

Alabama Medicaid Regional Care Organizations

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AGENDA

- Legislative History of RCOs
- 2013 Legislation – What’s in the Law?
- 2014 Legislation – What’s in the Law?
- 1115 Waiver History
- RCO Concepts and Implementation
- Populations
- Services Provided by RCOs
- Effecting Change
- What is Different?
- FY 2017 Medicaid Budget - RCOs



Legislative History of RCOs



Legislative History of RCOs

***Fall 2012
Medicaid
Advisory
Commission***

***Legislation
2013***

***Legislation
2014***



Medicaid Advisory Commission

October 2012 – January 2013

- Commission Members: Legislators, Physicians, Hospitals, Pharmacists, Nursing Homes, State Agencies, Advocacy Groups, Managed Care Organizations, and Others
- Charged with evaluating the financial structure of Medicaid and recommending ways to increase efficiency while also improving patient care
- Other State Medicaid Agencies and Commercial Managed Care Organizations made presentations
- Final recommendations made to Governor Bentley on January 31, 2013. Report can be found at www.Medicaid.Alabama.gov



2013 Legislation – What's in the Law?



2013 Legislation – What's in the Law?

Alabama Code §§ 22-6-150 through 22-6-165

Initial law enacted during 2013 legislative session

- Anti-trust/Collaboration requirements
- Requires capitated payments pursuant to a risk contract
- Board composition outlined
 - *12 risk bearing positions (investment required)*
 - *8 non-risk bearing positions (no investment)*
- Any willing provider
- Minimum reimbursement level established
- Quality Assurance Committee
- Describes process for achieving probationary and full RCO certification
- Timeline for implementation established



Timeline for Implementation

10/1/13 – Medicaid established RCO **regions**

10/1/14 – RCO **governing boards** approved by Medicaid

4/1/15 – RCOs proved they have the ability to form an
adequate provider network

10/1/15 – RCO met **solvency requirements**

10/1/16* – RCO must begin to provide services under an
executed risk bearing contract

***RCO law has been amended allowing the delay of this
date.**



Probationary Certification Process

For an entity to achieve probationary certification, an application had to be submitted by September 30, 2014, for a January 1, 2015, effective date.

The applicants were required to meet the following requirements:

- Must be incorporated as a non-profit corporation
- Governing Board must be approved by Medicaid that meets the requirements of the law and regulations
- Medicaid must approve the board composition, the board structure, powers, by-laws, and other rules of procedure and amendments
- Must have Citizen's Advisory Committee

By January 1, 2015, the Medicaid Agency awarded probationary certification to 11 organizations in 5 regions of the State.

Probationary certification does not assure that an organization will be granted full certification.



Full Certification Process

For an entity to receive full certification, they must meet the following requirements:

- The applicant must have a probationary certificate to apply
- The applicant must have an adequate service delivery network and meet the solvency and financial requirements
- The applicant must demonstrate the ability to meet all of the requirements pursuant to a risk contract and pass all readiness review assessments
- The entity must submit an application to receive full certification



2014 Legislation – What's in the Law?



2014 Legislation – What’s in the Law?

Alabama Code §§ 22-6-151, 22-6-153, 22-6-155, 22-6-163, and 22-6-164

2014 legislation made some adjustments to the following:

- Board voting requirements modified
- Allows formation of board executive committee
- Provider grievance and appeal provisions enhanced



1115 Waiver History



1115 Waiver History

**Determining
Federal
Strategy**

**1115 Waiver
Submitted
May 30, 2014**

**5 in-person
visits with CMS
1-2 CMS
conference
calls per week
NGA Policy
Academy**

**1115 Waiver
Approval –
\$748 million
February 9,
2016**



Budget Neutrality

- CMS requires the expected cost of providing services **with the Waiver** does not exceed the cost **without the Waiver**.
- The difference between the **with the Waiver** and **without the Waiver** costs represents the savings expected from implementation of the Waiver.
- The **without** Waiver projections are based on historical cost. **The methodology is specified by CMS.**
- Pharmacy services for the covered populations are included in the Waiver budget neutrality; however, they are not included in the amounts to be paid to the RCOs. Therefore, no savings are included in the budget neutrality associated with pharmacy services.



CMS Budget Neutrality Calculations

- The final CMS approved 1115 Waiver reflects the following **Without Waiver*** cost, **With Waiver** cost and savings:

	April '16 – Mar '17	April '17 – Mar '18	April '18 – Mar '19	April '19 – Mar '20	April '20 – Mar '21	Total
Waiver Summary – Savings**						
Without Waiver Total Expenditures	\$3,286	\$3,437	\$3,596	\$3,763	\$3,938	\$18,019
With Waiver Total Expenditures	\$3,132	\$3,244	\$3,302	\$3,390	\$3,496	\$16,565
Estimated Savings	\$154	\$193	\$294	\$373	\$442	\$1,454

*Without Waiver projections are based on CMS methodology.

**Dollars in millions. Note these are total dollars not State share dollars.

Failure to achieve financial goals of the Waiver could result in payback of federal funds.

