Alabama Medicaid Transformation

Regional Care Organizations as a Vehicle for Change

September 2013

Overview

- Alabama's current Medicaid delivery system
  - Characteristics of system
  - Budget Situation (FY13-FY15)
- Regional Care Organizations (RCOs) as a strategy for Medicaid Reform
- 1115 Waiver as a critical vehicle to facilitate reform

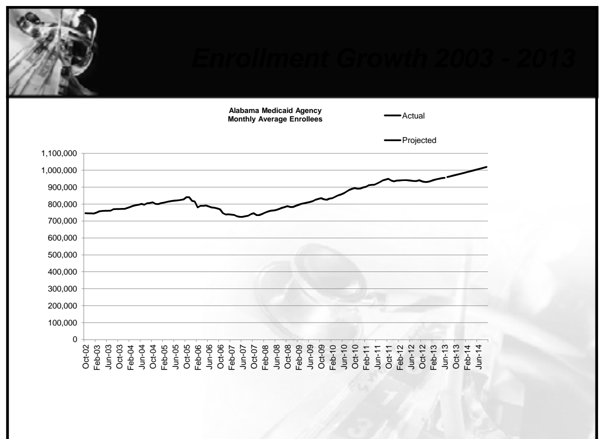
Alabama Medicaid Profile

- **For the most part, Alabama Medicaid is a traditional fee-for-service model program**
  - Characterized by steady enrollment growth due to recession (704,000 in 2003 - 940,000 in 2012)
  - But, inflation of cost per eligible is well below national average
  - And, cost per eligible is low compared to other states
- **The program is funded by state and federal sources (1/3 state - 2/3 federal)**
  - About 60 percent of state funds are provider taxes and contributions
  - 40 percent are from the state general fund
- **Recent dramatic increase in demand for General Fund – Medicaid now absorbs over 1/3 of General Fund**
  - Loss of Federal economic stimulus subsidies
  - Enrollment growth even as economy has improved

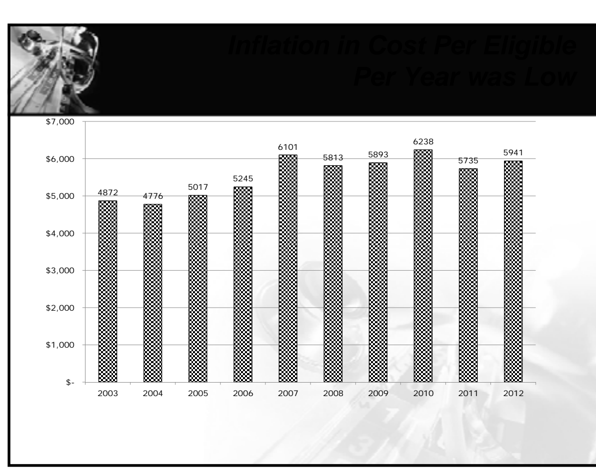
System Strengths & Challenges

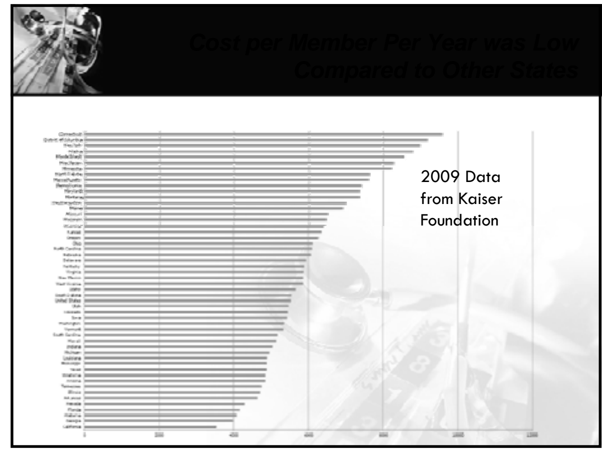
- **Delivery System Infrastructure:**
  - The care delivery system in Alabama is fragmented, with minimal infrastructure or incentives to coordinate care across providers to drive improved health outcomes.
- **Payment Methodologies:**
  - State reimbursement methodologies are based on per diem or fee schedule payments, which means that both providers and the State are focused on utilization and volume, rather than value and quality.
- **However, cost per eligible and rate of cost inflation are below national average**
  - Tight eligibility standards
  - Effective cost controls

