Georgia Department of Community Health

Georgia Medicaid and PeachCare for Kids®

Presentation to: 2013 Joint Study Committee on Medicaid Reform

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Date: August 28, 2013

Georgia Department of Community Health

Mission

The Georgia Department of Community Health

We will provide Georgians with access to affordable, quality health care through effective planning, purchasing and oversight.

We are dedicated to A Healthy Georgia.

Medicaid and PeachCare in Georgia

Topics for Discussion:

- Medicaid Trends
- Georgia Compared to Other States
- Historical Program Changes
- Affordable Care Act Impact
- Highlighted Current Projects

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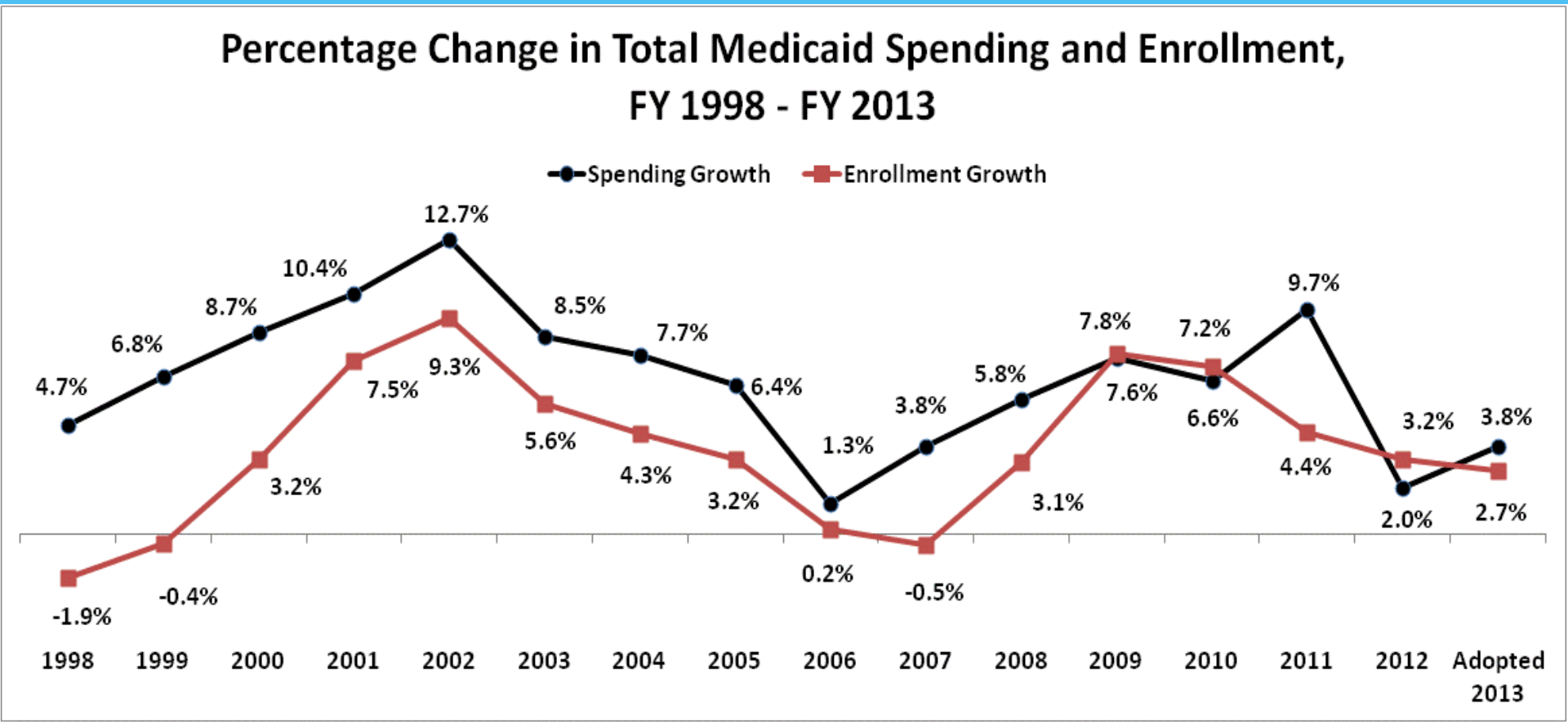
Medicaid Trends

National Expense and Enrollment Trend



Note: Enrollment percentage changes from June to June each year. Spending growth percentages in state fiscal year.

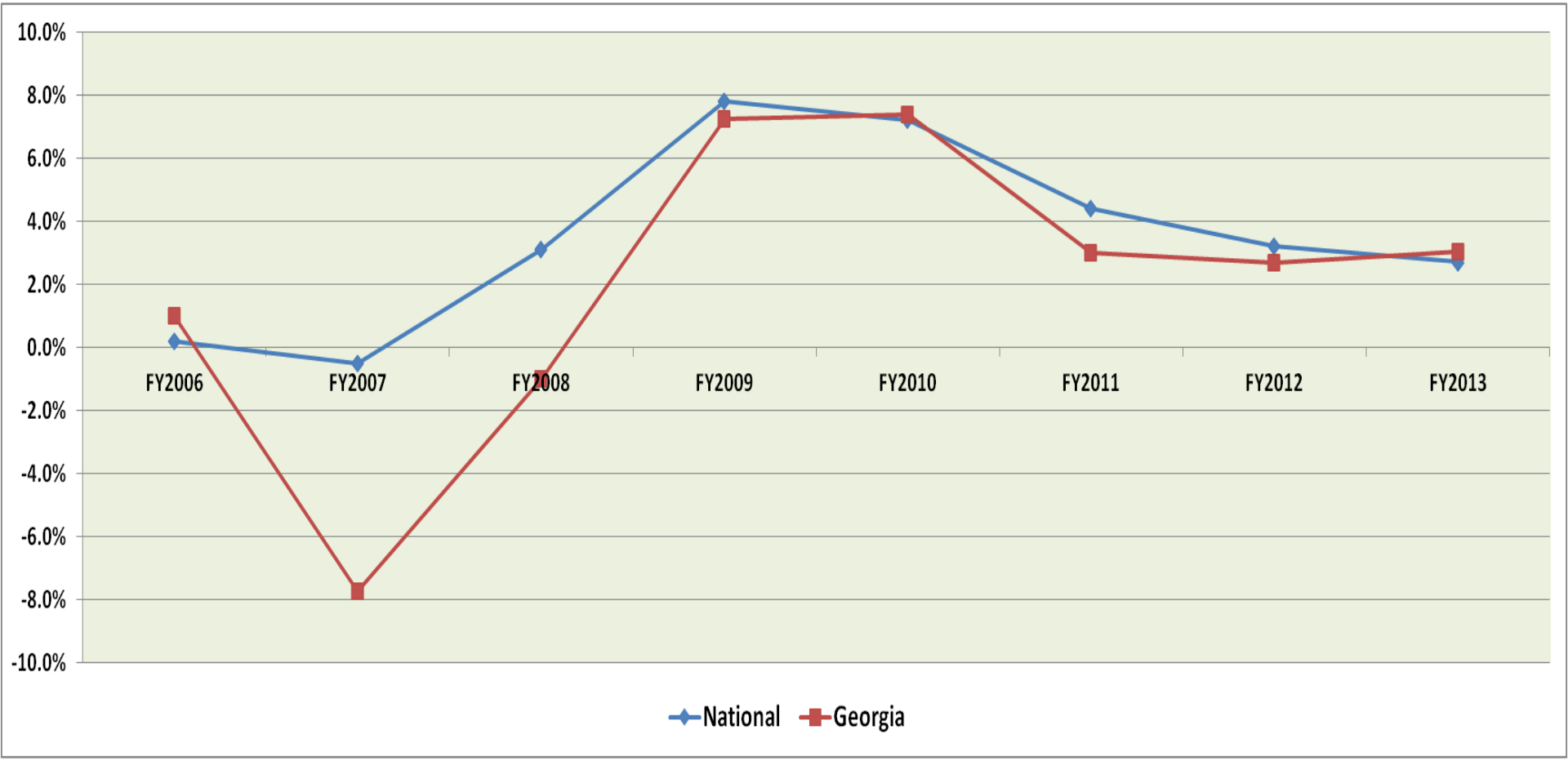
SOURCE: *Medicaid Enrollment June 2011 Data Snapshot, KCMU, June 2012.* Spending Data from KCMU Analysis of CMS Form 64 Data for Historic Medicaid Growth Rates. FY 2012 and FY 2013 data based on KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associations, October 2012.

