# 2014 Annual Medicaid Conference

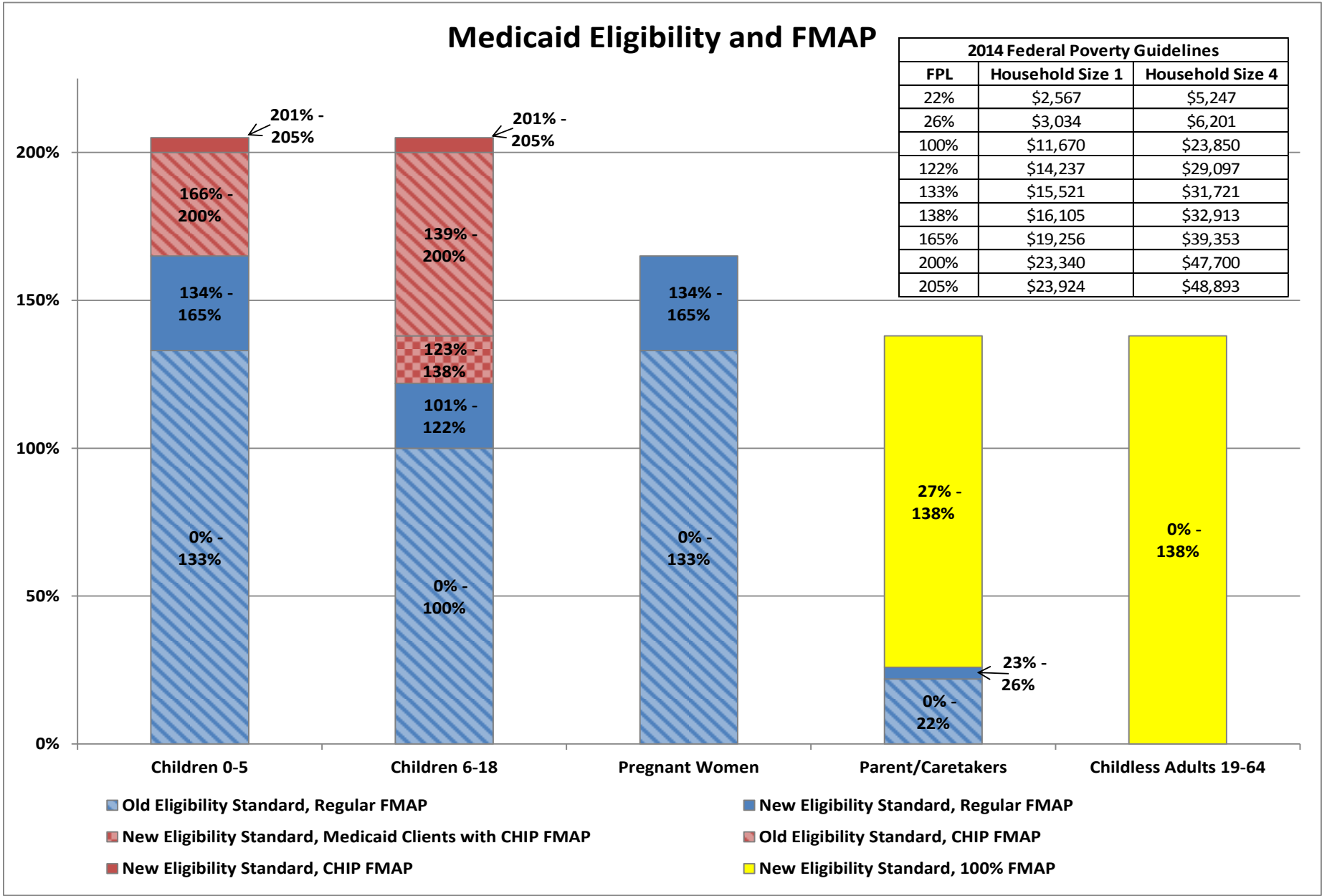
## *Medicaid Program Highlights*

## *A Summary of Updates*

