# The Healthy Idaho Plan (HIP)

"Building Accountability in Healthcare"

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# New Program Research and Evaluation

- In 2012, Governor Otter appointed a working group to evaluate the advantages and liabilities of expanding Medicaid to low-income adults
- The committee universally supported expanding Medicaid coverage in a program with the following components:
  - Personal Accountability
    - Encourage prevention and behavioral strategies to improve health outcomes and decrease overall costs
  - A redesigned health service delivery system
    - Shift provider incentives from volume of visits to value of care by creating provider payment incentives to keep people healthy

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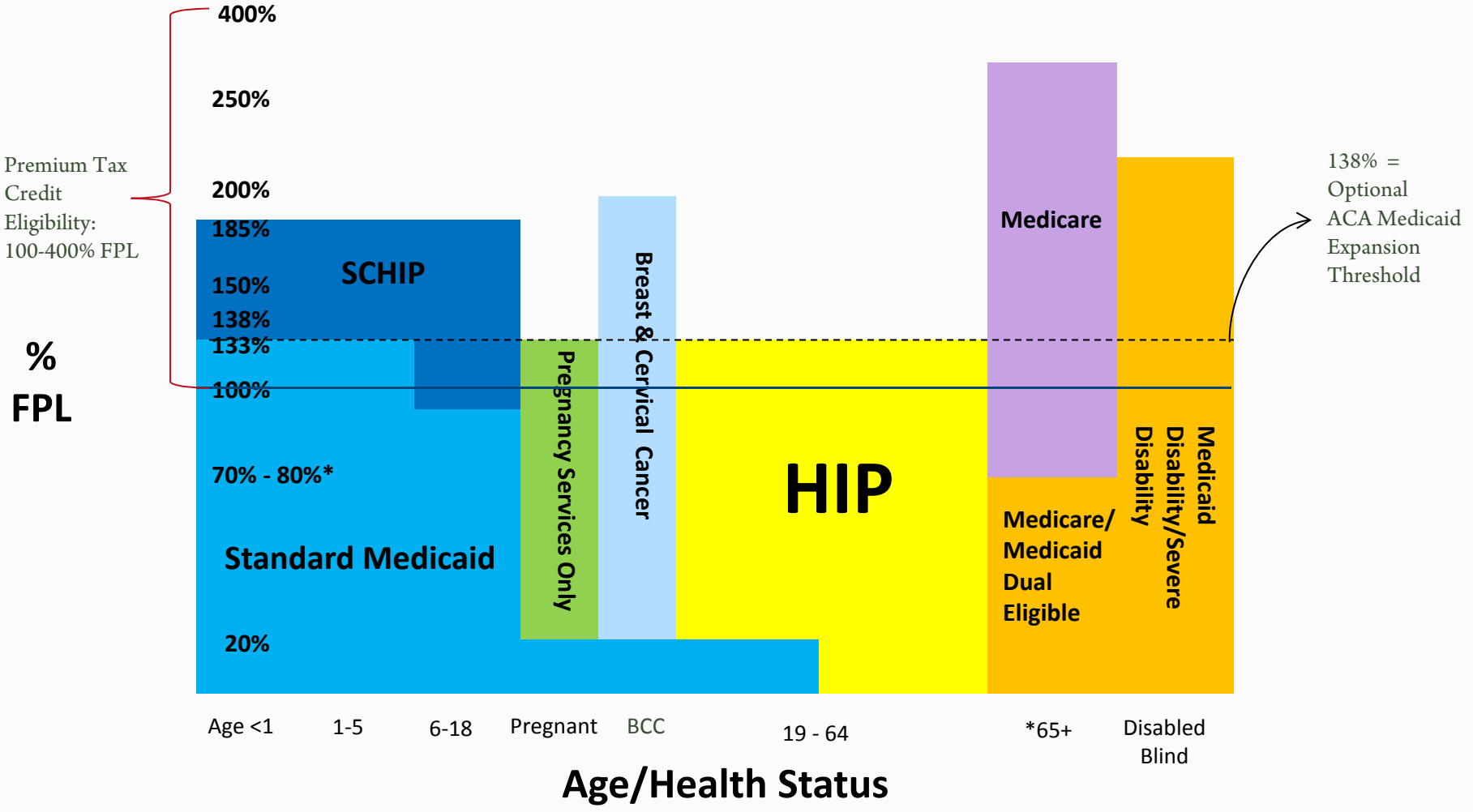
# Eligibility Chart




FPL is recalibrated annually and dependent on household size. In 2012, the FPL (100%) for a family of four is $23,050 of annual income.

