Healthcare Financial Management Association

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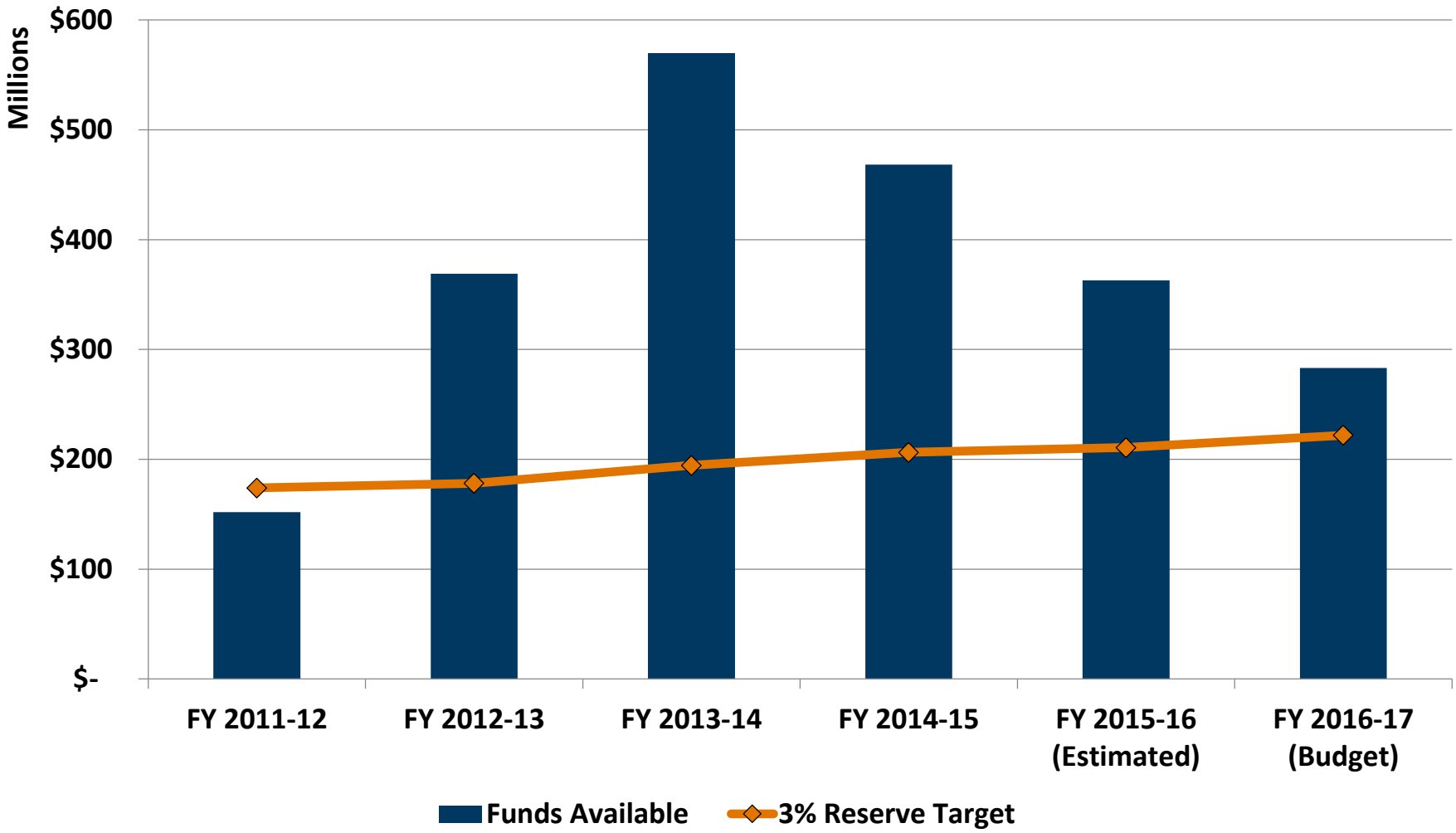
Agenda

- FY 2016-17 reserve status and budget request
- Enrollment and eligibility backlog updates
- Disproportionate Share (DSH)
- Upcoming reimbursement changes
- Managed Care updates
- SCRIPTS policy
- Hospital Transformation
- Medicaid Expansion Funding

