



Iowa Department of Human Services

Affordable Care Act: Overview of Impacts on Medicaid

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Introduction

- The Patient Protection and Affordable Care Act (ACA), also known as “Health Care Reform”, was signed into law on March 23, 2010.

- The law is complex and requires a significant amount of time and effort to plan and implement during the last 2 and coming year(s).

- There continues to be strong public policy debate on the law
 - Supreme Court Decision
 - Strong efforts to repeal or change the law in Congress.



Affordable Care Act (ACA)

- Key provisions take effect January 1, 2014
 1. Creation of Health Benefits Exchange (HBE).
 - Exchange is a “marketplace” to allow consumers to compare plan benefits and price, provide consumer assistance, facilitate plan enrollment.
 - Mandate for individuals to have insurance coverage; penalties for large employers who don’t offer insurance
 2. Option for Medicaid expansion to 133% of the Federal Poverty Level (FPL)
2013 133% FPL:
 - Household of 1: \$15,282
 - Household of 4: \$31,322
- Other provisions with various implementation dates
 1. Mandatory Iowa Medicaid Enterprise (IME) operational changes to ensure ACA compliance
 2. Optional opportunities to improve or re-balance health care programs



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Health Insurance Marketplace: Overview



What is a Health Insurance Marketplace?

- A new online way for individuals, families and small business employers to buy health insurance
 - Enrollment starts October 1, 2013
 - Coverage begins January 2014
- The Health Insurance Marketplace provides:
 - Access to affordable insurance options
 - Ability to buy certain private health insurance
 - Access to health insurance information
- Allows apples-to-apples comparison of Qualified Health Plans



How The Marketplace Works

- The Marketplace provides:
 - Coverage to fit individual needs
 - May get a break on costs through a new premium tax credit
 - Unbiased help and customer support provided
 - Quality health coverage that meets minimum standards
 - Easy to use



How The Marketplace Works

- One process to determine eligibility for:
 - Qualified Health Plan through the Marketplace
 - New premium tax credits to lower premiums
 - Reduced cost sharing
 - Medicaid
 - Children's Health Insurance Program (hawk-i)
- Choice of plans and levels of coverage
- Insurance companies compete for business



Marketplace Basic Rules

- Offer Qualified Health Plans that provide basic consumer protections
- Ensure high quality and choice of plans
- Provide information on plan premiums, deductibles, and out-of-pocket costs before you decide to enroll



Qualified Health Plans

- A Qualified Health Plan
 - Is offered by an issuer that is licensed by the state and in good standing
 - Covers Essential Health Benefits
 - Agrees to charge the same premium rate whether offered directly through Marketplace or outside the Marketplace



Essential Health Benefits

Qualified Health Plans cover Essential Health Benefits which include at least these 10 categories

Ambulatory patient services	Prescription drugs
Emergency services	Rehabilitative and habilitative services and devices
Hospitalization	Laboratory services
Maternity and newborn care	Preventive and wellness services and chronic disease management
Mental health and substance use disorder services, including behavioral health treatment	Pediatric services, including oral and vision care



When You Can Enroll

- Marketplace Initial Open Enrollment Period starts:
 - October 1, 2013 and ends March 31, 2014
- Annual Open Enrollment Periods after that start on:
 - October 15 and end on December 7
- Special Enrollment Periods available in certain circumstances during the year



Enrollment Process

- Complete one streamlined application for:
 - ✓ Insurance Affordability Programs Eligibility
 - Medicaid
 - Children's Health Insurance Program (hawk-i)
 - Premium tax credit and reduced cost sharing
 - ✓ Enrollment into Qualified Health Plan through the Marketplace

- Applications may be submitted online, by phone, by mail, or in person



Marketplace Affordability

- Financial help available for working families includes
 - Tax credits for health plans to lower the monthly premiums that qualified individuals pay
 - Reduced cost sharing to lower out-of-pocket spending for health care



Who is Eligible for the New Premium Tax Credits?