Medicaid Growth Trends – National View

	1966	2000	2010	2020
Enrollees (millions)	4	34	54	85
% of Population	2%	12.5%	17.47%	26.1%
Total Cost (billions)	$1.3	$206	$401	$871
% of GDP	<1/2%	2.1%	2.7%	3.7%

Georgia Compared to National Trend

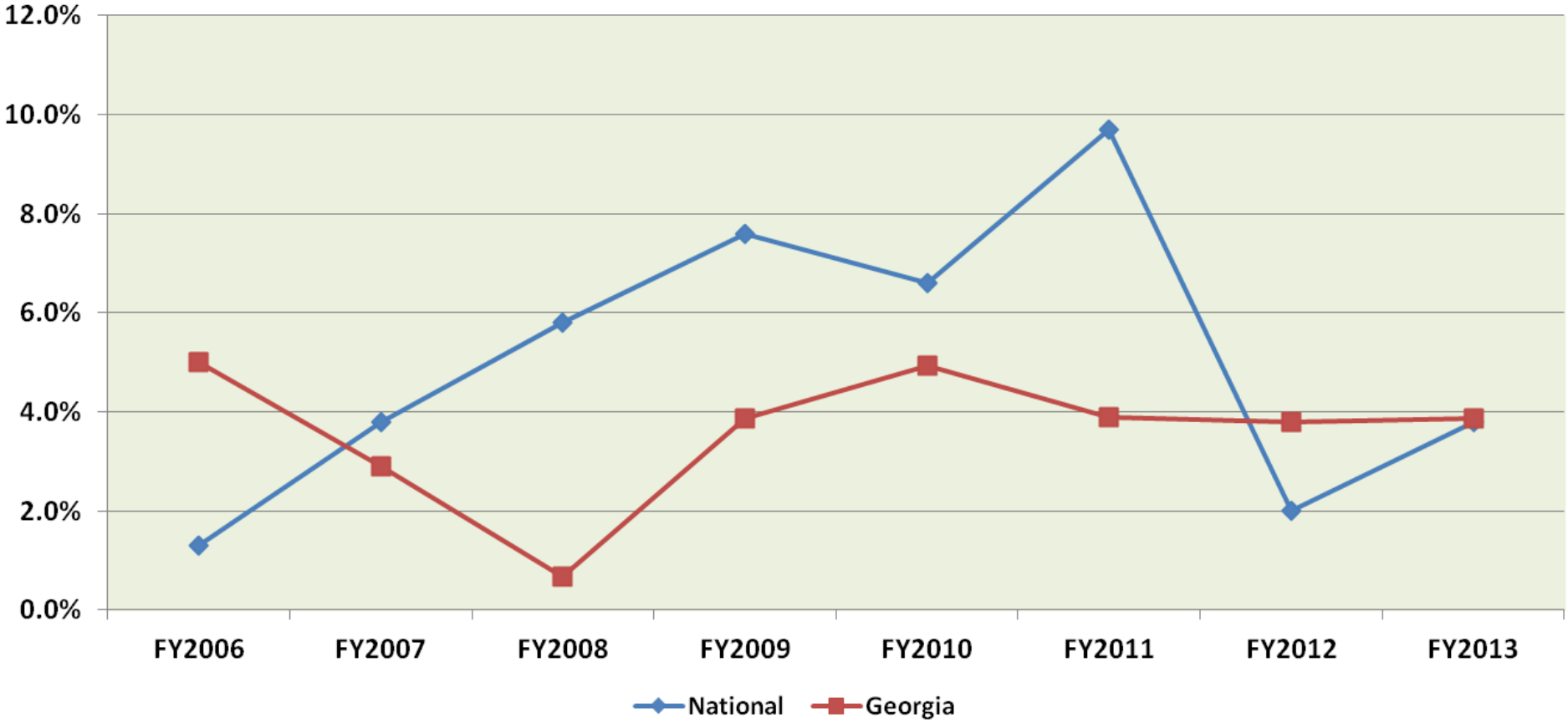
Percentage Change in Medicaid Enrollment



National percentages from Kaiser report also on slide 4.

Georgia Compared to National Trend

Percentage Change in Medicaid Cost (based on incurred dates of services)



