

STATE OF ALASKA

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OFFICE OF THE COMMISSIONER

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May 4, 2011

The Honorable Sean Parnell
Governor of the State of Alaska
Juneau, Alaska 99811

Dear Governor Parnell,

It is my pleasure to present the accompanying report "Options for Cost-Savings" on behalf of the Medicaid Task Force in accordance with your request.

In the fall of 2010 the Medicaid Task Force was convened to address the growth in Alaska's Medicaid program and budget. The group was comprised of eight legislators, four representatives and four senators, and four department leaders. Members included: Senator John Coghill, Senator Bettye Davis, Senator Lyman Hoffman, Senator Donny Olson, Representative Mia Costello, Representative Mike Hawker (through November 17, 2010), Representative Bob Herron, Representative Reggie Joule, Representative Wes Keller, former Commissioner Bill Hogan (through December 6, 2010), Commissioner Bill Streur, Assistant Commissioner Alison Elgee, and Dr. Ward Hurlburt.

The group found consensus on eight recommendations labeled A-H. They include: Patient-Centered Medical Home, Care Management, Increase Substitution to Generic Medication, Increase Generic Medication Utilization, Enhanced Preferred Drug List, State Maximum Allowable Cost (SMAC), Psychiatric Medication Policy and Community First Choice (Personal Care Attendant).

Each recommendation is briefly described in the Executive Summary and more thoroughly detailed in the body of the report. We are confident that these options provide an opportunity for future savings that could total in excess of \$20 million in the coming years. We do not see these suggestions as the end of the tasking, but the beginning of reforming Medicaid for all Alaskans.

It is our recommendation that this report be distributed to the Legislature, the Medicaid Task Force list serv and posted to the Medicaid Task Force website in order to be accessible to the public. Upon your approval, we will begin to move forward with implementation of these recommendations, beginning with the medical home and the pharmacy options.

Respectfully Submitted,



William J. Streur
Commissioner

MEDICAID

TASK FORCE

Options for Cost-Savings

Recommendations:

- OPTION A- Patient-Centered Medical Home
- OPTION B- Care Management
- OPTION C- Increase Substitution to Generic Medication
- OPTION D- Increase Generic Medication Utilization
- OPTION E- Enhanced Preferred Drug List
- OPTION F- State Maximum Allowable Cost (SMAC)
- OPTION G- Psychiatric Medication Policy
- OPTION H- Community First Choice (PCA)

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OPTIONS FOR COST-SAVINGS

Introduction & Executive Summary

INTRODUCTION

History

At the request of the Governor's Office, the Department of Health and Social Services convened a Medicaid Task Force in the fall of 2010. This task force was established to address the growth in the Medicaid program and budget in Alaska. The group was comprised of four department leaders and eight legislators, four representatives and four senators. Each of the legislators had been involved in health, finance and budget legislative committees and subcommittees. Members included: Former Commissioner Bill Hogan (through December 6, 2010), Commissioner Bill Streur, Assistant Commissioner Alison Elgee, Dr. Ward Hurlburt, Senator John Coghill, Senator Bettye Davis, Senator Lyman Hoffman, Senator Donny Olson, Representative Mia Costello, Representative Mike Hawker (through November 17, 2010), Representative Bob Herron, Representative Reggie Joule and Representative Wes Keller.

The first meeting the group examined national and state Medicaid budgets. The focus of the task force later moved to study cost-containment actions taken by states across the U.S. By January 2011 the task force had identified a dozen options that would be feasible in Alaska. In March 2011, the group had narrowed the original twelve options to eight. Those eight options later became the recommendations that the task force agreed to propose to the Governor for future consideration. They are: Patient-Centered Medical Home, Care Management, Increase Substitution to Generic Medication, Increase Generic Medication Utilization, Enhanced Preferred Drug List, State Maximum Allowable Cost (SMAC), Psychiatric Medication Policy and Community First Choice (Personal Care Attendant).

EXECUTIVE SUMMARY

OPTION A- Patient-Centered Medical Home

Under this option, up to four pilot medical homes will be incentivized through Medicaid to help them provide comprehensive, culturally competent, coordinated primary care services that proactively and holistically address chronic health condition. The four types of pilots anticipated are: rural, tribal, non-tribal independent, and non-rural. The pilot providers will agree to specific standards such as implementing a team-based, patient centered approach, barrier-free access, integrated behavioral health, proactive health improvement/management, and reporting of metrics. In exchange for the enhanced-value services, Medicaid will provide reimbursement in addition to the established fee-for-service payments. Evaluations of this model in other states suggest significant savings result from a decrease in recipient hospitalizations and emergency department use. While the precise model of payment and delivery are yet to be developed, initial savings are estimated to be between \$78,000 and \$165,000 per 1,000 enrolled participants.

OPTION B- Care Management

Care management programs target patients/recipients with chronic diseases or conditions and/or expensive recipients. These programs apply systems, science, incentives, and information to improve medical practice and assist consumers (recipients) and their support system to become engaged in a collaborative process designed to manage medical/social/mental health conditions more effectively. Programs identify and prioritize the consumers at the highest risk who offer the greatest potential for improvements in health outcomes and cost savings. They identify and enroll consumers prior to their use of avoidable emergency department and inpatient hospital services. Interventions are tailored to the consumer's needs and respect the role of the consumer as the decision maker in the care planning process. A cornerstone of care management programs is a positive ROI. After the initial startup, the program will reduce medical expenses in excess of the cost of the program. Potential saving is estimated to be \$340,000 in the first full year of the program.

OPTION C- Increase Substitution to Generic Medication

The average brand name prescription costs over \$200 per claim while the average generic prescription costs about \$30 per claim. When a prescription for a brand name multi-source medication is prescribed and a FDA approved generic product is available, the generic product is dispensed only 90% of the time. To increase the generic substitution percentage the Department will require prior authorization for all brand name multi-source products. This intervention is commonly used by other state Medicaid, Medicare and third party programs nationwide and is an industry standard edit to control costs without sacrificing safety or efficacy. Potential saving is estimated to be \$5.9 million for one year.

OPTION D- Increase Generic Medication Utilization

The average brand name prescription costs over \$200 per claim while the average generic prescription costs about \$30 per claim. Roughly 65% of prescriptions dispensed to Alaska Medicaid recipients are for generic medications. To increase the generic utilization percentage the Department will develop new step-edits and prior authorization requirements for brand name medications in drug classes where less

expensive but equally safe and effective generic alternatives exist. The edits could be implemented progressively in conjunction with the work effort to implement the State Maximum Allowable Cost pricing and edits to increase generic substitution. Potential saving is estimated to be \$1.4 million for one year.

OPTION E- Enhanced Preferred Drug List

The Preferred Drug List (PDL) is a list of medications maintained by the Department at the advisement of the Pharmacy and Therapeutics (P&T) Committee. Preferred medications are not only safe and effective, but they offer the best value to the state through the payment of supplemental rebates or utilization of lower cost generic medications. Virtually all states with a PDL require prior authorization from the prescriber to obtain a non-preferred medication; however, Alaska does not. Currently the Department utilizes a soft-edit to encourage prescribers to use preferred medications but the compliance rate has dropped from 80% compliance when the PDL began to 65% recently. Potential saving is estimated to be \$1.4 million for one year.