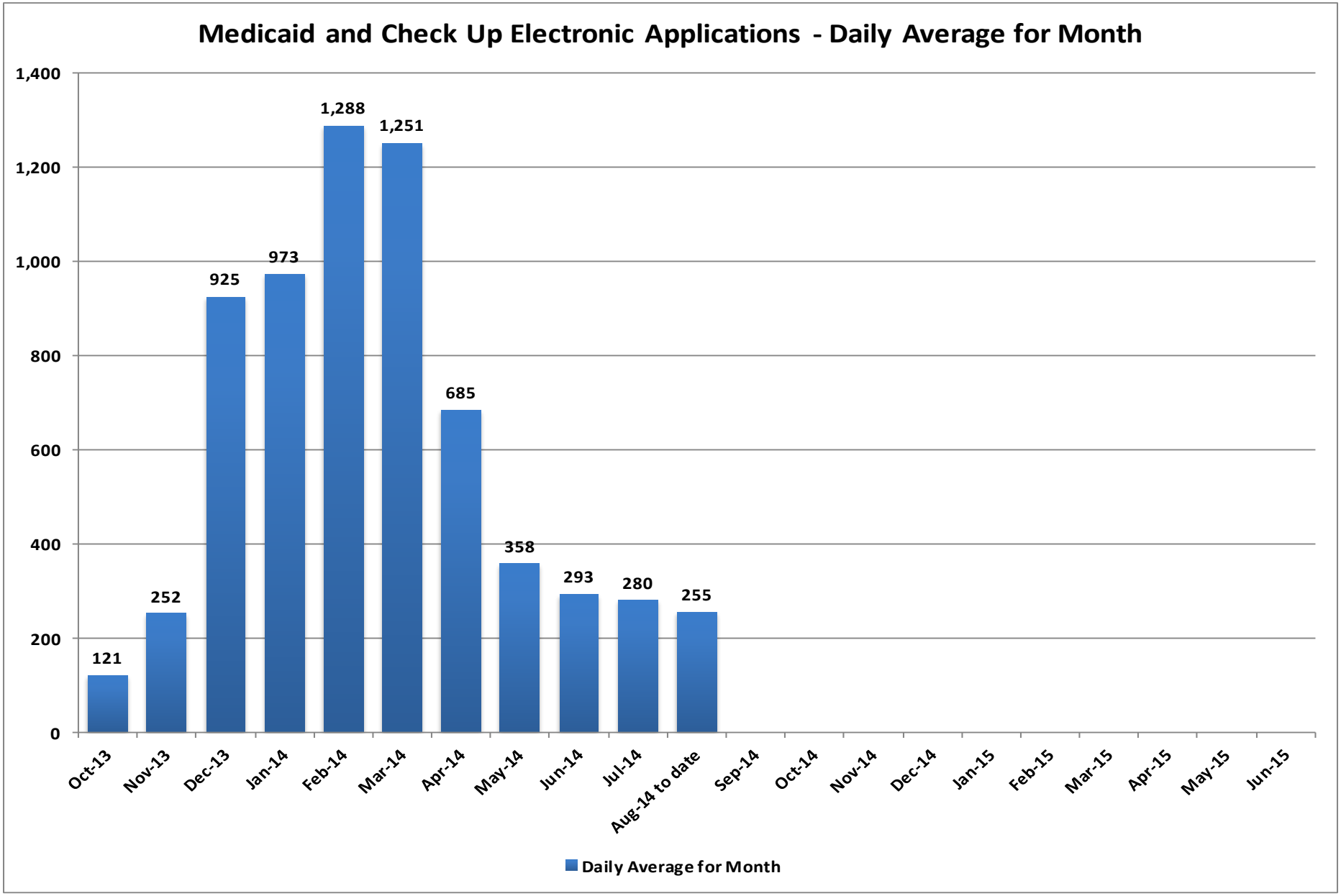
# Agenda

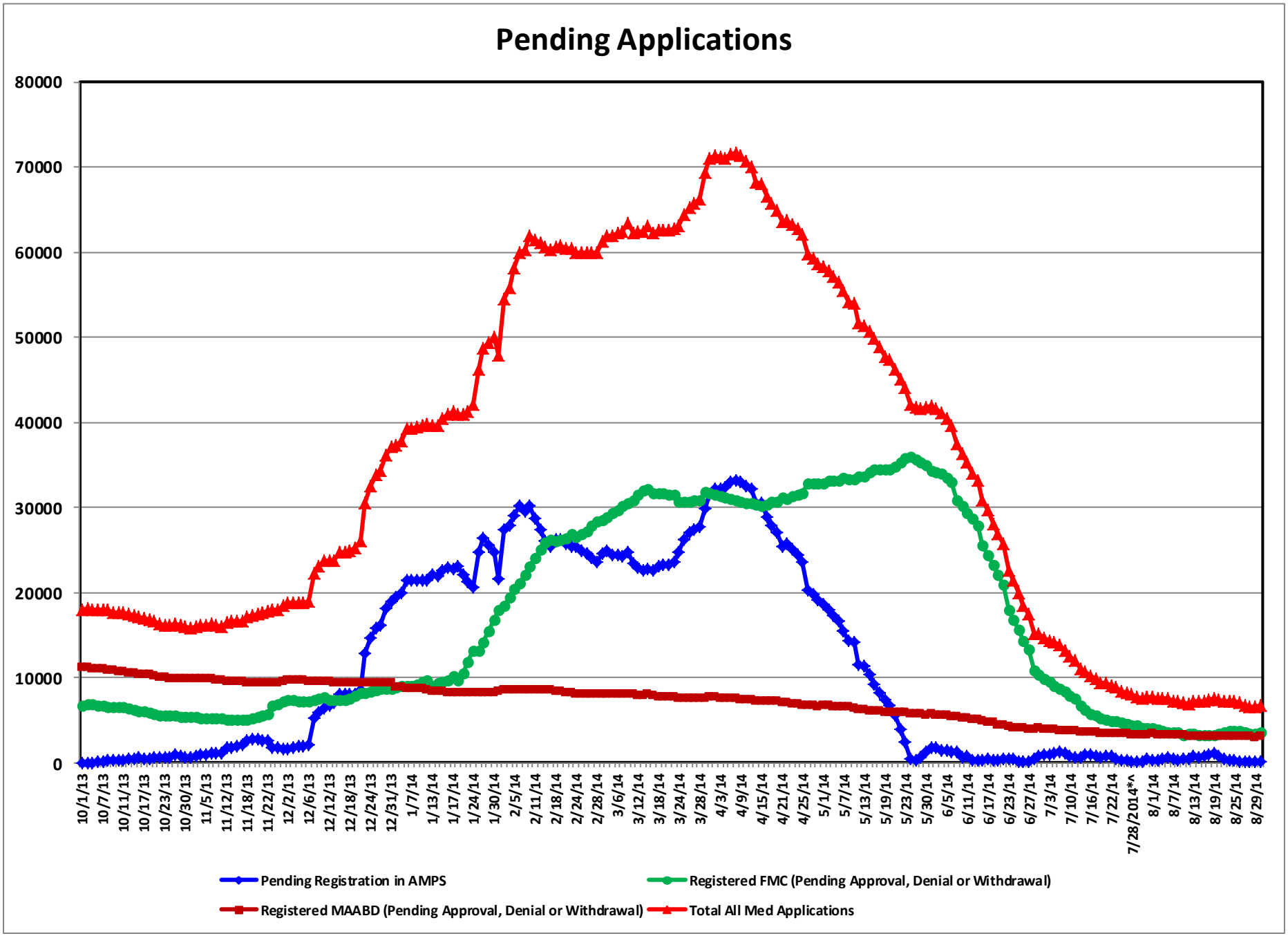
- The Affordable Care Act and Medicaid Expansion
- Access to Care
- Grants