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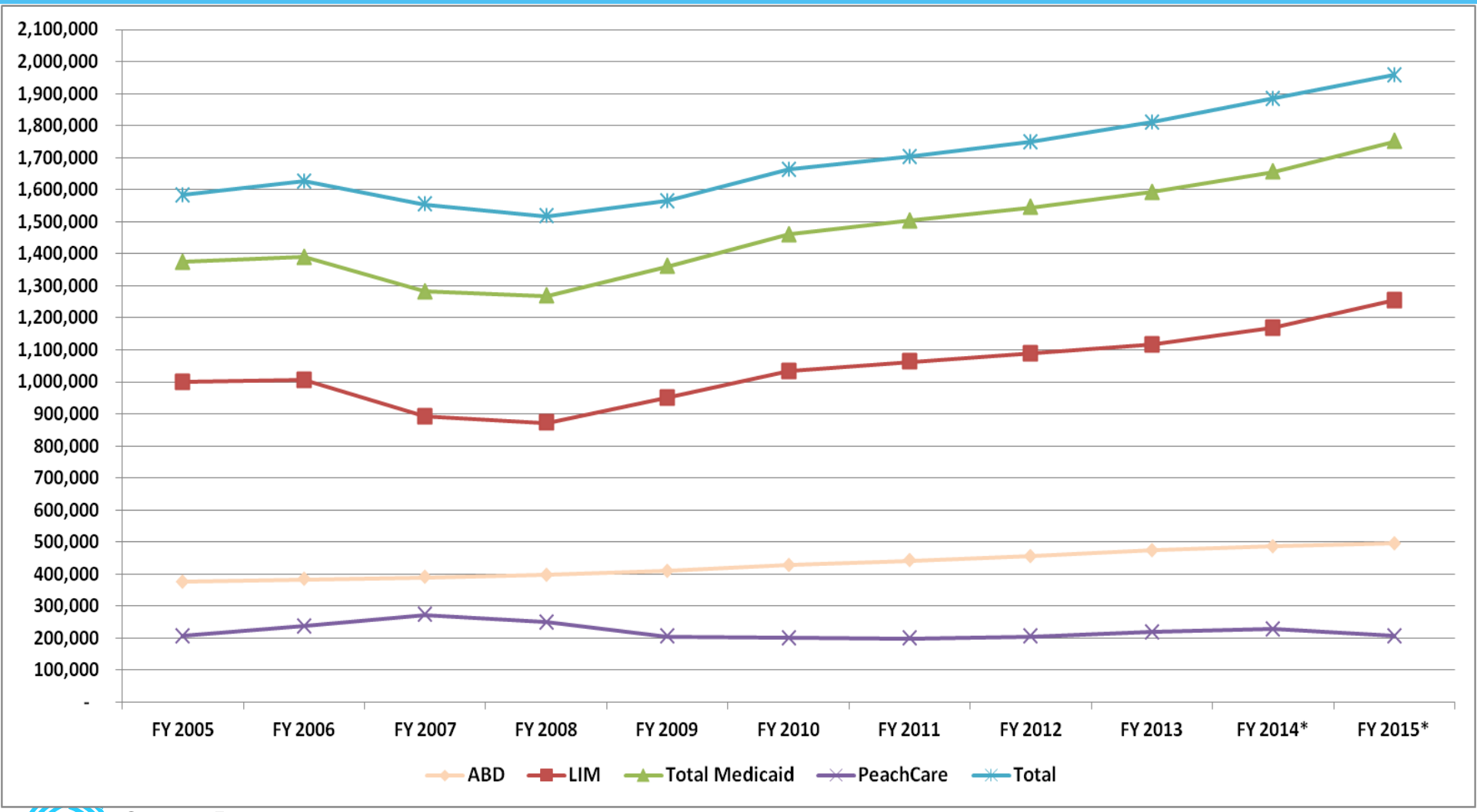
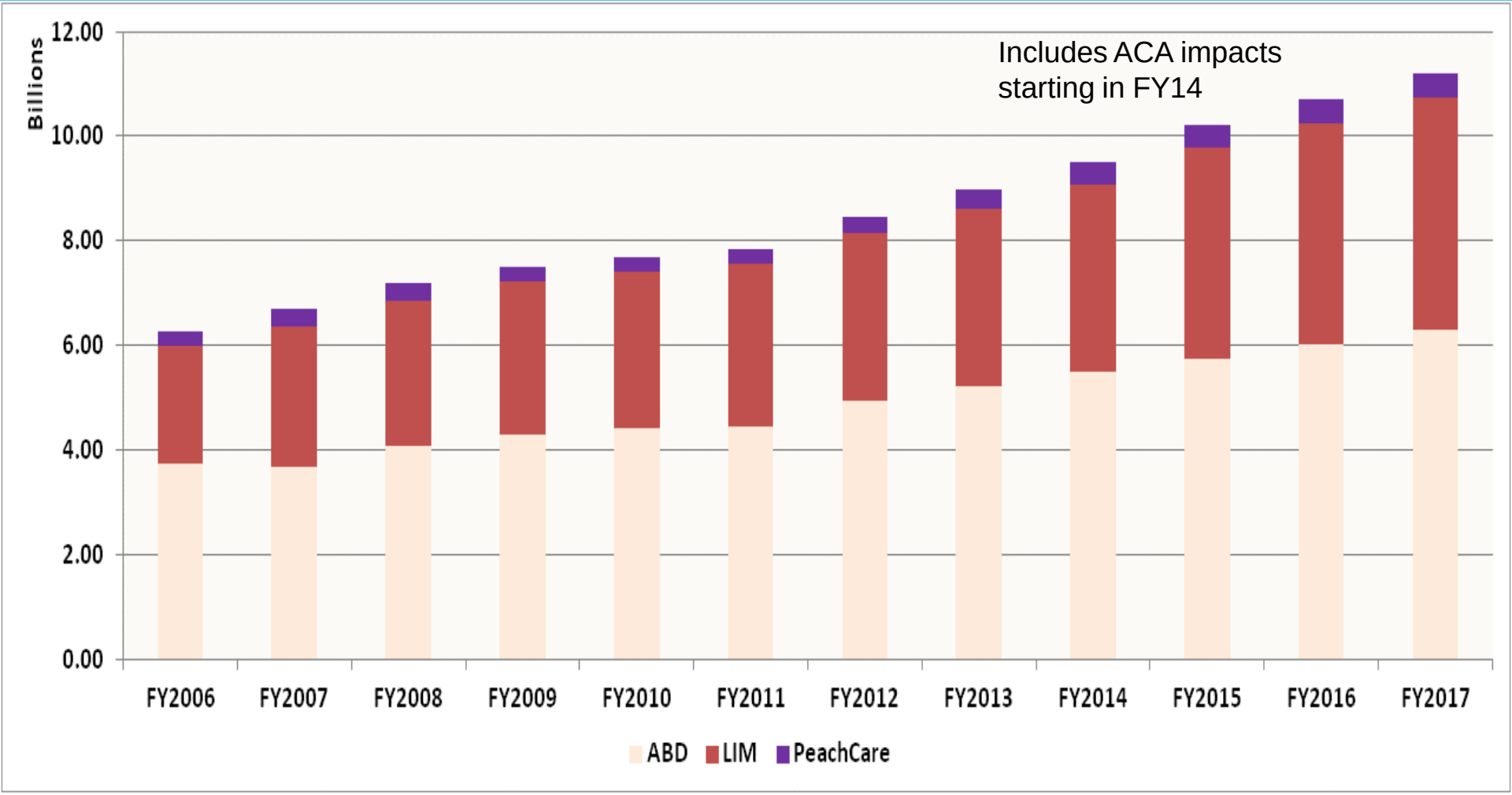
GA Medicaid and CHIP Enrollment Trend



* - FY2014 and FY2015 are projected

Medicaid and PeachCare Total Funds Cost Trends



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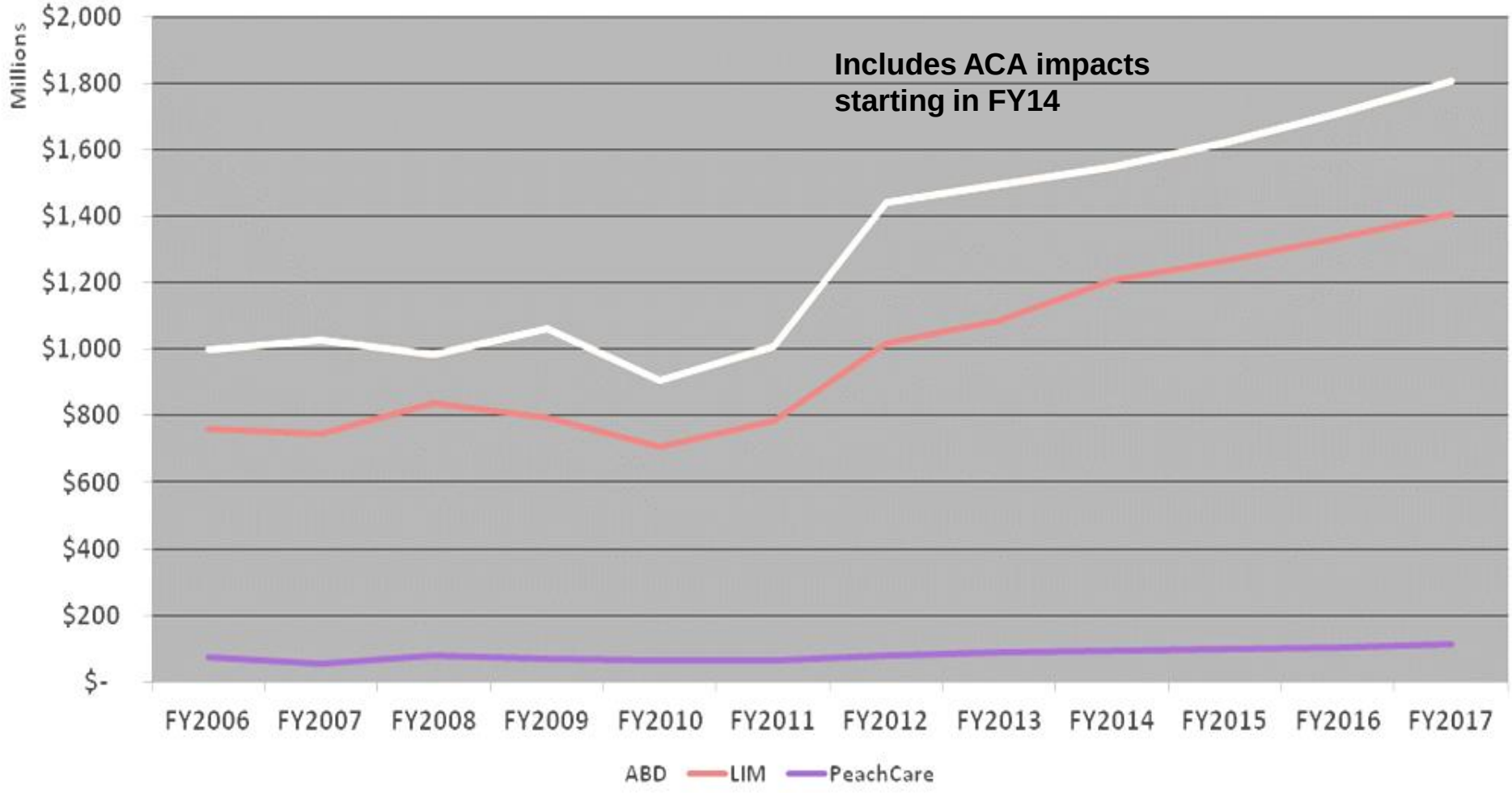
FY06-FY13 Represents paid claims for each fiscal year. FY14-FY15 represented projected expenses. FY16-FY17 are increased by an average rate of growth.

