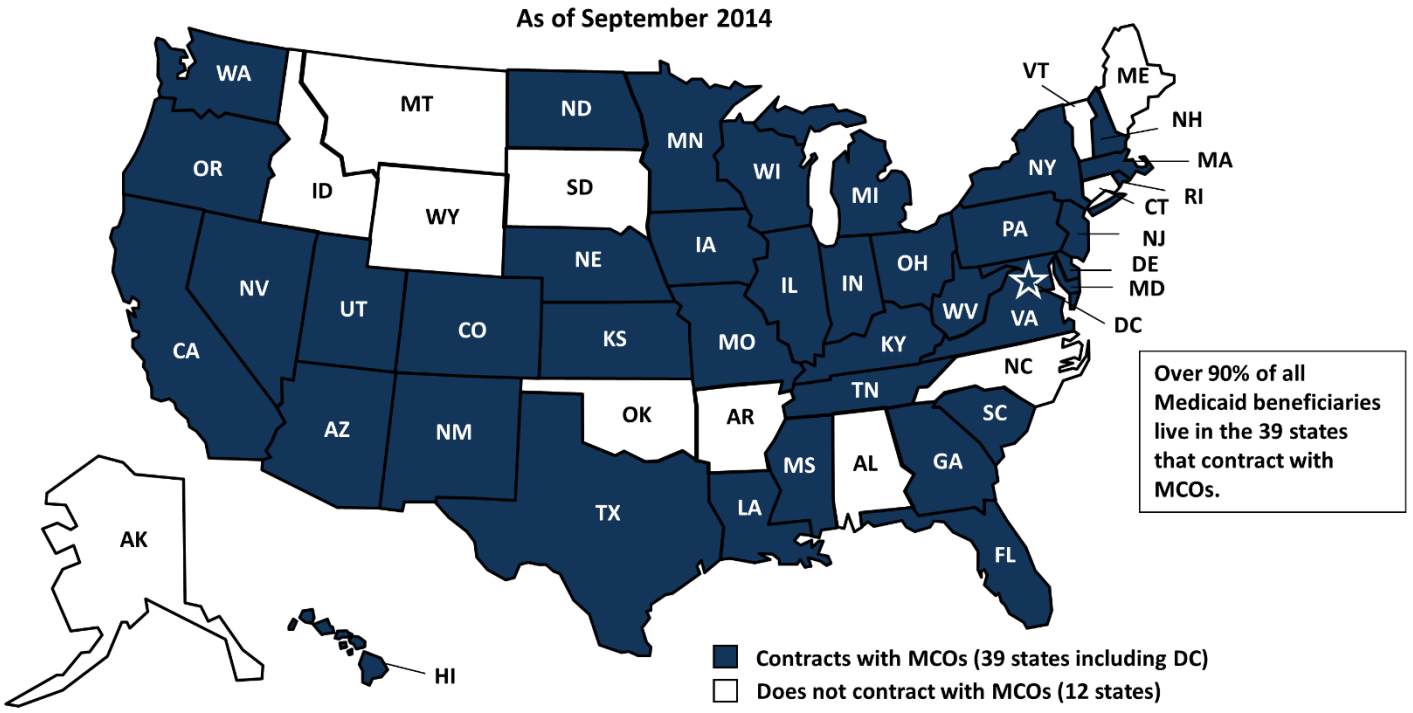
Medicaid Managed Care

- Provides for the delivery of:
  - Medicaid health benefits
  - Additional services
- Uses contracted arrangements between state Medicaid agencies and managed care organizations (MCOs)
- Accept a set per member per month (capitation) payment for these services (risk-based)

Managed Care is Widespread

39 state Medicaid programs contract with comprehensive MCOs.



