



# **Health Programs Fiscal Committee Update**

**December 16, 2015**

# Projection Summary – Medical Assistance

<b>SFY16 - In Millions</b>				
<b>Medical Assistance</b>	<b>DHS</b>	<b>DOM</b>	<b>LSA</b>	<b>Average</b>
State Revenue	\$1,631.2	\$1,631.2	\$1,631.2	\$1,631.2
State Expenditures	1,701.3	1,700.8	1,697.4	1,699.8
Ending Balance	(\$70.1)	(\$69.6)	(\$66.2)	(\$68.6)
<b>SFY17 - In Millions</b>				
<b>Medical Assistance</b>	<b>DHS</b>	<b>DOM</b>	<b>LSA</b>	<b>Average</b>
State Revenue	\$1,596.0	\$1,596.0	\$1,596.0	\$1,596.0
State Expenditures	1,670.2	1,663.3	1,663.9	1,665.8
Ending Balance	(\$74.2)	(\$67.3)	(\$67.9)	(\$69.8)

Note: SFY17 state revenue is lower than SFY16 due to one-time carry-forward funds available in SFY16; SFY17 state expenditures are lower than SFY16 due to annualized Modernization savings and increasing FMAP.

Other potential impacts:

- MCO pharmacy reimbursement methodologies.
- Continuation of cost settlements after implementation of managed care.
- Hospital rebasing and the potential impact on MCO capitation rates.
- Federal match on administrative contracts.

# Analysis of SFY16 Shortfall – Medical Programs

Item	Shortfall Amount (Millions)	Comments
End of Session Need Based On Forecasting Group Midpoint	\$43.2	\$40.6M Medical Assistance based on midpoint. Medical Contracts was funded \$1.8M below Gov. Rec. and CHIP was funded \$750,000 below Gov. Rec.
Integrated Health Home Contract Reduction	3.0	The SFY16 Medicaid budget was reduced by \$3M for assumed IHH contract adjustments. The basis for this adjustment is not clear. DHS is unable to implement this adjustment due to the reimbursement methodology.
Additional Need Based on DHS End of Session Estimate	11.6	The DHS Medicaid expenditure estimate was \$11.6 million higher than the forecasting group.
Iowa Plan Costs Shifted to SFY16	7.0	Due to delays in receiving CMS approval, the SFY15 Iowa Plan rate adjustment will not be paid until SFY16.
CY16 Medicare Premiums	3.6	Medicaid pays the Medicare Part A and B premiums on behalf of dual eligible members. The Part B premium is increasing from \$104.90 to \$121.80 in CY16.