OPTION F- State Maximum Allowable Cost (SMAC)

Generic medications are often available from multiple manufacturers at a variety of costs. A State Maximum Allowable Cost (SMAC) price would establish a maximum cost for generic medications based on the different prices in order to maximize cost savings from generic medications. Similar pricing methodologies are used by other third party payers including the Centers for Medicare and Medicaid Services (CMS) which has established a Federal Upper Limit (FUL) that is very similar to the SMAC for some generic medications. Potential saving is estimated to be \$880,500 for one year.

OPTION G- Psychiatric Medication Policy

An increasing number of children in Medicaid are receiving one or more psychiatric medications, to control disruptive behavior and to treat other mental health problems, including a class of strong medicines known as atypical antipsychotics. An emerging body of evidence shows that this class of medications is not without risks, including metabolic and endocrine disorders, weight gain, and elevated blood glucose levels that can lead to the development of type II diabetes. The Department is developing a psychiatric medication policy to reduce the risks associated with these medications in children. This primary goal of the proposed policy is to improve the quality of care for Medicaid recipients, but a secondary outcome may be a reduction in future program costs by decreasing secondary metabolic diseases. Potential saving is estimated to be \$182, 000 in the first year.

OPTION H- Community First Choice (PCA)

This is a proposed redesign of the existing state plan PCA (personal care attendant) program. It is similar in that a recipient must be financially eligible for services and has been found, upon assessment, to demonstrate a functional need significant enough to qualify according to established standards. The PCA service is delivered by a qualified attendant, either chosen by the recipient (self-directed) or agency-based employee. This program would allow the state to develop an assessment process and service array that is more aligned with the needs of Alaskans.. Under a fee-for-service model this would be billed out as payments per unit of service rendered according to an established payment rate. Potential savings are estimated to be \$5.1 million in FY12 and \$6.6 million in FY13.

OPTION A

Patient-Centered Medical Home

OPTION A- Patient-Centered Medical Home

Definition | Patient Centered Medical Home (PCMH) model of care is one where there is a single, continuous source of comprehensive care. The care delivered considers the whole person in the context of their family and community.

Description of components | The medical home: (1) puts the patient at the center of their health care decisions, (2) makes it easier for patients to get care and advice when they need it, (3) provides the right care at the right time and eliminates unnecessary procedures, (4) improves health outcomes, (5) coordinates care across multiple providers, and (6) partners patients with their own team of primary care providers.

Payment method | Payment methods may include fee-for-service, fee-for-service with higher payment levels, fee-for-service with lump sum payments (e.g., provider sharing in cost savings resulting from more efficient and effective care), fee-for-service with per member/per month fee, and fee-for-service with enhanced payments for performance related to quality measures.

Challenge | Alaska Medicaid could proceed fairly quickly to identify PCMH standards and a methodology to pay PCMH providers for their services. However, private efforts to transform the delivery system to a PCMH model will be a challenge. Affected parties will need support for planning and implementation. Providers will require coordination, ongoing education, and technical assistance.

Electronic medical records will be imperative. As of March 2011, Alaska Medicaid will offer incentive payments to eligible professionals and eligible hospitals to adopt, implement or upgrade, and demonstrate meaningful use of electronic health record technology but these resources alone are not enough to support Alaska providers in this transformation.

The kind of innovation necessary for PCMHs is taking place in Southcentral Foundation's health care system. Their unique position of owning and managing their system has enabled SCF to make dramatic improvements in health outcomes, per capita spending, and satisfaction.

Prior experience | There are providers in Alaska who currently follow some of the primary concepts related to PCMHs, however, Medicaid has not yet funded such a project. However, through a 5-year grant, the Alaska Medicaid program has initiated a 5-year demonstration to among other things, support the implementation of a handful of PCMH sites and evaluate their impact.

Relationship/similarity to other options | Medicaid homes share some components of the next option, Care Management. Each relies on an enhanced communications between the patient and primary care provider, electronic medical records, and adherence to evidence-based practice guidelines. PCMHs that seek to reduce inpatient hospital and emergency department use will generally be those that focus on enrollees with costly and complex chronic conditions, the target populations for Care Management programs.

Anticipated reaction of providers and other potentially affected parties | Leading primary care clinics, practices and medical facilities across Alaska are already engaged in transforming their models of care to include many, if not all, of the principles embodied in medical homes. As with any transformational change, there are early adopters who understand and embrace the need for the PCMH and there are

those who will lag or resist for a variety of reasons. Some providers will be opposed to Medicaid-supported PCCMs as a move toward managed care.

Cost Containment | Evaluations of Medicaid medical home programs in other states suggest a decrease in hospitalizations and emergency department use. North Carolina offers the clearest results with a 40 percent decrease in hospital admissions rates, 16 percent lower emergency department use rate, and 93 percent receipt of appropriate maintenance medications. (NASHP, 2009) An upfront \$10.2 million investment for North Carolina Community Care operations in SFY04 saved \$244 million in overall healthcare costs for the state with similar results in 2005 and 2006. (Mercer, 2007) In Michigan, a Blue Cross/Blue Shield plan shows very promising results including:

- PCMH practices have a 7.4 percent lower rate of adult high-tech radiology usage than non-PCMH practices, and a per member per month cost that is 4.3 percent lower;
- PCMH practices have a 2.8 percent lower rate of adult ER visits than non-PCMH practices;
- For patients with manageable chronic conditions, PCMH practices have a 25.5 percent lower rate of adult inpatient admissions than non-PCMH practices;
- PCMH practices have a 4.2 percent higher rate of dispensing generic drugs than non-PCMH practices; and,
- PCMH practices have a 7.0 percent lower rate of pediatric ER visits than non-PCMH practices.

Quality improvement | States that reimburse practices that function as medical homes are putting in place measurable quality standards and developing a process for recognizing which practices meet those standards. Many states plan to use the National Committee for Quality Assurance Physician Practice Connections - Patient Centered Medical Home (NCQA PPC-PCMH) tool—either alone or in conjunction with other state requirements.

Federal Requirements | State Medicaid programs receive federal Medicaid reimbursement for medical homes through a variety of authorities. The most recent opportunity is for enhanced federal reimbursement for health homes for recipients with chronic conditions.

Experiences of other states | Over 34 states contract with a health plan and 30 states directly operate a Medicaid primary care case management (PCCM) program- a managed care option for state Medicaid programs. As of June 2009, over 7.3 million Medicaid recipients were enrolled in a PCCM. In a recent survey, 33 states indicated that they will likely establish “health homes” under a new federal opportunity.

Unintended Consequences | Some states, providers and other experts have raised concerns that transforming provider practices will place too much weight on technology, will be too costly, and will limit recognition to physician practices only.