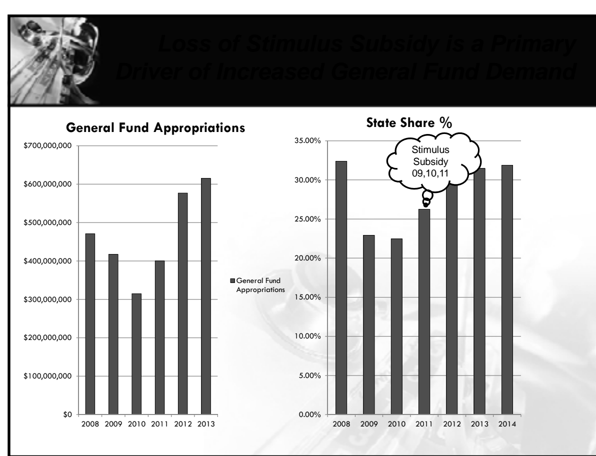
Enrollment Growth 2003 - 2013

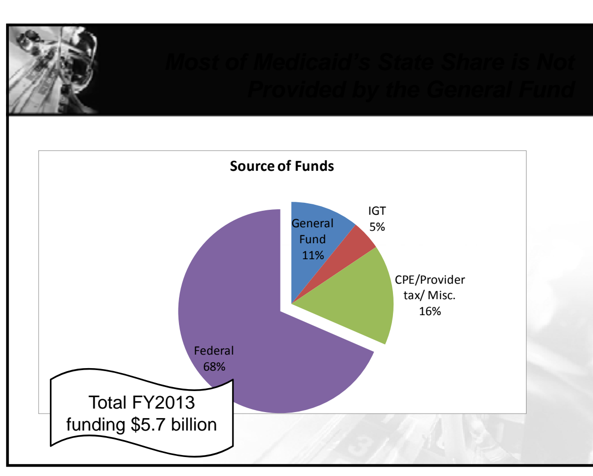


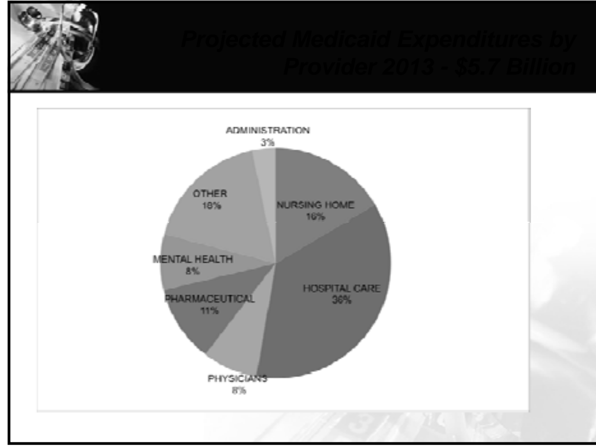
Inflation in Cost Per Eligible Per Year was Low




Cost per Member Per Year was Low
Compared to Other States
2009 Data
from Kaiser
Foundation


Loss of Stimulus Subsidy is a Primary
Driver of Increased General Fund Demand
General Fund Appropriations
$700,000,000
$600,000,000
$500,000,000
$400,000,000
$300,000,000
$200,000,000
$100,000,000
$0
2008 2009 2010 2011 2012 2013
General Fund Appropriations
State Share %
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
2008 2009 2010 2011 2012 2013 2014
Stimulus
Subsidy
09,10,11


Most of Medicaid's State Share is Not
Provided by the General Fund
Source of Funds
General
Fund
11%
IGT
5%
CPE/Provider
tax/ Misc.
16%
Federal
68%
Total FY2013
funding $5.7 billion



State Agencies Provide Essential Services and Pay Match

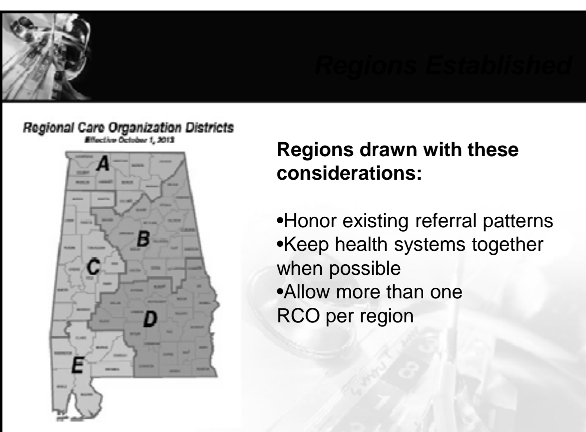
- Decisions must be made to include or exclude services and match now provided by state agencies.
- They have systems of care developed over the years that serve as a safety net to extremely vulnerable populations.
- It would not be in the state interest to disrupt these arrangements without making provision for these patients and the programs that serve them.
- State services will be folded into RCOs only when these considerations are addressed.