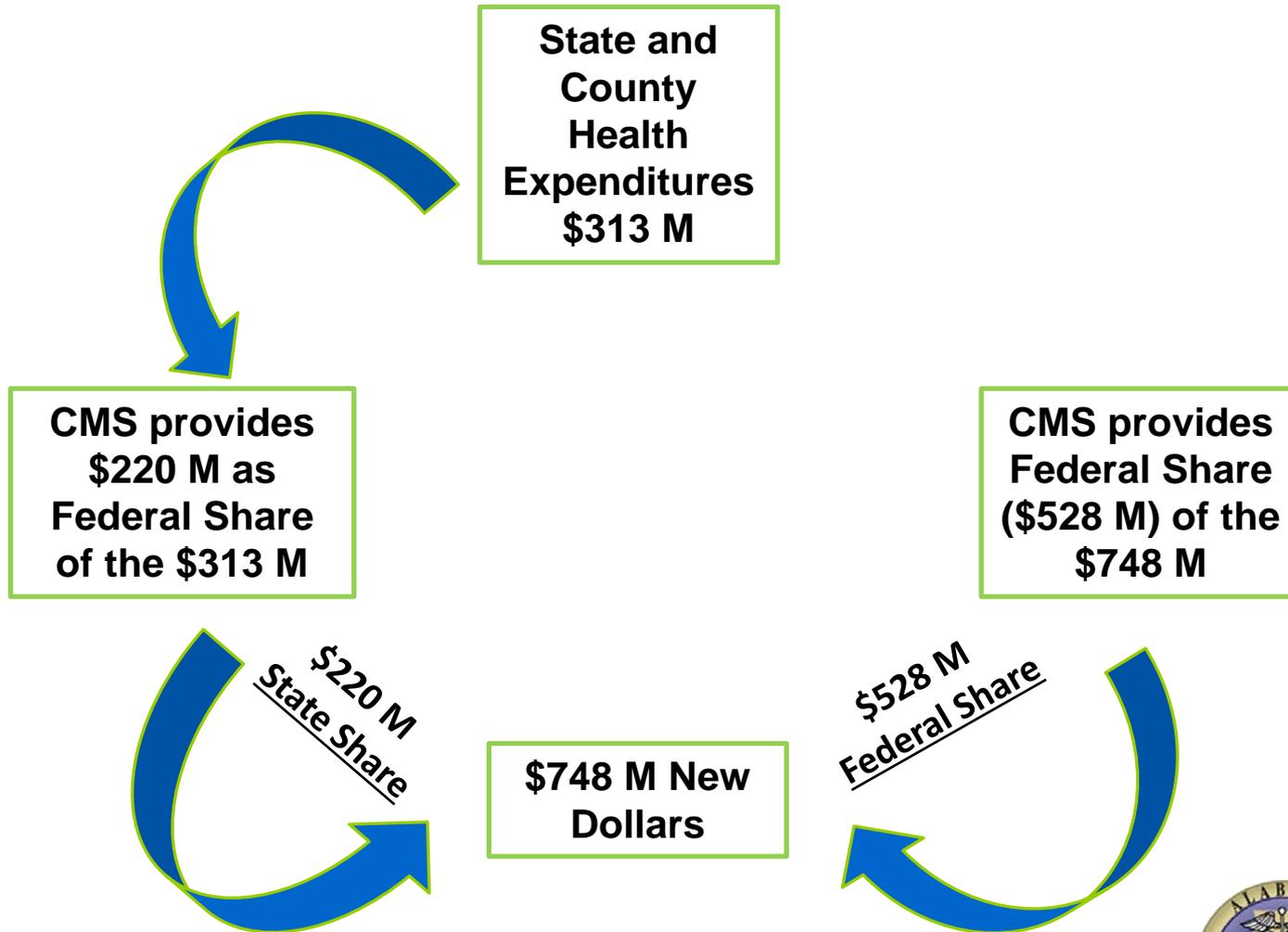


How do we obtain the \$748 million?

- **Designated State Health Programs (DSHP) funds:** Represents \$313 million dollars currently being spent by the State or Local governments on Medicaid-like programs:
 - Includes health programs which are not matched by Federal Funds.
 - CMS approved these programs as matchable under the Waiver and will provide the Federal match.
 - In accordance with CMS approval, Medicaid will use the State dollars freed up by the new Federal match to fund the State share of the additional expenditures provided by the Waiver.



Waiver Fund Flow Process



Final Waiver Funds vs Previous Requests

	DY 1	DY 2	DY 3	DY 4	DY 5	Total
Final Approved Waiver	\$213	\$213	\$162	\$112	\$48	\$748
Original May 2014 Request	\$125	\$125	\$125	\$125	\$125	\$626
March 2015 Request	\$213	\$213	\$213	\$213	\$213	\$1,065

*Dollars in millions. Note these are total dollars not State Share dollars.

- Original request – the State revised the request in January 2015 to exclude pharmacy and shift Waiver start date from October 2014 to October 2015.
- Final approved Waiver – CMS reduced Waiver Funds in the last three years of the Waiver to position the State for sustainability without dependence on supplemental funds.



What is the State required to do to receive the Waiver Funds?

Continued receipt of the \$313 million of DSHP funding (which makes the \$748 million possible) is dependent upon achievement of specific targets:

- **DY 1:** \$89.2 million for the initiation of the Waiver.
- **DY 2:** \$89.2 million dependent on having a contract with an RCO in every Region in DY 1.
- **DY 3:** \$67.4 million is dependent on implementing APR-DRGs in DY 2.
- **DY 4:** \$47 million dependent on increasing well child and adolescent visits in DY 3.
- **DY 5:** \$20 million is dependent on reducing hospital admissions that could have been handled in the office and increasing prenatal visits in DY 4.

Note that DSHP funding provides the State Share for all Waiver Funds (the \$748 million).

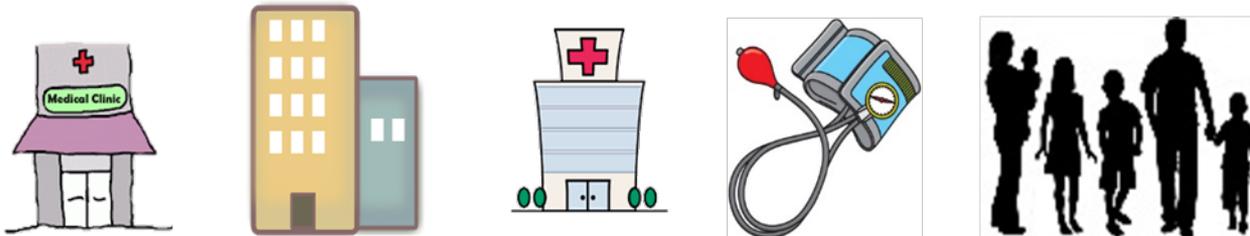


RCO Concepts and Implementation



RCO Key Concepts

- RCOs are **provider-led** managed care organizations that will receive an established **per member per month** fee (capitation payment) from the State to **coordinate care and pay** providers for covered services for most Medicaid recipients.
- Provider-led managed care was a key strategy in achieving 1115 Waiver approval.



Fully-certified RCOs will be at financial risk which will achieve one of the State's goals in this program.



RCO Foundational Concepts

- Alabama-based leadership
- Citizen involvement
- Quality standards established by medical professionals
- Recipient access to an adequate provider network
- Financial solvency
- Integration of physical and behavioral health
- Coordinated, managed care – statewide health home
April 1, 2015
- Quality incentives aligned with State, Federal goals
- Rigorous data collection, reporting, and measurement



Regions Established

Regional Care Organization Districts Effective October 1, 2013



Regions drawn with these considerations:

- Honor existing referral patterns
- Keep health systems together when possible
- Allow more than one RCO per region

