Paul Leary, Medicaid Benefits Administrator
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August 22, 2011

STATUS REPORT
HOUSE BILL 260

HB 260 STATUS REPORT

- Change Pharmacy Reimbursement Methodology to Average Acquisition Cost and tiered dispensing fee
  - Generics implemented 7/5/11
  - Single source drugs reimbursement change to Average Actual Acquisition Cost (AAC) targeted for 10/1/11
  - Tiered dispensing fee to implement with AAC
  - Projected general fund savings $2,000,000

HB 260 STATUS REPORT

- Reduce adult PSR to 4 hrs/week
  - Implemented 7/1/11
  - Projected general fund savings $2,270,000
- Management tool for PSR
  - Quality assurance work performed by Mental Health Care management staff incorporated the use of the LOCUS/CALOCUS beginning 7/1/11 to further enhance the overall management of PSR service usage
  - Subsequent routine reporting will focus on appropriate and inappropriate service usage

HB 260 STATUS REPORT

- Adult DD budgets – Adjust for health and safety only
  - Implemented 4/1/11
  - Projected general fund savings $2,000,000
- Blended Rate for adult Developmentally Disabled Group and Individual Therapy
  - Implemented 7/1/11
  - Projected general fund savings $1,100,000

HB 260 STATUS REPORT

- No rate increases for SFY 2012
  - Implemented 7/1/11
  - Projected general fund savings $4,700,000
- Set reimbursement at 90% of Medicare for non-Primary Care Procedures
  - Implemented 7/1/11
  - Projected general fund savings $1,500,000
- Eliminate Audiology Services for Adults
  - Implemented 7/1/11
  - Projected general fund savings $70,000

HB 260 STATUS REPORT

- Align PT, OT and Speech with Medicare Caps
  - Implementation 1/1/12
  - Projected general fund savings $200,000
- Reduce Outpatient Hospital – PT, OT and Speech to 90% of Medicare
  - Implemented 7/1/11
  - Projected general fund savings $300,000

HB 260 STATUS REPORT

- Reduce Adult Dental Benefit reduced to medically necessary oral surgery and palliative services
  - Implemented 7/1/11
  - Agreed on codes to be included with Idaho State Dental Association
  - Projected general fund savings $1,700,000

HB 260 STATUS REPORT

- Reduce Chiropractic coverage to 6 visits per year
  - Implemented 7/1/11
  - Projected general fund savings $200,000
- Limit adult Podiatry service and Optometry services based on chronic care criteria
  - Implemented 7/1/11
  - Projected general fund savings $800,000
- Worked with professional associations on implementation

HB 260 STATUS REPORT

- Establish co-payments – chiropractic visits, podiatrist visits, optometrist visits, physical therapy visits, occupational therapy visits, speech therapy visits, outpatient hospital visits and physician office visits
  - Implementation 11/1/11 chiropractic, optometry and podiatry – the remainder will be implemented 1/1/12 (significant system requirements)
  - Projected general fund savings $750,000

HB 260 STATUS REPORT

- Rule authority to make HB 701 changes permanent
  - Continued from SFY 2011
  - Projected general fund savings $6,940,000
    - Move primary care management fee to tiered payment
    - Eliminate payment for collateral contact
    - Eliminate duplicative skill training
    - Restrict Partial Care to diagnosis of severe and persistent mental illness
    - Eliminate personal care service coordination
    - Eliminate supportive counseling
    - Reduce annual assessment hours
    - Reduce plan development hours
    - Eliminate requirement for annual plans
    - Reduce plan and assessment administrative requirements

HB 260 STATUS REPORT

- Move individuals from institution to community – Money Follows the Person grant
  - Implementation 10/1/11
  - Projected general fund savings $1,300,000
- Implement claims payment edits to avoid paying for duplicative services (NCCI)
  - Implemented 7/1/11
  - Projected general fund savings $50,000

HB 260 STATUS REPORT

- Initiate application/certification fees for CFHs
  - Implemented 7/1/11
  - Projected general fund savings $294,000
- 8 additional Medicaid Integrity staff
  - Initiated hiring 7/1/11 will have all hired by 10/1/11
  - Projected general fund savings $1,100,000

HB 260 STATUS REPORT

- Add to Hospital Assessment
  - Implementation 6/30/12
  - Projected general fund savings $3,500,000
- Add to Nursing Home Assessment
  - Implemented 12/31/11
  - Projected general fund savings $3,500,000
- New ICF/ID Assessment
  - Implemented 12/31/11
  - Projected general fund savings $500,000

HB 260 REPORT – Managed Care

56-261: Medicaid Cost Containment and Health Care Improvement Act:

- identifies the current health care delivery system of payment to Medicaid health care providers on a fee-for-service basis fails to provide the appropriate incentives and
- can be improved by incorporating managed care tools, including capitation and selective contracting, with the objective of moving toward an accountable care system that results in improved health outcomes.