Difficulty | Challenges exist in the development of a PCMH model, primarily education within the practice, buy-in from physicians and staff, transformation of workflow and practices and the cost for adoption of technology, technical assistance and electronic health records. Opportunity cost is another factor as the process is time consuming and day to day operations cannot stop during the transformation. Infrastructure may also need to be considered. Further, standards used to recognize PCMHs are urban based and do not apply to remote or rural areas in Alaska. Standards will need to be adjusted to meet Alaska’s delivery system.

Timeline | It is anticipated that it will take 3 to 5 years for private parties to transform the delivery system to a PCMH model depending upon the scope and number of demonstration sites. A year is needed to develop a model with measurable standards that Alaska can adopt, as the urban based models do not apply for rural and frontier sites. Once the model is deployed, it is expected to take four years to transform and develop the participating sites. Technology and additional workforce should also be considered to assist in the development.

Responsibility for/coordination | State Medicaid agencies play a key role in advancing medical homes. As large purchasers and payers of health care, they are partnering with other stakeholders, such as commercial payers, Primary Care Associations, primary care providers and the organizations that represent patients, other private providers, and advocacy groups. These other stakeholders are important partners in the support, program design, implementation and operation.

Legal requirements | A Medicaid State Plan and statutory change may be required if the PPACA Health Home option is pursued as a “separate service” under federal authority.

Costs | Additional Medicaid program expenditures will include a performance or incentive based fee to PCMH providers, probably a “per member/per month” payment. These expenditures will depend on the number of providers and recipients that enroll in the PCMH program. In addition to these costs, the department will need resources to establish standards for the potential providers, analyze data to identify potential savings and outcomes, establish program priorities, recruit providers and recipients to participate in the program, and oversee the program.

ADDENDUM A

Patient-Centered Medical Home

Addendum A

Brief Description

Medicaid will work with stakeholders to identify up to four pilot medical homes. Under this model, these pilot homes will be incentivized through Medicaid to help them provide comprehensive, culturally competent, coordinated primary care services that proactively and holistically address chronic health condition. The four types of pilots anticipated are: rural, tribal, non-tribal independent, and non-rural. The pilot providers will agree to the *(to be established)* standards such as implementing a team-based, patient centered approach, barrier-free access, integrated behavioral health, proactive health improvement/management, and reporting of certain metrics.

In exchange for the enhanced-value services, Medicaid will provide reimbursement in addition to the established fee-for-service payments. While the precise model of payment is yet to be developed, it may resemble that of another state's experience such as noted below. ***The model narratives below describe the respective State's model, the charts reflect draft Alaska dollar amounts:***

Oregon Model

Providers receive up to 20 percent additional reimbursement based on performance in three tiers of measures. These additional payments are made on a monthly basis based on the performance level of the prior quarter. These are per-member, per-month (PMPM) payments with adjustments for the level of risk of the population served. In addition to the three incentive tiers below, support is provided by the Medicaid program through a sponsored ongoing learning collaborative.

- **Payment for capacity to do work (tier one):** This level of payment is provided to recognize the involvement in the steering committee, ongoing participation in the collaborative project and is intended to encourage capacity development.
- **Payment for improvement (tier two):** This payment is for performance on the established metrics (6-8 metrics in the CareOregon program – for example, diabetes hemoglobin A1c levels below 8 percent). The payment is based on the level of performance improvement within the practice rather than national benchmarks.
- **Payment for outcomes (tier three):** This added incentive is for any collaborative participating practice that reaches a performance level of 90th percentile of tier two performance measures.

| PROJECTED COST SAVINGS | | | | | |
|--|------------------------------|--------------------|--------------------|---------------------|--------------------|
| BUDGET RAW | | | | | |
| Enrolled Participants | 1,000 | 5,000 | 15,000 | 30,000 | |
| ED/Urgent (368 x .4*) | \$110,400 | \$736,000 | \$2,208,000 | \$4,416,000 | |
| Hospital (1647 x 2 x .3**) | \$494,100 | \$2,470,500 | \$7,411,500 | \$14,823,000 | |
| Total/Yr | \$604,500 | \$3,206,500 | \$9,619,500 | \$19,239,000 | |
| * 40% reduction in ED/urgent care visits for enrollees | | | | | |
| ** 30% reduction in hospital days for enrollees | | | | | |
| Incentives | | | | | |
| Tier 2 paid at 60% success rate. Tier 3 paid at 40% success rate. | Enrolled participants | | | | |
| | | 1,000 | 5,000 | 15,000 | 30,000 |
| | Tier 1 \$7 PMPM | \$84,000 | \$420,000 | \$1,260,000 | \$2,520,000 |
| | Tier 2 \$2 PMPM (x .6) | \$14,400 | \$72,000 | \$216,000 | \$432,000 |
| | Tier 3 \$3 PMPM (.4) | \$14,400 | \$72,000 | \$216,000 | \$432,000 |
| | Total Incentives | \$112,800 | \$564,000 | \$1,692,000 | \$3,384,000 |
| | Contract/staff cost | \$250,000 | \$250,000 | \$250,000 | \$250,000 |
| | Collaborative delivery | \$50,000 | \$50,000 | \$50,000 | \$50,000 |
| | Total Cost | \$525,600 | \$1,428,000 | \$3,684,000 | \$7,068,000 |
| | Less Savings | \$604,500 | \$3,206,500 | \$9,619,500 | \$19,239,000 |
| NET SAVINGS | \$78,900 | \$1,778,500 | \$5,935,500 | \$12,171,000 | |

North Carolina Model

Primary care practices receive a \$1.00 per-member-per-month fee for providing a medical home with 24/7 access and coordination of specialty care for enrollees. These practices receive an addition \$1.50 PMPM for joining a community network, which supports individual practices with medical directors, case managers, pharmacists, quality improvement specialists and tools, a statewide case management information system, and training and technical support.