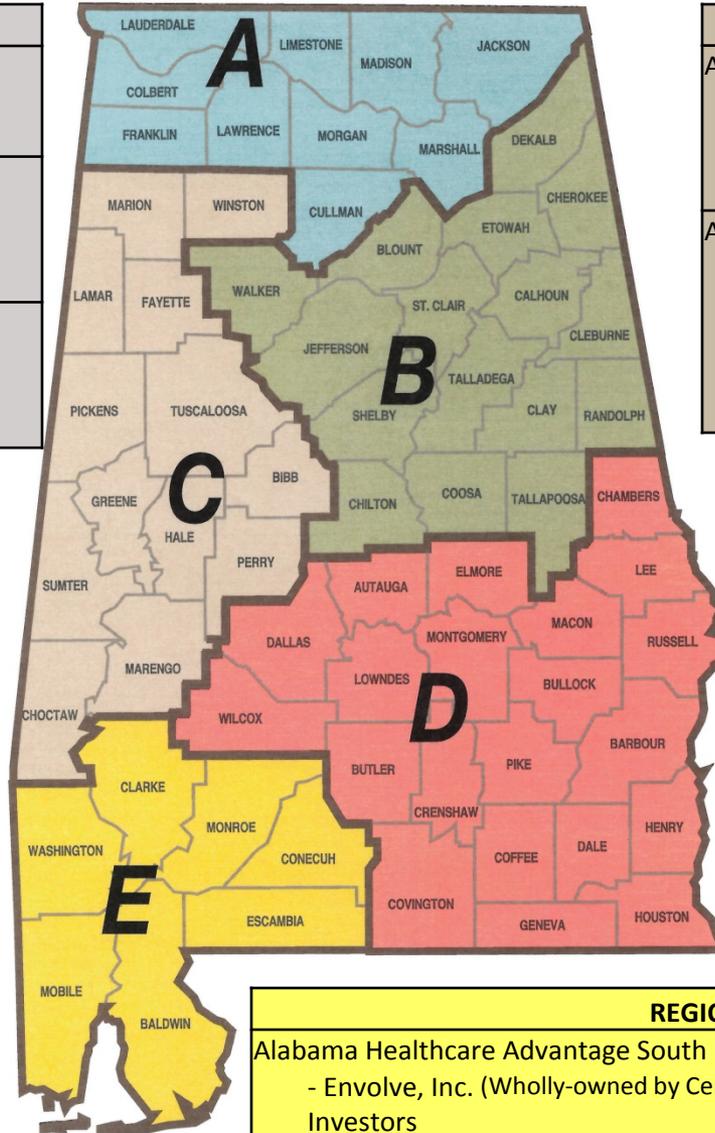




ALABAMA MEDICAID



Probationary Regional Care Organizations and Contributing Entities



REGION A
Alabama Community Care - Region A
- Sentara
- Huntsville Hospital System
Alabama Healthcare Advantage North
- Envolve, Inc. (Wholly owned by Centene)
- Individual Investors
My Care Alabama
- Healthcare Business Solutions, LLC (Wholly-owned by BCBS)
- North Alabama RCO Holding Co, LLC

REGION B
Alabama Care Plan
- UAB Health System
- St Vincents Health System
- Triton Health Systems
Alabama Healthcare Advantage East
- Envolve, Inc. (Wholly-owned by Centene)
- Ball Health Services
- Anniston EMS
- Individual Investors
- WellDyneRX

REGION C
Alabama Community Care - Region C
- Sentara
- Huntsville Hospital System
- DCH Health System
- Mental Health Retardation Board of Bibb, Pickens and Tuscaloosa Counties
Alabama Healthcare Advantage West
- Envolve, Inc. (Wholly-owned by Centene)
- WellDyneRX
- Individual Investors

REGION D
Care Network of Alabama
- East Alabama Health Care Authority
- East Alabama Medical Center
- Triton Health Systems
- Health Care Authority for Baptist Health
- Houston County Health Care Authority
- Univ of Ala Board of Trustees for UAB
Alabama Healthcare Advantage
- Envolve, Inc. (Wholly-owned by Centene)
- Jackson Hospital - Individual Investors
- WellDyneRX

REGION E
Alabama Healthcare Advantage South
- Envolve, Inc. (Wholly-owned by Centene), WellDyneRX, Individual Investors
Gulf Coast Regional Care Organization
- USA HealthCare Management LLC, AltaPoint Health Care Systems