Medicaid Faces Budget Questions in FY2015; Reform Can Help, But Not Answer Fully

- **FY2013**
  - Budget appears stable with a small carry-forward.
  - FY2013 Operating deficit will reduce carry-forward available for FY2014.
- **FY2014**
  - Level funding of $615m GF requires cuts to providers, increases in assessments.
  - Cost increases exacerbate operating deficit.
  - System reforms will not be in place to materially effect funding/costs during 2014.
  - At best, FY2014 will end at break even; however, even a modest negative event could trigger payment deferrals into 2015.
- **FY2015**
  - We estimate an operating deficit for FY2015 of over $100 million state share.
  - To fund 2015, reforms must be underway in FY2014 and significant increase in state contributions must be realized.

New Law Establishes RCOs

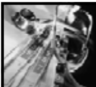
- Enacted during 2013 Legislative Session
- Dental Carved out for now
- Long Term Care and Dental Evaluations due 10/1/15
- Anti-trust / Collaboration requirements
- Board composition
- Timeline
- Medicaid will enroll recipients into RCOs / Recipient choice or assignment if no choice is made
- Reporting requirements



Regions Established

Regions drawn with these considerations:

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



Regional Care Organizations as a Strategy for Medicaid Reform

- Alabama has established a new system of healthcare financing and service delivery.
- The goal is to improve care and reduce cost inflation that would otherwise be incurred through the existing fee-for-service system.
- Actuaries initially estimated the new system would reduce future increases in state funding costs by between $40 million and $85 million per year compared to the current fee-for-service system.
- The strategy is to establish a capitated managed care system through regional care organizations (RCOs).
- An RCO is a corporate entity established under state law that is governed by a Board of Directors representing providers, the public, and investors.
- Eligibility groups to be included and services to be covered are currently under review.

Anti-Trust Provisions

- The state has determined that it is in the public interest for providers, individuals, and other community entities to cooperate in the formation and operation of the RCO's.
- To that end, provision was made to protect that collaboration from federal anti-trust rules, which is in the public interest, .
- To prevent abuse of that limited immunity, strict rules are under development.
- A collaboration certificate is required of all collaborators with specific standards for reporting covered activities.
- To facilitate this process, an online collaboration portal is under development and will be fully operational soon.

RCO Board Composition

- Twelve risk bearing participants
- Eight non-risk bearing participants (also cannot be an employee of a risk bearing entity)
- Five medical professionals who provide care in the region: 3 primary care physicians (one must be from a FQHC), one optometrist, and one pharmacist
- Three community representatives (chair of citizens' advisory committee, another member of the committee, and a business executive)
- *A majority of the members of the board may not represent a single type of provider.*

RCO Planning Principles

- Multiple RCOs will be allowed in each region.
- Member's residence determines RCO regional assignment for capitation.
- Any willing provider applies not only within region, but also across regional lines. For example, physicians and hospitals will be able to contract within their region as well as with adjacent regions.
- Medicaid will establish a floor for applicable provider payments for all regions, including out-of-region contracts.
- To accelerate reform, Medicaid favors single enrollment and a common analytical system.

Benefits of RCOs

- Potential for improved care coordination, especially for patients with complex medical issues or at risk for poor health outcomes
  - Quality Assurance Committee
  - Grievance Procedures / Peer Review Committee
  - Medicaid Oversight
  - Coordination of care across health care settings (hospital, doctor, pharmacy, ancillary care)
- Ability for RCOs to innovate by offering different or more services to better manage risk
- Regionally-led organizations help localize services to patient and community needs
- Improved data collection for quality improvement

Transition of Primary Care Networks to RCOs

- Medicaid currently has funded four primary care networks (PCN) that provide a level of managed care in 21 counties.
- Enhanced federal funding is available to expand that program statewide.
- As a transition step, Medicaid is considering the use of probationary RCOs to facilitate expansion
- This action will give Medicaid and the RCOs an opportunity to develop strategies to improve care and analytical capabilities.

Critical Dates Established by Law

- **10/1/13** - Medicaid establishes RCO regions
- **10/1/14** - Governing boards for each region approved
- **4/1/15** - RCO must prove its ability to establish an adequate network
- **10/1/15** - RCO must meet solvency requirements
- **10/1/16** - RCO must demonstrate ability to provide services under a risk contract (RCOs start bearing risk) no later than this date

1115 Waiver

- **1115 Waiver** is a federal program used to test new ways to deliver and pay for health care services in Medicaid that
  - improve care,
  - increase efficiency, and
  - reduce cost
- **Principal building blocks of the RCO 1115 waiver:**
  - A medical or health home for every Medicaid beneficiary, building on the State's recent successes with the Alabama Patient Care Network (PCN)
  - Development of provider-based RCOs to manage and coordinate care for the majority of the Medicaid population.
    - Through a capitated payment, RCOs would manage the full scope of Medicaid benefits, including physical, behavioral, and pharmacy services.
  - New strategies to more effectively address the behavioral health and physical health needs of Medicaid beneficiaries who have chronic needs, mental illnesses and substance use disorders.