SOURCE: KFF Medicaid Managed Care Market Tracker

THE HENRY J. KAISER FAMILY FOUNDATION

Existing Managed Care in Iowa

- MediPASS
  - Meridian Health Plan, the state's lone Medicaid MCO, had around 41,000 individuals enrolled across 23 counties as of early 2014.
- Magellan Behavioral Health
  - 90,000 Iowans enrolled for Behavioral Health Services
- Iowa Wellness Plan
  - Not full-managed care but uses similar approach (PCP assignment, PMPM payments)
  - 108,000 enrollees

Estimates

Eligibility	Enrollees (Estimated)	Annual Spending (Estimated)	PMPM (Estimated)
Adults/Children	412,500	$923,571,000	$187
Aged/Disabled	110,000	$2,377,709,000	$1,801
Foster Care	11,000	$72,933,000	$553
Other/Unknown	16,500	$125,787,000	$635
Total Managed Care Population	**550,000**	**$3,500,000,000**	**$530**

Source: HMA estimates based on federal spending data by category of eligibility

Assuming an even distribution across health plans, an awarded contract in Iowa under this RFP could equate to 137,500 to 275,000 in new membership and $875 million to $1.75 billion in annual revenue, depending on whether DHS awards two, three, or four plans.

http://www.healthmanagement.com/assets/Weekly-Roundup/021815-HMA-Roundup.pdf

Background on Iowa

- Award two to four statewide contracts to begin serving Iowa's 570,000 Medicaid beneficiaries in January, 2016
- Iowa has had limited geographic and population penetration of managed care
- Governor Branstad targeting $51 million in savings through managed care in first six months of 2016.

http://www.desmoinesregister.com/story/news/health/2015/01/20/branstad-medicaid-managed-care/22070663

Managed Care Goals

- State Goals:
  - Reduce Medicaid program costs
  - Better manage utilization of health services
  - Improve health plan performance
  - Health care quality outcomes

Request for Proposal Summary

State of Iowa

MED-16-009

Iowa High Quality Healthcare Initiative

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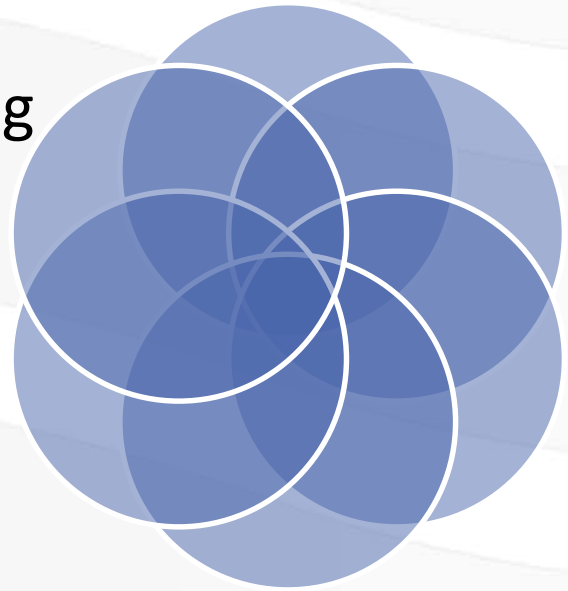
RFP "Themes"