*MOE requirement on CHIP through 2019

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# Federal Poverty Level Income Breakdowns

| FPL | <100% FPL | 100% FPL to 125% FPL | 125%FPL to 138% FPL |
|---|---|---|---|
| Annual Income - Individual | $0 - $11,170 | $11,171 - $13,963 | $13,964 - $15,083 |
| Annual Income - Family of 4 | $0 - $23,050 | $23,051 - $28,812 | $28,813 - $31,809 |

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# Four Major Goals

**Building Upon Current Successes**

1. Ensure fiscal prudence and sustainability
2. Incentivize personal responsibility
3. Leverage private market innovation
4. Redesign health delivery system to focus on outcomes

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# Ensuring Fiscal Prudence and Sustainability

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# Program Funding

- Provide insurance coverage that supports primary & preventative, outpatient care & medications so that costly hospital stays can be avoided
- The federal government pays the full cost of health care expenditures from 2014 to 2016 for HIP
  - Actuarial analysis indicates the program will cost the state approximately $648.8 M while providing state and county savings of $1,127.5 M during the same period (2014-2024) resulting in a net savings of $478.6 M in state and county funds
- State capitated payments to Exchange plans will provide budget certainty for the State

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# Incentivizing Personal Responsibility

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# Incent Personal Responsibility & Accountability for Health

- Incentivizes members to be cost-conscious consumers of health care services
- Holds members accountable for improving their health
- Requires financial participation in healthcare
- Aligns member and provider incentives
- Provides member access to contributions through an HRA debit card

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# Member Health Responsibility Account

- All members will have a Health Responsibility Account (HRA) established accessible via a debit card
- Members above 100% FPL will be required to make monthly contributions to the HRA
- HRA funds can be used to pay member's cost-sharing requirements as well as to purchase State approved health related services and products

| % FPL Level | Required Monthly Contribution | Annual Contribution |
|---|---|---|
| **0-100%** | $0 | $0 |
| **101-125%** | $20** | $240 |
| **126-138%** | $25** | $300 |

*** Consistent with cost-sharing requirements for tax credits for individuals above 100% FPL*

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# Member Cost-Sharing

- All members are required to pay co-pays for all services they receive, including doctor visits, hospital care, prescription drugs and therapies
  - Only preventive services, family planning services, and pregnancy-related services are exempt from co-pays
- All members pay co-pays up to 5% of their income, as permitted by federal regulation
- Providers, including pharmacies and hospitals, may require individuals to pay cost-sharing as a condition for receiving the service, per Federal regulations for individuals above 100% FPL
- Members are provided a monthly statement indicating services rendered and costs incurred
  - Indicates copayments member paid out of HRA with debit card
  - Evidences the value of their health insurance
  - Provides consistency with commercial insurance EOBs

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# Co-payment Amounts

- Co-payments are assessed for all services

  Total cost-sharing is limited to 5% of income

| | Payment ≤100% FPL* | Payment 101% - 138% FPL* | Current Medicaid Co-payments^ |
|---|---|---|---|
| **Preferred Prescription Drugs** | $4 | $4 | N/A |
| **Non-Preferred Prescription Drugs** | $8 | $8 | N/A |
| **Non-Emergency use of ER** | $8 | $8 | $3.65 |
| **Outpatient Services** | $4 | Not to exceed 10% of the cost of the service | $3.65 |
| **Inpatient Services** | 50% of cost of the first day of care | 50% of cost of the first day of care or 10% of the cost for entire stay | N/A |

*__All__ HIP participants will be required to share the cost of their care through co-payments.

^SCHIP participants and __some__ Medicaid participants share the cost of their care through co-payments and premiums. This cost-sharing amounts to approximately $8,841,000 each year.

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# Healthy Behavior Bonuses

- Incentives will be developed to encourage healthy behaviors and encourage the member to actively participate in their healthcare.
- These may include examples such as:

| Healthy Behavior | HRA Bonus Contribution |
|---|---|
| Completing Health Risk Assessment | $20 |
| Annual Physical | $20 |
| Completion of Preventive Services | $20 |
| Adhering to Prescribed Drug Regimens | $20 |
| Participating in Smoking Cessation | $20 |
| Participating in Weight Management Class | $20 |

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# Non-Payment Penalties

- Members have 60 days to pay their monthly HRA contribution
- May seek a "hardship waiver," provided it is received before payment is due
- Members failing to make HRA payments will be terminated from the program and face a mandatory 12 month lock-out
  - Member will be eligible to purchase insurance on the Exchange during this period
- When these members attempt to re-enroll in the program after the 12 month lock-out they must pay the debt they incurred prior to coming back on to the program

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# Remaining Balances

- At year end, members may have money left over from contributions and Healthy Behavior Bonuses
- There are various ways that these funds can be treated at annual re-enrollment
- The State proposes to roll over these funds to reduce contributions for the member for the following year

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# Leveraging Private Market Innovation

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# Coordination with Exchanges

