ACA Implementation: Medicaid and MnCare in 2014 and Beyond

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Carol Backstrom
Medicaid Director
MN Department of Human Services

Minnesota Department of Human Services

Agenda

- Basic Health Program (BHP) update
- Overview of program/eligiblity changes
- Medicaid and MnCare reform: Where do we want to go?

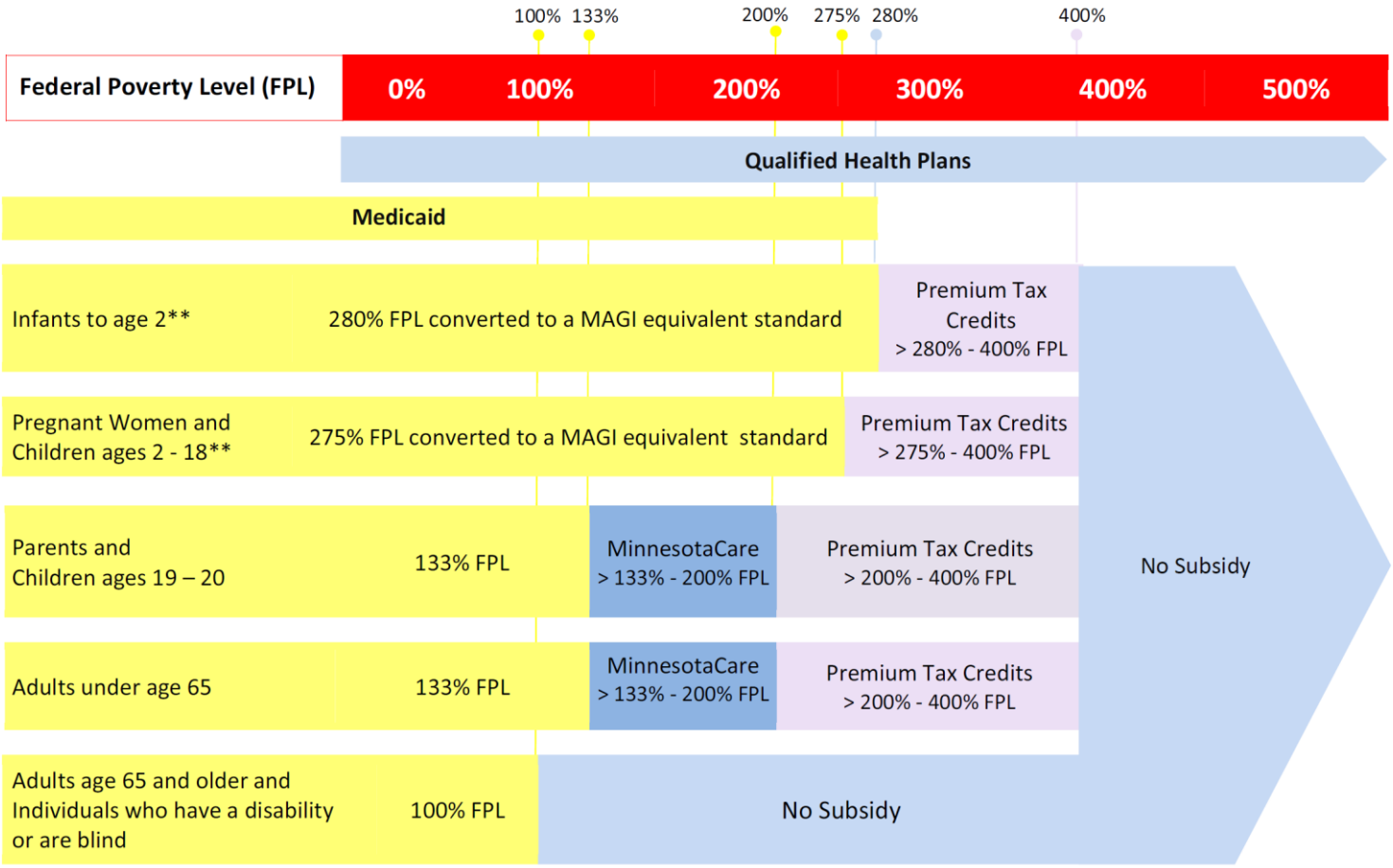
Basic Health Program

- Option under the ACA, offering states the option to create program for adults with income between 133 – 200 percent of FPG
- States to receive 95 percent of what the federal government would have spent on tax credits and subsidies for this population

Basic Health Program

- ACA calls for implementation in 2014; CMS delay of one year
- Regulation detailing program being drafted now
- In meantime, MN legislature opted to continue MnCare in 2014 at current match rate (vs. putting this population on the exchange)
- Conforming changes were needed to make MnCare BHP-compliant

Minnesota Coverage Continuum in 2014*



* Subject to additional federal guidance related to maintenance of effort requirements.
**Income standard in effect on June 1, 1997, must be maintained to comply with the CHIP maintenance of effort.

Department of Human Services
May 7, 2013

Coverage Changes

- **45,000 new enrollees in MA**

- **MinnesotaCare enrollment expected to be 193,000 by 2016**
  - 110,000 current MinnesotaCare enrollees move to MA
  - 10,000 current MinnesotaCare enrollees move to Tax Credits
  - 32,000 current MinnesotaCare enrollees remain on MinnesotaCare
  - 40,500 new MinnesotaCare enrollees in January 2014
  - 143,000 new MinnesotaCare enrollees by January 2015

- **Number of Uninsured Expected to Decline**
  - From 500,000 to 160,000 by 2016 – 68% reduction!