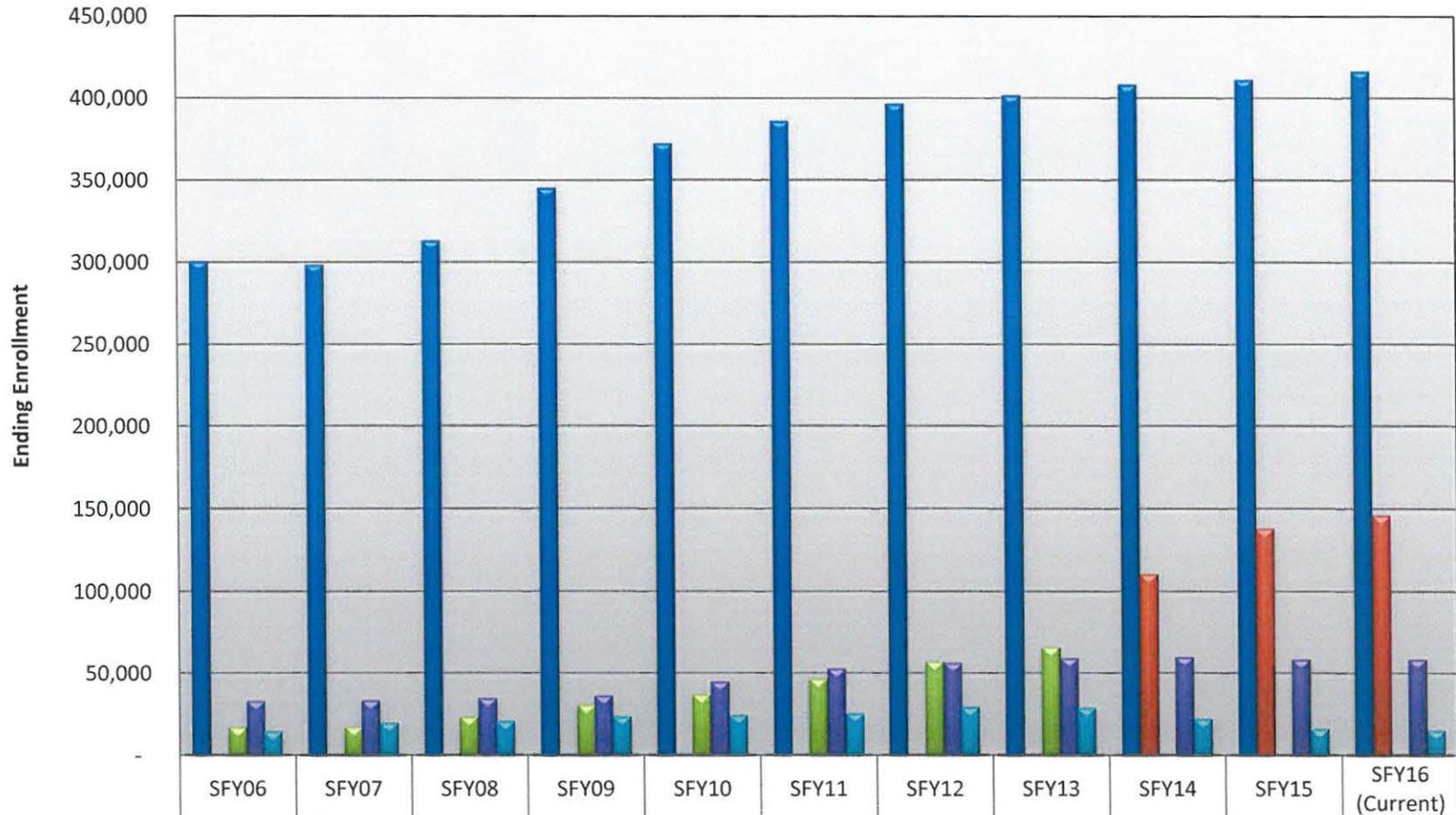
# Analysis of SFY16 Shortfall – Medical Programs

(continued)

Item	Shortfall Amount (Millions)	Comments
Reduced SFY16 Revenue	1.0	Reduced Health Care Trust Fund and Palo Tax revenue assumptions.
Revised SFY16 Trend	5.4	The current projection assumes a slightly higher expenditure growth rate. Primary driver is prescription drug spending.
Additional Prior Year Carry-Forward	(4.7)	At the end of session, it was assumed that SFY15 balances totaling \$30.7 million in would be available for Medicaid in SFY16. The actual amount available was \$35.4 million.
<b>Total</b>	<b>\$70.1</b>	

- This assumes achievement of \$51.1 million Modernization savings.
- The unfunded need is \$121.2 million without Modernization savings.
- The \$70.1 million is the current DHS estimate. As noted previously, the forecasting group average is \$68.6M.