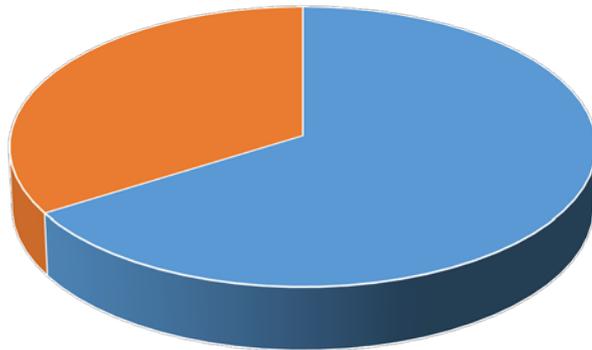
Populations



FY 2015 Estimated RCO Profile

Population

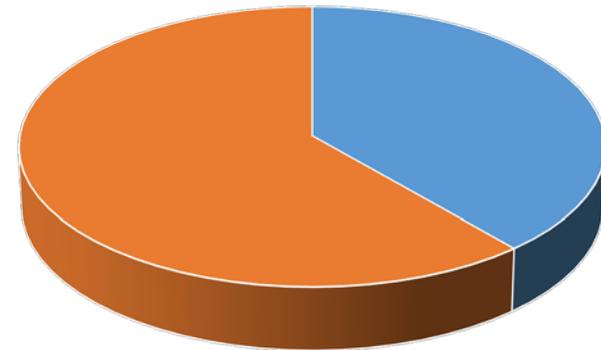
Non-RCO
Population
34%



RCO
Population
66%

Expenditures

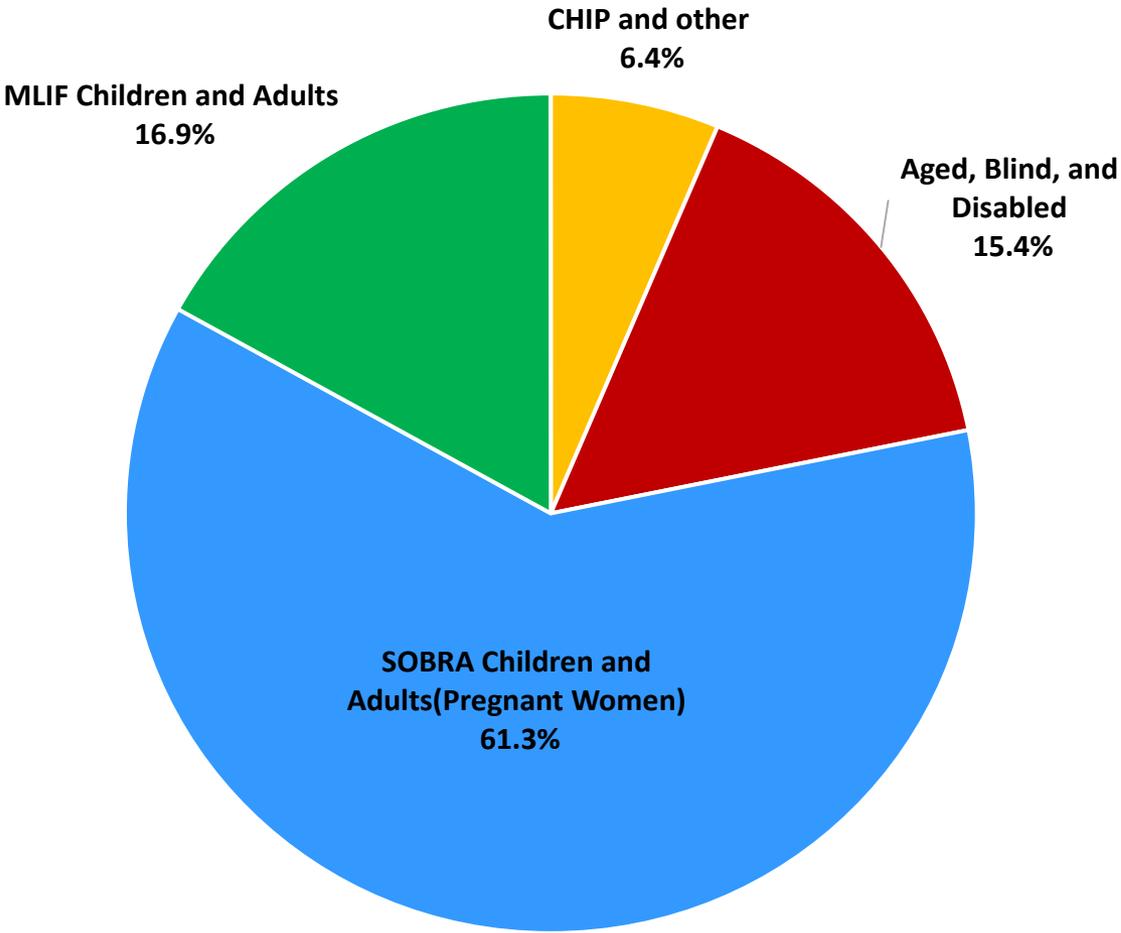
RCO
Expenses
\$2.2 B
38%



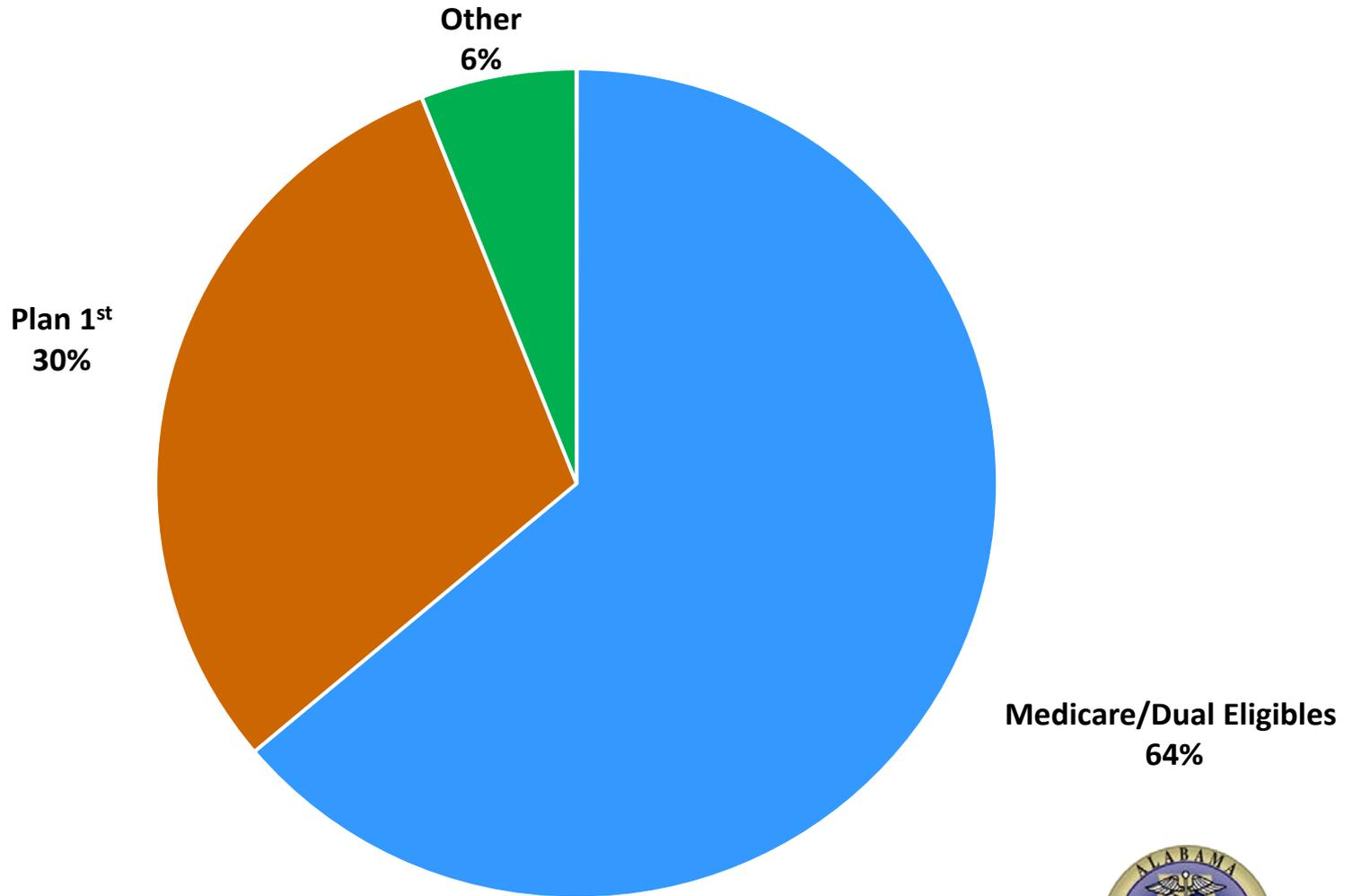
Non-RCO
Expenses
\$3.6 B
62%



RCO Covered Populations by Eligibility Category



Carved Out Populations



Services Provided by RCOs



Covered Services

Medicaid covered services to be provided by RCOs include, but are not limited to:

- Hospital inpatient and outpatient care
- Emergency Room
- Primary and Specialty Care
- FQHCs/RHCs
- Lab/Radiology
- Mental/Behavioral Health
- Eye Care
- Maternity

Recipients will receive medically necessary covered services available under the Medicaid State Plan, the same as other Medicaid recipients; RCOs may add services or benefits but will not receive additional capitation payments



Carved Out Services

Services carved out of the RCOs include:

- Pharmacy
- Long term care
- Dental services
- Substance abuse services



Effecting Change



Effecting Change

- Provide opportunities and flexibility to RCOs for innovations that improve the quality of health care
- Recognize and reward RCOs that improve quality
- Encourage use of technology to reduce service duplication
- Increase the number of Medicaid recipients who get preventive health services
- Shift focus from visits/volume to outcomes and quality
- Place the RCOs at financial risk
- Require enhanced supervision and management of high cost recipients