Changes in Fund Balances



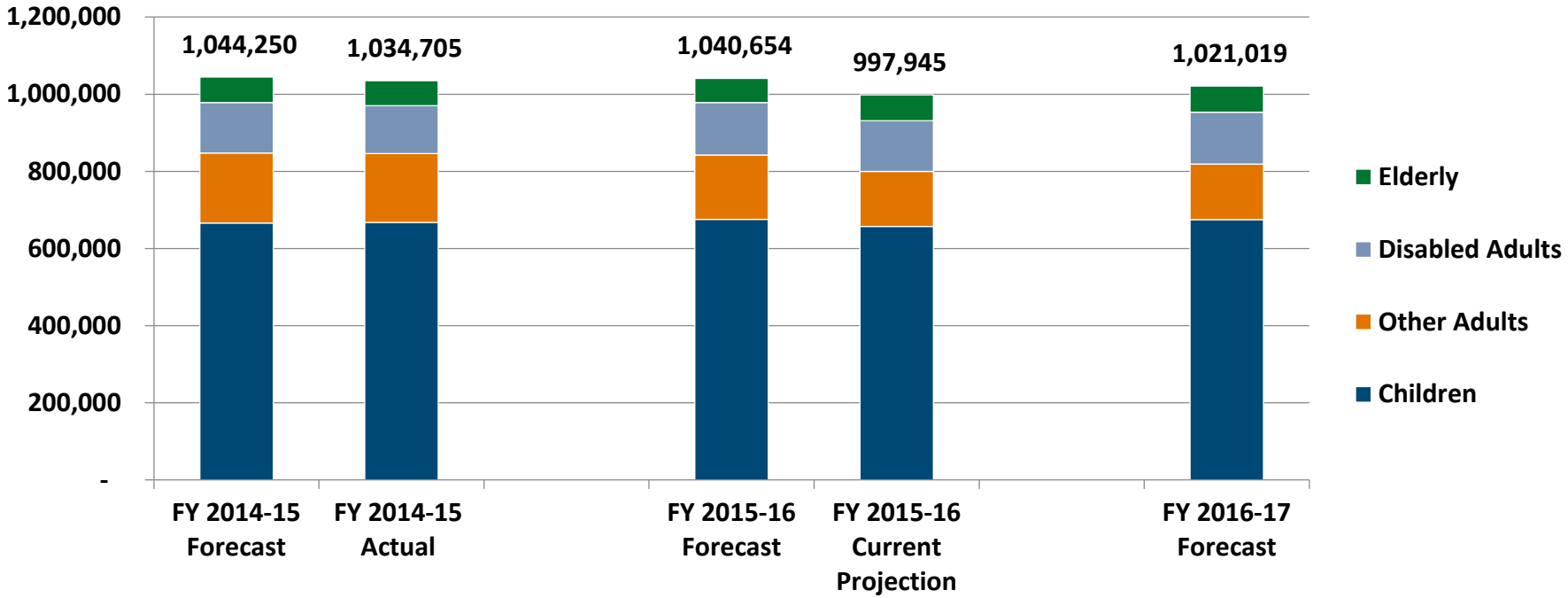
* *FY 2016-17 assumes the agency's request is approved as submitted.*

FY 2016-17 Budget Request

	General Fund	All Funds
Recurring Requests		
1. Partial Annualization (#7594)	$ 149,416,874	$ 382,491,600
2. Cost Reductions (#7409)	$ (20,261,796)	$ (55,442,868)
3. Personnel Base Realignment (#7372)	$ -	$ -
4. Health Insurance Allocation (#7283)	$ 144,919	$ 399,336
FY 2016-17 Recurring Changes	***$ 129,299,997***	***$ 327,448,068***
Non-Recurring Request		
5. Non-Recurring: MMIS (#7247)	$ 8,474,579	$ 8,474,579