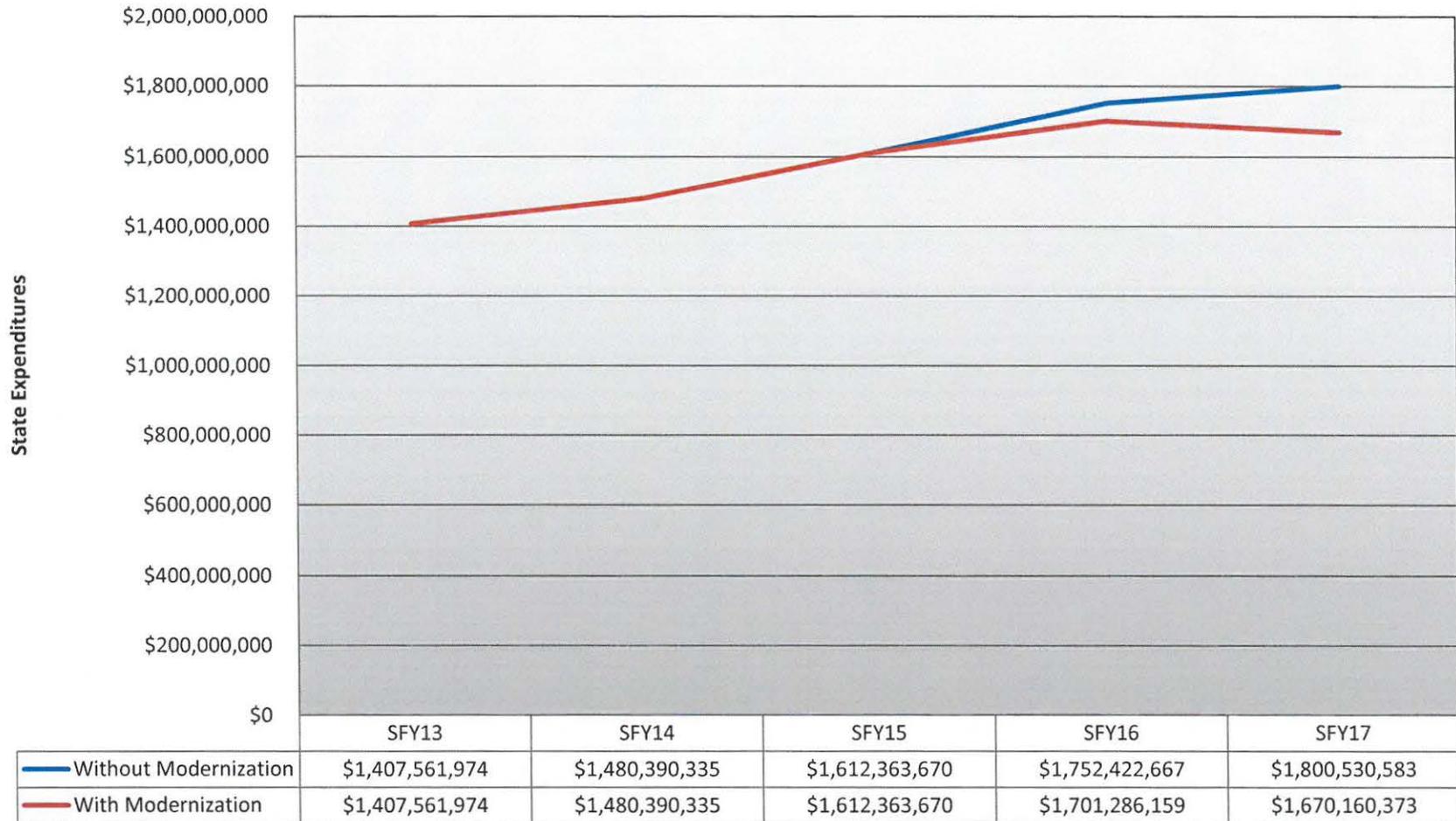
## Iowa Department of Human Services Medicaid and CHIP Enrollment History



	SFY06	SFY07	SFY08	SFY09	SFY10	SFY11	SFY12	SFY13	SFY14	SFY15	SFY16 (Current)
■ Medicaid	300,589	298,760	313,219	345,392	372,556	386,336	396,862	402,077	408,356	411,259	416,372
■ Health and Wellness Plan	-	-	-	-	-	-	-	-	110,533	138,106	146,006
■ IowaCare	17,118	17,287	23,434	30,832	36,876	46,561	57,076	66,042	-	-	-
■ CHIP	32,984	33,403	34,580	36,483	44,870	52,818	56,253	59,218	59,882	58,350	58,480
■ Family Planning Waiver	14,649	19,861	20,906	23,877	24,677	25,655	29,513	29,245	22,195	16,322	15,371