Access to Care/Provider Networks

Quality Reporting

Covered Benefits



Utilization Management

Continuity of Care/Care Coordination

Rate Setting/Capitation

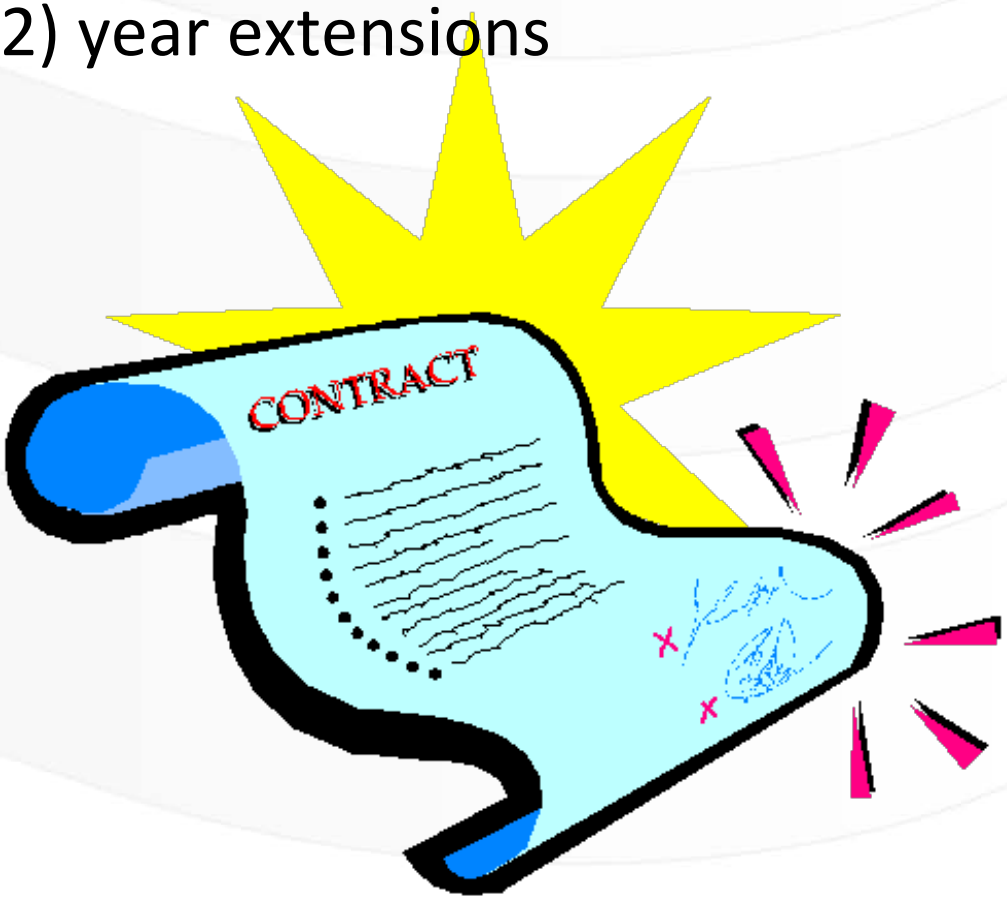
RFP Summary

- Award Contracts to 2-4 MCOs
- Offer Statewide Medicaid managed care contracts
- Begin January 1, 2016.
- 30-day network adequacy requirement following bid awards
- More than $3.5 billion in annual spending.

Timeframe of Contracts

- Contract resulting from RFP process will be for
  - an initial three (3) year term
  - two (2) optional two (2) year extensions

MED-16-009 § 1.1



Organizational Structure

- Must support collection and integration of data across Contractor's delivery system and internal functional units to accurately report Contractor's performance.
- Contractor must have in place sufficient administrative and clinical staff and organizational components to achieve compliance with all Contract requirements and performance standards.

MED-16-009 § 2.8

Covered Populations

- Nearly all Medicaid beneficiaries in Iowa, including:
  - Both expansion and non-expansion populations
  - Dual eligibles
  - Users of long-term supports and services (LTSS) in both nursing facilities and in home
  - Community based (HCBS) settings
  - Foster care populations
  - Behavioral health
  - Substance use disorder services

MED-16-009 § 3.1.1; Exhibit C

Excluded Populations

- Undocumented immigrants receiving temporary coverage
- Retroactive Medicaid eligibility period
- Voluntary enrollments in the Program of All-Inclusive Care for the Elderly (PACE)
- Individuals covered by the Health Insurance Premium Payment (HIPP)
- Persons only eligible for Medicare Savings Program
- Native American populations will have the option to voluntarily enroll in managed care

MED-16-009 § 3.1.1.2

Covered Benefits

- All benefits and services (deemed medically necessary services) are covered under the Contract
  - MCOs cannot:
    - Arbitrarily deny or reduce the amount, duration and scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary.
    - Deny reimbursement of covered services based on the presence of a pre-existing condition

Covered Benefits, cont.

- MCO's may:
  - Place appropriate limits on a service on the basis of medical necessity criteria for the purpose of utilization control, provided the services can reasonably be expected to achieve their purpose.
- MCO's shall:
  - Allow each enrollee to choose his or her health professional to the extent possible and appropriate.