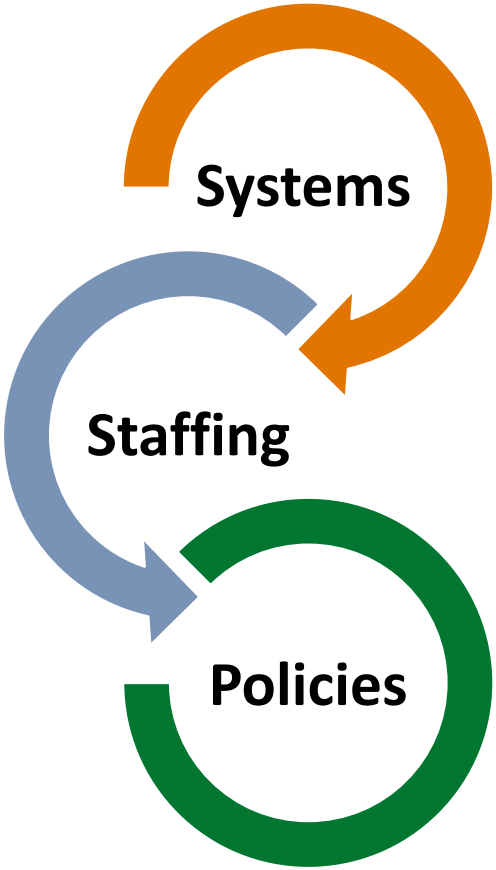
- **If budget is passed as requested, agency total funds budget will be $7.36B.**
- **The agency used about $100 million from reserves in FY 2014-15 and expects to use another $100 million from reserves in FY 2015-16.**
- **The FY 2016-17 request is part of two year request to keep reserves above 3%.**
  - **Cut spending growth to about half of recent levels**
  - **"Builds in" recurring programs funded from reserves (HOP, 2.5% hospital rate increase, etc.)**
  - **Still requires use of $79 million in reserves in FY 2016-17**

Full-Benefit Membership



- **Full-benefit membership continues to hold around 1 million, even with required restart of annual reviews.**
  - **Added an additional month of prior notice of reviews.**
  - **Sharing better reports with managed care plans, earlier than in the past.**
  - **Authorized plans to outreach to members to complete annual review forms.**

Eligibility and Enrollment



Eligibility and Enrollment

- Systems
  - Increased data-matching to send continuation notices instead of review forms, exploring options to utilize data-matching for express lane eligibility.
    - Auto renewals applied to 56% of April annual reviews.
  - Weekly "data fixes," monthly patches/upgrades, bi-weekly IBM meetings.
  - Planning a phased, careful transition for remaining eligibility categories.
- Staffing
  - Posted 170 eligibility slots since July 1st; also using over 300 state and vendor temps.

Eligibility and Enrollment

- **Staffing continued:**
  - **Currently have three shifts of over 150 workers in dedicated processing centers.**
  - **Established Eligibility Administrative Support Team (EAST) to provide status updates on applications.**
  - **Posted 30 positions to establish an Escalation Team to provide more provider support for high-priority cases.**
- **Policies**
  - **Streamlined documentation requirements for long-term care applications.**
  - **Implemented Business Process Redesign to increase first-touch resolution, cut processing time.**
- **For priority cases that need immediate attention, contact MemberRelations@scdhhs.gov.**

DSH Audits

- Interim DSH payments are estimated based on most recent available data, which is two years old.
- CMS is requiring states to perform retrospective reviews of DSH payments to reconcile interim payments to actual uncompensated care costs.
- In FFY 2011, SCDHHS began recovering payments paid to hospitals in excess of their audited hospital specific DSH limits.
  - Approximately $3 million was recovered from 5 hospitals and distributed to 54 hospitals.
- Effective for FFY 2012, SCDHHS amended its state plan to recalculate and redistribute DSH payments to actual costs.
  - $33.6 million in payments shifted with 29 hospitals being overpaid and 29 hospitals being underpaid.
  - Much of the redistribution was a result of the DSH recovery percentage decreasing from the interim rate of 57.33% to the audited rate of 53.43%.
- Hospitals should consider booking reserves and reconciling interim DSH payments to actual.

Reimbursement Changes

- Removed third party coverage workflow attestation link to DSH
- Supplemental Teaching Physician Payment (Phase 1)
  - CMS will no longer allow current methodology of 35% of billed charges.
  - The agency will submit plan amendment to transition to average commercial rate methodology April 1.
- Rehabilitative Behavioral Health Services (RBHS)
  - All RHBS and associated outpatient services will be carved into the managed care benefit July 1.
- FQHCs prospective payment effective July 1
- Nurse Practitioner/Physician Assistant reimbursement
  - NP/PAs were required to enroll separately from physician.
  - Effective July 1, providers will be required to bill separately.