# Can managed care bend the cost curve?

## Iowa Department of Human Services State Medical Assistance Expenditures SFY13 - SFY17





## Iowa Medicaid Cost Drivers

### Enrollment

### Legislated rate increases

- \$75 million over the past 5 years

### Other increased cost of services

- Cost-based reimbursement
- Utilization of services

### Federal Medical Assistance Percentage (FMAP)

- Drives state/federal share



## Creating a more sustainable medical programs budget

- Enrollment & FMAP
  - Limited ability to impact
- Rate increases
  - Risk and performance based managed care contracts
  - Provider reimbursement
    - Performance based reimbursement
    - Value based purchasing



## Creating a more sustainable medical programs budget

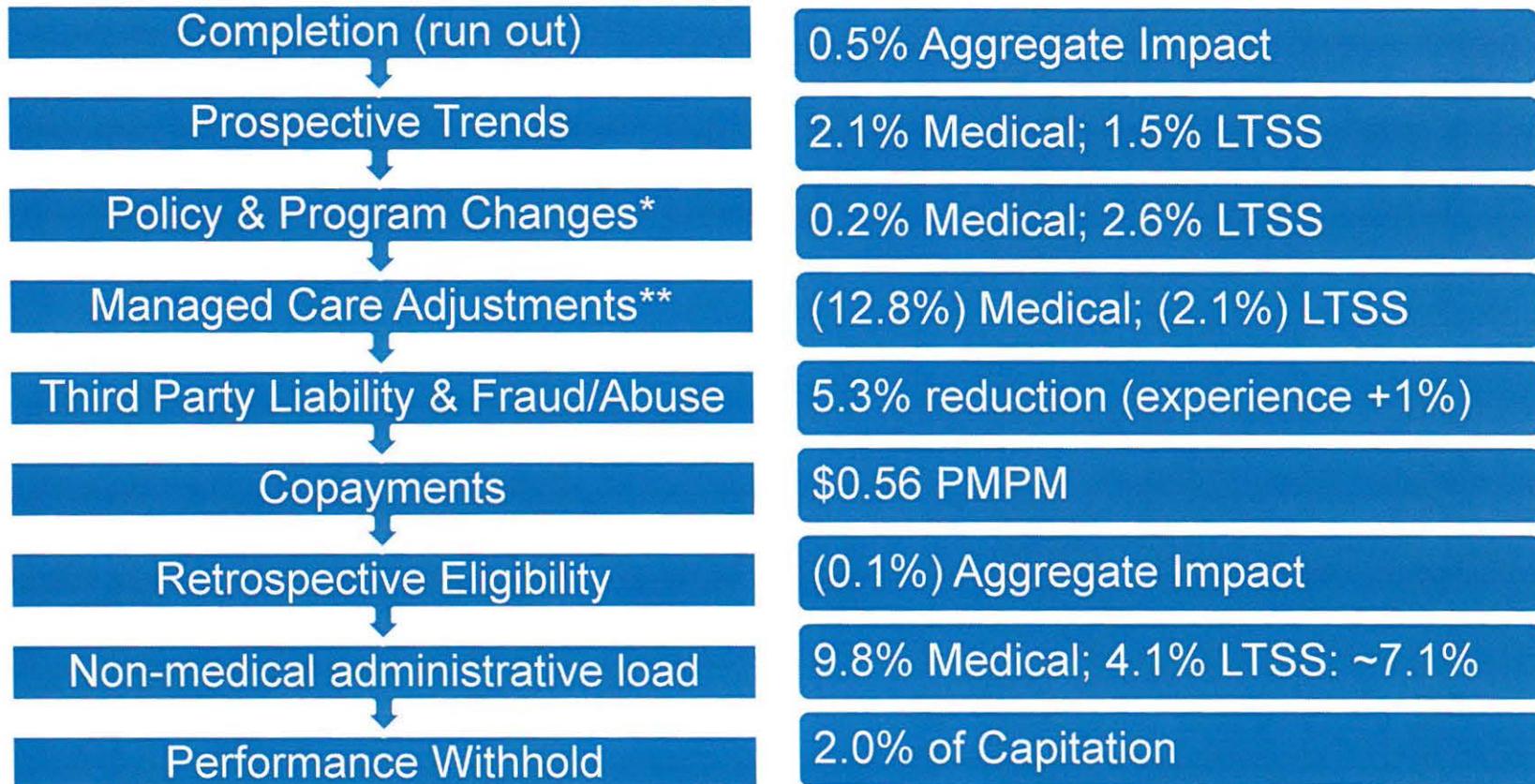
- Other increased cost of services
- Federally-approved reimbursement methods with accountability for cost management
- Coordination of care
  - Maximize use of PCP and medical home model
  - Ensure essential primary care
  - Coordinate essential preventive and health management services
  - Minimize duplication of services