# New Medicaid Eligibility, With Expansion

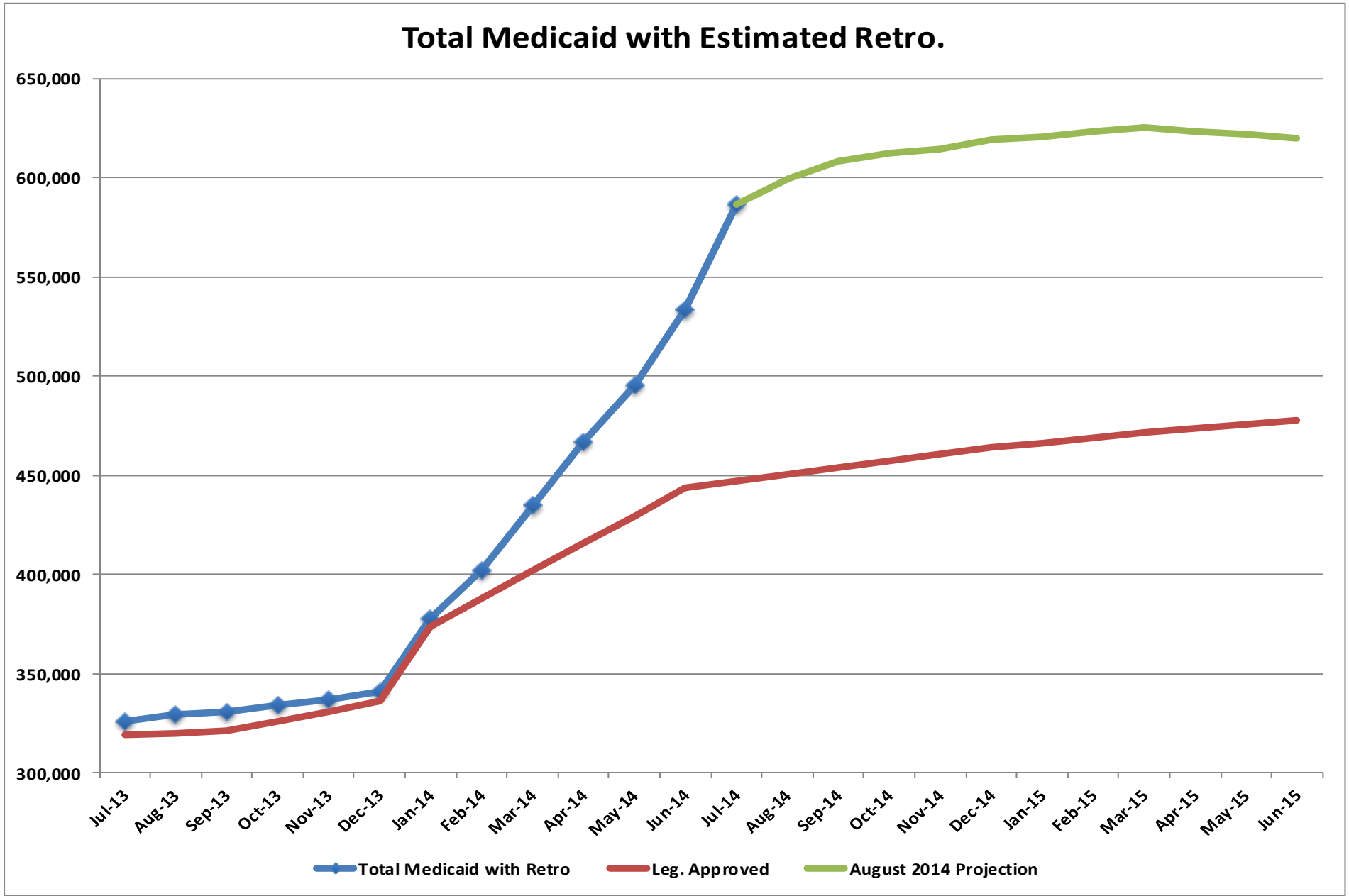


# The Applications Arrived

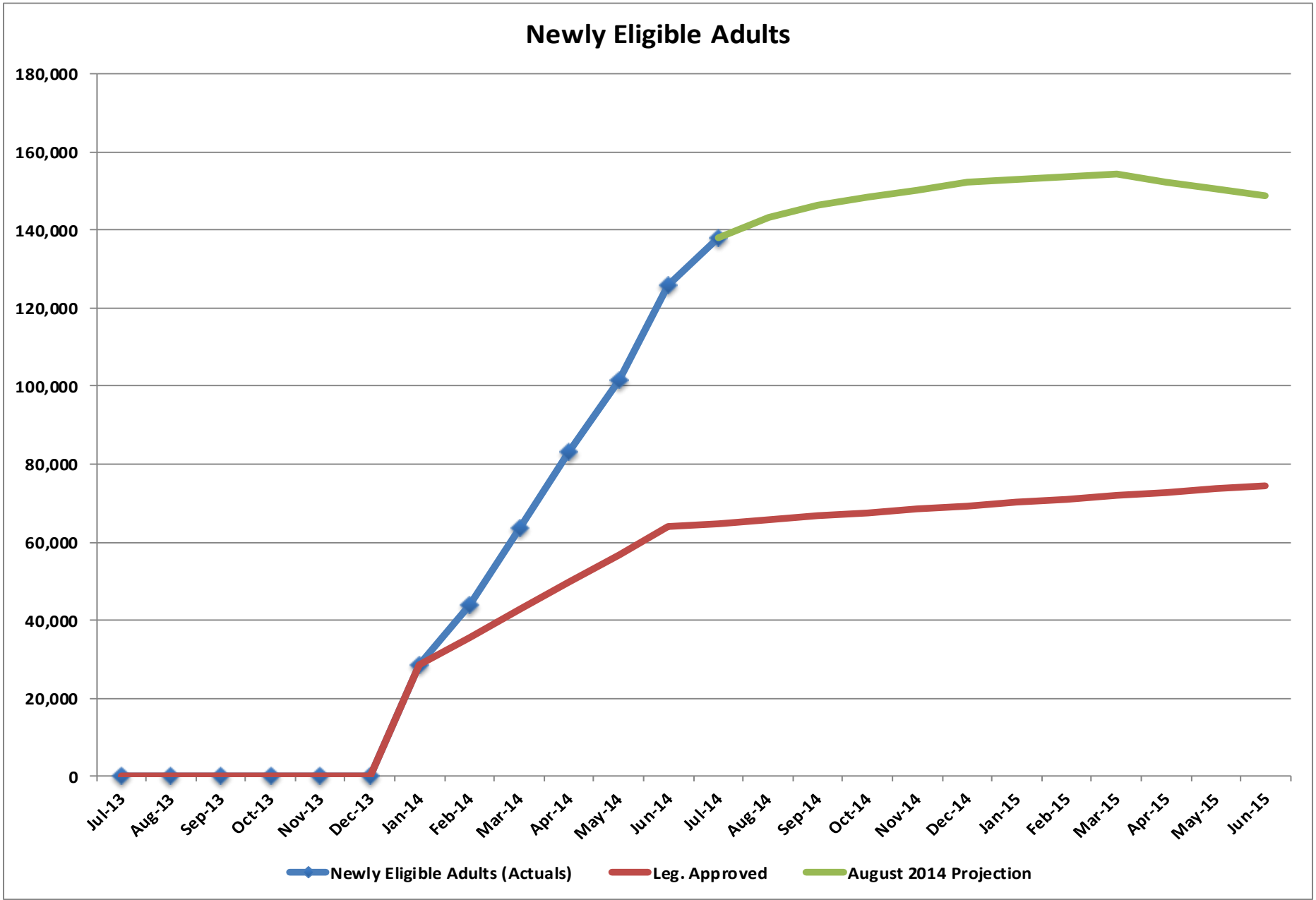



Pending Applications
80000
70000
60000
50000
40000
30000
20000
10000
0
10/1/13
10/7/13
10/11/13
10/17/13
10/23/13
10/30/13
11/5/13
11/12/13
11/18/13
11/22/13
12/2/13
12/6/13
12/12/13
12/18/13
12/24/13
12/31/13
1/7/14
1/13/14
1/17/14
1/24/14
1/30/14
2/5/14
2/11/14
2/18/14
2/24/14
2/28/14
3/6/14
3/12/14
3/18/14
3/24/14
3/28/14
4/3/14
4/9/14
4/15/14
4/21/14
4/25/14
5/1/14
5/7/14
5/13/14
5/19/14
5/23/14
5/30/14
6/5/14
6/11/14
6/17/14
6/23/14
6/27/14
7/3/14
7/10/14
7/16/14
7/22/14
7/28/2014*^
8/1/14
8/7/14
8/13/14
8/19/14
8/25/14
8/29/14
Pending Registration in AMPS
Registered FMC (Pending Approval, Denial or Withdrawal)
Registered MAABD (Pending Approval, Denial or Withdrawal)
Total All Med Applications