Future Reimbursement Updates

- **Supplemental Teaching Physician Payment**
  - Phase 2 – Define "teaching physician" requirements, consider additional provider types (late 2016/early 2017)
  - Phase 3 – Establish "discretionary pool" of up to 15% to achieve specific policy priorities
- **Readmissions**
  - Original approach was to implement prepayment review and reduce payment as appropriate
  - Modified approach seeks to address structural issues causing readmissions
  - Hospital/MCO workgroup will become the forum for readmission policy
  - Focus on subset of clinical conditions that drive the most readmissions (early 2017)

Future Reimbursement Updates

- **Hospital outpatient payment methodology**
  - Current outpatient methodology outdated - not reflective of service costs, relies on multipliers and historic hospital cost structure
  - SCDHHS in early stages of assessing potential outpatient payment methodologies
    - Potential options include commercial vendor payment models, Medicare-like model, hybrid approach, etc.
    - Will look at other states' outpatient payment methodology
  - Target implementation October 2017 – replacement of MMIS will affect timing

Managed Care Updates

- **Wellcare announced acquisition of Advicare**
  - Affects approximately 32,000 members
  - Members will have option to transfer to other plans as well
- **MCO contract extension**
  - Current contract expires June 30
  - Draft contract available at https://msp.scdhhs.gov/managedcare/node
- **Medical Loss Ratio (MLR) of 87.5% effective SFY 2017**
  - MLR = $\frac{\text{Incurred claims plus quality improvement expenditures}}{\text{Earned premiums less taxes and fees}}$
  - Sets minimum requirement for MCOs to expend capitated payments on medical claims
- **Reimbursement workgroup meeting April 7th at SCDHHS**

Opioid Abuse and Overdose

- **Governor's task force was formed in response to OIG report highlighting SC's lack of a plan to address the growing epidemic of opioid abuse and overdose.**
  - **Mandatory use of the Prescription Drug Monitoring Program (PDMP) was one of the strongest recommendations.**
- **In November 2014, Joint Revised Pain Management Guidelines were approved by the SC Boards of Medical Examiners, Dentistry, and Nursing :**

  It will be considered the standard of care to assess and evaluate the current status of pain treatment prior to initiating new treatment or adjusting current treatment. The registration and utilization of SC PMP…is considered mandatory for prescribers to provide safe, adequate pain treatment.

SCRIPTS Policy

- **Beginning April 1, 2016, Medicaid providers must assess a patient's controlled substance prescription activity through SCRIPTS before issuing a prescription for any controlled substance.**
  - **Provider must maintain documentation that the SCRIPTS database was evaluated prior to the issuance of the prescription.**
  - **Failure to perform an evaluation of the SCRIPTS data will result in recoupment of Medicaid funds for the office visit during which the prescription was issued.**
- **Certain instances are exempt from this requirement.**
- **Additional information is being made available at: www.scdhhs.gov/scriptsfaqs**

Hospital Transformation

- **Program Overview**
  - Designed to help Target Hospitals transition to sustainable service delivery models.
  - Focuses on long-term partnerships between rural hospitals and community, tertiary and teaching facilities.
  - $40 million from FFY 2015 DSH pool to fund partnerships, up to $4 million per plan.
  - Provides funding for Target Hospital sustainability plans.
- **Status**
  - To date the agency has funded 3 transformation plans.
  - Several other proposals have been submitted with a couple more anticipated.
  - 9 Target hospitals have engaged a consultant to create a sustainability plan.
  - Deadline for submission April 1; deadline for payment September 30.

Medicaid Expansion Funding

- **Recent forecast by the state's actuary (Milliman) estimates expansion will cost the state nearly $1 billion by FY 2021-22.**
- **This increase to expenditures would compound the current need to use reserves to fund recurring expenditures for the existing program.**
- **Even at very conservative growth levels, natural program growth will cost the state $70-80 million in new state funds annually without Medicaid expansion.**

	State Share	Cumulative State Share	Federal Participation	Enrollment
FY 2016-17	$ 46,800,000	$ 46,800,000	95%	263,500
FY 2017-18	$ 118,500,000	$ 165,300,000	94%	375,300
FY 2018-19	$ 151,400,000	$ 316,700,000	93%	412,200
FY 2019-20	$ 198,400,000	$ 515,100,000	90%	416,400
FY 2020-21	$ 237,200,000	$ 752,300,000	90%	420,600
FY 2021-22	$ 244,800,000	$ 997,100,000	90%	424,900