MA Eligibility Changes 1/1/2014

- **Changes to Income and Asset Standards**
  - Increase in income standards
    - Children under age 19 – 275% FPG
    - Children ages 19-20 – 133% FPG
    - Parents and caretakers – 133% FPG
    - Adults without children – 133% FPG
  - Asset test for parents and caretakers is eliminated

- **Changes to Income Methodology**
  - Modified Adjusted Gross Income (MAGI) methodology for children and adults under age 65 whose MA eligibility is not based on disability
  - MAGI is based on a household's taxable income and tax filing unit as stated on the tax return with some adjustments

MinnesotaCare Eligibility Changes 1/1/2014

- **Changes to Income and Asset Standards**
  - 19-20 year old children and adults with income > 133%-200% FPG
  - Children under 19 who are not eligible for MA solely due to federal household composition rules with income 0%-200% FPG
  - Lawfully present noncitizens who are ineligible for MA because of immigration status with income 0%-200% FPG
  - Asset test for parents and caretakers is eliminated
  - Individuals who are eligible for MA are not eligible for MinnesotaCare
- **Changes to Income Methodology**
  - Modified Adjusted Gross Income (MAGI)

MinnesotaCare Eligibility Changes 1/1/2014 (continued)

- **Changes to Insurance Barriers**
  - 4-month waiting period for individuals who had access to other coverage or who fail to pay a premium is eliminated
  - 18-month waiting period for individuals who had access to employer-subsidized insurance is eliminated
  - Insurance barrier on other current health insurance remains
  - Individuals who have access to affordable ESI where the employee premium is within 9.5% of household income

MinnesotaCare Eligibility Changes 1/1/2014 (continued)

- **Changes to Verification Requirements**
  - Relies on electronic data sources. If not available, self-attestation accepted and used to determine eligibility. Verification must be provider during the reasonable opportunity period (95 days).

- **Changes to Covered Services**
  - $10,000 annual cap on inpatient hospital services eliminated
  - 10% co-pay (up to $1,000) on inpatient hospital services eliminated

- **Changes to Premium Scale**
  - Each individual required to pay a premium based on income level
  - Aligns premiums across all family sizes based on income level

Where do we want to go: Why transformation is needed

- Addressing budget challenges will require important changes in provider payment and methods of delivering care
- Key roles need to be played by all--consumers, employers, providers, health plans, government and other--to effect this transformation
- Payment systems should:
  - Give providers the freedom and support necessary to foster innovation within the delivery system to determine the most efficient and effective means of providing and improving health
  - Provide the opportunity to replicate these innovative care models across the state of Minnesota.

MN's Approach to Medicaid ACO Development

- Define the "what" we seek, rather than the "how"
- Work in partnership with providers to develop process
- Providers are able to voluntarily participate
- Provide multiple opportunities for innovation under a framework of several models
- Allow for local flexibility and innovation under a common framework of accountability

Two Examples

1. Minnesota Medicaid ACO model: Health Care Delivery Systems (HCDS) Demo

2. Hennepin Health: A Safety-Net ACO

Example 1: Health Care Delivery Systems (HCDS)

Authorizing language:

"The Minnesota Department of Human Services shall develop and authorize a demonstration project to test alternative and innovative health care delivery systems, including accountable care organizations that provide services to a specified patient population for an agreed-upon total cost of care or risk/gain sharing payment arrangement."

(Minnesota Statutes, 256B.0755)

HCDS Characteristics

HCDS are able to:

- Deliver the full scope of primary care services.
- Coordinate with specialty providers and hospitals.
- Demonstrate how they will partner with community organizations and social service agencies and integrate their services into care delivery.
- Have flexibility in governance structure and care models to encourage innovation and local solutions.

Provider Agreements with DHS

- HCDS providers contract with DHS for both managed care and FFS enrollees under one of two models:

  Model 1: Virtual HCDS — for primary care providers who are not part of an integrated delivery system. Allows organizations to participate in a shared savings with the state.

  Model 2: Integrated HCDS — for integrated provider delivery systems with both inpatient and ambulatory care. Begins with shared savings and phases in downside to 2-way risk sharing of both savings and losses by year 3. HCDS have flexibility to propose amount of risk they assume.

- The models include the same framework but have different financial arrangements.
- The goal was to ensure broadest possible participation and available options.
- The agreements are 1-year contracts that renew annually for the 3-year demo period.

Example 2: Hennepin Health

- A Medicaid ACO focused on Minnesota's early Medicaid expansion population (<75% FPG)
- An MCO-ACO that integrates medical, behavioral and social services for single adults –expansion group – that are high users of county services)

Hennepin Health

- Hennepin county receives capitation rate roughly equivalent to MCO cap rates
- Opportunity for savings outside the Medicaid program (i.e. corrections and social services
- Care model includes integration of medical care with
  - Behavioral health,
  - Social services
  - Other county services unique to Hennepin
- Focused on high-need populations that are frequent users of county services
- Incentives aligned under county-run safety hospital and clinics, HMO, FQHC, behavioral health, and other traditional county services.

Next Steps

- Minnesota's SIM grant builds on HCDS
- Additional RFP for HCDS
- Expansion to additional populations (duals, complex)
- Strong emphasis on integration of acute care and other care settings and LTSS (more global community responsibility)
- Learning lessons from the Hennepin Health demo (with interest in statewide applicability)