

# Medicaid Reform Advisory Group Draft Report for Governor Parnell December 1, 2014

Governor Parnell established the Medicaid Reform Advisory Group during 2014 to develop a proposal for reforming the state's Medicaid program to meet the following three conditions:

1. Stability and predictability in budgeting,
2. Increase the ease and efficiency of navigating the system by providers, and
3. Provide whole care for the patient by uniting physical and behavioral health treatment.

DHSS Commissioner William Streur was charged with Chairing the Advisory Group. Members were:

- William Streur, Chair
- Renae Axelson
- Senator John Coghill
- Ilona Farr, MD
- Sandra Heffern
- Representative Pete Higgins
- Mike Navarre
- Gene Peltola
- John Torgerson
- Kevin Turkington

The Advisory Group met six times during 2014 to consider various proposals and hear public testimony. Meeting dates were April 23, May 28, June 24, September 17, and October 29.

The Advisory Group's report to Governor Parnell was due November 15, but was not completed prior to the transition. Following is the draft report as of December 1, 2014, at the time of the transition to the Walker Administration.

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## Person Centered Case Management (PCCM)

### *September 17, 2014 Advisory Group Action:*

Advisory Group recommends the Department identify and draft the necessary regulations to implement a care management program for the over utilization of services by Medicaid patients, and start identifying and working with providers and making necessary regulations to implement a case management system for all Medicaid recipients.

**Motion:** Torgerson

**Second:** Coghill (1<sup>st</sup> motion) Turkington (second motion)

**Vote:** Passed without objection

In the Care Management Program model, a recipient who is found to have over-utilized a specific service is assigned to specific providers (typically a primary care physician, dentist and/or pharmacy) for a period of 12 months of eligibility. This was formerly known as the Lock-in Program.

Currently, Alaska's Care Management program can accommodate a maximum of 300 recipients. The program is administered by an outside contractor.

The estimated annual savings to the Medicaid program for Care Management is up to \$4.5 million per year.

Case Management is utilized when a recipient is hospitalized and receives evidence-based case management practices. This function is performed by an outside contractor.

Referrals to this program come from the Division of Public Assistance, Insurance Companies, Providers/Physicians, the Division of Health Care Services, and even some self-referrals.

During fiscal year 2013 925 cases were referred of which 114 were opened. The reported savings was \$3.5 million for a return on investment of \$4.94 for every \$1 spent.

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## **Comprehensive Payment Reform**

### ***September 17, 2014 Advisory Group Action:***

Advisory Group recommends the Department form a comprehensive payment reform working group comprised of stakeholders including medical providers, payers, and patients to review and make recommendations on which payment reform systems could be implemented in Alaska.

**Motion:** Torgerson

**Second:** Coghill

**Vote:** Passed 5-1

Comprehensive Payment Reform includes the following seven avenues for approaching payment reform: bundled payments; specialty management, pay for outcomes; DRG reimbursement system; cost sharing; cost methodology; and acuity rates.

*Bundled Payments:* In the past two decades, there have been several studies to determine monetary savings of bundled payments. Studies look at potential savings using a single type of care, such as a knee replacement. The savings found under several studies are as follows:

- >8-10% savings – Knee/Hip Replacement
- >10% savings - Heart Bypass
- 2-23% savings - Heart Bypass
- 5% savings - Non-emergency CABG procedures

*Specialty Management:* In light of forming its own Technical Expert Panels (TEPs), the State can view summaries of CMS's TEPs at [http://www2.mitre.org/public/payment\\_models/](http://www2.mitre.org/public/payment_models/).