MED-16-009 § 3.2.1

Geographic Coverage/Service Area

- Contractor must submit proposals providing for statewide coverage
- No regional coverage
- Any proposal not offering adequate statewide coverage will not be considered in the bid evaluation process

MED-16-009 § 3.1.3

Rate Setting and Risk Adjustment

- Rates will be risk adjusted for each MCO based on morbidity of their enrolled members relative to all enrolled members every 12 months after the fist six months

MED-16-009 § 2.3.3

Rate Setting and Risk Adjustment

~~MCOs must pay current Medicaid rates for the first six months of the program, negotiated rates after.~~

- **Amendment – MCOs must pay providers at least existing Medicaid rates.**

- DHS will assess MCO performance annually.
  - MCOs with low performance could have patients re-assigned or be assigned fewer patients

Medical Loss Ratio (MLR):

- The RFP indicates that plans will be required to maintain a minimum MLR of 85 percent, with the state retaining the right to recoup a portion of payments from plans not meeting the MLR requirement.

MED-16-009 § 2.7

- ~$600 million in potential earnings for MCOs

Network Adequacy

- Contractor shall maintain a network sufficient to offer members a choice of providers to the extent possible and appropriate

MED-16-009 § 6.2.1

- With the exception of family planning, emergency services and continuity of care requirements, once the Contractor has met the network adequacy standards Contractor may require all of its members to seek covered services from in-network providers

MED-16-009 § 6.2.4

Provider Agreements

- Contractor will establish written agreements with all network providers.
- Under the terms of the provider agreement, the provider must agree that all applicable terms and conditions set out in the RFP, the Contract, any incorporated documents and all applicable state and federal laws, as amended, govern the duties and responsibilities of the provider with regard to the provision of services to members.
- The Contractor must also include in all of its provider agreements provisions
  - to ensure continuation of benefits.
  - the provider's responsibility regarding third party liability, including the provider's obligations to identify third party liability coverage before submitting claims to the Contractor
  - require submission of claims, not involving a third party payer, within ninety (90) days of the date of service.

MED-16-009 § 6.1.2

Provider Agreements

- Contractor is encouraged to into value-based purchasing agreements with its provider network
- Any risk sharing agreements are to be disclosed for any providers paid on a capitated basis the submission of encounter data within ninety (90) days of the date of service.

MED-16-009 § 6.1.2

- MCOs must pay current Medicaid rates for the first six months of the program, negotiated rates after

MED-16-009 § 6.2.2.7

Care Coordination

- Components:
  - Performance of an initial health risk screening
  - Placement of members in a care coordination program based on assessed level of risk
  - Performance of a comprehensive health risk assessment for members identified as having a special health care need
  - Care plan development
  - Reassessment

MED-16-009 § 9.1

Utilization Management

- The Contractor must maintain a UM program that:
  - Identifies over- and under-utilization of emergency room services and other health care services
  - Identify problematic provider practice patterns
    - Especially related to emergency room, inpatient services and drug utilization
  - Evaluate efficiency and appropriateness of service delivery
  - Identify critical quality of care issues.
  - Encourage health literacy and informed health care decisions

MED-16-009 § 11.1.6

Prior Authorization

- PA decisions cannot exceed 7 calendar days after the request for services.
- An extension of up to 14 calendar days is permitted by DHS approval

MED-16-009 § 11.2.7.2.1

- In situations where a provider indicates or the Contractor determines that following the standard timeframe could seriously jeopardize the member's life or health
  - Expedited authorization provides a decision within 3 business days after receipt of the request

MED-16-009 § 11.2.7.2.2

Emergency Services

- Emergency services shall be available twenty-four (24) hours a day, seven (7) days a week
- Contractor must cover emergency services without need for prior authorization
- May not limit reimbursement to in-network providers
- Contractor must cover medical screening examination, provided to a member who presents to an emergency department with an emergency medical condition

MED-16-009 § 3.2.5

Emergency Room Policy

- Required to reimburse providers for the screening examination,
  - **Not required to reimburse for non-emergency services not meeting "Prudent layperson" standard**
- May not limit what an emergency medical condition by lists of diagnoses or symptoms
- May not deny or pay less than allowed amount for the Current Procedural Terminology (CPT) code without medical record review to determine if prudent layperson standard was met

MED-16-009 § 3.2.5.1

Emergency Room Policy, cont.