A place to start: Managing High Cost recipients

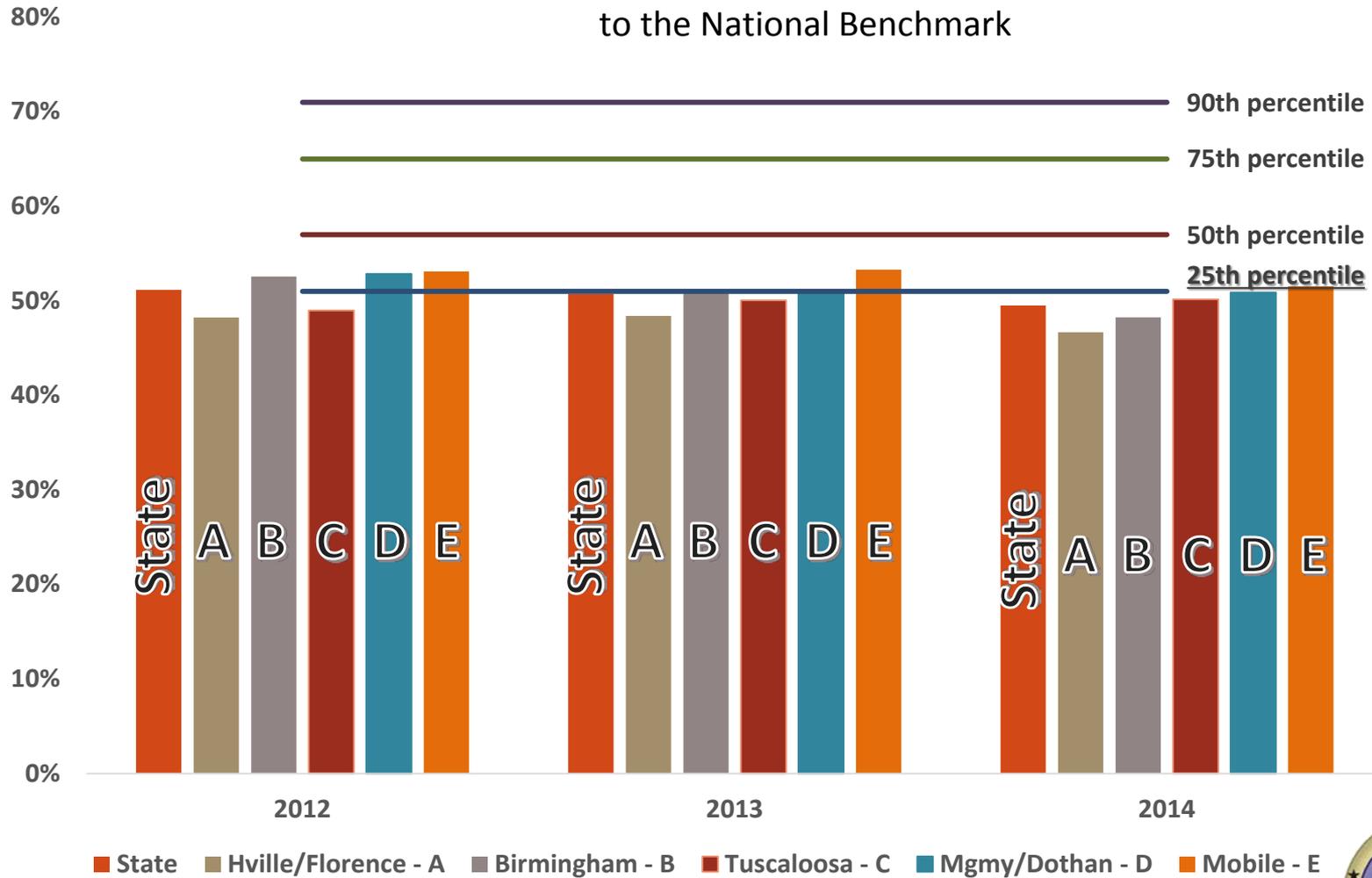
In FY 2015:

- **Breast Cancer:**
 - 4,560 recipients
 - \$72 million or \$15,900 per recipient
- **Cervical Cancer:**
 - 686 recipients
 - \$14 million or \$21,000 per recipient
- **Severe and Persistent Mental Illness**
 - 70,930 recipients
 - \$1.1 billion or \$15,600 per recipient
- **RCOs will manage the medical care of these recipients**
- **Preventive Care is usually less costly than treatment**