| PROJECTED COST SAVINGS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|--------------------|--------------------|---------------------|--|-----------------------|--|--|--|-------|-------|--------|--------|-----------------|----------|-----------|-----------|-------------|------------------------|----------|-----------|-----------|-----------|-------------------------|-----------------|------------------|--------------------|--------------------|---------------------|-----------|-----------|-----------|-----------|------------------------|----------|----------|----------|----------|-------------------|------------------|------------------|--------------------|--------------------|--------------|-----------|-------------|-------------|--------------|--------------------|------------------|--------------------|--------------------|---------------------|
| BUDGET | | | | RAW | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Enrolled Participants | 1,000 | 5,000 | 15,000 | 30,000 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ED/Urgent (368 x .4*) | \$110,400 | \$736,000 | \$2,208,000 | \$4,416,000 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Hospital (1647 x 2 x .3**) | \$494,100 | \$2,470,500 | \$7,411,500 | \$14,823,000 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Total/Yr | \$604,500 | \$3,206,500 | \$9,619,500 | \$19,239,000 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| * 40% reduction in ED/urgent care visits for enrollees | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ** 30% reduction in hospital days for enrollees | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Incentives/Costs | <table border="1"> <thead> <tr> <th rowspan="2"></th> <th colspan="4">Enrolled participants</th> </tr> <tr> <th>1,000</th> <th>5,000</th> <th>15,000</th> <th>30,000</th> </tr> </thead> <tbody> <tr> <td>Tier 1 \$3 PMPM</td> <td>\$36,000</td> <td>\$180,000</td> <td>\$540,000</td> <td>\$1,080,000</td> </tr> <tr> <td>Tier 2 \$4 PMPM (x .7)</td> <td>\$33,600</td> <td>\$168,000</td> <td>\$504,000</td> <td>\$432,000</td> </tr> <tr> <td>Total Incentives</td> <td>\$69,600</td> <td>\$348,000</td> <td>\$1,044,000</td> <td>\$1,512,000</td> </tr> <tr> <td>Contract/staff cost</td> <td>\$250,000</td> <td>\$250,000</td> <td>\$250,000</td> <td>\$250,000</td> </tr> <tr> <td>Collaborative delivery</td> <td>\$50,000</td> <td>\$50,000</td> <td>\$50,000</td> <td>\$50,000</td> </tr> <tr> <td>Total Cost</td> <td>\$439,200</td> <td>\$996,000</td> <td>\$2,388,000</td> <td>\$3,324,000</td> </tr> <tr> <td>Less Savings</td> <td>\$604,500</td> <td>\$3,206,500</td> <td>\$9,619,500</td> <td>\$19,239,000</td> </tr> <tr> <td>NET SAVINGS</td> <td>\$165,300</td> <td>\$2,210,500</td> <td>\$7,231,500</td> <td>\$15,915,000</td> </tr> </tbody> </table> | | | | | Enrolled participants | | | | 1,000 | 5,000 | 15,000 | 30,000 | Tier 1 \$3 PMPM | \$36,000 | \$180,000 | \$540,000 | \$1,080,000 | Tier 2 \$4 PMPM (x .7) | \$33,600 | \$168,000 | \$504,000 | \$432,000 | Total Incentives | \$69,600 | \$348,000 | \$1,044,000 | \$1,512,000 | Contract/staff cost | \$250,000 | \$250,000 | \$250,000 | \$250,000 | Collaborative delivery | \$50,000 | \$50,000 | \$50,000 | \$50,000 | Total Cost | \$439,200 | \$996,000 | \$2,388,000 | \$3,324,000 | Less Savings | \$604,500 | \$3,206,500 | \$9,619,500 | \$19,239,000 | NET SAVINGS | \$165,300 | \$2,210,500 | \$7,231,500 | \$15,915,000 |
| | Enrolled participants | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 1,000 | 5,000 | 15,000 | 30,000 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Tier 1 \$3 PMPM | \$36,000 | \$180,000 | \$540,000 | \$1,080,000 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Tier 2 \$4 PMPM (x .7) | \$33,600 | \$168,000 | \$504,000 | \$432,000 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Total Incentives | \$69,600 | \$348,000 | \$1,044,000 | \$1,512,000 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Contract/staff cost | \$250,000 | \$250,000 | \$250,000 | \$250,000 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Collaborative delivery | \$50,000 | \$50,000 | \$50,000 | \$50,000 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Total Cost | \$439,200 | \$996,000 | \$2,388,000 | \$3,324,000 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Less Savings | \$604,500 | \$3,206,500 | \$9,619,500 | \$19,239,000 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| NET SAVINGS | \$165,300 | \$2,210,500 | \$7,231,500 | \$15,915,000 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Tier 1 \$3.00 PMPM for all collaborative participants. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Tier 2 \$4.00 PMPM for network participants. (est. 70%) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Oklahoma Model

Each member is linked to a primary care provider who serves as a medical home and manages basic health care needs, including after hours care and specialty referrals. Primary care case management/care coordination fees are paid based on type of practice and what level of medical home a practice is. There are three tiers of medical homes: Tier 1 is an entry level medical home; Tier 2 is an advanced medical home; and Tier 3 is an optimal medical home. Medical home practices receive provider support and care management from Oklahoma Medicaid staff, including nurses and social service coordinators who provide telephonic support and utilize a web-based clinical case management system. They have over 770 medical home providers servicing more than 400,000 Medicaid eligibles.

Options for Cost Savings

| COST SAVINGS | | | | | |
|--|------------------------|--------------------|--------------------|---------------------|---------------------|
| BUDGET | | | | | RAW |
| Enrolled Participants | 1,000 | 5,000 | 15,000 | 30,000 | |
| ED/Urgent (368 x .4*) | \$110,400 | \$736,000 | \$2,208,000 | \$4,416,000 | |
| Hospital (1647 x 2 x .3**) | \$494,100 | \$2,470,500 | \$7,411,500 | \$14,823,000 | |
| Total/Yr | \$604,500 | \$3,206,500 | \$9,619,500 | \$19,239,000 | |
| * 40% reduction in ED/urgent care visits for enrollees | | | | | |
| ** 30% reduction in hospital days for enrollees | | | | | |
| BUDGET | | | | | RAW |
| Incentives | Contract/staff cost | \$250,000 | \$250,000 | \$250,000 | \$250,000 |
| | Collaborative delivery | \$50,000 | \$50,000 | \$50,000 | \$50,000 |
| Tier 1 \$5.50 PMPM (est. 60% volume) | Total Cost | \$451,200 | \$1,056,000 | \$2,568,000 | \$4,836,000 |
| Tier 2 \$7.00 PMPM (est. 20%) | Less Savings | \$604,500 | \$3,206,500 | \$9,619,500 | \$19,239,000 |
| Tier 3 \$8.00 PMPM (est. 20%) | NET SAVINGS | \$153,300 | \$2,150,500 | \$7,051,500 | \$14,403,000 |

Stakeholders

Key stakeholders include interested/involved providers, Medicaid recipients, advocacy groups.

Lead agency

The lead agency in this effort is the Department of Health and Social Service, Division of Health Care Services, in conjunction with others involved: Division of Public Assistance, Division of Senior and Disabilities Services, Division of Behavioral Health, and the Pioneer Homes.

| TIMELINE OF KEY ACTIVITIES | |
|-----------------------------------|--|
| DATES | ACTIVITY |
| March 2011 | <p>Medicaid Task Force presentation/determination to pursue pilots for:</p> <ul style="list-style-type: none"> • 1 rural area • 1 tribal entity • 1 independent • 1 non-rural. |
| April 2011 | <p>Identification of internal development team and external key stakeholders. Analyze models from other State Medicaid programs and prepare to present summary to key stakeholders. Develop detailed work plan. Determine criteria for pilot participation. Determine support model (state staff vs. contractor) for essential elements such as: Care Coordination training, learning collaborative facilitation, metrics development and training and consumer engagement. Issue RFP or draft position description if internal.</p> |
| April/May 2011 | <p>Present draft work plan to key stakeholders. Evaluate payment methodologies. Seek CMS approval for pilot project.</p> |
| May 2011 | <p>Convene task force of key stakeholders to review. Develop a communication strategy for educational campaign on definition of medical home in Alaska and implementation plan.</p> |
| June/July 2011 | <p>Finalize Implementation plan. Develop outcome measures.</p> |
| August 2011 | <p>Develop plan for adopting payment structure into MMIS or alternative processing.</p> |
| September 2011 | <p>Develop and initiate education/technical assistance plans.</p> |
| October 2011 | <p>Pilot program enroll recipients.</p> |