- Contractor shall base coverage decisions for emergency services on severity of the symptoms at time of presentation
- Shall cover emergency services where presenting symptoms are of sufficient severity to constitute an emergency in the judgment of a prudent layperson, even if condition turned out to be non-emergency in nature

MED-16-009 § 3.2.5.1

Emergency Room Policy

- Prudent layperson review must be conducted by Contractor staff who does not have medical training
- Contractor shall not impose restrictions on coverage of emergency services more restrictive than those permitted by the prudent layperson standard
- **Contractor may not refuse to cover emergency services based on the emergency room provider or hospital failing to notify the Contractor or primary care provider within ten (10) calendar days of presentation for emergency services**

MED-16-009 § 3.2.5.1

Emergency Room Policy

- Contractor must demonstrate management of ER utilization:
  - methods for providers or Contractor representatives to respond to all emergency room providers 24/7 **within one hour;**
  - methods to track notification to Contractor of member's presentation for emergency services
  - methods to document a member's primary care provider (PCP) referral to the emergency room and pay claims accordingly

MED-16-009 § 3.2.5.5

Quality Programs

- Contractor accountable for improving quality outcomes and developing a program that incorporates ongoing review
  - MCOs will develop incentive programs for both providers and members, with the ultimate goal of improving member health outcomes.

Concerns:

- Lays out a “status quo” managed care program
- Designed around capitated, fee-for-service (FFS) payment system
- Shows few signs of innovation
- No alignment with other payment and delivery system reform models that are currently underway
  - The State Innovation Model
  - The Iowa Health and Wellness Plan
  - Hospital Engagement Network

Contractor Requirements

Letters of Intent

- Aetna Better Health of Iowa Inc.
- Amerigroup Corporation (Anthem BCBS)
- AmeriHealth Caritas Iowa
- CHA HMO, Inc. (Humana)
- Cigna HealthSpring
- Gateway Health Plan, LP
- Goold Health Systems (Emdeon)
- Health Information Designs
- Iowa Total Care, Inc. (Centene)
- Magellan Complete Care of Iowa, Inc
- Medica Health Plans
- Meridian Health Plan
- Molina Healthcare, Inc
- MultiPlan
- Shared Health
- UnitedHealthcare Plan of the River Valley, Inc.
- UnityPoint Health
- WellCare Health Plans, Inc.

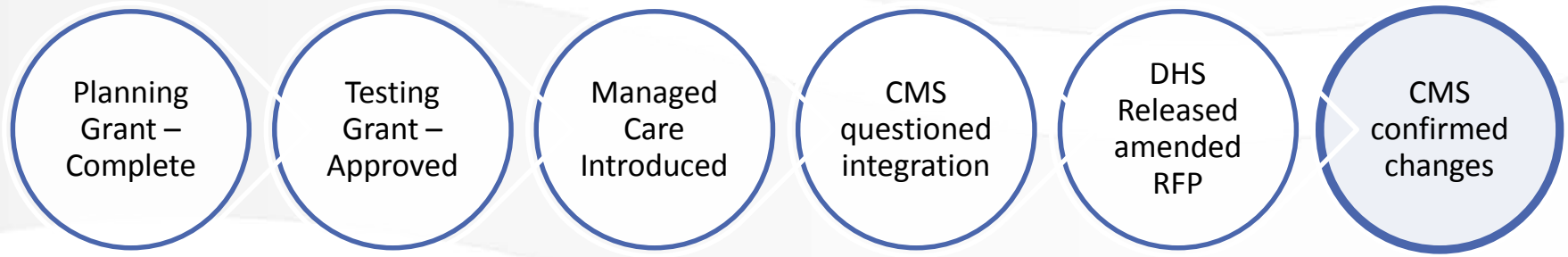
Contractor Pay for Performance

- DHS withholds a portion of the approved capitation payments from MCOs.
- In the first year of the Contract, the withheld amount shall be two percent (2%).
- The MCO may be eligible to receive some or all of the withheld funds based on the Contractor's performance.