Medicaid and PeachCare State Cost Trends



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FY06-FY13 Represents paid claims for each fiscal year. FY14-FY15 represented projected expenses. FY16-FY17 are increased by an average rate of growth.

Medicaid and PeachCare Growth Trends – Georgia View

	2000	2010	2014	2020
Enrollees	1,044,406	1,662,756	1,885,330	2,396,016
% of State Population	11.56%	17.16%	18.56%	21.15%
State Funds (millions)	$ 1,409	$ 1,681	$ 2,850	$ 3,907
% State Revenue	10.20%	11.58%	15.57%	16.59%
Total Funds	$ 3,537	$ 7,684	$ 9,496	$ 12,840
PMPM	$ 282.18	$ 385.08	$ 419.74	$ 446.59

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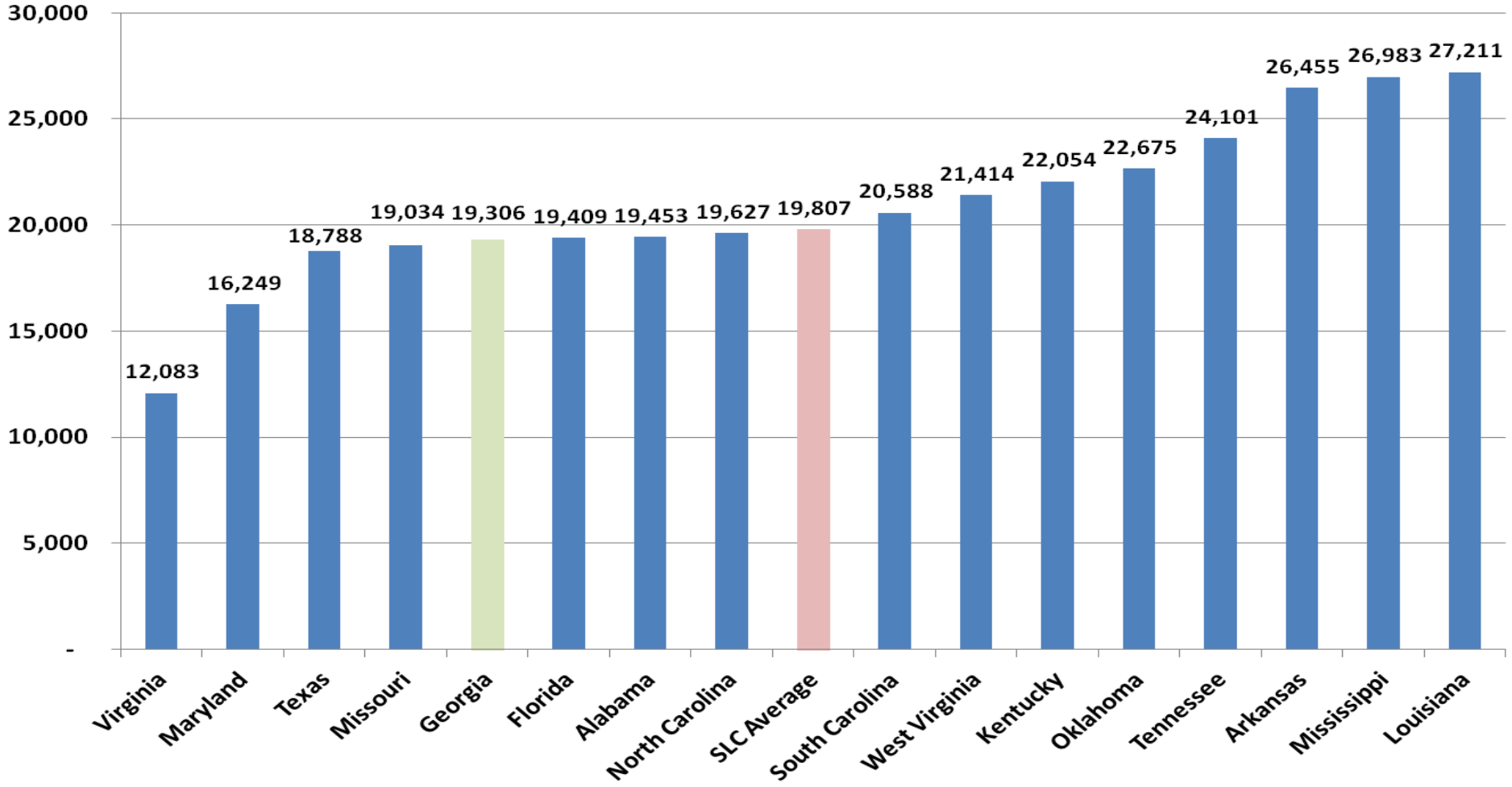
Georgia Compared to Other Southern States