HB 260 REPORT – Managed Care

56-263: Medicaid Managed Care Plan

- Directs the Department to present to next year's legislature a plan for Medicaid managed care with focus on high-cost populations
- Requires that the plan include certain elements:
  - Improved care coordination through medical homes
  - Improved coordination & case management of high-risk, high-cost adults
  - Managed care for behavioral health benefits
  - Elimination of practices that result in unnecessary utilization and costs
  - Contracts based on gain sharing, risk-sharing or a capitated basis

HB 260 REPORT – Managed Care

HB 341 Section 24 DHW Appropriations Bill

Directs Medicaid to:

- complete an actuarial analysis of all Medicaid plans by population, subgroup and region before November 1, 2011
- Provide a copy of the actuarial report to DFM and LSO by December 1, 2011 and
- Provide the report with recommendations for the next phases for implementation of managed care to JFAC during the 2012 session.

HB 260 REPORT – Managed Care

Status of activities as of August 2011:

Amended existing actuarial contract.

- All adults and children enrolled in Medicaid by Plan type
- All costs by county
- Subgroup of CHIP costs
- Subgroup of Dual eligibles costs
- By risk factors such as chronic diseases

HB 260 REPORT – Managed Care

Status of activities as of August 2011:

Improve Care Coordination through Medical Homes

- Participating in the Governor's Multi-Payer Medical Home Collaborative. Planned pilots will seek to determine if a change in payment method to primary care practices will result in improved health outcomes and reduced utilization of ED and hospital admissions
- Hiring project support staff funded through Medicaid appropriation to support practices and assist with developing a framework for monitoring outcomes
- Aligning work with definitions with the Medicaid "Health Home" State Plan which provides enhanced 90/10 match for the capitation payment

HB 260 REPORT – Managed Care

Status of activities as of August 2011:

Establish managed care for behavioral health benefits.

- Initiated a Request for Information – received six responses from health plans
- Scheduled a Public Forum on August 30th to engage a panel of mental health experts to obtain advice on desired Idaho requirements for a Request for Proposal. As part of this effort, we have a established a web site that includes our RFI, FAQs, educational material on managed care and an avenue for the public to submit questions and suggestions.
- Planning underway to develop a timeline for implementing managed care beginning with Medicaid mental health with a second phase of Medicaid substance abuse benefits.

HB 260 REPORT – Managed Care

Status of activities as of August 2011:

Exploring opportunities to further develop managed care for the dual eligibles.

- Reviewing a technical assistance opportunity from CMS to pilot new financing models to improve system integration, Medicare & Medicaid benefit coordination, and payment reform to improve health outcomes.
- This sub group of Medicaid enrollees is on the radar of most Medicaid states because they are the highest cost population, less mobile, most stable enrollment and provides a better opportunity to reduce costs.
- Will be engaging stakeholders including Medicare Advantage Plans to discuss how Idaho might develop an improved approach.

HB 260 REPORT – Managed Care

Next steps:

- Schedule a public forum and invite health care delivery system stakeholders for a panel discussion to obtain advice on how best to implement managed care in Idaho. Panel participants will include representatives from hospitals, physicians, nursing homes, community-based services, safety-net providers, and others.
- Target October/November.

HB 260 REPORT – Managed Care

Next Steps:

- Monitor other State Medicaid managed care initiatives. Participate in upcoming national dialogue with other State Medicaid Directors on the next phases of managed care and accountable care organizations.
- Invite other State Medicaid managed care experts to Idaho to share best practices and lessons learned. Target October/November

HB 260 REPORT – Managed Care

Report will be delivered according to legislative requirements and will include:

- Actuarial analysis results,
- Summary of 2012 activities regarding development, and
- Recommendations.

Questions?

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Thank you!