Performance Measure	Required Contractual Standard	Standard Required to Receive Incentive Payment	Amount of Performance Withhold at Risk
Timely Claims Processing	90% of clean claims within 14 ~~20~~ days 99.5% ~~99%~~ of clean claims within 20 ~~60~~ days 100% of all claims within 90 days	100% clean claims within 14 ~~20~~ days	20%
Prior Authorization Processing	100% of PA within 7 calendar days and 3 days for expedited and 100% of pharmacy PA within 24 hours	100% of PAs within 4 calendar days and 2 business days for expedited and 100% of pharmacy PA within 12 hours of the request for service	20%
Provider Network	PCP w/i 30 miles/minutes; behavioral health provider w/i 30 miles/minutes; Contract with 2 HCBS providers per county for HCBS waiver populations.	Within 6 months, PCP w/i 20 miles/minutes, behavioral health provider w/i 20 miles/minutes; Contract with 3 HCBS providers per county for HCBS waiver populations	20%

Performance Measure	Required Contractual Standard	Standard Required to Receive Incentive Payment	Amount of Performance Withhold at Risk
Completion of Initial Health Screening	Each quarter, at least 70% of the Contractor's new members, who have been assigned to the Contractor for a continuous period of at least 90 days, shall complete an initial health risk screening within 90 days.	**Completion Screening %** 73-76% = 25% performance bonus 76-79% = 50% performance bonus 79-100% = 100% performance bonus	20%
Provider Credentialing	Credentialing of all providers applying for network provider status shall be completed as follows: 90% within 30 calendar days 100% within 45 calendar days	**Contractor completes:** 90% within 20 calendar days and 100% within 30 calendar days.	20%

State Innovation Model



SIM Components in Original RFP

- Value Index Score

SIM Components in Amended RFP

- Patient Assignment
- Value-Based Purchasing/Contracting
- Added "SIM" Liaison staff position required by MCOs

Areas Not Addressed by the RFP

- Oversight
  - Legislative attempts have failed
- Patient Enrollment and Assignment
  - 3rd edit included req. that patients under a risk-based arrangement will be required to have PCP assignment.
- Reimbursement
  - IME/GME?
  - DSH?
  - Provider Assessment (hospital, nursing home)?
  - Other UPL/IGT programs?

Areas Not Addressed by the RFP

- Standardization/Alignment
  - Provider Credentialing Alignment
  - Standard Claims form
  - Utilization Management and Prior Authorization
  - Quality Measurement/Incentives
  - Denials and Appeals
  - Safeguards: i.e. MCOs ready to contract but haven't released provider manuals; network adequacy not met, etc.

State Innovation Model

- Appears to be moving forward.
  - $42 million in federal money
- Carving out various pieces of the SIM that could interact with MCOs.
  - Care Coordination
  - Behavioral Health/Long-term care integration
  - Integration of waiver programs
  - Health risk assessment
  - Healthy behaviors programs
  - Patient assignment
  - Incentive payments to providers
  - ACO development (risk/value-based contracting)

Timeline

Timeline	Date
RFP Released	February 16, 2015
Bidder Comments on RFP Due	February 25, 2015
Capitation Rate Data Book	March 10, 2015
Letter of Intent to Bid Due	March 11, 2015
First Round Questions Due	March 11, 2015
First Round Answers Posted	March 26, 2015
Second Round Questions Due	April 2, 2015
Second Round Answers Posted	April 10, 2015
Capitation Rates Released	April 13, 2015
Proposals Due	**May 8, 2015**
Notice of Intent to Award	**July 31, 2015**
Implementation	**January 1, 2016**

Concerns:

- Broadly, IHA is disappointed that the RFP
  - Lays out a “status quo” managed care program
  - Designed around a capitated, fee-for-service (FFS) payment system
  - Shows few signs of innovation

Questions?

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