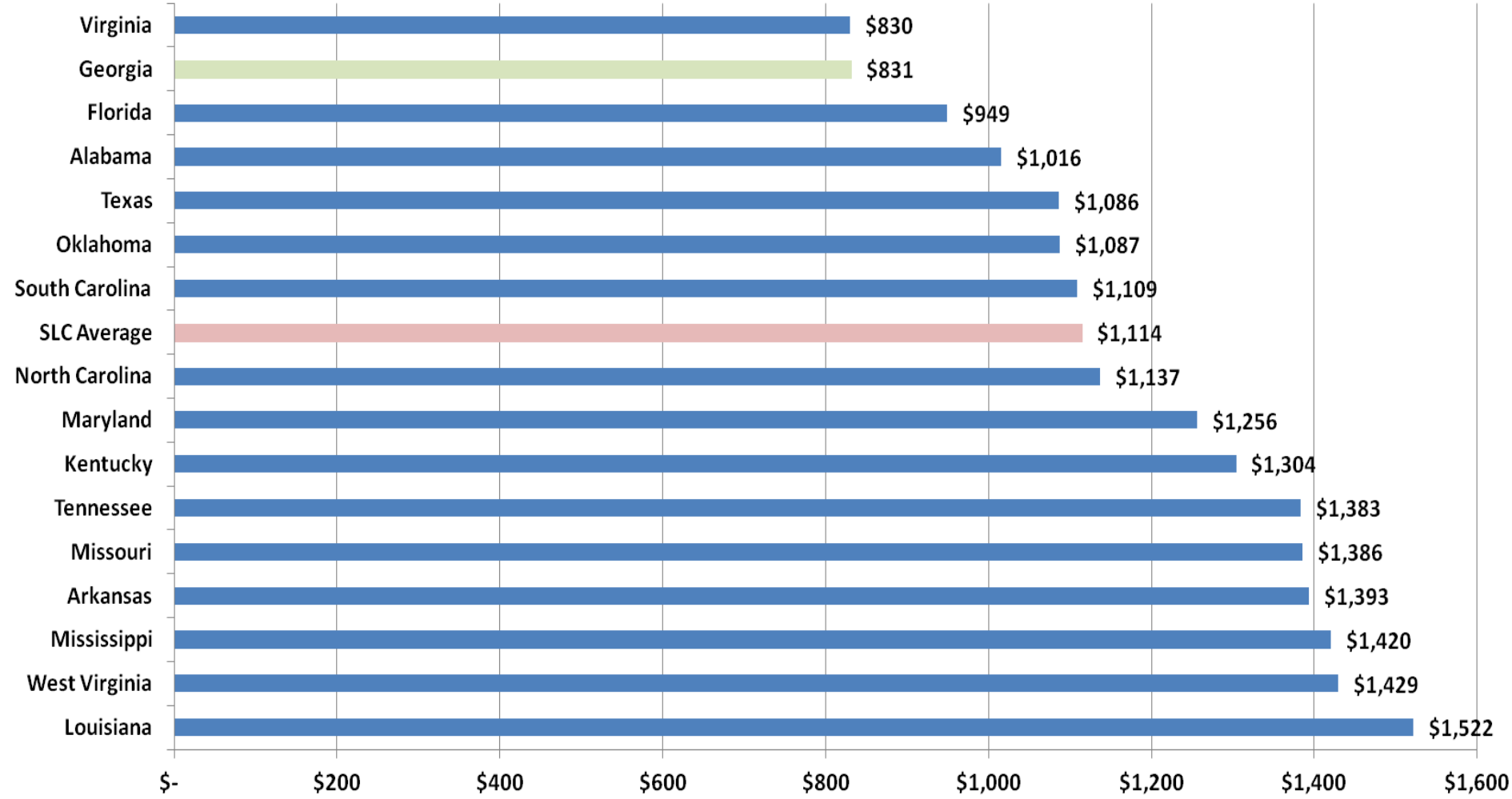
Georgia Comparison

- Comparison is based on information from the *Comparative Data Report on Medicaid* 2010 from the Southern Legislative Conference.
- Data is from Federal Fiscal Year 2010 and represents only Medicaid.
- Southern Legislative Conference includes: Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, Missouri, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia.

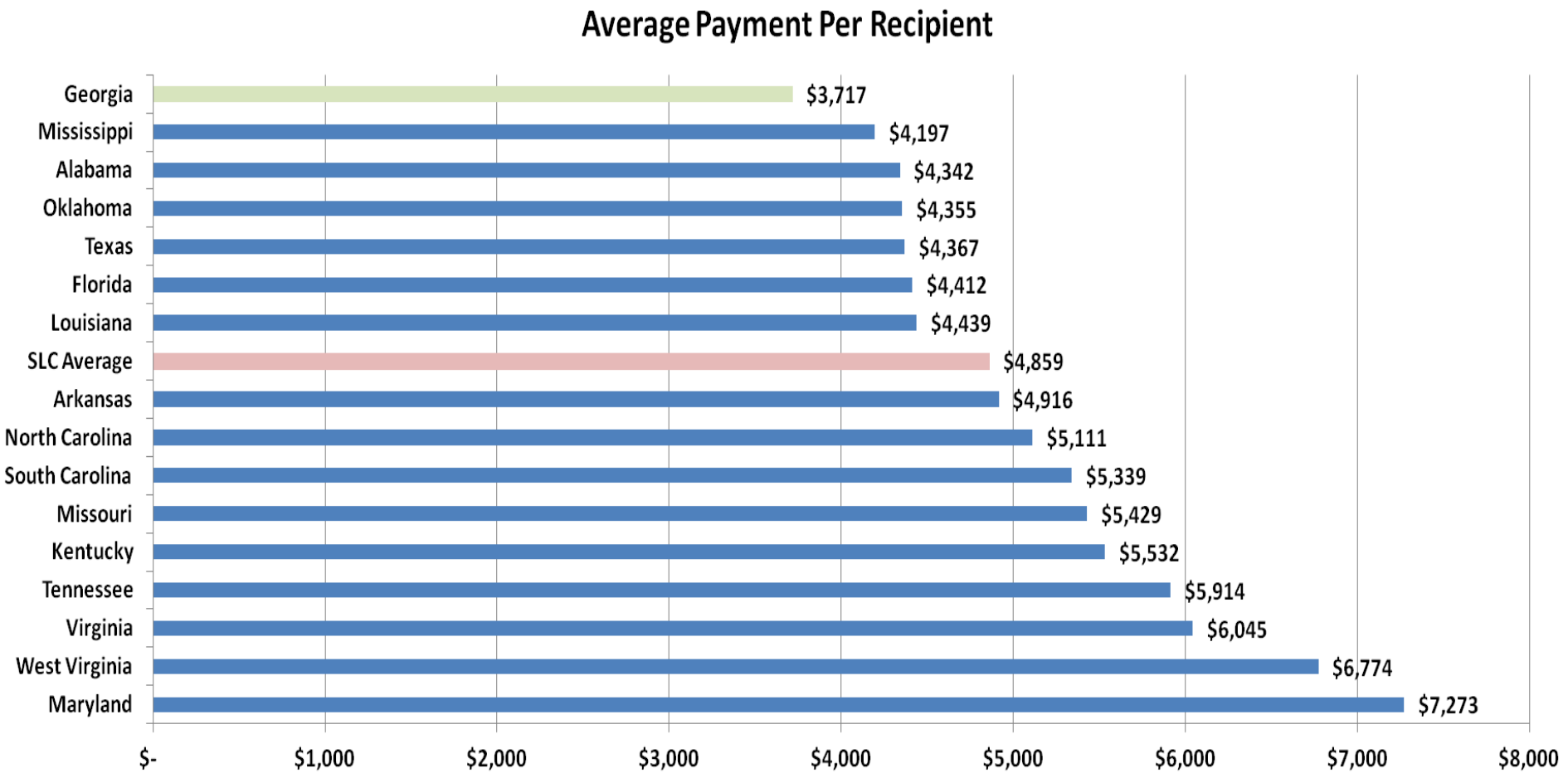
Medicaid Recipients per 100,000 Population (FFY10)



Medicaid Expenditure per Capita (FFY10)



Average Medicaid Payment per Recipient (FFY10)



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Historical Program Changes

Managing Cost in Medicaid

- There are four main categories the State can use to control Medicaid spending growth:
  - **Eligibility**
  - **Scope of Benefits**
  - **Utilization**
  - **Price**

Medicaid Cost Control Initiatives

FY 2004 - 2005

- Pharmacy Program Management
  - Preferred Drug List
  - Supplemental Rebates
  - Quantity Limits
- Outpatient hospital reimbursement reduced

FY 2006

- Care Management Organizations Statewide capitated program for Low Income Medicaid and PeachCare for Kids - June 2006
- Disease Management for select Aged, Blind, and Disabled members
- Eligibility Criteria more stringently applied
  - Emergency Medical Assistance
  - Katie Beckett (FY 2005)
  - Proof of Citizenship and Income
  - Asset Transfer for Long Term Care
- Medicare Part D implementation

FY 2007

- Administrative Services for non-CMO members
  - Level of Care Determination
  - Clinical Reviews
  - Fraud and Abuse

FY 2008 – FY 2010

- Review and Removal of duplicate Medicaid ID's
- Focus on community-based long term care services to delay/avoid institutional care
- Medicaid Program Integrity
  - Fraud and Abuse Detection
  - False Claims Act
- Drug Company National Settlements
- CMO rates set at the low end of the actuarially sound rate range
- Transition to a PASRR provider delivery system versus a vendor delivery system
- Conversion to new MMIS resulting in further clean up of eligibility files and enhanced ability to control the medical benefit.
- Modifications to drug rebate program and dispute resolution process increase drug rebates
- Realignment of DME pricing methodology
- Hospital Provider Fee

