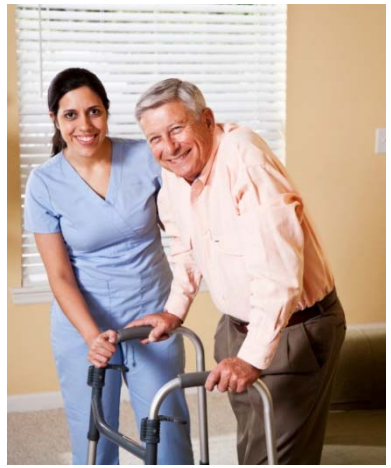






Health Care Finance and Administration
FY 2015 Budget Presentation

Darin Gordon
Dr. Wendy Long
Casey Dungan

Improving Quality, Controlling Cost

TennCare was the first state in the nation to enroll its entire Medicaid population into managed care. The use of managed care along with proper oversight has allowed TennCare to control medical trend while improving quality.

Quality

HEDIS Scores and NCQA Rankings

Showed improvement over last year in 73 out of 99 continuing HEDIS measures:

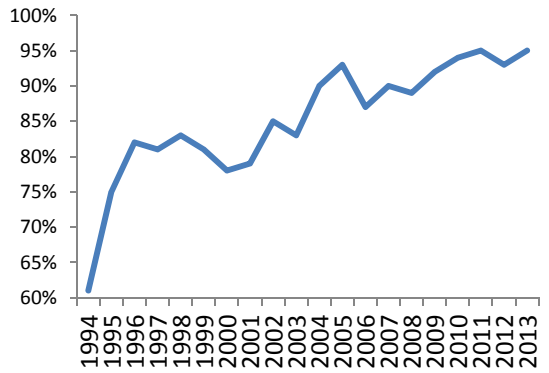
- 64 out of 99 measures ranked above the 2012 HEDIS National Average. Examples of improved measures include:
  - Prevention and screening measures such as Adult BMI Assessment, Childhood and Adolescent Immunizations and Cervical Cancer Screening.
  - Disease specific measures related to asthma and cardiovascular conditions.
  - Access to primary care physicians across all ages.
  - Utilization of care such as Frequency of Ongoing Prenatal Care and Well–Child Visits.

NCQA Accreditation:

- All three MCOs are rated “commendable”.
- All of TennCare’s health plans continue to be ranked in the top 100.
- TennCare plans represent three of the top four rated Medicaid plans in the Southeast.

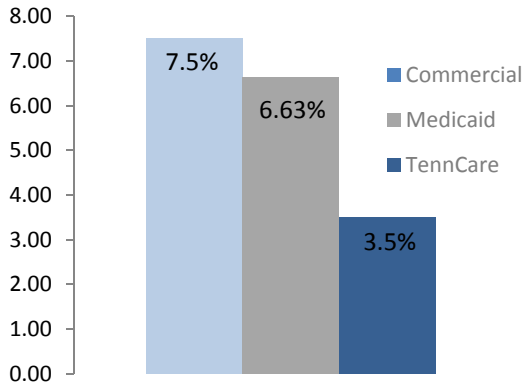
Member Satisfaction

- UT conducts an annual survey of TennCare members.
- Satisfaction has remained above 90% for the past 6 years.



Costs

This graph shows projected medical trend average over a three-year period for commercial insurance, Medicaid as a whole, and TennCare. (Sources: Price WaterhouseCooper, CMS Office of the Actuary and TennCare budget data)