- Creates seamless coverage and reduces issues surrounding churn as members move between Medicaid and Exchange
- Strengthens and supports Idaho Health Insurance Exchange by providing more covered lives for Exchange carriers
- Exchange plans have vested interest in participating as it gives them greater market share and attracts clients that move in and out of Medicaid
- Members churning between Exchange and Medicaid will have comparable plan, benefit, and networks

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# Program Design

- Through RFP process, State selects QHPs/ACOs to offer Medicaid plan
  - Carrier is a QHP/ACO, but the plan/benefits are modified to comply with Medicaid Rules
  - Carrier maintains same network as Exchange plans
  - Carrier QHP/ACO must meet State solvency standards and be registered as a Risk Carrying entity
- State pays selected QHPs negotiated monthly per member per month capitation rate
- QHPs required to maintain network of patient-centered medical homes (PCMH) and allow members to select one
- Benefits are similar to Essential Health Benefits (EHB) Benchmark Plan for State of Idaho
  - Blue Cross of Idaho Health Services Inc. PPO plan
  - The State will supply wrap-around services to comply with Medicaid requirements such as EPSDT and transportation

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# QHPs versus Medicaid

| | QHP | Medicaid Requirements |
|---|---|---|
| **Premiums** | Premiums indexed to individuals income, 2% of income 100% to 133% FPL, 3% of income 133% to 150% FPL. | Premium restrictions. |
| **Cost-Sharing** | Cost-sharing reductions increase the actuarial value of the plan and reduce what an individual would be expected to pay. No limit by income. | Limited to cost-sharing in 42 CFR PART 447, total cost sharing may not exceed 50% of individuals income |
| **Benefits** | Requires commercial market EHB as designated by the department of insurance. If permitted by department plans may substitute actuarially equivalent benefits. | Required to meet Medicaid EHB rules. EPSDT required, assurance of non-emergency transportation required. Medicaid prescription drug coverage can remain the same. Medicaid must define habilitative services. |
| **Plan metal level** | QHPs must meet plan metal level requirements and associated actuarial value. (Bronze 58-62%, Silver 68-72%, Gold 78-82%, etc,) | With cost-sharing limited by enrollee income, QHP plans on Exchange may not be able to meet metal level requirements when covering Medicaid recipients |
| **Dental** | Exchange QHP plans may or may not offer pediatric dental | Medicaid enrollees are exempt from the pediatric dental requirement, this is replaced by the requirement to offer EPSDT services. |
| **Three R's** | QHPs are subject to the three Rs:<br>Risk adjustment, Reinsurance and Risk corridors | Does not apply to Medicaid |

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# Redesigning Health Delivery System to Focus on Outcomes

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# Medical Home Integration

- Patient Centered Medical Homes (PCMH) provide comprehensive primary care by helping patients access, coordinate, and understand healthcare options.
- Positive Outcomes:
  - Quality of care, patient experiences, care coordination and access are demonstrably better
  - Reductions in ER visits and inpatient hospitalizations produce cost savings
  - Physician-patient relationship encourages a move from acute-focused episodic care to proactive preventive care
  - Provides care coordination, disease and case management and conducts health risk assessments

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# Idaho Medical Home Initiative

- Idaho Medical Home Collaborative (IMHC)
  - Collaboration of primary care physicians, private health insurers, healthcare organizations, and Idaho Medicaid
  - Recommendations on the development, promotion, and implementation of patient-centered medical home (PCMH) models statewide
- Pilot Program
  - Participants: Blue Cross of Idaho, Idaho Medicaid, Pacific Source and Regence Blue Shield of Idaho
  - Kicked off January 1, 2013

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# Improves Health Outcomes

- All members select or are assigned to a medical home
  - Physician-patient relationship encourages a move from acute-focused episodic care to proactive preventive care
  - Conducts health assessments and provides care coordination, disease and case management
- Provider incentive programs to achieve key outcomes
  - Encourage risk assessments, preventive health services, and goals related to diabetes care, hypertension, depression, asthma, and patient satisfaction
- Monitor positive outcomes to identify best and most cost-effective programs
- Modify goals and incentive programs to address emerging public health issues and priorities

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# Next Steps

- A majority of the program is already within CMS Regulations:
  - Copayments
  - 5% Out of Pocket Maximum per Member
  - Benefits
- CMS has authority to waive requirements under the 1115 waiver provisions
- Key waivers needed to implement HIP:
  - Required monthly HRA Contributions for those over 100% FPL
  - 12 month lock-out for failure to pay
  - Member being responsible for debt before being eligible for re-enrollment
  - No retroactive coverage

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# 1115 Waivers

- Section 1115 waivers may be granted by CMS
- 1115 Waivers give the Secretary of HHS broad authority to approve demonstration programs that test innovative Medicaid policy
- 1115 Waiver proposals must be truly innovative, not simply replicating an idea already demonstrated elsewhere
- 1115 Waivers must demonstrate federal budget neutrality

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