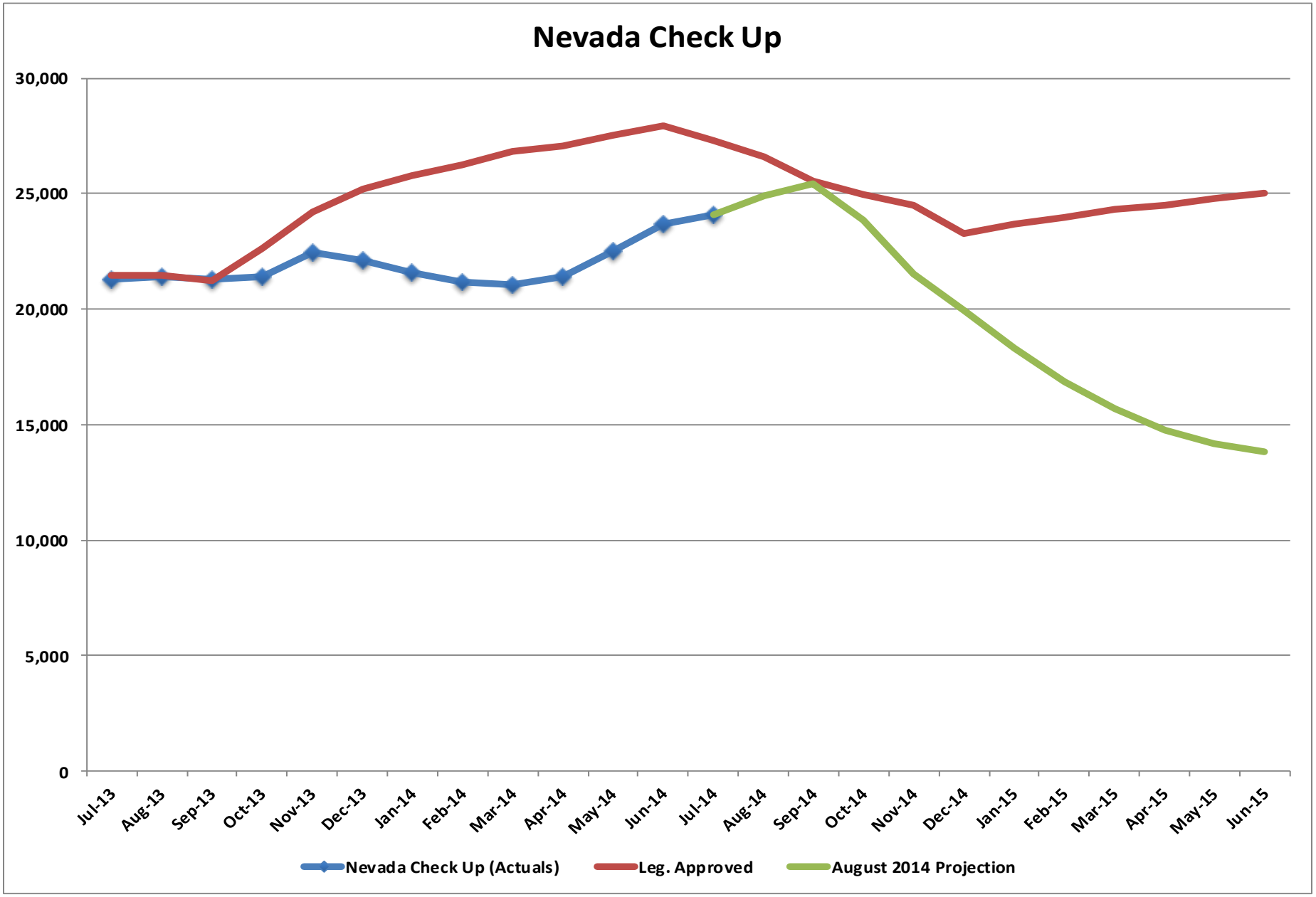
# Caseload Growth

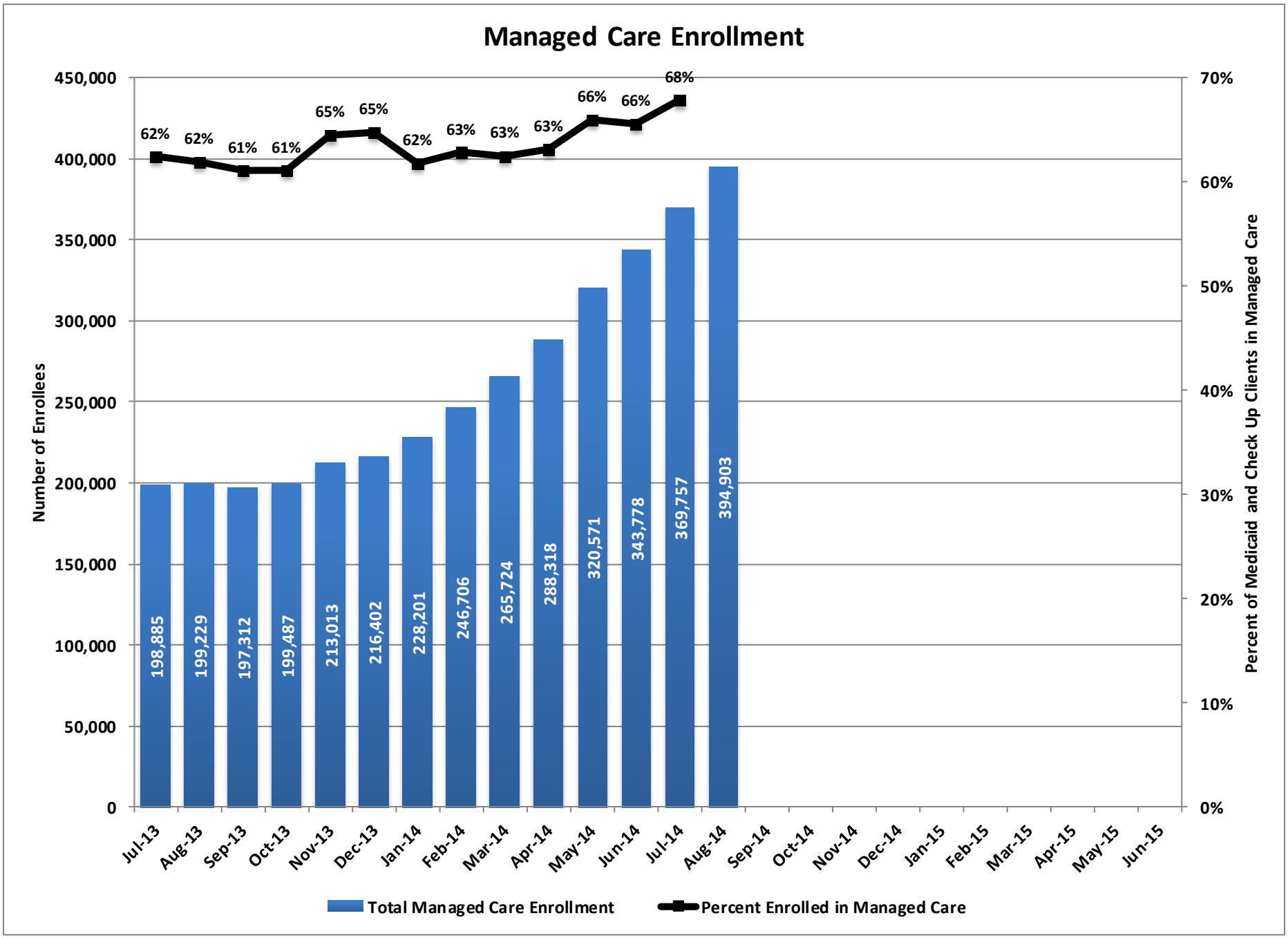


# Caseload Growth

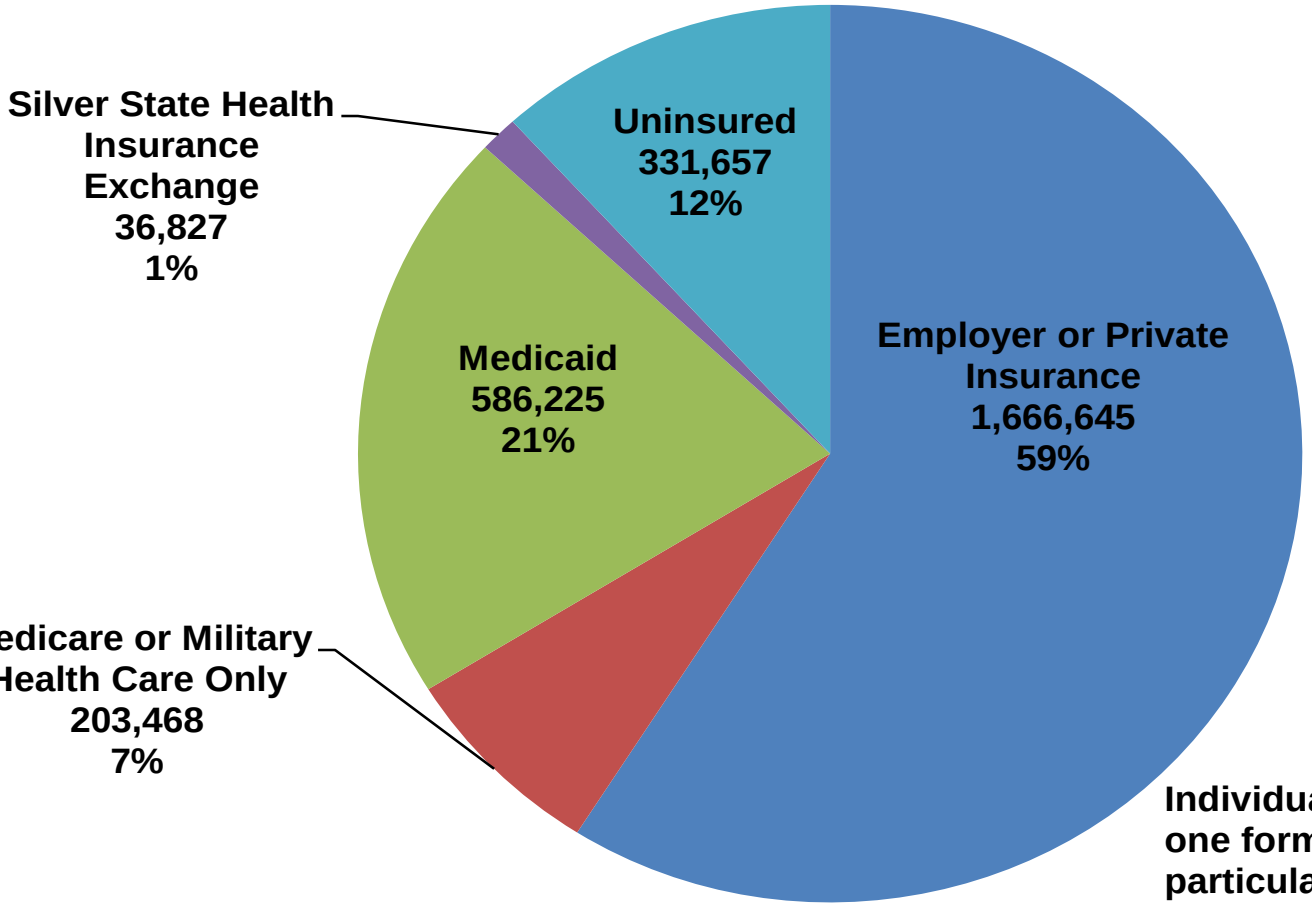


# Caseload Transition



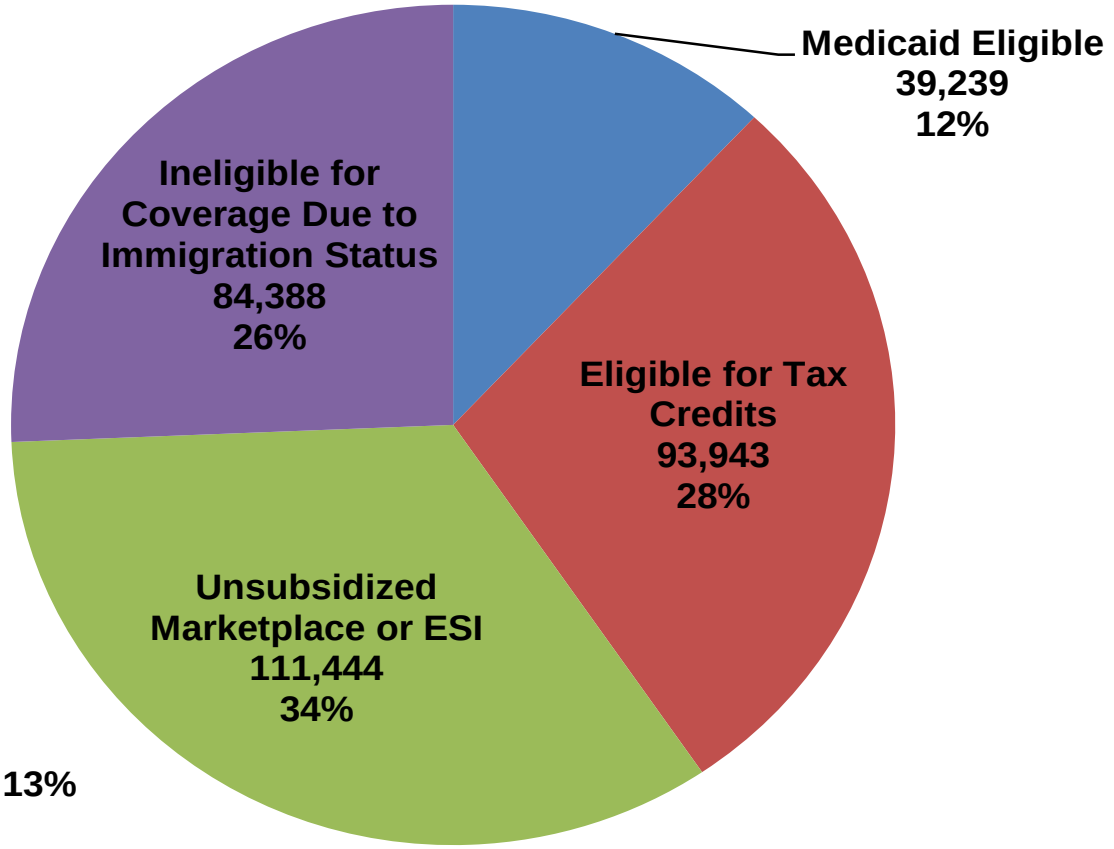

Managed Care Enrollment
Number of Enrollees
Percent of Medicaid and Check Up Clients in Managed Care
450,000
400,000
350,000
300,000
250,000
200,000
150,000
100,000
50,000
0
70%
60%
50%
40%
30%
20%
10%
0%
62%
62%
61%
61%
65%
65%
62%
63%
63%
63%
66%
66%
68%
198,885
199,229
197,312
199,487
213,013
216,402
228,201
246,706
265,724
288,318
320,571
343,778
369,757
394,903
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
Dec-13
Jan-14
Feb-14
Mar-14
Apr-14
May-14
Jun-14
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Total Managed Care Enrollment
Percent Enrolled in Managed Care