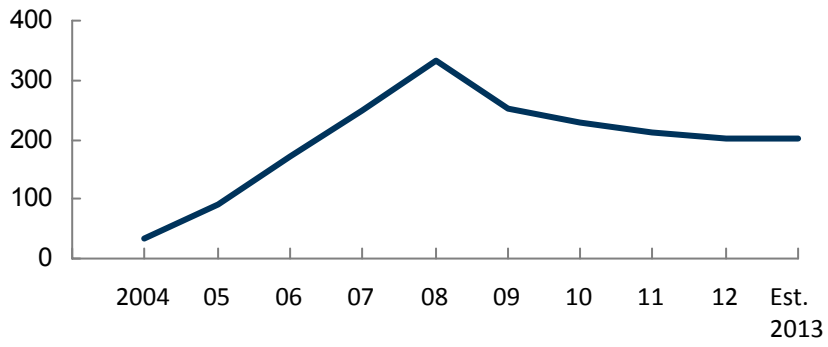
Data-Driven Decision Making

Effective use of data helps control costs

- TennCare was a pioneer and continues to be recognized as a leader in translating enrollment and encounter data into actionable information. The health care analytics unit was created in 2002.
- This unit allows HCFA to identify cost-drivers and modify programs to reduce trend.

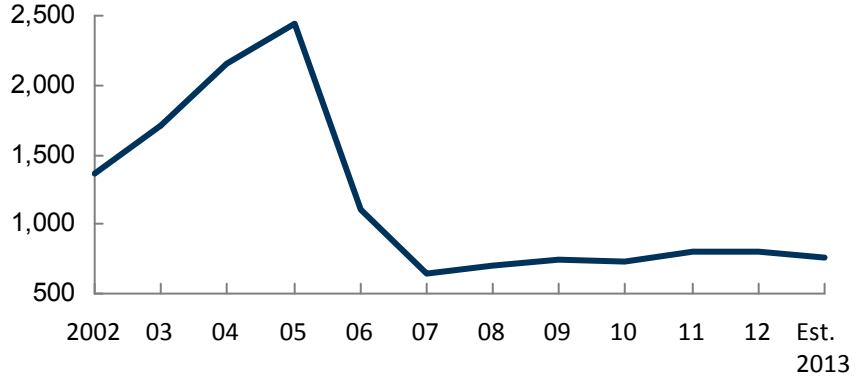
HH/PDN spend

$ Millions



Pharmacy spend

$ Millions



Efficiencies Through Service Integration

Health Plan

Medical

Behavioral

Long-Term Services and Supports

Next steps on integration of dual eligible enrollees

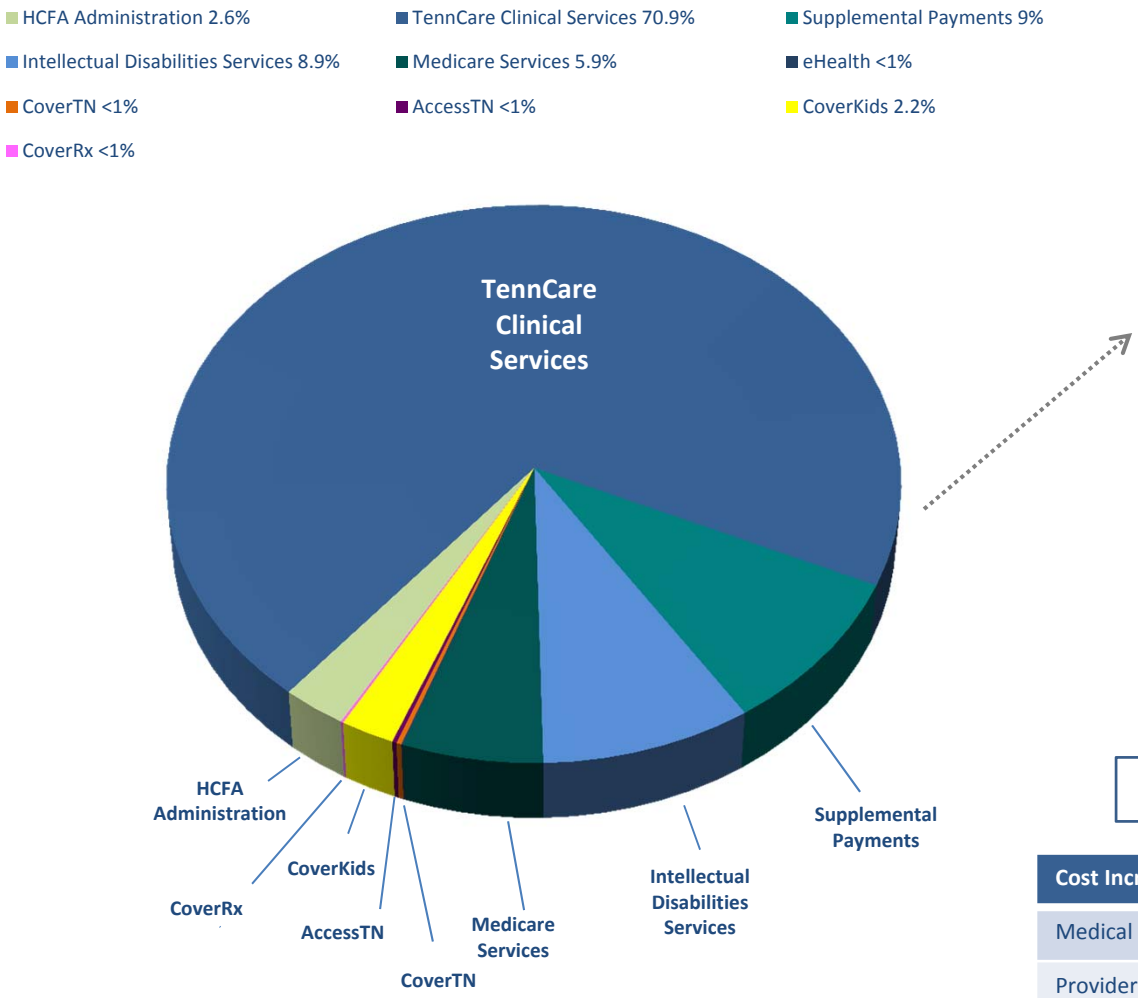
- Leverage Medicare managed care authority and member education to help align dual eligible members' enrollment in the same health plan for Medicare and Medicaid.
- Continue to develop requirements and state monitoring processes to improve coordination over time.
- Help shape federal policy that will support better integration and coordination of care.