- Eligibility for the new tax credit is based on household income and family size for the year
 - ✓ Income between 100% to 400% of the Federal Poverty Level (FPL), which is \$23,550 to \$94,200 for a family of four in 2013.
 - ✓ Ineligibility for other health benefits coverage, other than the individual insurance market
- Tax credit amount depends on income as a percentage of the Federal Poverty Level (FPL)
 - ✓ Based on a sliding scale
 - ✓ Based on the cost of the second lowest silver Qualified Health Plan, adjusted for the age and rating area of the covered person
 - ✓ Limits premium payments as a percent of income



Who is Eligible for a Cost Sharing Reduction?

- Eligibility for reduced cost sharing is based on
 - ✓ Incomes at or below 250% of the FPL (\$58,875 annually for a family of four in 2013)
 - ✓ Receiving the new tax credit
 - ✓ Meeting enrollment requirements
 - ✓ Enrolling in a Marketplace silver-level plan

- Members of Federally-recognized Indian Tribes
 - ✓ No cost sharing if income is <300% FPL



Enrollment Assistance

- Help available in each Marketplace
 - Toll-free call center
 - Website
 - Navigator program
 - Organizations paid by the Marketplace to help consumers “navigate” the Marketplace and obtain health insurance coverage
 - Certified Application Counselors
 - Volunteers, much like Navigators, to provide the same type of assistance
 - Community-based organizations
 - Agents and brokers



Simplifying Medicaid and CHIP (hawk-i)

- Modernized rules to rely on electronic data to reduce need for paper documentation
- Apply on-line, by phone, mail, or in person
- 12-month eligibility period for, adults, parents and children
- Simplified process for renewing coverage



Eligibility Determinations - Partnership

- Eligibility determinations for insurance affordability programs (APTC/CSR, Medicaid and CHIP) must be “seamless”; goal is to assist consumers to be assisted through “no wrong door”
- Iowa responsible to determine eligibility for Medicaid/CHIP
- FFE responsible to determine eligibility for subsidies
 - Before individual can access subsidies, must be screened for Medicaid/CHIP eligibility
- Individual account information transferred from Iowa to FFE and from FFE to Iowa
- DHS developing new integrated eligibility system to support the required functionality (ELIAS)



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Iowa Health and Wellness Plan: Overview



Background

- The Iowa Health and Wellness Plan was enacted to provide **comprehensive health coverage** for low-income adults
 - Begins January 1, 2014
 - Covers Iowans age 19-64 with income up to and including 133% of the Federal Poverty Level (FPL)
 - Replaces IowaCare, which ends December 31, 2013



Iowa Health & Wellness Plan

- Begins January 1, 2014
- Covers Iowans age 19-64 with income up to and including 133% of the Federal Poverty Level (FPL)



Goals and Objectives

- Focus on health and improved outcomes
- Incentives for healthy behavior
- Emphasis on care coordination
- Based on local access to care



One Program, Two Plans

Iowa Wellness Plan: For adults age 19-64 with income up to and including 100% of the Federal Poverty Level

Marketplace Choice: For adults age 19-64 with income 101% to no more than 133% of the Federal Poverty Level



Iowa Wellness Plan: 0-100% FPL

- For individuals with income up to and including 100% FPL
 - \$11,490 for family of one person
 - \$15,510 for a family of two people
- Administered by Iowa Medicaid



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Iowa Wellness

Plan:

0-100% FPL

- Provides comprehensive health services
- Equivalent to the State Employee Health Benefits Package

Benefit Categories Covered

Ambulatory patient services

Emergency services

Hospitalization

Mental health and substance use disorder services (including behavioral health treatment)

Rehabilitative and habilitative services and devices

Laboratory services

Preventive and wellness services

Home & community based services for persons with chronic mental illness, equal to Medicaid benefit

Prescription drugs, equivalent to the Medicaid benefit

Dental services



Iowa Wellness Plan: 0-100% FPL

- **Provider Network**

- Members will have access to the same providers currently available in regular Medicaid
- Members will be able to choose their primary care physician, who will also coordinate the member's services with other providers



Iowa Wellness Plan: 0-100% FPL

- Out of Pocket Costs:
 - No copayments except for non-emergency use of the ER
 - No monthly contributions or premiums during the first year (2014)*
 - No premiums for those with income below 50% FPL*
 - Costs cannot exceed 5% of income