OPTION B

Care Management

OPTION B - Care Management

Program Description | “Care management programs apply systems, science, incentives, and information to improve medical practice and assist consumers and their support system to become engaged in a collaborative process designed to manage medical/social/mental health conditions more effectively. The goal of care management is to achieve an optimal level of wellness and improve coordination of care while providing cost effective, non-duplicative services.” (CHCS, October 2007)

Using both clinical and non-clinical information, care management programs identify and prioritize the consumers at the highest risk who offer the greatest potential for improvements in health outcomes and cost savings. Interventions are tailored to the consumer’s needs and respect the role of the consumer as the decision maker in the care planning process.

Care management programs usually target patients/recipients with chronic diseases or conditions and/or expensive recipients. In FY 2010, nearly half of all Alaska Medicaid recipients had one or more chronic diseases and conditions and represented 86% of all payments. In the same year, the 5% most expensive patients (6,004) accounted for nearly 52% of all payments. The hallmark of care management is the timely identification and enrollment of recipients prior to their use of avoidable emergency department and inpatient hospital services.

Alaska Medicaid is currently analyzing which recipients offer the greatest opportunity for improvement in health outcomes and cost savings. Analysis is underway on recipients with diabetes, congestive heart failure, and chronic mental illness.

Program Components | *Care management programs have both client and provider components. The client provisions include:*

- **A call center** staffed by nurses and/or health coaches offering telephonic care management including client health assessments, individual plans of care, support to clients enabling them to adhere to their care plans, follow-up reminder calls;
- **Educational brochures and materials** specific to a disease(s);
- **Self-management education and skill building** for clients (primary prevention, risk-appraisals, behavior modifications, problem solving skills and goal setting;
- (In the most complex cases), in-person care management (in-office, in-home, group); and,
- **In-home monitoring** devices and **personal health records**.

The provider provisions include:

- Promotions for the adherence to **evidence-based and broadly accepted practice guidelines**;
- **Provider education and support** enabling better provider-patient (client) communication and prevention and management of chronic conditions;
- Support for **client health risk assessments and plans of care**; and,
- **Electronic clinical client information**.

Payment method | A contractor would be paid based on a Return-on-Investment (ROI) calculation.

Prior experience | In FY2008, the department designed an outsourced Medicaid disease management program. The program was not funded. HCS and DPH Chronic Disease Section analyzed Medicaid claims data on 3 program types: (1) specific chronic diseases (asthma and heart disease), (2) most expensive recipients (cancer, mental disorders, premature/NICU babies), and (3) populations with the greatest

opportunity of saving money and improving health outcomes. The greatest ROI was expected for the Aged, Blind, and Disabled Medicaid recipients.

Relationship/similarity to other options | Care management programs, like PCMHs, rely on enhanced communications between the patient and health providers, care plans, electronic medical records, and adherence to evidence-based practice guidelines.

Anticipated reaction of providers and other potentially affected parties | Care management programs have been established by other health plans in Alaska. Medicaid providers will likely not object to a Medicaid care management program.

Cost containment and quality improvement | A cornerstone of chronic care management programs is a positive ROI. After the initial startup, the program will reduce medical expenses in excess of the cost of the program.

Federal requirements | A Medicaid state plan amendment would be required.

Experiences of other states | Over the FY 2010 and FY 2011 period, nearly half of all states implemented or plan to implement new care management programs or policies. Most existing programs have been viewed favorably however the focus of some programs has been adjusted over time.

Unintended consequences | None identified at this time.

Difficulty | The development of a care management program would be relatively straightforward. The most difficult aspect of implementing a care management program is the design of the ROI methodology. The methodology should incentivize the contractor to manage the care of the most expensive recipients.

Legal requirements | Legislation will probably not be necessary; however, the department appreciates the inclusion of intent language in the budget to signify legislative support.

Costs | The cost of a care management program will vary depending on the specific target population and the ROI requirements. The department's preferred program size includes a target population of 3,300 recipients, a \$50 Per Member Per Month payment, and a ROI of 1.25.

One-time program costs are expected to include a \$50,000 technical assistance contract in the initial program year. In addition to the care management contract, ongoing program expenses are estimated to include 0.5 FTE data analyst, and other department staff services estimated at \$50,000 per year. In the first full year of the care management program, the department expects a net savings of \$340,000.

ADDENDUM B

Care Management

Addendum B

Brief Description

Care management programs usually target patients/recipients with chronic diseases or conditions and/or expensive recipients. Care management programs apply systems, science, incentives, and information to improve medical practice and assist consumers (recipients) and their support system to become engaged in a collaborative process designed to manage medical/social/mental health conditions more effectively. Programs identify and prioritize the consumers at the highest risk who offer the greatest potential for improvements in health outcomes and cost savings. Interventions are tailored to the consumer's needs and respect the role of the consumer as the decision maker in the care planning process.

Alaska Medicaid is currently identifying which recipients offer the greatest opportunity for improvement in health outcomes and cost savings. Analysis is underway on recipients with diabetes, congestive heart failure, and chronic mental illness.

Stakeholders

Stakeholders include hospitals, physicians, nurse practitioners, physician assistants, and other practitioners, as well as their professional associations. All Medicaid recipients as well as consumer advocacy organizations for the aged and disabled Medicaid populations are stakeholders.

Lead agency

The Division of Health Care Services within the Department of Health and Social Services would be responsible for the implementation of an outsourced care management program.

Options for Cost Savings

The table below includes the cost savings and budget for 4 care management programs of the following population sizes: 2,500 eligible recipients, 3,300 recipients, 5,000 eligible recipients, and 7,500 eligible recipients. The department's (initial) preferred program include 3,300 eligible recipients, a savings of \$2.5 M in avoided inpatient hospital and emergency department services, and an annual cost of \$2.166 M for net savings of \$340,000.