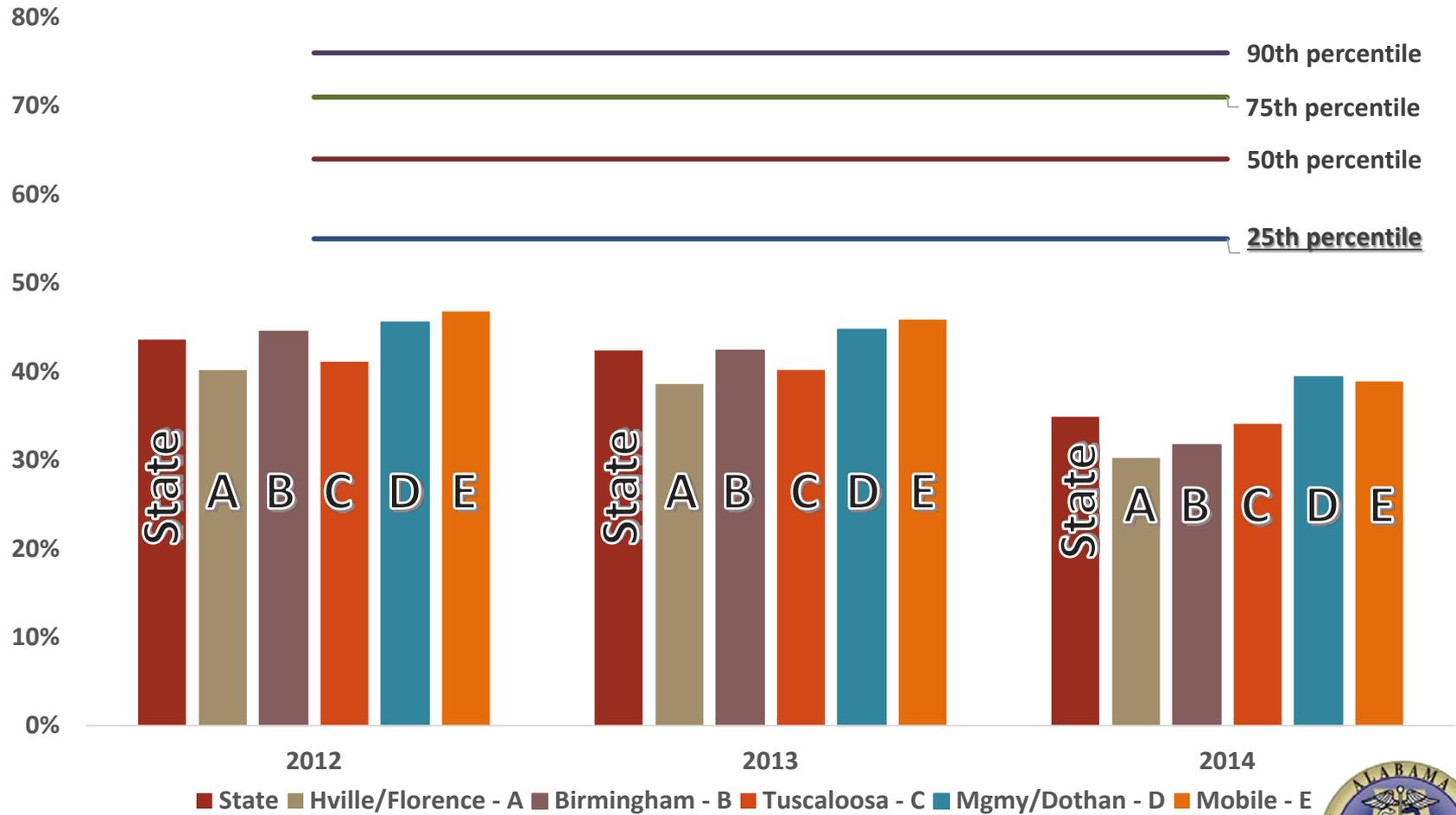
Breast Cancer Screenings

State/RCO Region Percentages in Comparison to the National Benchmark



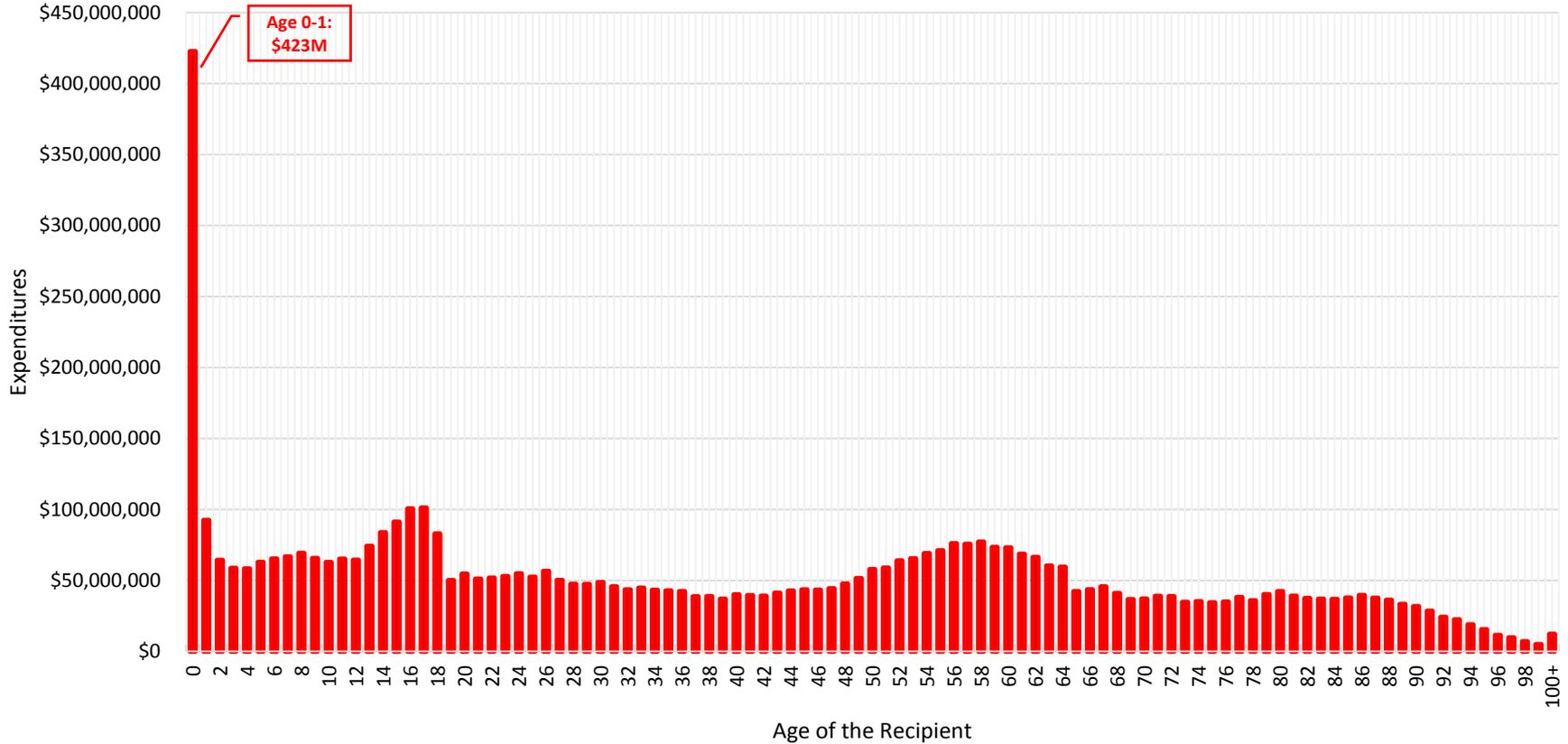
Cervical Cancer Screenings

State/RCO Region Percentages in Comparison to the National Benchmark



Managing High Cost Subgroups: FY 2015 Expenses by Age Group

Alabama Medicaid Agency
Expenditures for Medical and Support Services
Fiscal Year 2015
By Age at the Date of Service