## How are MCO capitation rates developed?

- Fee-for-service historical base data
- Managed care encounter experience
- Thorough review of all experience to find areas for increased efficiency and opportunity for additional savings
- Assumptions including: trends, managed care efficiency adjustments, policy and program change adjustments, and administrative cost allowance

# Capitation Rates & Current Savings Projection



\* e.g., cost containment and legislated rate increases

\*\* aka, degree of health management

**Savings inherent in current rates = \$43.1M**  
**Iowa Plan contract reserves = approx. \$4M**  
**Net fiscal impact = \$47.1 Million**



## Managed Care Savings

- Reduced hospital admission and readmissions
- Reduced hospital outpatient and ER utilization
- Decreases in duplication of services (e.g., radiology and pathology services)
- Pharmacy savings
  - Improved pharmacy care management
  - Dispensing fee is 20% of spend



## Managed Care Savings

- LTC rebalancing across applicable cells
  - Savings driven primarily from rebalancing
- Maternity case rates (kick payments)
- 18-month initial rate period
  - Spreads savings over 18-month period
  - Savings is smaller in the early periods of managed care
  - Savings inherent in capitation rates
  - Legislative impacts will impact capitation rates



## Medical Loss Ratio (MLR)

- Portion of each dollar paid to the MCOs that is used for claims expenses
- Capitation rates assume 92.9% medical costs
- Minimum MLR requirement of 88%
  - Protects state, providers and members from inappropriate denial of care to reduce medical expenditures
  - Protects state if capitation rates are significantly above actual managed care experience (state recoups)



## Administrative Loss Ratio (ALR)

- Portion of each dollar paid to the MCOs that is used for administrative expenses
- ALR is 7.1% (on average across rate cells)
  - Including 0.5% profit (underwriting ratio)
- Administrative expenses (in rank order of avg. spend)
  1. Human capital
  2. Taxes & fees
  3. Outsourcing
  4. Operating expenses
  5. Other
  6. Bricks & mortar

See <http://us.milliman.com/insight/2015/Medicaid-risk-based-managed-care-Analysis-of-administrative-costs-for-2014/>



## Capitation Rates Financial Summary

- Capitation rates assume 92.9% medical costs and 7.1% administrative load (on average across rate cells)
  - Including 0.5% profit (underwriting ratio)
- 5% flexibility for MLR and administrative costs
  - Administrative costs will be higher in initial periods



## Comparison to National Financial Results

- Iowa provider reimbursement is high relative to average
  - Iowa MLR is higher than average
  - Iowa ALR is lower than average
- Milliman 2014 Medicaid risk-based managed care financial results
  - 182 plans, 37 states, \$110 billion annual revenue
  - Composite mean MLR 86%
  - Composite mean Administrative loss ratio (ALR) 11.9%
  - Composite mean Underwriting ratio 2.1%

See <http://us.milliman.com/uploadedFiles/insight/2015/medicaid-risk-based-managed-care.pdf>



## Can MCOs bend the cost curve?

- Better quality and improved health outcomes lead to lower cost over time
- MCOs are incented to deliver effective care management through capitated, risk-based reimbursement
  - Collaborative effort
  - Enhance the quality of care
  - Maximize efficiency of care delivery



## Can MCOs bend the cost curve?

- Savings are inherent in contracted capitation rates
- As managed care programs mature, the quality of care provided to Medicaid clients will continue to increase
- By enhancing quality of care and access to providers, MCOs are generating more value for every healthcare dollar spent under the Medicaid program