| COST SAVINGS | | | | |
|--|-------------|--------------------|-------------|-------------|
| Eligible Population | 2,500 | 3,300 | 5,000 | 7,500 |
| <i>Actively managed cases, during any month</i> | 330 | 435 | 660 | 990 |
| AVOIDED - Inpatient Hospital and Emergency Department Services (per year) | \$1,900,000 | \$2,500,000 | \$3,800,000 | \$5,700,000 |
| BUDGET | | | | |
| Professional Services Contract - \$50 PMPM | \$1,500,000 | \$2,000,000 | \$3,000,000 | \$4,500,000 |
| Program Manager – | 0 | 0 | 0 | 0 |
| Data Analyst (0.5 FTE) | \$60,000 | \$60,000 | \$60,000 | \$60,000 |
| Other department staff – physician consultation, etc. | \$50,000 | \$50,000 | \$50,000 | \$50,000 |
| (One-time) Professional Consultation Services | \$50,000 | \$50,000 | \$50,000 | \$50,000 |
| Total Costs (in first year) | \$1,660,000 | \$2,160,000 | \$3,160,000 | \$4,660,000 |
| NET SAVINGS | | | | |
| NET SAVINGS PER YEAR (estimates) | \$240,000 | \$340,000 | \$640,000 | \$1,040,000 |

| TIMELINE of KEY ACTIVITIES | |
|-----------------------------------|--|
| Dates | Tasks |
| 1-July 2011 | Program funds available, program manager hired to manage program, data analyst assigned to program |
| 1-September 2011 | HCS program design finalized |
| 1-October 2011 | RFP released |
| 1-January 2012 | Contract awarded, program begins |
| Ongoing | Evaluation |
| FY 2013 | First full year of contract |

OPTION C

Increase Substitution to Generic Medication

OPTION C- Increase Substitution to Generic Medication

Definition | The substitution rate for brand name multi-source medications is approximately 90% and enhanced requirements are under review to further increase the utilization of generic medications whenever possible.

Description | The pharmacy program would add requirements for the therapeutic failure of two different manufacturers of a generic medication before allowing the recipient to obtain the expensive brand name drugs with the same active ingredient. In FFY 2010, roughly 7% of pharmacy claims were submitted for brand name multi-source medications accounting for 13% of total program expenditures. Physicians would be required to submit therapeutic failures or adverse reactions with the generic products to the FDA using the MedWatch forms before receiving authorization from the department for the brand name product.

Prior experience | The pharmacy program has had previous experience implementing prior authorization requirements.

Anticipated reaction of providers and other potentially affected parties | This submission of the required information by physicians is easy and has the added benefit of notifying the FDA of drug problems, however, this is an additional task for providers to complete. In terms of the provider community, the addition of a restriction to pharmacy services presents an easier implementation each time another restriction is added.

Cost containment and quality improvement | This method of restriction is cost effective and could cost avoid \$ 6.0 million in one year. This is a method of restriction used by many other States to improve generic utilization. There is no anticipated negative impact on care.

Federal requirements | A Medicaid state plan amendment will be required.

Unintended consequences | This adds to the onerous challenges for our prescribers and could increase their costs of doing business. The step-edit option (below) can be more onerous to the pharmacy if the recipient fails with the first pass of the edit as a therapeutic substitution becomes necessary and the prescriber must be contacted to change the medication or obtain the prior authorization.

Difficulty | This option will not be difficult to implement.

Timeline | The total estimated time to implement this brand name prior authorization option is nine months. The programming changes in the pharmacy system are necessary and those may take three months to complete. This option requires a regulation change and State Plan submittal, there would be a lead time of at least six months before implementation.

Responsibility for/coordination | The HCS Pharmacy Unit in collaboration with the Systems Unit will be responsible for the programming changes and regulation adoption. The Pharmacy Unit will draft a provider notice explaining the changes to be sent thirty days prior to the implementation date.

Legal requirements | A regulation change is required.

Costs | The cost of implementation is minimal.

ADDENDUM C

Increase Substitution to Generic Medication

Addendum C

Brief Description

The average brand name prescription costs over \$200 per claim while the average generic prescription costs about \$30 per claim.

When a prescription for a brand name multi-source medication is prescribed and a FDA approved generic product is available, the generic product is dispensed only 90% of the time. To increase the generic substitution percentage the Department will require prior authorization for all brand name multi-source products. Recipients will have to try two different manufacturers of the generic product before obtaining authorization to receive the more expensive brand name multi-source version. All treatment failures or adverse reactions experienced with the generic products will need to be documented on a MedWatch form to report the events to the Food and Drug Administration. A regulation change and state plan amendment would be required to implement this initiative.

This intervention is commonly used by other state Medicaid, Medicare and third party programs nationwide and is an industry standard edit to control costs without sacrificing safety or efficacy.

Stakeholders

Stakeholders would include the following practitioners and their professional organizations: Dentists, Pharmacists, Physicians, Podiatrists, Nurse Practitioners, Physician Assistants, and Tribal Health Programs.

Additional non-practitioner stakeholders would include advocacy groups and the Pharmaceutical Research and Manufacturers of America (PhRMA).

Lead agency

The Division of Health Care Services within the Department of Health and Social Services would be responsible for the implementation of the edits.

| COST SAVINGS | Direct |
|---|--------------------|
| Estimated Savings from increased generic substitution – 1 year | \$6,000,000 |
| | |
| BUDGET | Raw |
| Programmer and Systems costs (one time cost) | \$12,000 |
| Call Center (post-implementation – estimated annual cost) | \$20,000 |
| Provider Notification (one time cost – 2 mailings) | \$4,000 |
| TOTAL – year one | \$36,000 |
| | |
| NET ESTIMATED SAVINGS | \$5,964,000 |

| TIMELINE of KEY ACTIVITIES | |
|-----------------------------------|--|
| Dates | Tasks |
| 2-May 2011 | Internal kick-off meeting |
| 3-May 2011 | Prepare draft regulation and initiate regulation change procedures |
| 1-June 2011 | Release draft regulation for public comment (6 weeks) |
| | Send draft regulations and request for consultation to tribal health programs |
| 2-June 2011 | |
| 13-July 2011 | Close public comment on draft regulation |
| 14-July 2011 | Begin evaluation of public comment and tribal health consultation |
| 19-Aug 2011 | Complete revisions and evaluation of public comments |
| | Final regulation to Lt. Governor and begin programming changes for POS system |
| 1-Sept 2011 | |
| 3-Oct 2011 | Begin state plan amendment process (Q4-2011) and 1 st provider notice |
| 7-Nov 2011 | 2 nd provider notice |
| 1-Dec 2011 | Completion of coding changes |
| 7-Dec 2011 | Implementation |

OPTION D

Increase Generic Medication Utilization

OPTION D- Increase Generic Medication Utilization

Definition and description | The step-edit is a simple process to guide drug utilization to lower drug costs. The pharmacy program uses step-edits for certain drugs and is evaluating the expansion of these edits to additional medications. The step-edit is like an automatic prior authorization, it requires a recipient first use a less expensive drug (or have a specific diagnosis on file) to obtain the first option (the least expensive medication). If the recipient tries the first level medication and the medication fails to exert proper action, the prescriber may obtain a prior authorization for the more expensive drug with similar efficacy. If the patient meets the criteria, a more onerous prior authorization process is not necessary. If the patient fails the criteria, prior authorization allows the prescriber to obtain the authorization for the drug.