Medicaid Cost Control Initiatives

FY2012 – Present

- Home and Community Based Services
- Eliminated payment for elective births prior to the 39th gestational week
- Reduced the number of narcotic prescriptions without prior authorization to 4 per month
- Eliminated reimbursement for preventable admissions and hospital acquired conditions
- Implemented the National Correct Coding Initiative (NCCI) procedure to procedure code edits
- Better enforcement of level of care qualifications analysis for long term care and home and community based services
- Moved from Consultation Codes to E&M Codes for Physician Services
- Tightened Level of Care enforcement for waiver programs
- Modified payment methodology for certain Medicare crossover payments
- Established a specialty pharmacy reimbursement rate

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Affordable Care Act (ACA) Impact

Affordable Care Act Impact

- The items below represent required changes to Medicaid even with Georgia opting out of the expansion:
  1. Woodwork Effect
  2. Federal Premium Tax
  3. Transfer of kids aged 6-18 year old with a federal poverty level of 100%-138% from PeachCare to Medicaid
  4. Primary Care Physician provider rate increases to match Medicare rates (January 1, 2013 – December 31, 2014)
  5. Change from six month to twelve month eligibility reviews

Woodwork Effect

- DCH is planning on an additional 46,000 Georgians in FY14 and 65,000 in FY15 who meet current Georgia requirements for Medicaid.
- These are members who have not been previously enrolled in the program. DCH expects these members to qualify for Medicaid and PeachCare for three reasons:
  - Through the federal mandate on individuals required to have health coverage or face a financial penalty,
  - Use of the Exchange to identify additional Medicaid and PeachCare members,
  - And the increase in advertising of ACA.
- State cost – for FY14 $14.3 million and $40.9 million in FY15

Federal Premium Tax

- Part of ACA funding mechanisms is a new federal premium tax on all managed care companies including those who provide Medicaid services.
- The tax is based on the total book of business not just the work in Medicaid.
- This new tax will increase the capitation rates paid to the three CMOS participating in the traditional Georgia Families program and the new Foster Care and Adoption Assistance managed care program.
- These additional tax funds are due annually in September.
- Estimated State Cost for FY15 = $29,300,000

PeachCare Transfer to Medicaid

- ACA expanded the minimum Medicaid coverage for children 6-18 years old. The new minimum coverage is now up to 138% from 100%.
- Children in PeachCare who are 6-18 with income 100%-138% will be transferred to Medicaid.
- Federal government is allowing the state to maintain the enhanced FMAP on these children even after they move. Plus Georgia is allowed to collect enhanced FMAP for any future children who meet these qualifications.
- Approximately 59,000 members will transfer from PeachCare to Medicaid.

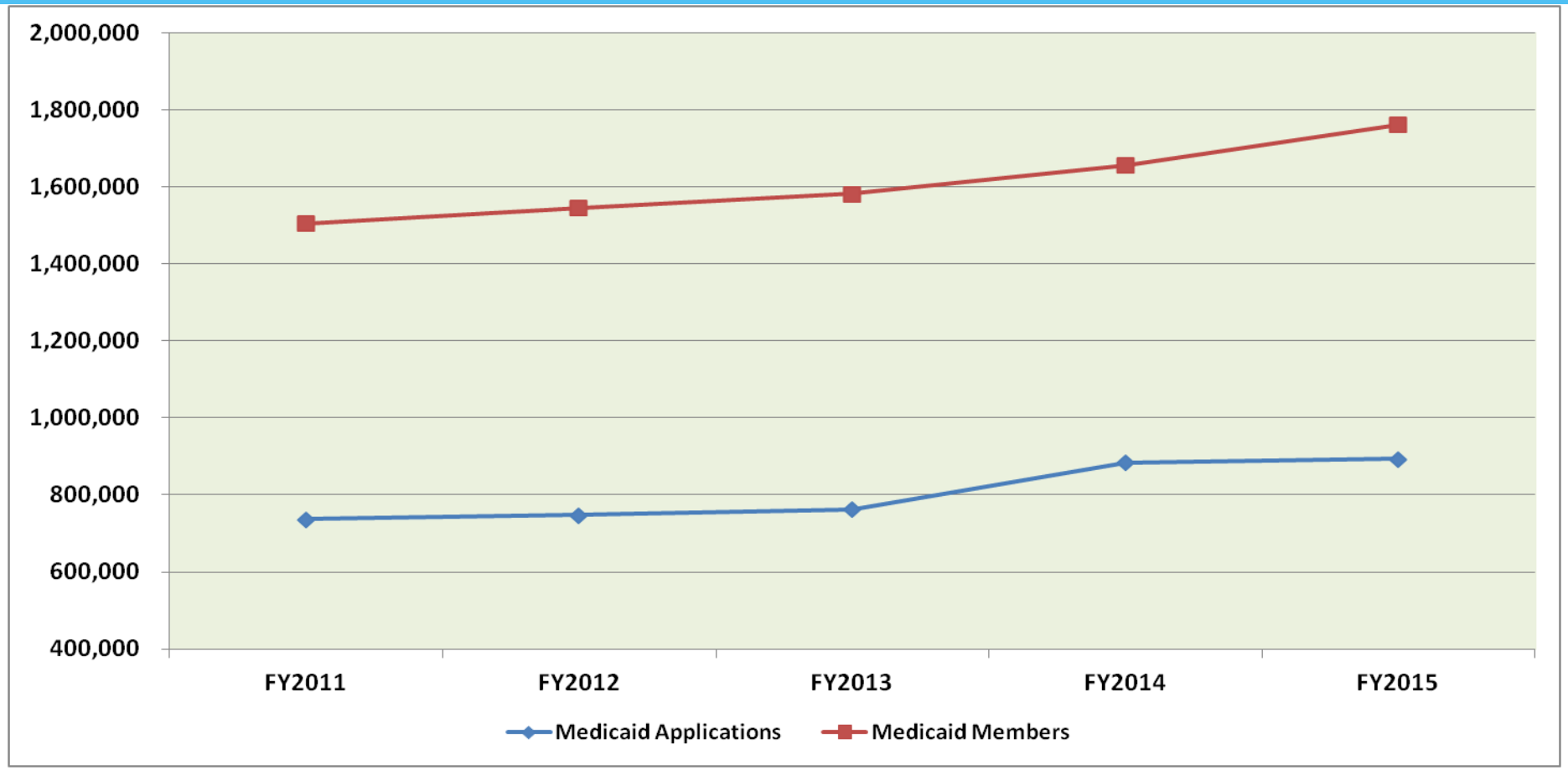
Primary Care Physician Payment Rate Increase

- ACA requires that primary care physician rates match Medicare rates from January 1, 2013 – December 31, 2014.
- The additional funds required for the rate increase is supposed to be 100% funded by the federal government.
- However, there is one increase not covered by the CMS. State funds are required for the increase in the capitation rate for the state CMO tax caused by increasing the provider rates.
- Approximate cost to the state - $2.1 million in FY14 and $1.1 million in FY15.

Six to Twelve Month Eligibility Reviews

- ACA requires that eligibility for Medicaid recipients be reviewed on a 12 month basis. Not to be confused with 12 month continuous eligibility which is still not required.
- This requirement changes DCH's current policy of eligibility reviews every 6 months for adults and children in LIM. ABD members are already reviewed every 12 months.
- This requirement begins January 1, 2014.
- State costs - $9.7 million in FY14 and $28.7 million in FY15

Medicaid Application Projections



FY2011, FY2012 and FY2013 are actual application counts per DHS. FY2014 and FY2015 are projected based on ACA impacts.