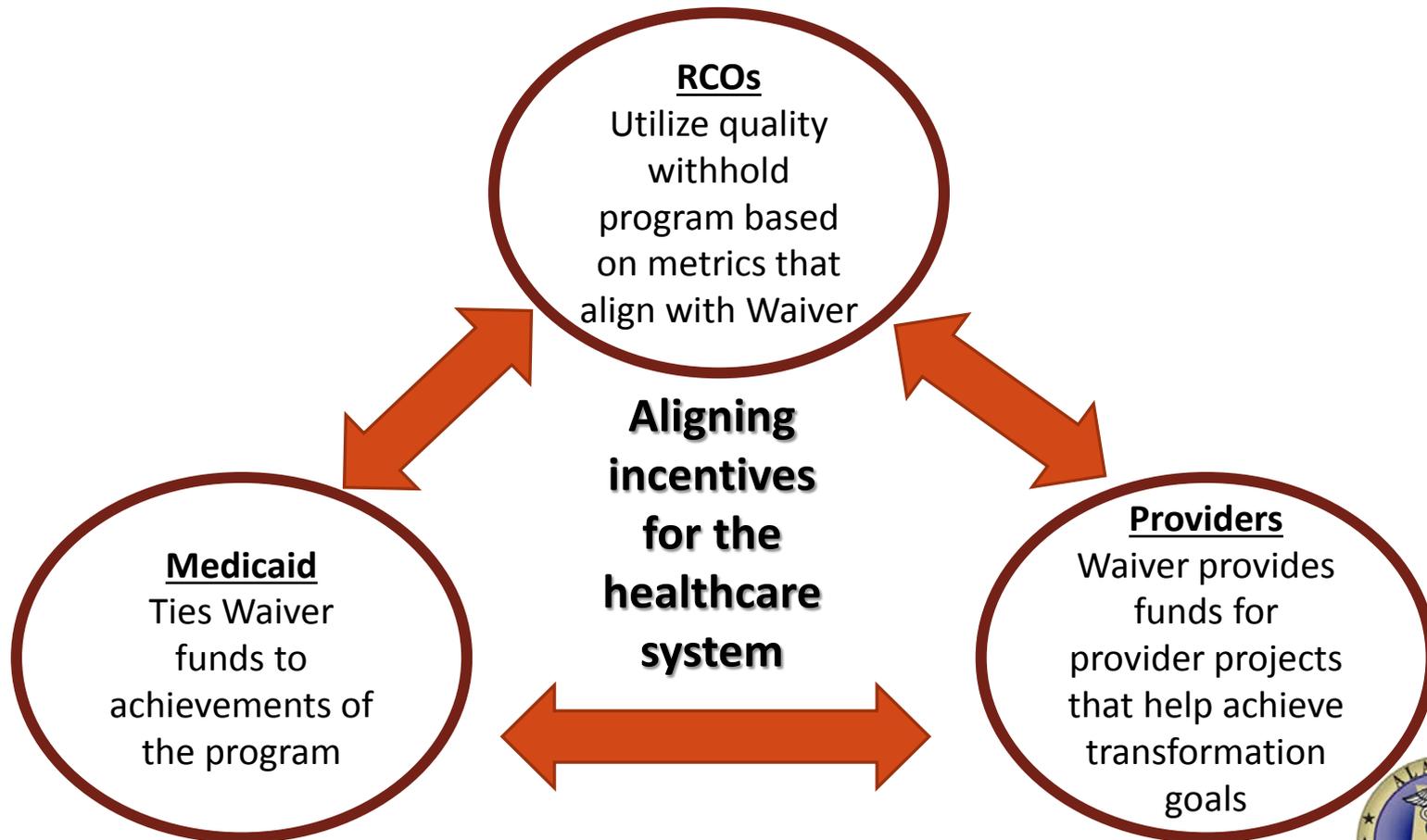


RCOs Tie Maternity Care and Newborn Outcomes Together

- A child born at 36 weeks of gestation or less incurs on average 8 times higher claims costs during the first year of life than a child born at 37 weeks of gestation or later
- First-year per recipient claims costs based on gestational age (CY 2013 Medicaid births)
 - 36 weeks or less: \$36,795
 - 37 weeks or more: \$4,545
- Case management can improve birth outcomes and save money



Alignment of Quality Improvement Goals



Setting Quality Improvement Standards

- State-level Quality Assurance Committee
 - Establishes statewide quality measures to hold the RCOs accountable
 - 60% of the members are Medicaid enrolled physicians
 - 42 measures approved in 2015
 - 10 of 42 measures chosen as incentive measures
- RCO-level Provider Standards Committee
 - Adopts quality standards for RCO-contracted providers
- RCO-level Citizens' Advisory Committee
 - Mandated diverse membership; includes Medicaid beneficiaries and advocates for the indigent, disabled population
 - Provides input on RCO policy decisions



Alabama RCO Withhold Program: 2017 Incentive Measures

Diabetic testing (HbA1c) and eye exams for adults

Cervical Cancer Screening

Ambulatory Care – Sensitive Condition Admission

Well-child visits for pre-schoolers

Well-child visits for adolescents

Medication management for children and adults with asthma

Medication management for adults receiving anti-depressants

Percent of Live Births that are < 2,500 grams (5.5 pounds)

Follow-up after hospitalization (BH-related primary diagnosis)

Prenatal and postpartum care



Alabama RCO Withhold Program

- Promote quality improvement within the RCO program by withholding 2.5% of each RCO's annual Total Capitation Payments until it meets Medicaid quality objectives
- Medicaid has selected 10 Incentive Measures from the set of 42
- To the extent possible, Medicaid will distribute withhold dollars no later than three months after the end of each fiscal year (FY) based on performance in the previous calendar year (CY)



What is Different?



What are the big differences for Medicaid?

- **Over time, monitoring RCOs will become the primary focus for the Agency**
 - Instead of paying claims, Medicaid will make capitated payments to RCOs and collect encounter claims data from the RCOs
 - Medicaid will execute a CMS approved contract with the RCOs and monitor for compliance
 - Instead of rewarding visits and volume, Medicaid will incentivize quality and outcomes
 - Medicaid will monitor financial solvency of the RCOs and timely payment to the providers
 - Skill-set of the Medicaid workforce will evolve accordingly
- **Agency must establish actuarially sound capitated rates**
 - CMS must pre-approve the capitated rates
 - Medicaid will not have the same flexibility to cut reimbursement rates
- **Currently, Medicaid has very limited ability to incentivize and affect quality outcomes**
 - Medicaid will be able to incentivize RCO quality outcomes
 - RCOs will also help improve access



What are the big differences for Providers?

- **RCO implementation will significantly change the relationship between providers and Medicaid**
 - Providers will have to contract with individual RCOs and continue to enroll with Medicaid
 - Providers will submit claims directly to the RCO
 - Fee-for-Service claims for recipients not in the RCO program will continue to be submitted to Medicaid
 - Referral and prior authorization requirements may change
 - Policies may vary by RCO – EPSDT services are required by federal law, but how services are prior authorized and referred may vary
- RCOs will assume responsibility for assigning recipients to individual Primary Care Physicians



What are the big differences for Recipients?

- Enrollment:
 - Three months prior to the start of RCOs the enrollment broker will reach out to recipients
 - Enrollment Broker will help recipients make an informed RCO choice
 - Enrollment Broker will have a list of each RCO's contracted Primary Care Physicians and other providers
 - Recipients who do not select an RCO will be auto assigned
 - Recipients will have a three month window during which time they may change from one RCO to another
 - After the 3 month period, they can only change annually without cause
- Enhanced Case Management of complex diseases
- Non-Emergency Transportation will be coordinated through the RCO
- The recipient will be able to choose from the network providers contracted with their RCO



Recipient Experience: Fee-for-Service vs. RCO

Recipient Event	Fee-for-Service Medicaid	Under RCO
Apply / Award / Renew Medicaid Eligibility	Medicaid determines eligibility	Same
ID card issued to recipient	Card received from Medicaid	Card received from RCO and Medicaid
Recipient assigned to primary care provider (PCP)	PCP Assignment process managed by Medicaid	RCO manages PCP assignment process
Recipient allowed choice of doctor / clinic for primary care services	Yes	Within their RCO network
Recipient wants to change primary care doctor / clinic	Contacts Medicaid	Contacts RCO
Adult recipient office visits	14 visit limit	RCOs may offer more visits