**Monthly contributions subject to CMS approval*



Iowa Wellness Plan: 0-100% FPL

- Monthly contributions* waived beginning in 2015 if the member completes wellness activities
 - Could include preventive services, health risk assessment, other wellness activities

**Monthly contributions subject to CMS approval*



Iowa Wellness Plan: 0-100% FPL

- The program will include innovations that will:
 - Ensure **coordination of care** for members through ‘medical homes’, and
 - Ensure health care providers are **accountable for achieving high quality and cost effective care** that is focused on meeting the needs of the patient
- These program innovations will continue to be developed through a statewide planning process related to the State Innovation Model* grant

*Go to <http://www.ime.state.ia.us/state-innovation-models.html> for more information



Marketplace Choice Plan: 101-133% FPL

- For individuals with income 101% FPL up to and including 133% FPL
 - \$11,491-\$15,856 for a family of one
 - \$15,511-\$21,404 for a family of two



Marketplace Choice Plan: 101-133% FPL

- Members select a certain ***commercial health plan*** available on the Health Insurance Marketplace
- Medicaid pays the premiums for the commercial health plan on behalf of the member
 - Often referred to as “premium assistance”



Marketplace Choice: 101-133% FPL

- Commercial health plan
- Coverage must be at least equivalent to State Employee Benefit Plan

Benefit Categories Covered

Ambulatory patient services

Emergency services

Hospitalization

Mental health and substance use disorder services (including behavioral health treatment)

Rehabilitative and habilitative services and devices

Laboratory services

Preventive and wellness services

Home & community based services for persons with chronic mental illness, equal to Medicaid benefit

Prescription drugs, equivalent to the Medicaid benefit

Dental services



Marketplace Choice Plan: 101-133% FPL

- Covered benefits not provided by commercial health plan will be provided by Medicaid*
- Uses commercial plan's provider network
 - Includes primary care, specialists, hospitals



Marketplace Choice Plan: 101-133% FPL

- Out of Pocket Costs:
 - No copayments except for non-emergency use of the ER
 - No monthly contributions or premiums during the first year (2014)
 - Costs cannot exceed 5% of income



Marketplace Choice Plan: 101-133% FPL

- Innovation: Purchasing private coverage
 - Allows individuals to stay enrolled in their current plan if their income changes



Plan Summaries

Wellness Plan

0-100% FPL

Benefits equivalent to State Employee Benefit Plan

Plan managed by Iowa Medicaid

Monthly member contributions

- Waived in 2014
- Waived beginning 2015 for completing wellness activities

Uses Medicaid provider network and involves ACOs

Marketplace Choice

101-133% FPL

Commercial benefits, at least equivalent to State Employee Benefit Plan

Plan managed by commercial insurer

Monthly member contributions

- Waived in 2014
- Waived beginning 2015 for completing wellness activities

Uses commercial insurer's provider network



Medically Frail

- Members who are considered ‘Medically Frail’ must be given the option of enrolling in regular Medicaid or Wellness Plan
- Medicaid will have definitions and a process to screen for medically frail members, both at enrollment and after enrollment
 - Ensures members with serious medical needs have full access to necessary services provided by Medicaid
 - Helps keep high risk members out of commercial health risk pools



Waiver Process

- Iowa Medicaid required to submit **two** waivers for plan approval to the Centers for Medicare & Medicaid Services (CMS)
 - One waiver for Wellness Plan
 - One waiver for Marketplace Choice
- Working with CMS continually on plan details



Waiver Process

- Process includes public hearings
- Public comment period for the draft waivers
 - Open until 4:30 p.m. on August 15, 2013
 - Comments available upon request



Timeline

Date	Event
Jul. 15, 2013	Draft Waivers Released for Public Comment
Jul. 29-30, 2013	Public Hearings Held
Aug. 15, 2013	Public Comment Submission Deadline
Aug. 20, 2013	Waivers Submitted to CMS
Aug. 2013 – Mar. 2014	Public Outreach and Education
Oct. 1, 2013	Beginning of Open Enrollment Period Applications Accepted
Jan. 1, 2014	Iowa Health & Wellness Coverage Begins