*Pay for Outcomes:* Literature on the impact of health care outcomes under pay for performance show mixed results. Fewer studies have attempted to estimate the monetary savings of pay for performance. Dr. Goldfield and Dr. Averill, in their study of New York and Maryland Medicaid, were able to estimate savings by limiting each category of potentially preventable events. The savings found are as follows:

- 3% for Reducing preventable readmissions
- 8% for Preventing unnecessary readmissions
- 2% for Reducing preventable complications
- 2% for Preventing unneeded ER visits
- 3% for Deterring unnecessary outpatient procedures

*DRG Reimbursement System:* An estimate on the potential savings by switching to a DRG Reimbursement system is difficult without a determination of how the DRG Reimbursement System would be implemented. The state would have to determine if it would adopt a single base rate for all hospitals, several tiers of base rates, or a separate base rate for each hospital. Once a decision is made regarding the base rate, analysis of the type and number of diagnoses, and their associated RVUs, for all inpatient procedures for all or selected hospitals would be needed to estimate the fiscal impact and whether it be applied only to large hospitals or all hospitals.

*Cost Sharing:* The Department is not able to provide specific cost savings associated with this recommendation at this time. The Department is actively analyzing the current cost sharing system.

*Cost Methodology:* Rates for inpatient services and nursing home services are currently set using a provider specific cost survey methodology and hence would not have any additional fiscal impact unless the reimbursement for these services were calculated using cost methodology to set a single rate for all inpatient services or nursing homes.

*Acuity Rates:* The Department is not able to provide specific cost savings associated with this recommendation at this time. The State may incur costs to change administrative and computer systems to accommodate tracking of client acuity for the purposes of proper reimbursement.

The seven avenues for approaching payment reform equate to a total system overhaul in Alaska. Each change would require not only an administrative system overhaul but a computer system overhaul as well. Any proposed changes would require Centers for Medicare and Medicaid Services (CMS) approval. Each of the seven avenues would be affected by the implementation of ICD-10.

## **Cost Savings through Contracted Services — Pharmacy**

### ***September 17, 2014 Advisory Group Action:***

Advisory Group recommends the Department not restrict the Alaska Pharmacy providers from providing prescriptions, but should explore the option of a contract pharmacy for a limited number of specialty drugs as new specialty prescriptions or bio-meds become available and mandated by law.

**Motion:** Torgerson

**Second:** Coghill

**Vote:** Passed without objection

Some health plans and fee for service Medicaid programs utilize contract pharmacies to provide their recipients with pharmacy benefits. It is not uncommon for a payer to restrict “specialty drugs” to a contract “specialty pharmacy.”

Specialty pharmacies accept lower reimbursement for specialty drugs through these contracts because they gain a larger patient pool to service when they are designated the sole supplier of specialty drugs for a payer.

In SFY 2014 there were 3,582 claims with a total payment amount of greater than \$1,500 per prescription. These 3,582 claims accounted for about \$13.4 million in payments.

Potential annual savings for non-tribal specialty drug claims are estimated at up to \$500,000 with the actual savings depending on the specialty pharmacy contract rate and specialty drugs included.

One subgroup of specialty drugs is hemophilia clotting factor. A contract pharmacy providing clotting factor for Medicare’s rate, or less than Medicare’s rate, would be expected to yield at least a 20% savings of about \$260,000 a year on non-tribal claims.

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## **Cost Savings through Contracted Services — Assessments**

### ***September 17, 2014 Advisory Group Action:***

Advisory Group recommends the Department use contract services for all or part of assessments or re-assessments, and that it is not restricted in the types of personnel to be used for this purpose.

**Motion:** Torgerson

**Second:** Peltola

**Vote:** Passed without objection

As a condition for eligibility for Medicaid Home and Community-Based Waivers and the Personal Care program, applicants must be assessed and recipients must be reassessed annually. That results in the need for approximately 8,200 assessments annually; about 13% are initial assessments, the rest are reassessments.

Annual savings to the state by contracting out 2,500 urban reassessments could be up to \$660,000 per year over the current cost of state employee assessors; half of that would be General Fund dollars.

Alaska provides assessment and level of care determination directly through state employees, not through care coordinators. The State is piloting the provision of screening and intake through Aging and Disability Resource Centers, reducing the role of the care coordinator at the front end of the process.

Reducing initial assessments translates into a potential reduction of \$215,296 annually, half of that is General Fund monies. If overall demand grows, then savings would grow as well.