"**Tennessee** is often recognized nationally as the **gold-star standard** for managed care contracting and management of MCOs."

Rebid of the TennCare MCOs

- RFP released Oct. 2 – proposals were due to the state Nov. 21.
- Winners have been announced:
  - Blue Cross and Blue Shield
  - Amerigroup
  - United
- Members will transition to the selected MCOs starting in Jan. 2015.
  - Focus special attention on members who are pregnant, have chronic diseases, or are enrolled in CHOICES.
  - Daily calls for at least two weeks prior to transition and after go-live to ensure appropriate handling of member transitions.
- Highlights of the new contract:
  - TennCare will have three statewide MCOs. Today there are two operating in each grand region.
  - Continued emphasis on improved quality and move toward value-based purchasing.

Current HCFA Budget and Cost Increases



Total FY 2014 Budget

- **HCFA : $10.3 billion ($3.3 billion state)**
- **Of which, $10 billion ($3.2 billion state) is TennCare**

FY 2015 Est. Cost Increases

Cost Increases	State	Total
Medical inflation and utilization	$62,725,000	$179,547,700
Provider integrity positions	-	432,400
TOTAL	**$62,725,500**	**$179,980,100**

HCFA FY 2015 Reduction Plan

Item	State	Total
Reduced costs through managed care	**($14,093,200)**	**($40,850,000)**
• Renegotiate pharm. supplemental contracts	(897,000)	(2,600,000)
• Risk component in dental service contract	(2,846,200)	(8,250,000)
• Savings from more efficient lab contracting	(7,245,000)	(21,000,000)
• Reduce unnecessary inpatient care before behavioral health treatment	(1,725,000)	(5,000,000)
• Improve case management and care coordination for home health	(862,500)	(2,500,000)
• Value-based trend reduction	(517,500)	(1,500,000)
Targeted utilization management strategies	**(2,863,500)**	**(8,300,000)**
• Changes to PDL and clinical criteria for ADHD drugs	(1,138,500)	(3,300,000)
• Establish limits on adult incontinence products	(1,035,000)	(3,000,000)
• "Choosing Wisely" Initiative	(690,000)	(2,000,000)
Combat fraud and abuse	**(2,898,000)**	**(8,400,000)**
• Changes to PDL and quantity limits for opiates	(1,173,000)	(3,400,000)
• Fraud reduction from out-of-network narcotic prescriptions	(1,725,000)	(5,000,000)
ACA-related eligibility changes	**(22,581,000)**	**(55,352,200)**
• Eliminate Standard Spend Down program due to health reform	(11,121,800)	(32,237,100)
• Cover Tennessee Reductions	(9,584,200)	(23,115,100)
• State dollar savings from enhanced federal match for eligibility system	(1,875,000)	