The step-edit process involves therapeutic substitution rather than generic substitution involved in Option C. Therapeutic substitution requires a change from a brand name medication to therapeutically equivalent and different generic medication. An example of therapeutic substitution is Drug A – a brand name medication is prescribed, would deny under the step-edit. Then pharmacist would discuss this denial with the prescriber and the prescriber would prescribe Drug B – a different therapeutically equivalent generic drug which would pass under the step-edit, or the prescriber would seek prior authorization for Drug A.

Prior experience | The Pharmacy Unit has implemented other step-edit authorizations. The department processes use the Drug Utilization Review Committee to point out candidate medications for the step-edit or the candidate medications are determined by the Pharmacy Unit.

Relationship to other options | This step-edit method works well with E-prescribing as the rules for step-edits can be built into the E-prescribing interface. Additional savings will be available when the new regulation SMAC (State Maximum Allowable Cost) list option is implemented.

Anticipated reaction of providers and other potentially affected parties | Providers will be notified in advance of the implementation. The Pharmacy Unit would write a provider notice explaining the changes to be sent thirty days prior to the implementation date. Prescribers should keep the class of drugs in mind in order to facilitate appropriate utilization.

Cost containment and quality improvement | Many expensive brand name drugs have equally efficacious therapeutically equivalent generic alternatives available at a fraction of the cost. In FFY 2010 generic medications accounted for roughly 65% of pharmacy claims and only 21% of program costs. At 50% compliance with the lowest cost medication, there would be a \$ 2.7 million savings to the program. There is no anticipated negative impact on care.

Federal requirements | A SPA is not required.

Experiences of other states | The step-edit process is used by many states to control utilization.

Unintended consequences | None identified at this time.

Difficulty | This option will not be difficult to implement.

Timeline | The step-edit requests are taking three months to implement for one or more drug classes. The HCS Pharmacy Unit has plans to implement three new step edits in the next 60 days for Statins, Proton Pump Inhibitors, and Antihistamines.

Options for Cost Savings

Responsibility for/coordination | Pharmacy system programming is necessary to implement each step-edit. The Pharmacy Unit submits work orders to the Systems Unit for transmittal to Magellan, the pharmacy system contractor.

Legal requirements | None.

Costs | The cost of implementation is minimal.

ADDENDUM D

Increase Generic Medication Utilization

Addendum D

Brief Description

The average brand name prescription costs over \$200 per claim while the average generic prescription costs about \$30 per claim.

Roughly 65% of prescriptions dispensed to Alaska Medicaid recipients are for generic medications. To increase the generic utilization percentage the Department will develop new step-edits and prior authorization requirements for brand name medications in drug classes where less expensive but equally safe and effective generic alternatives exist. Prescriptions for the more expensive products would require the recipient first try a less expensive product before the expensive alternatives that often offer no therapeutic benefit over the generic alternatives. No changes would be required to the current prior authorization regulations or state plan to implement the step-edits or prior authorizations; however, a new Preferred Drug List would need to be adopted into reference. The edits could be implemented progressively in conjunction with the work effort to implement the State Maximum Allowable Cost pricing and edits to increase generic substitution.

Stakeholders

Stakeholders would include the following practitioners and their professional organizations: Dentists, Pharmacists, Physicians, Podiatrists, Nurse Practitioners, Physician Assistants, and Tribal Health Programs.

Additional non-practitioner stakeholders would include advocacy groups and the Pharmaceutical Research and Manufacturers of America (PhRMA).

Lead agency

The Division of Health Care Services within the Department of Health and Social Services would be responsible for the implementation of the edits.

| COST SAVINGS | Direct |
|--|--------------------|
| Estimated savings from increased generic utilization – 1 year | \$2,031,000 |
| | |
| BUDGET | Raw |
| Programmer and Systems costs (varies with each coding effort) | \$35,000 |
| Call Center (post-implementation – estimated annual cost) | \$25,000 |
| Provider Notification (one time cost – 3 mailings) | \$6,000 |
| Lost supplemental rebates | \$500,000 |
| TOTAL – year one | \$566,000 |
| NET ESTIMATED SAVINGS | \$1,465,000 |

| TIMELINE of KEY ACTIVITIES | |
|-----------------------------------|---|
| Dates | Tasks |
| Current | Work is already underway to implement some new step-edits. |
| 2-May 2011 | Public Notice new Preferred Drug List with the medication classes to be added to step-edit removed |
| 2-June 2011 | Public comment ends; finalize coding changes for statins and proton pump inhibitors |
| 13-June 2011 | Provider Notice on Preferred Drug List changes and step-edit changes |
| 15-July 2011 | Implement statin and proton pump inhibitor step-edits; coding for 2 nd generation antihistamines and sleep aids begins |
| 1-September 2011 | Testing for 2 nd generation antihistamines and sleep aids to the State. |
| October-November 2011 | Provider Notice for additional step-edits 30 days prior to implementation. Coding and testing to be performed in conjunction with other coding efforts. |

OPTION E

Enhanced Preferred Drug List

OPTION E- Enhanced Preferred Drug List

Definition | This approach will enhance the Preferred Drug List program by requiring prior authorization of all non-preferred drugs rather than the current method of only requiring the prescriber to document on the prescription that a non-preferred medication is “medically-necessary.”

Description | The existing pharmacy overrides would no longer be available for pharmacists to bypass the Preferred Drug List. Appropriate edits to achieve dose optimization would be employed to utilize less expensive dosage units. This approach would improve prescribing compliance of preferred drugs where there is a cost advantage to the program; however, it will make the process more burdensome for the prescriber and pharmacist.

Prior experience | Over the first few years using the preferred drug list the department enjoyed a high rate of acceptance for the preferred drug list with a compliance rate of over 80%. At this time compliance has dropped to 65%, therefore it is important to review methods to increase compliance. This is one method to increase the compliance.

Relationship to other options | This option is not expected to have a significant impact on other options. The adoption of Option C will enhance Option E, as many of the medications on the preferred drug list are generics. The restriction override of generic substitution and the override of non-preferred medications should be similar to prevent improper overrides of medications on the preferred drug list.

Anticipated reaction of providers and other potentially affected parties | This option creates a more stringent preferred drug list. It will create a situation where it will be easier for the prescriber to utilize the preferred medication than a non-preferred medication.

Cost containment and quality improvement | This measure improves on preferred drug list compliance and the supplemental rebates associated with the National Medicaid Pooling Initiative. This is a cost containment measure that is not expected to impact health outcomes.

Federal requirements | A Medicaid state plan amendment will not be necessary.

Experiences of other states | Virtually all states with a preferred drug list use this deterrent to use the non-preferred medications.

Unintended consequences | Additional prescriber and pharmacist attention will be required, at least initially.

Timeline | This option is expected to take a minimum of five months to implement.

Responsibility for/coordination | The HCS Pharmacy Unit in collaboration with the Systems Unit will be responsible for this option. Extensive system programming may be necessary to require the prior authorization on the over 1,000 medications on the preferred drug list. Notice to providers will be required.

Legal requirements | Regulation changes will not be required.

Costs | Extensive system programming will be required to implement this option.