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**Require responsible relatives to financially support child relative in residential care after transition to Medicaid coverage through copay or other cost sharing provision. Investigate capping length of service for out of home treatment.**

***September 17, 2014 Advisory Group Action:***

Advisory Group recommends the Department review the eligibility into family financial responsibility provision by exploring the potential capping of services and reviewing the elimination of the loophole allowing relatives to refuse financial support for Medicaid eligible recipients.

**Motion:** Torgerson

**Second:** Peltola

**Vote:** Passed 5-1

The Division of Health Care Services indicates expenditures of approximately \$31 million in Medicaid costs for children in residential treatment facilities annually. Approximately 25% of these children have been in residential treatment for over 180 days. The costs for residential care are subject to 50% federal match. The state should explore options where possible to require some cost sharing from resourced parental households to ensure continued involvement by parents in the child's return to the home setting.

Because the Department has not tracked family income of children in treatment, it will be difficult to determine financial impact of a copay for the child's care.

## **Utilization limits for Physical Therapy, Occupational Therapy, Speech Therapy & Speech Language Pathology**

### ***September 17, 2014 Advisory Group Action:***

Advisory Group recommends the Department adopt “Innovation #15” (use of annual care plan in prior authorization process for therapies).

**Motion:** Torgerson

**Second:** Heffern

**Vote:** Passed without objection

Alaska Medicaid reimbursed \$26 million for “Therapy and Rehabilitation” services in 2013—roughly 2% of total spending.

Significant savings could potentially be realized by controlling coverage based on a clearly developed annual care plan, though for a variety of reasons an exact amount is difficult to estimate. Also, limiting therapy for certain beneficiaries could potentially increase other Medicaid costs.

Alaska Medicaid should consider policy changes to more appropriately provide PT, OT and ST coverage, primarily through benefit design based on need, acuity and, potentially chronicity. The State should work with the provider community to ensure efficient and effective services and service levels, through a consistent authorization, review and delivery system that is periodically reviewed for those measures.

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## **Allow aged and permanently disabled with fixed incomes to be automatically renewed based on cost of living increases**

### ***September 17, 2014 Advisory Group Action:***

Advisory Group Recommends the Department adopt “Innovation #19” (allow automatic renewal for aged and disabled).

**Motion:** Torgerson

**Second:** Turkington

**Vote:** Passed without objection

This innovation is self-explanatory and would eliminate the necessity for an annual review of this class of recipients when there is little or no health status change. The Department could recognize a total savings of approximately \$1.6 million by implementing this innovation.

## Limit total Medicaid Spending to no more than 4% annual growth

### September 17, 2014 Advisory Group Action:

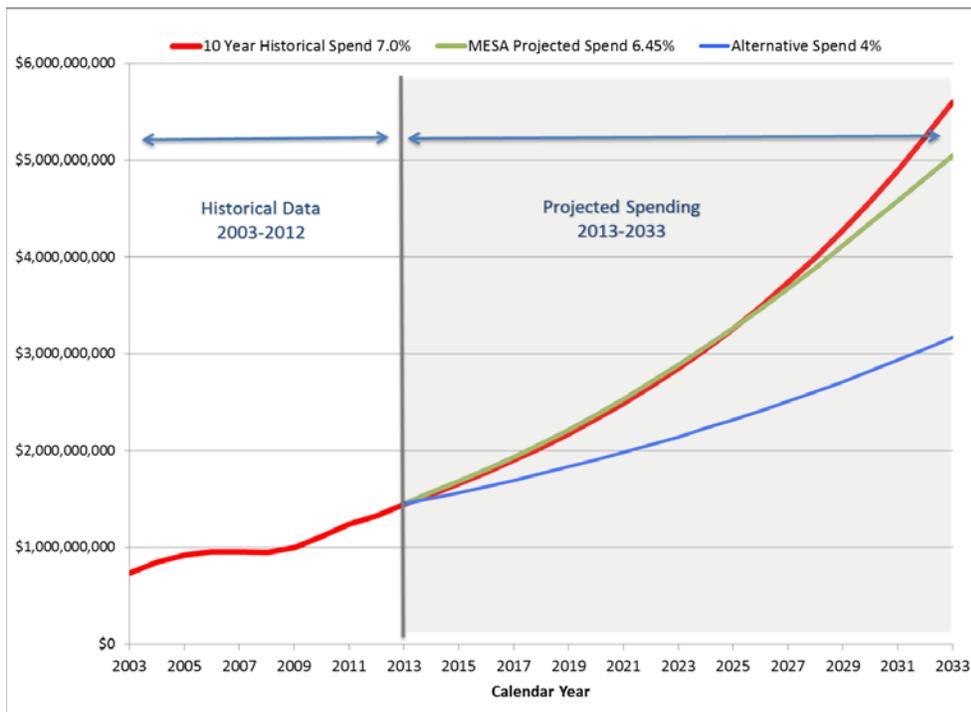
Advisory Group recommends the Department establish a plan to manage Medicaid growth to 4% per year or less and implement that plan to the best of its ability.