Recipient Experience: Fee-for-Service vs. RCO

Recipient Event	Fee-for-Service Medicaid	Under RCO
Adult recipient needs preventive care / well visit	Few preventive services covered	RCOs may provide more preventive care to avoid or detect disease earlier and potentially reduce costs
Recipient needs a prescription filled	Goes to pharmacy of recipient's choosing	Same
Recipient stops getting medication filled	Physician only becomes aware when patient has problem or if learned from the patient	RCO will have timely data to monitor enrollees' drug refills for compliance



FY 2017 Medicaid Budget – RCO



Some budget factors will continue to be beyond Medicaid's control

- The Federal Medical Assistance Percentage (FMAP)
- The number of people eligible for Medicaid
- Mandatory federal minimum covered service requirements



FY 2017 Budget Request Summary

In millions

General Fund 2016		\$685
Additional funding to support 2016 expenditures		
Carryforward used in 2016	37	
One time funding used in 2016	36	73
TOTAL 2016 funding necessary to match expenditure level		\$758
Additional funding to support 2017 expenditures		
Inflation and utilization increases	22	
Increase in paybacks	12	
Other, Rounding	-2	32
TOTAL 2017 without RCOs		\$790
Incremental RCO costs 2017		
Increase in RCO capitated rates over current spend	37	
Funding of claim runoff	15	52
Total 2017 with RCOs		<u>\$842</u>



RCO Impact on 2017 Medicaid Budget

- 2017 budget forecast numbers are based on RCO estimated expenditures which were available in November 2015
- Amounts will change when Capitation Rates are finalized
- Capitation Rates will be impacted by the following:
 - Utilization of actual claims information through December 2015
 - Any 2017 budget cuts and other program changes
 - Any delay in implementation of the Waiver including RCO capitated payments
 - Structure of outpatient hospital reimbursement



RCO Impact on Medicaid Budget 2017 continued

2015 Breakout of RCO Covered Services*

	2015 Actual	2015 RCO Covered Services
Nursing homes	\$945	\$0
Hospitals	\$2,146	\$1,463
Physicians	\$517	\$437
Pharmacy	\$685	\$0
Health Support	\$222	\$120
Alternative Care	\$364	\$87
Mental health	\$462	\$73
Insurance	\$335	\$0
Family Planning	\$59	\$14
CHIP	<u>\$81</u>	<u>\$26</u>
Total benefit cost	\$5,816	\$2,220

*Dollars in millions. Note these are total dollars not State share dollars

- This table shows an estimate of 2015 expenditures for services that would be covered by the RCOs.



RCO – Illustrative CAP Rate Buildup – 2017 Budget

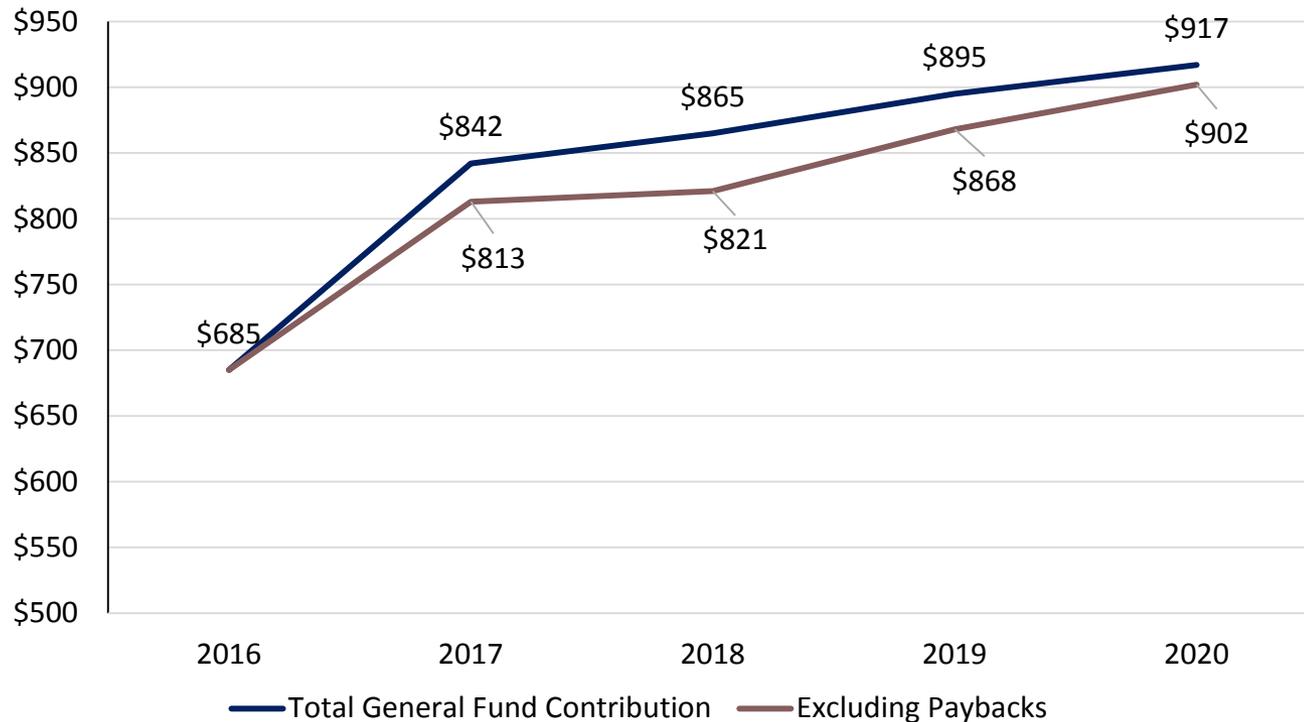
- Budgeted 2017 RCO Expenditures (estimated CAP rate) equal \$2.374M.
 - The estimate was developed by the State’s actuaries based on actual expenditures by per member per month cost trended forward from base years 2014 and 2015.
- To illustrate at a high level the impact of factors going into the Budgeted RCO CAP payment

	Total \$	State Share \$
2015 Base Year	\$2,220.4	\$662.6
Inflation	\$107.3	\$23.1
RCO Admin	\$186.2	\$55.6
Managed Care Savings	(\$139.7)	(\$41.7)
2017 Estimated RCO Payment	\$2,374.2	\$699.6



Five Year General Fund Estimates

(in millions)



There are assumptions made that are beyond Medicaid's control, e.g. Hospital funding, FMAP changes, enrollment, etc.



Summary

- The \$748 million Waiver dollars will assist the state in transforming the healthcare system
- The RCO program will provide a coordinated care system with aligned quality and financial incentives
- The RCOs will share risk with the state which, over time, will help budget predictability and bend the cost curve
- RCOs are a provider led strategy for improving healthcare outcomes in Alabama
- Alabama Medicaid has a budget crisis with or without RCOs