Item	State	Total
Reductions in grant funding	**(2,650,000)**	**(2,650,000)**
• Eliminate discretionary grants	(2,650,000)	(2,650,000)
Increase patient co-payments	**(6,737,700)**	**(19,529,700)**
• Increase medical co-payments to new maximums	(6,737,700)	(19,529,700)
Provider reimbursement changes	**(24,467,000)**	**(70,918,800)**
• Extend non-emergency triage fee to providers treating members ages 1-2	(586,500)	(1,700,000)
• Reduce rate for brand-name drugs	(5,382,000)	(15,600,000)
• Reduce provider rates by 1% (non IDD waiver services)	(18,498,500)	(53,618,800)
Total Reductions	**($76,290,400)**	**($206,000,700)**

Total Recommended FY 2015 Budget*:

- **HCFA: $10.5 billion ($3.4 billion state)**
- **Of which, $10.2 billion ($3.3 billion state) is TennCare**

*Figures include non-recurring sources of revenue such as the enhanced coverage fee and the nursing home bed tax which total approximately $1.5 billion total ($532.1 million state).

Impact of ACA and FMAP Change

As a state, we must comply with provisions included in the Affordable Care Act (ACA). Some of these provisions have required considerable time and resources in order to meet requirements of the Act.

Changes to the Cover Tennessee Programs

CoverKids: Coverage for the buy-in population ended Dec. 31 as families are able to purchase insurance in the Marketplace. The buy-in population was families who made too much to qualify for the program - over 250% FPL.

CoverTN: Coverage ended Dec. 31 as the program does not meet the new requirements mandated by the Affordable Care Act and due to the fact that individuals are able to obtain coverage through the Marketplace. The federal government denied the state's request to extend coverage due to enrollment difficulties in the Marketplace

AccessTN: Members not receiving premium assistance will have access to coverage in the Marketplace at lower premiums. Since individuals will be able to access lower cost coverage in the Marketplace, eligibility was scheduled to be limited to those existing members with incomes below the federal poverty level AND who currently receive premium assistance on Dec. 31, 2013. However due to reported enrollment difficulties in the Marketplace coverage for all members has been extended to April 30, 2014.

CoverRx: CoverRx closed to members above the federal poverty level on Dec. 31, due to new opportunities through the Marketplace.

Complete Redesign of Eligibility and Enrollment Systems and Process

- The federal government, under the ACA, made changes to the way income is calculated for Medicaid and CHIP and changed the way individuals apply for/access coverage.
- HCFA is creating a new Service Center to assist individuals with the application process as well as support the eligibility determination process.

Mandated Changes to the TennCare program

- Mandatory coverage of benzodiazepines and barbiturates.
- Mandatory expansion of eligibility for children.

FY2015 Cost Increases due to ACA and FMAP	State	Total
ACA-related cost increases	$76,903,500	$220,133,100
Annualized cost of Eligibility Service Center	1,250,000	5,000,000
FMAP rate change	32,866,800	-
Total	**$111,020,300**	**$225,133,100**