Iowa Department of Human Services

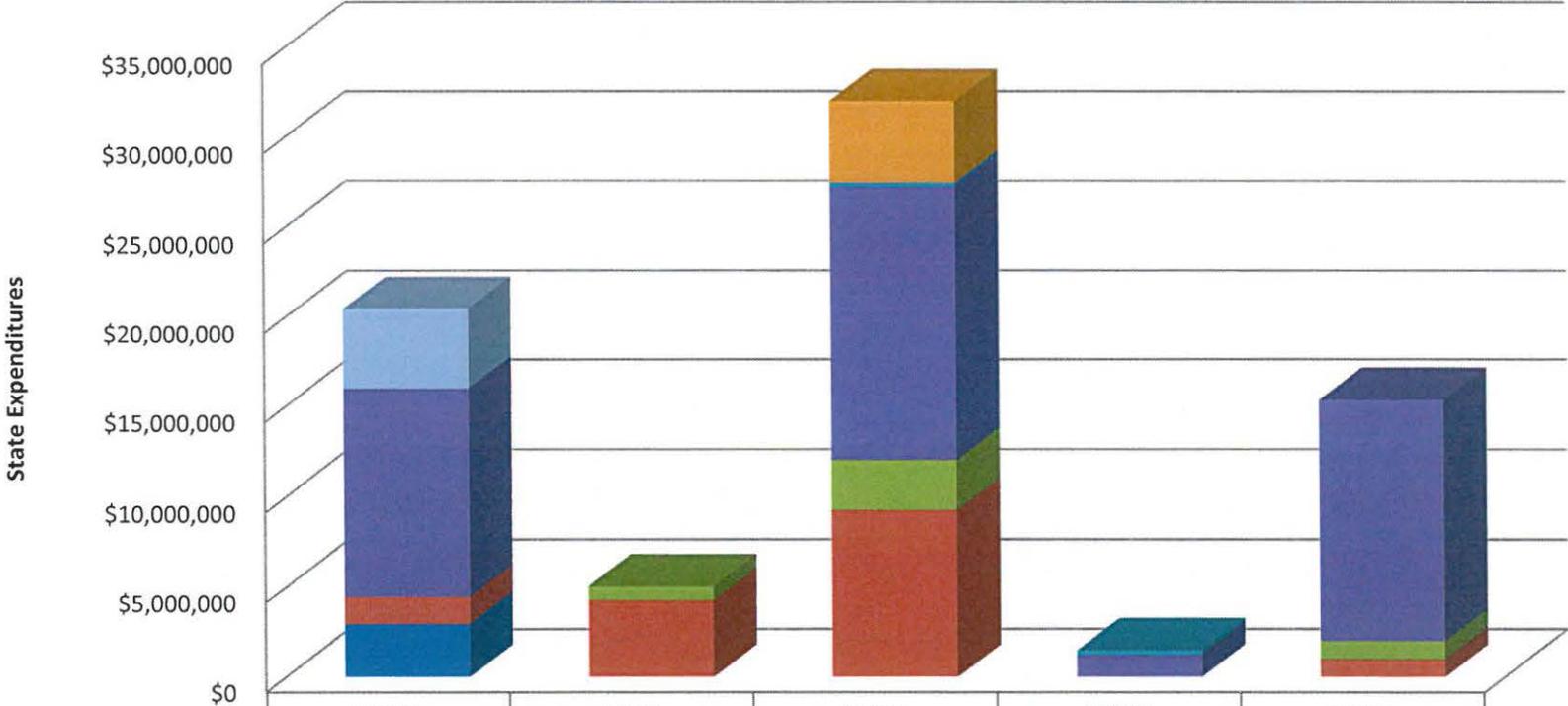
Questions?