Comprehensive Reform Initiatives

- **Delivery Model Reforms**
  - Mandatory enrollment in a care management entity.
  - Medical/health home model for all Medicaid beneficiaries.
  - Include most Medicaid beneficiaries.
  - Manage all health and behavioral health services.
  - Connection with the Statewide Health Information Exchange.
- **Provider Reimbursement Reforms**
  - Implement value-based purchasing strategies.
  - Enhance coverage and payments for targeted services to enhance access.

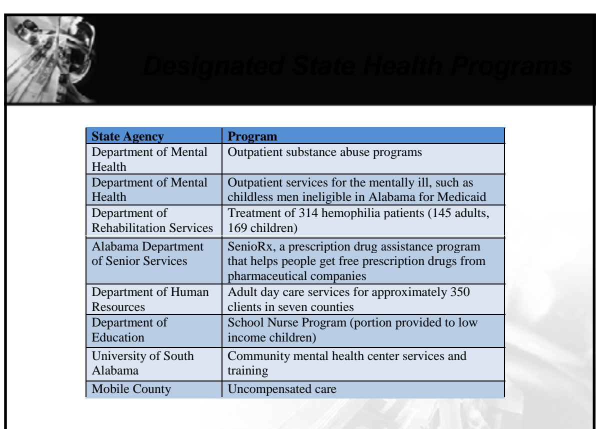
Why Change to RCOs Now?

- Influx / removal of federal stimulus funds for Medicaid
- Steady growth in state General Fund expenditures
- State leaders' desire to reduce Medicaid's dependence on state general fund by shifting risk away from state
- Desire to see more appropriate utilization by providing the system with tools such as enhanced data sharing, expanded care management resources, and more flexibility to modify the system at the provider level
- Not due to health care reform or Affordable Care Act

Budget Neutrality and Infrastructure Development

- **Savings**
  - Alabama and the federal government could potentially save between $750 million and $1.08 million over five years compared to expected expenditures in the fee-for-service system.
- **Use of 1115 Federal Investment**
  - RCO Investments
  - Quality of Care Pool
  - Provider Transformation Payment Transition Pool
- **Funding State Share for 1115 Waiver**
  - Designated State Health programs (DSHP)
  - With DSHP funding, the State will be able to redirect state funding to make the State Medicaid Agency an active purchaser and partner in delivery system transformation.

Designated State Health Programs



State Agency	Program
Department of Mental Health	Outpatient substance abuse programs
Department of Mental Health	Outpatient services for the mentally ill, such as childless men ineligible in Alabama for Medicaid
Department of Rehabilitation Services	Treatment of 314 hemophilia patients (145 adults, 169 children)
Alabama Department of Senior Services	SenioRx, a prescription drug assistance program that helps people get free prescription drugs from pharmaceutical companies
Department of Human Resources	Adult day care services for approximately 350 clients in seven counties
Department of Education	School Nurse Program (portion provided to low income children)
University of South Alabama	Community mental health center services and training
Mobile County	Uncompensated care

Stable State Funding Base Essential

- **Funding has been maintained by one-time stopgaps**
- **Even with reform, low costs and tight controls on eligibility, operating deficits require substantial additional state funding**
- **Growth in demand for state funds cannot keep pace with operating deficits and enrollment growth**
- **Additional federal funds derived through 1115 waiver cannot be used to fund the state operating deficit**

Pharmacy Study Commission

- The Governor appointed an Alabama Medicaid Pharmacy Study Commission to review and study options for delivery of pharmacy benefits to Medicaid eligibles.
- The commission is evaluating current costs and systems and making comparisons to other states.
- The Commission is to present its findings to the Governor by December 1, 2013.

Outstanding Task in RCO Implementation

- Anti-Trust issues
  - Rules on collaboration
  - Registration portal
  - Active state supervision
- Identification of who and what services will be covered by the RCO
  - Engagement of public and private stakeholders
- Development of criteria for probationary RCO certification beyond governing board
  - Solvency
  - Provider network
- Role of medical home expansion
- Decisions on Pharmacy delivery system

Summary

- Alabama's traditional Medicaid program has done a good job of controlling cost of services at a "bare bones" level.
- Loss of federal matching funds and increases in the number of eligibles has driven increased demand on the state General Fund.
- Transformation through community-led managed care (RCO) has promise to reduce future cost increases and improve patient care. It will not offset structural deficits in the existing program.
- Many steps remain to bring about reform that will require active collaboration of Medicaid, providers, state agencies and the federal government.
- Financial success is dependent on federal approval of an 1115 waiver which will inject additional funds needed for investment in reform.

Contact Information

Alabama Medicaid Website
www.medicaid.alabama.gov

Recipient Help Line: 1-800-362-1504

Provider Assistance Center:
1-800-688-7989