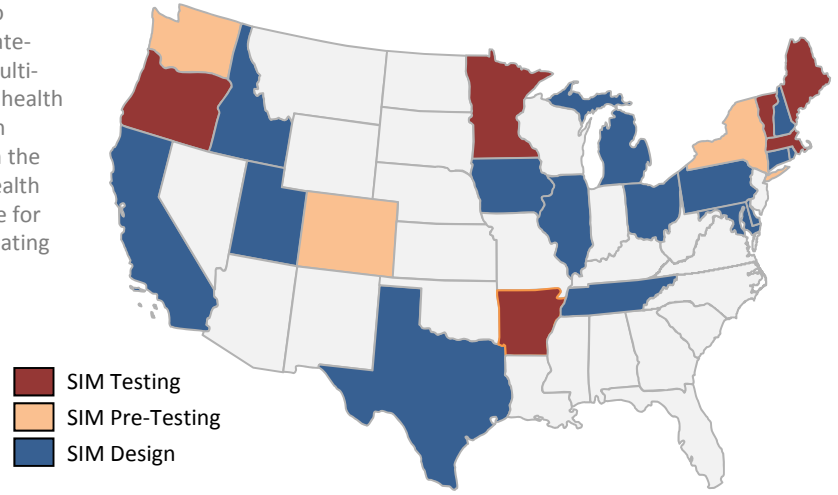
Delivery System Transformation

- Payment Reform is essential since the current health care delivery system as a whole is simply not sustainable.
- Right now the system is mostly "fee-for-service" meaning a service is provided and the provider submits a claim for reimbursement. Therefore more services means more payment.
- Our goal is to pay for outcomes and for quality care, rather than for the amount of services provided – value-based care instead of volume-based.
- This is an issue being examined nationwide and Tennessee is recognized as a leader in this effort.
- The state is working collaboratively with hospitals, medical providers, and payers to work towards meaningful payment reform.
- By working together, we can make significant progress toward sustainable medical trends and improving care.

- Met with more than 100 different groups from across the state in more than 80 meetings between Feb. and Oct. 2013.
- Includes providers, payers and other stakeholders.
- Focus on population-based care (preventative) and episode-based care (acute).
- Three technical advisory groups focused on three initial episodes: total joint replacement, asthma, and labor and delivery.
- Plan to add new episodes every six months.

The State Innovation Models Initiative provides funding for states to develop and test state-based models for multi-payer payment and health care delivery system transformation with the aim of improving health system performance for residents of participating states.

States with SIM Grants



Delivery System Reform

Basis of payment	TN Payment Reform Approach	Examples
▪ Maintaining patient's health over time, coordinating care by specialists, and avoiding episode events when appropriate.	▪ Patient centered medical homes (PCMH)	▪ Encouraging primary prevention for healthy consumers and care for chronically ill, e.g., ▪ Obesity support for otherwise healthy person ▪ Management of congestive heart failure
▪ Achieving a specific patient objective including all associated upstream and downstream care and cost.	▪ Retrospective Episode Based Payment (REBP)	▪ Acute procedures (e.g., hip or knee replacement) ▪ Perinatal ▪ Acute outpatient care (e.g., asthma exacerbation) ▪ Some behavioral health ▪ Some cancers

How retrospective episodes work for patients and providers

Patients and providers deliver care as they do today

1

Patients seek care and select providers as they do today

2

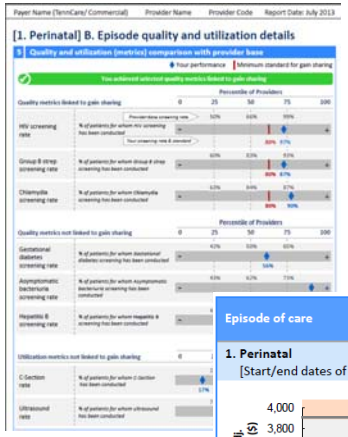
Providers submit claims as they do today

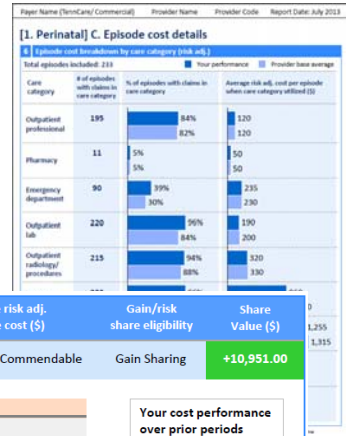
3

Payers reimburse for all services as they do today

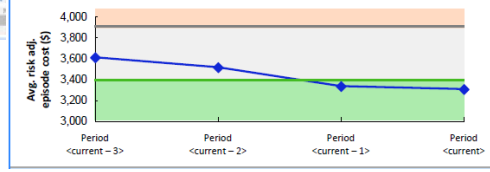
Payers calculate incentive payments based on outcomes after a pre-defined period