## Appendices

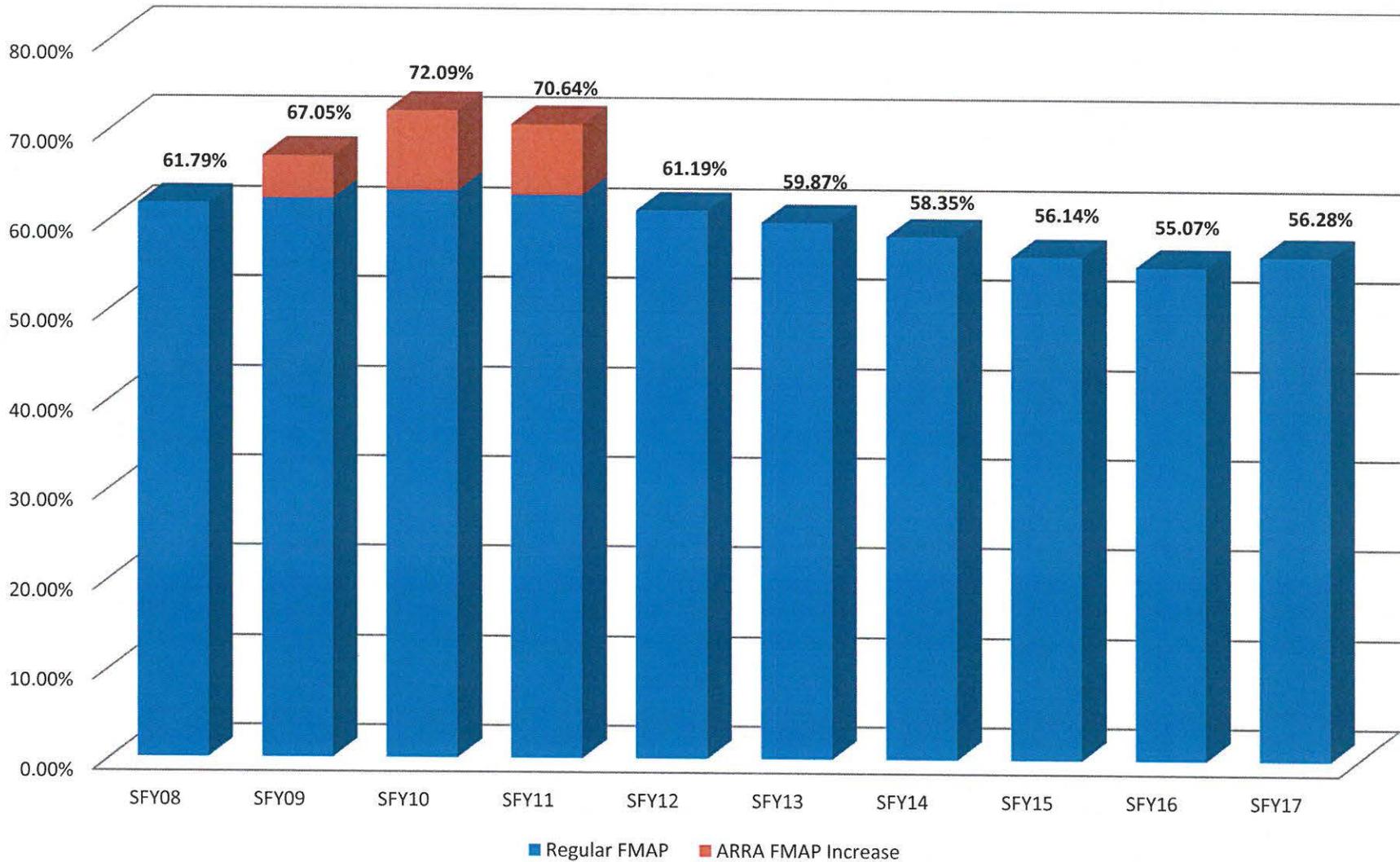
- Legislated provider rate increases
- FMAP history
- Future FMAP increases in Iowa Health and Wellness

## Iowa Department of Human Services Historical Rate Increases Authorized by the Legislature



	SFY12	SFY13	SFY14	SFY15	SFY16
Hospital Rebase	\$4,500,000				
1% Across the Board			\$4,538,558		
Ambulance			\$226,950	\$238,938	
Nursing Facility	\$11,555,173		\$15,268,148	\$1,250,000	\$13,400,000
Home Health		\$761,348	\$2,765,655		\$1,000,000
HCBS	\$1,500,000	\$4,315,134	\$9,308,335		\$1,000,000
Dispensing Fee	\$2,981,980				

# Iowa Department of Human Services Medicaid FMAP By State Fiscal Year 10-Year History



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**Iowa Department of Human Services  
Iowa Health and Wellness Plan  
SFY16 - SFY 21 Newly Eligible FMAP Analysis**