Summary of Fiscal Impact of ACA

FY2014

Budget Item	ABD	LIM	PeachCare	Administration	Total
ACA - Move to 12 month reviews	$ -	$ 9,700,000	$ -	$ -	$ 9,700,000
ACA – State Insurance Premium Tax	$ -	$ 2,100,000	$ -	$ -	$ 2,100,000
ACA - Woodwork impact	$ -	$ 9,700,000	$ 4,600,000	$ -	$ 14,300,000
ACA - MMIS contract increase	$ -	$ -	$ -	$ 755,000	$ 755,000
Total ACA	**$ -**	**$ 21,500,000**	**$ 4,600,000**	**$ 755,000**	**$ 26,855,000**

FY2015

Budget Item	ABD	LIM	PeachCare	Administration	Total
ACA - Federal premium tax	$ -	$ 26,300,000	$ 3,000,000	$ -	$ 29,300,000
ACA - Move to 12 month reviews	$ -	$ 28,700,000	$ -	$ -	$ 28,700,000
ACA – State premium tax increase	$ -	$ 1,100,000	$ -	$ -	$ 1,100,000
ACA - Woodwork impact	$ -	$ 29,000,000	$ 11,900,000	$ -	$ 40,900,000
ACA - MMIS contract increase	$ -	$ -	$ -	$ 1,690,000	$ 1,690,000
Total ACA	**$ -**	**$ 85,100,000**	**$ 14,900,000**	**$ 1,690,000**	**$ 101,690,000**

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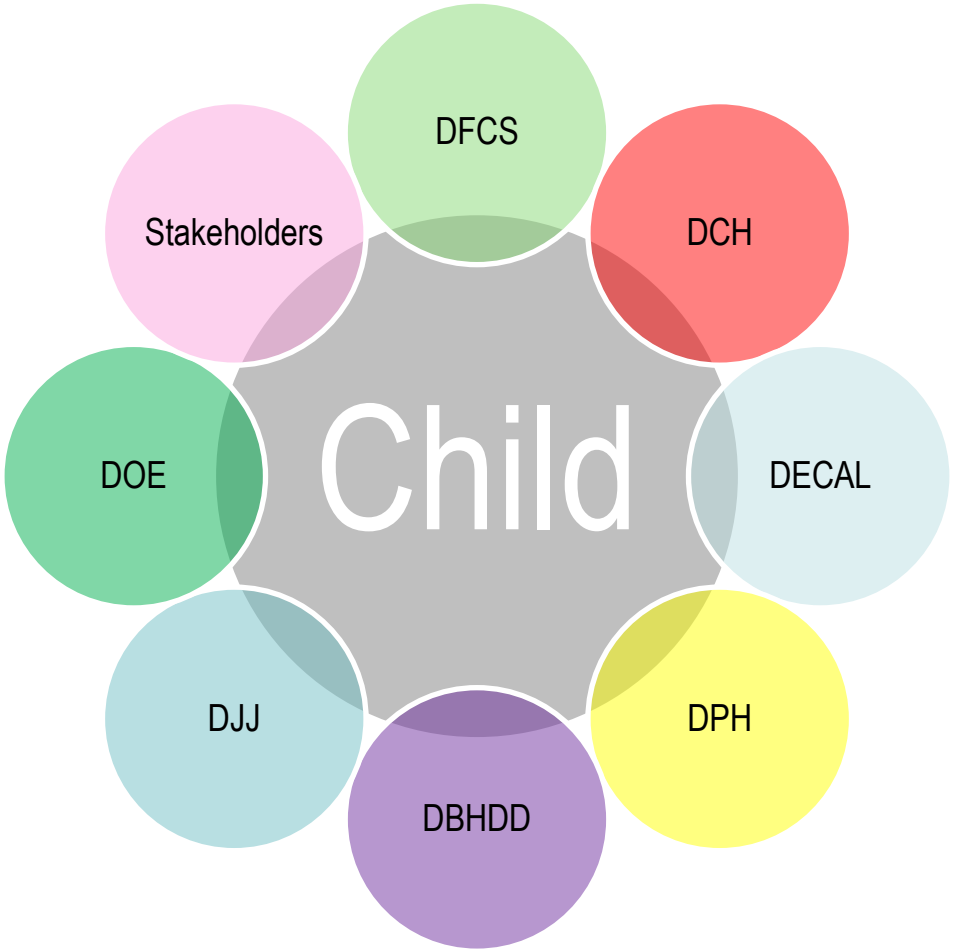
Highlighted Current Projects

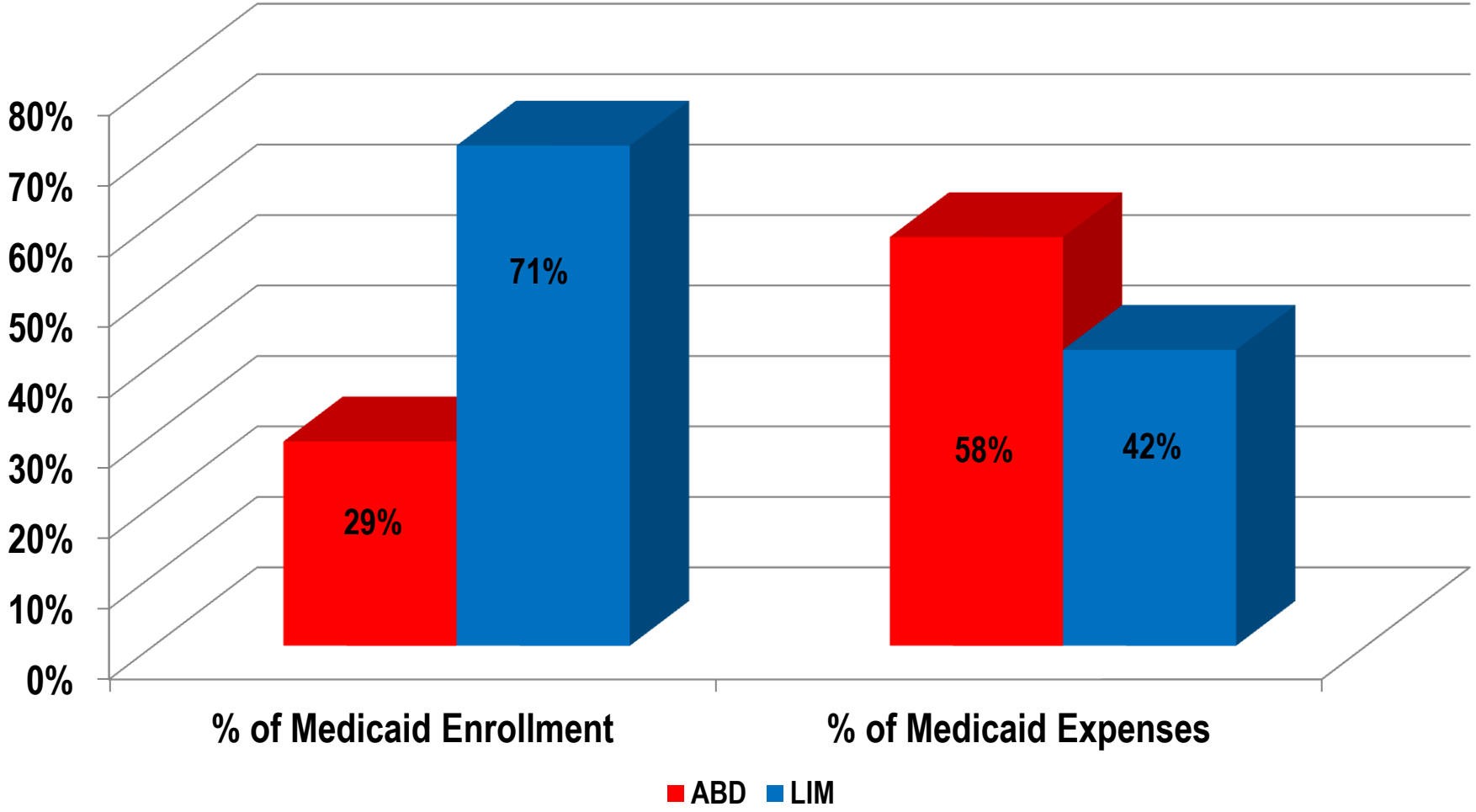
Foster Care and Adoption Assistance

- Transition ~27K Children to a single, state-wide CMO
- Targeted implementation: January 2014
- Develop a portable health record
- Improve medical oversight
- Better coordinated care
- Increase preventive screening rates
- Appropriate treatment of behavioral health conditions
- Enhance coordination across sister agencies