'Quarterbacks' are provided detailed information for each episode which includes **actionable data**

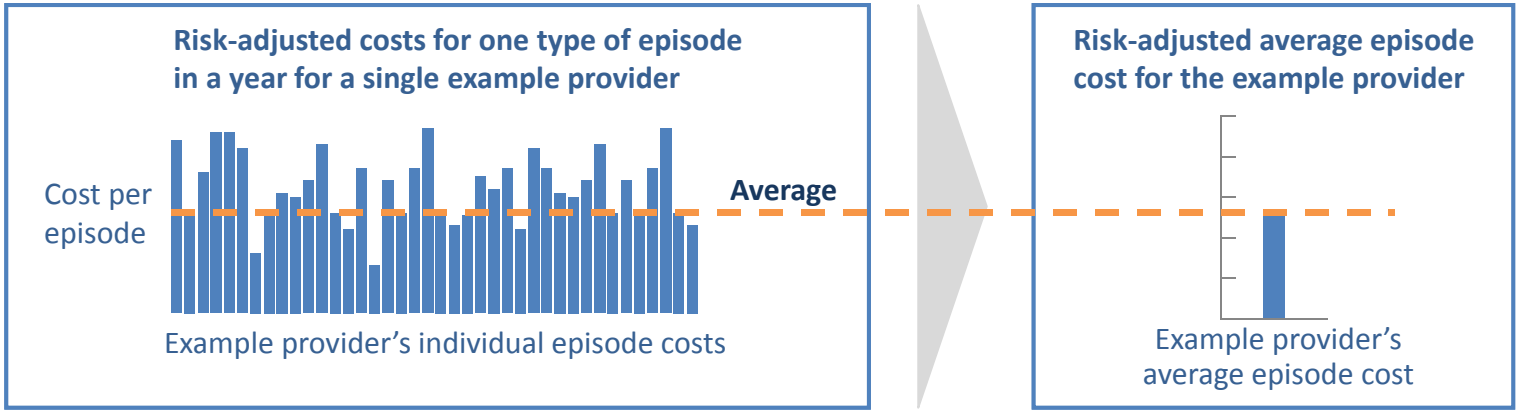


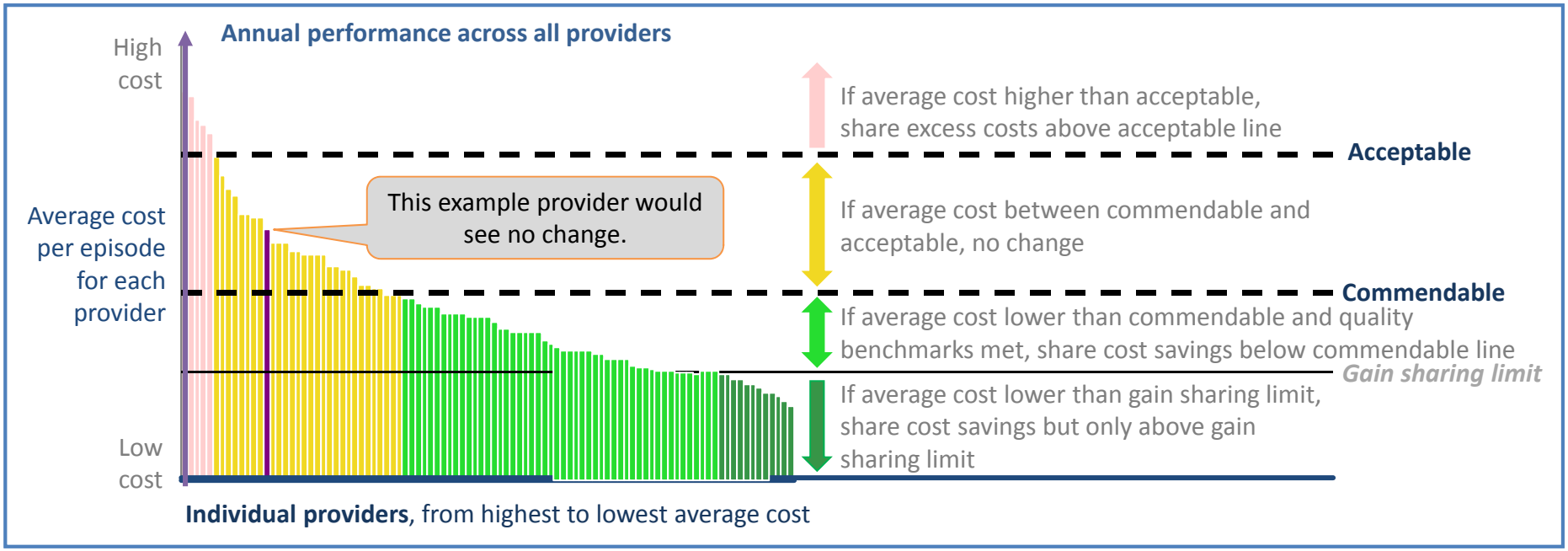


Episode of care	Quality metrics	Average risk adj. episode cost ($)	Gain/risk share eligibility	Share Value ($)
1. Perinatal [Start/end dates of period]	Met	3,300.00	Commendable	Gain Sharing	+10,951.00



Delivery System Reform



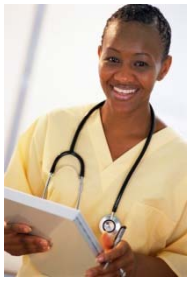


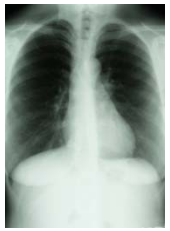
Evolution of Population-Based Reform

Most medical costs occur outside of the office of a primary care physician (PCP), but PCPs can guide many decisions that impact those broader costs, improving cost efficiency and care quality. The vision for Tennessee's Patient Centered Medical Home (PCMH) program is a team-based care delivery model led by a primary care provider that comprehensively manages a patient's health needs.