Outreach and Education

- Planning statewide outreach and education efforts (Aug 2013-March 2014)
 - Partner with local organizations
 - Target uninsured population in Iowa, current IowaCare members
 - Member benefits education once enrolled
 - More information to come



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Application Process

All individuals can apply through the Federal Health Insurance Marketplace at **HealthCare.gov** beginning Oct. 1, 2013

www.HealthCare.gov

Can also apply online through DHS website or at any local DHS office



Information

Find up-to-date information on the Iowa Health and Wellness Plan at:

<http://www.ime.state.ia.us/iowa-health-and-wellness-plan.html>



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IowaCare Transition



IowaCare Transition

- IowaCare will end on December 31, 2013
- Current members will continue to have same access to services until the program ends
 - Continue to seek care at medical home



IowaCare Transition

- Enrollment closed to new members as of July 1, 2013
 - Closed to help begin the transition process
- Current members will have coverage until December 31, 2013
 - No renewals required



IowaCare Transition

- Current members will not be cancelled unless:
 - Premiums are not paid
 - Get other health insurance
 - Turn 65
 - Move out of the state



IowaCare Transition

- Member outreach and education will begin late summer-early fall 2013
 - Encourage all current members to apply for Iowa Health and Wellness Plan or other Health Insurance Marketplace plans



IowaCare Transition

- Iowa Medicaid will:
 - Coordinate with medical homes on outreach
 - Leverage Certified Application Counselors to help with the application process
 - Reach out to members multiple times to make sure they are aware of transition



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Application Process

All IowaCare members can apply through the Federal Health Insurance Marketplace at **HealthCare.gov** beginning Oct. 1, 2013

www.HealthCare.gov



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Resources

Link to Iowa Health & Wellness Plan Information:

<http://www.dhs.state.ia.us/>

Links to federal Marketplace information:

<http://www.cms.gov/ccio/>

<http://marketplace.cms.gov/index.html>

<http://www.healthcare.gov>



Mandatory IME Operational Changes

➤ Requirements for ACA Compliance:

- ✓ **Administrative Simplification:** Improve automation of health care administrative processes (claims). Result in reduced time and effort related to contacting physicians and health plans for claims resolution, denials of claims, additional postage and paperwork costs. Phase I 1/1/13; Phase II 1/1/14; Phase III 1/1/16.
- ✓ **Increased Payments to Primary Care Physicians (PCPs):** Medicaid will pay the Medicare rates to qualified PCPs for eligible services during CY 2013 and CY 2014. Payments will be made (adjusted) upon CMS approval. See Info. Letter No. 1194.
- ✓ **Provider Screening and Enrollment:** Enhanced screening procedures required based on provider type's risk of fraud, waste or abuse. Enhanced disclosures required on application. Allow referring and prescribing providers to enroll without billing privileges (effective 4/1/13). Application fees required by certain providers. See Info. Letter No. 1179.
- ✓ **Program Integrity:** Increased federal requirements regarding mitigation of fraud, waste and abuse. Suspend payments during credible allegation of fraud; require NPI's on enrollment applications; overpayments due within 60 days.



ACA Options

➤ **ACA opportunities to improve or re-balance health care programs:**

- ✓ **Presumptive Eligibility:** Hospitals and other qualified providers can conduct presumptive eligibility determinations on all potential Medicaid members.
- ✓ **Adult Health Quality Measures:** Grant received to implement and report various quality measures. Requires submission of MMIS claims data to CMS. Will support the new provider quality improvement initiatives.
- ✓ **Health Homes:** Comprehensive, coordinated care to members with chronic conditions. Began in July 2012, and currently IME has enrolled entities in 21 counties as providers. This covers over 32 different sites and over 300 individual practitioners. Another SPA in process for a Serious and Persistent Mental Illness (SPMI) health home.
- ✓ **Balancing Incentive Payment Program (BIPP):** Assist States in transforming their long-term care systems by providing greater access to home and community based services and reducing unnecessary reliance on institutional care. Will be achieved by improving systems performance and efficiency; creating tools to facilitate person-centered assessment and care-planning; and enhancing quality measurement and oversight.



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Questions?

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