**Motion:** Torgerson

**Second:** Coghill

**Vote:** Passed without objection

Medicaid is an entitlement program, so in order to keep the increase to only 4% we have to control utilization. Many believe that a block grant will cap Medicaid spending but what it does over time is shift the costs to the states. This would result in the state being responsible for the ever increasing health care costs. Costs can be contained by reducing or freezing provider payments, controlling prescription drug costs, reducing benefits, reducing eligibility, managed care, disease management programs, long-term care initiatives, effectiveness and cost of care reviews and by targeting fraud and abuse.



## **1915K- capture additional 6% Federal match. Change 1915 C Waiver system to 1915K Include PCA Services**

### ***September 17, 2014 Advisory Group Action:***

Advisory Group recommends the Department adopt “Innovation #22” (adopt 1915K waiver option).

**Motion:** Torgerson

**Second:** Peltola

**Vote:** Passed without objection

Section 1915(k) of the Social Security Act gives states a different option for providing home and community-based attendant services and supports under the Medicaid program. Although the option references attendant services, the actual language and policy guidance suggests that a wide range of services now provided under home and community-based waivers could be included under the 1915(k) option, though not all.

If Alaska were to adopt the 1915(k) option to replace as much as possible the service provided through the current 1915(c) waivers and the personal care program, the enhanced federal match would be significant. Currently, 1215 individuals receiving personal care services are receiving waiver services, at an estimated annual cost of \$28.9 million. The additional 6% federal match would be approximately \$1.7 million.

The waiver services of residential and day habilitation, chore, respite, adult day care, and residential supported living most closely fit the definition of hands on assistance, supervision and cueing. In FY 13, DHSS spent \$221 million on these services. The additional 6% federal match could be about \$13.3 million. In total, the General Fund savings obtained by implementing 1915(k) could be about \$15 million per year.

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## **Across the board rate freeze for one year**

### ***September 17, 2014 Advisory Group Action:***

Advisory Group recommends the Department work with providers to actualize a one year rate freeze. Additionally, the Advisory Group recommends the Department work with providers to reduce the overall administration burden and cost of existing and potential new regulations.

**Motion:** Torgerson

**Second:** Coghill

**Vote:** Passed 5-1

Numerous Medicaid services experience a resetting of rates in a given year. This process is specifically known as “rebasings.” Rebasings is a critical function because it allows for reimbursement rates to be revised in a way that reflects current cost data. Both the methodology and schedule for rebasing vary from service to service.

Given the importance of updating reimbursement rates to reflect accurate cost data, and given the fact that processes and schedules for rebasing can vary significantly among Medicaid services, including changes to rates from rebasing in an across the board rate freeze for one year is not advisable. Rather, focusing on freezing all inflationary rate increases for one year is the most predictable and least disruptive approach for accomplishing innovation item #23.

There are six service groups that have rates that receive annual inflation increases. They are physician services, federally qualified health centers (FQHC) / rural health centers (RHC), home and community-based waiver services (Waiver) / personal care attendant services (PCA), hospital inpatient services, long term care services, and ambulatory surgical services.

Based on ORR's projections, if the Department were to take all necessary steps to enact an across the board rate freeze for one year for the six service groups that receive annual inflation increases, the State could realize savings in an approximate amount of about \$8.8 million in general fund monies.