Patients & families

Specialists



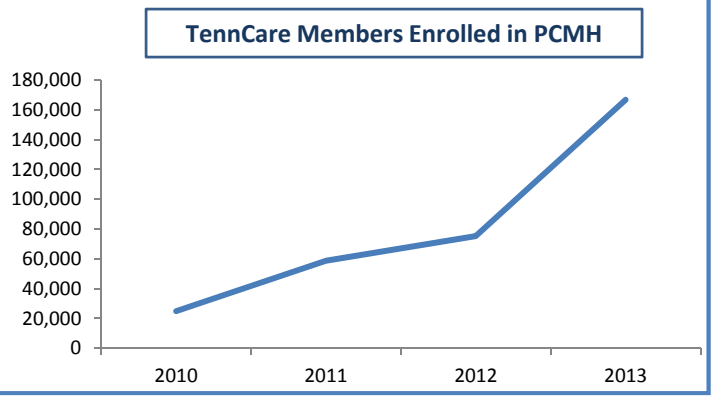


Ancillaries (e.g., outpatient imaging, labs)

Community supports

Hospitals, ERs

- Providers are responsible for managing health across their patient panel.
- Coordinated and integrated care across multidisciplinary provider teams.
- Focus on prevention and management of chronic disease.
- Expanded access.
- Referrals to high-value providers (e.g., specialists).
- Improved wellness and preventative care.
- Use of evidence-informed care.



Conclusion

- Continued leadership – managed care, integration, improving quality, controlling trend.
- Health care reform continues to put financial pressure on the program and the state of Tennessee.
- Persistent cost pressures apart from health care reform.
- Must remain constantly vigilant to effectively manage health care programs.