Multi-Agency/Partner Effort



Aged, Blind and Disabled versus Low Income Medicaid



How Much Does It Cost?
Costs Per Member (FY2013 vs. FY2012)

Program	Age Group	FY12 Per Member Per Year	FY13 Per Member Per Year	Percentage Change
Medicaid	Age less than 1 year	$ 8,283.08	$ 8,013.45	-3.26%
	Age 1 - 5 years	$ 2,043.17	$ 2,047.59	0.22%
	Age 6 - 12 years	$ 2,013.39	$ 2,019.55	0.31%
	Age 13 - 18 years	$ 3,036.22	$ 2,969.52	-2.20%
	Age 19 - 20 years	$ 4,870.30	$ 3,534.17	-27.43%
	Age 21 - 44 years	$ 7,997.25	$ 7,674.07	-4.04%
	Age 45 - 64 years	$ 11,370.12	$ 11,490.41	1.06%
	Age 65 - 74 years	$ 4,889.20	$ 5,051.06	3.31%
	Age 75 - 84 years	$ 8,434.24	$ 9,138.81	8.35%
	Age 85 years and up	$ 17,141.52	$ 19,155.61	11.75%
	Average	$ 5,128.12	$ 5,108.93	-0.37%
PeachCare	Age less than 1 year	$ 2,645.78	$ 3,069.36	16.01%
	Age 1 - 5 years	$ 1,586.03	$ 1,777.63	12.08%
	Age 6 - 12 years	$ 1,583.62	$ 1,699.60	7.32%
	Age 13 - 18 years	$ 1,800.63	$ 1,939.93	7.74%
	Age 19 - 20 years	$ 1,811.07	$ 1,947.39	7.53%
	Average	$ 1,659.66	$ 1,800.99	8.52%

ABD Care Coordination Model

What we heard from stakeholders:

- *Segments of ABD population would significantly benefit from intensive care management*
- *Use navigators to help members obtain timely needed services*
- *Use a person-centered model with a holistic view of an individual's needs*
- *Improve care coordination for Medicaid/Medicare dual eligibles*
- *Contractor monitoring and oversight must be DCH priority*

ABD Approach

- Designing Care Coordination model for all ABD populations
- Features:
  - Single statewide vendor
  - Fee-for-Service environment
  - Care coordination, case management, disease management
  - Patient Centered Medical Home
  - Primary Care Case Management Model
  - Provider Engagement
  - Value Based Purchasing

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Integrated Eligibility System (IES)

Integrated Eligibility System (IES)

- Call for Change
  - Current eligibility system is over 15 years old
  - Federal government offering 90% federal match on development of new eligibility systems
  - Hard coded system with limited flexibility
  - Numerous modifications needed comply with ACA requirements
- $10 Million bond money approved by 2012 General Assembly

Integrated Eligibility System (IES)

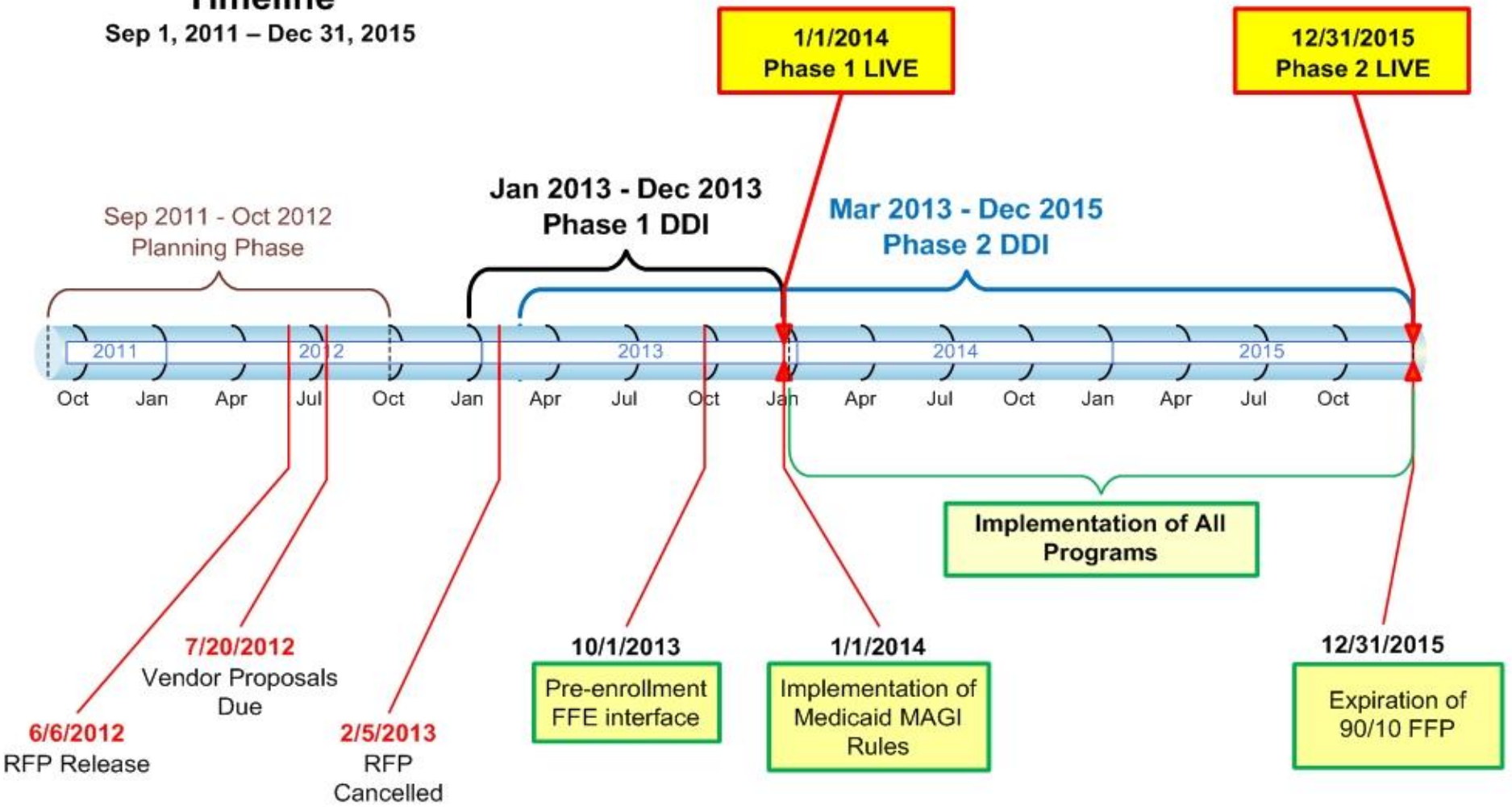
- Multiple Agency Involvement
  - State Level
    - DCH, DHS, DPH, DECAL, GTA, OPB, DOAS
  - Federal Level
    - CMS, FNS, ACF, CCIO
- Replace Eligibility System for Public Assistance Programs
  - Medicaid; TANF; Food Stamps; Subsidized Child Care; Low Income Energy Programs
- Phased Approach

Phased Approach

- IES implementation is in two phases:
  - **Phase 1** – compliance with Affordable Care Act Medicaid Changes
  - **Phase 2** – full replacement of current Eligibility System incorporating multi-agency programs

Integrated Eligibility System Timeline

Sep 1, 2011 – Dec 31, 2015



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Questions & Answers