# Insurance Coverage of All Nevadans in July, 2014; 2,824,822 Total




Individuals may have more than one form of insurance, particularly Medicare or Military Health Care combined with Private or Medicaid Insurance

# Eligibility for Coverage in July, 2014 Among Currently Uninsured Non-Elderly Nevadans; 329,014 Total




| | |
|---|---|
| Uninsured Rate for Non-Elderly Nevadans | 13% |
| Uninsured Rate for All Nevadans | 12% |

# Access to Care

When the number of Nevadans with Health Care Coverage increases and the statewide provider pool remains the same, access to care becomes a statewide issue.

# What is Medicaid Doing – Access to Care

- Implementation of Telehealth Expansion
- Advanced Practice Registered Nurses
- Physician Forums with FFS and MCO
- Prior Authorization Alignment between FFS and MCO
- Health Care Guidance Program for high need Fee for Service Recipients
- Increased Inpatient Psychiatric Rate
- Pursuing In Lieu of Option for MCO

# TELEHEALTH

- Policy is being updated to remove geographic restrictions.
- Telehealth is the use of a telecommunications system instead of an in-person recipient encounter for professional consultations, office visits, office psychiatry services and a limited number of other medical services. The originating site is the location where an eligible Medicaid/Nevada Check Up recipient is at the time the service is being furnished via a telecommunications system. Nevada Medicaid and Nevada Check Up providers may bill HCPCS code Q3014 (Telehealth originating site facility fee).
- The distant site is the site where the provider delivering services is located at the time the service is provided via telecommunications system. The distant site uses the appropriate CPT code with modifier GT (via interactive audio and video telecommunication system) in field 24D of the CMS-1500 Claim Form.

# Advanced Practice Registered Nurses

- Assembly Bill 170 – 2013 Legislative Session
  - Changed Advanced Practice Nurse (APN) to Advanced Practice Registered Nurse (APRN)
  - Collaborative agreement with physician no longer required if practiced as APN >2 years or >2000 hours

# Physician Forums

- Face-to-face meetings with pediatricians and pediatric subspecialists to hear medical care concerns regarding children in Northern Nevada
- Opportunity to clarify differences and similarities between Medicaid MCOs and Medicaid FFS
- Issues are addressed and solutions offered.
- Resulted in new physicians signing on as providers

# Prior Authorization Alignment

- With an access to care issue with dermatologists, the MCOs removed many of the PA requirements on dermatology in order to make it easier on providers. The FFS side of Medicaid agreed to do the same with support from our medical review physicians.
- It became clear that most of the physician medical reviewers were approving the medical necessity of removal of skin tags, lesions, etc. so there was no concern about removing the PA requirements. However, revision of eyelids, and other procedures that could be considered cosmetic will remain on the PA requirement list.

# The Health Care Guidance Program

- Nevada received approval from CMS through a research and demonstration waiver (Section 1115 Waiver) to provide Care Management Services to high need/high cost recipients in our fee for service program who are not otherwise care managed.
- Goal is to improve quality of care, health outcomes and satisfaction while controlling costs (improved health, decreased re-hospitalization).
- This program will help recipients through transitions from inpatient to outpatient care and to follow through on health care needs. It will help physicians by supporting attendance at appointments, assisting with care access and care follow through.

# Inpatient Psychiatric Care

- The Psychiatric Inpatient Per Diem Rate paid to General Acute Hospitals who provide Psychiatric Services increased from $460 to $944 with a implementation date of July 1, 2014.
- Freestanding psychiatric hospitals are reimbursed at a negotiated rate (the lowest rate acceptable to Nevada Medicaid and the provider).

# MCO and In Lieu of Service

- "In Lieu of" services is an option allowable for Medicaid Managed Care Organizations.
- The MCO may provide services in alternate licensed inpatient settings ***in lieu of*** services in an inpatient hospital when these settings are lower cost than traditional inpatient settings.
- The DHCFP is able to support this option under our existing 1932(a) State Plan Authority.
- The DHCFP must amend our MCO contracts to add this option.
- The DHCFP must demonstrate to CMS the cost-effectiveness of the in lieu of services.

# Grants

- Money Follows the Person – goal is to transition persons from institutional based care to community based, person centered, consumer directed care. ($9.9M, 2011 – 2016, no cost extension to 2019)
- Medicaid Incentives for the Prevention of Chronic Diseases – study of use of incentives in the Medicaid population to encourage prevention and healthy behaviors to control disease and improve outcomes ($3.5M, 2011 – 2015)

# Grants

- Received CMS Balancing Incentive Payment Program allowing additional federal funds for home and community based services to shift from institutional to community based care improve single point of entry and conflict free case management.