ADDENDUM E

Enhanced Preferred Drug List

Addendum E

Brief Description

The Preferred Drug List (PDL) is a list of medications maintained by the Department at the advisement of the Pharmacy and Therapeutics (P&T) Committee. Preferred medications are not only safe and effective, but they offer the best value to the state through the payment of supplemental rebates or utilization of lower cost generic medications. Virtually all states with a PDL require prior authorization from the prescriber to obtain a non-preferred medication; however, Alaska does not. Currently the Department utilizes a soft-edit to encourage prescribers to use preferred medications but the compliance rate has dropped from 80% compliance when the PDL began to 65% recently.

To improve compliance with the PDL the Department proposes to require prior authorization for all non-preferred medications. No changes to the current regulations or state plan would be required.

Stakeholders

Stakeholders would include the following practitioners and their professional organizations: Pharmacists, Physicians, Nurse Practitioners, Physician Assistants, and Tribal Health Programs.

Additional non-practitioner stakeholders would include advocacy groups and the Pharmaceutical Research and Manufacturers of America (PhRMA).

Lead agency

The Division of Health Care Services within the Department of Health and Social Services would be responsible for the implementation of the edits.

| COST SAVINGS | Direct |
|--|--------------------|
| Increased supplemental rebates – 1 year | \$1,500,000 |
| | |
| BUDGET | Raw |
| Programmer and Systems costs (one time cost) | \$12,000 |
| Call Center (post-implementation – estimated annual cost) | \$38,500 |
| Provider Notification (one time cost – 2 mailings) | \$4,500 |
| TOTAL – year one | \$52,300 |
| | |
| NET ESTIMATED SAVINGS (direct) | \$1,447,700 |

| TIMELINE of KEY ACTIVITIES | |
|-----------------------------------|---|
| Dates | Tasks |
| 2-May 2011 | Internal kick-off meeting |
| 3-May 2011 | Programming changes begin to the point-of-sale system |
| 4-May 2011 | 1 st Provider notice |
| 1-Aug 2011 | Completion of trouble shooting with coding changes |
| 29-Aug 2011 | 2 nd Provider notice |
| 1-Oct 2011 | Implementation |

OPTION F

State Maximum Allowable Cost

OPTION F- State Maximum Allowable Cost

Definition and description | Generic medications are often available from multiple manufacturers for different costs. The State Maximum Allowable Cost (SMAC) price would establish a maximum cost for generic medications based on the different manufacturer prices in order to maximize the cost savings benefits of generic medications.

Federal requirements | A Medicaid state plan amendment is already underway.

Experiences of other states | With this medication payment methodology, Alaska will join the 46 states that use this feature in their payment methodology.

Relationship to other options | This option will enhance the generic medication substitution option as this option will lower the price the department pays for generic drugs.

Anticipated reaction of providers and other potentially affected parties | This payment feature has been vetted through the regulation process and is moving toward implementation. Pharmacies have expressed angst about this new reimbursement mechanism.

Responsibility for/coordination | The HCS Pharmacy Unit in collaboration with the Systems Unit are responsible for implementation. The Pharmacy Unit will write a provider notice explaining the changes to be sent thirty days prior to the implementation date.

Timeline | This project is on track to be implemented this summer.

ADDENDUM F

State Maximum Allowable Cost

Addendum F

Brief Description

Generic medications are often available from multiple manufacturers at a variety of costs. A State Maximum Allowable Cost (SMAC) price would establish a maximum cost for generic medications based on the different prices in order to maximize cost savings from generic medications. Similar pricing methodologies are used by other third party payers including the Centers for Medicare and Medicaid Services (CMS) which has established a Federal Upper Limit (FUL) that is very similar to the SMAC for some generic medications.

The regulation change necessary to implement SMAC pricing was completed in January of 2011 and a state plan amendment is currently being submitted.

Stakeholders

Stakeholders would include pharmacists and their professional organizations and Tribal Health providers.

Lead agency

The Division of Health Care Services within the Department of Health and Social Services would be responsible for the implementation of the SMAC pricing.

| COST SAVINGS | Direct |
|--|--------------------|
| Estimated savings from SMAC pricing – 1 year | \$5,500,000 |
| | |
| BUDGET | Raw |
| Programmer costs (one time cost) | \$35,000 |
| Annual operational costs | \$180,000 |
| Provider Notification (one time cost) | \$4,500 |
| TOTAL – year one | \$219,500 |
| | |
| DISPENSING FEES | |
| Dispensing fees are being increased to account for the true cost of dispensing and will be offset by savings achieved through SMAC pricing. | \$4,400,000 |
| | |
| NET ESTIMATED SAVINGS | \$880,500 |

| TIMELINE of KEY ACTIVITIES | |
|-----------------------------------|--|
| Dates | Tasks |
| Present | Several Key Activities, such as regulation changes and SPA submission, have already occurred; the timeline reflects key activities still needed for implementation |
| 5-April 2011 | Programming changes begin to the point-of-sale system |
| 2-May 2011 | Provider notice |
| 1-June 2011 | Completion of trouble shooting with coding changes |
| 2-June 2011 | 2 nd Provider notice (if needed) |
| 15-June 2011 | Implementation |

OPTION G

Psychiatric Medication Policy

OPTION G- Psychiatric Medication Policy

Definition | A psychiatric medications policy will require monitoring the utilization of psychiatric medications by children in state custody and/or receiving treatment in inpatient or residential psychiatric facilities receiving payments from the Alaska Medicaid program. The purpose a (department) psychiatric medication policy would primarily be to reduce the incidence of metabolic side effects associated with psychiatric medications, namely the atypical antipsychotics, by reducing the use of these medications when other treatment options exist or have not been tried.

Description | Many youth in Alaska are on psychiatric medications which are sometimes used as the only treatment to control disruptive behaviors and aggression. Side effects for these medications can include obesity and weight gain, type II diabetes, thyroid problems, hypertension and elevated blood glucose. Recent studies indicate that children on Medicaid are four times more likely to be treated with psychiatric medications than other types of treatment. The policy will require the authorization of all psychiatric medications, informed consent for treatment by the parents or guardians, monitoring using established protocols, and program review and evaluation.

Relationship to other options | This option is not related to others.

Anticipated reaction by providers and other potentially affected parties | Psychiatric care providers may not want to see this implemented as they may have to spend more resources on non-medication interventions. The HCS Pharmacy Unit expects prescribers will embrace this program once implemented.

Cost containment | While the focus of the psychiatric medication policy is not direct cost savings, a reduction in the pharmacy program costs may be realized from two potential sources.

First, there may be cost savings from quantity limits on expensive brand name medication. Through the use of quantity limits for claims with dates of service 6/01/2010 – 12/31/2010, there was a potential for over \$225,000 in cost savings. Additional cost savings may be seen with quantity limits for each of the brand name atypical antipsychotics.

Second, there may be a reduction in the number of prescriptions for expensive brand name medications. For dates of service 9/01/2008 – 9/01/2009 the average prescription for an atypical antipsychotic cost roughly \$450 for a 30 days' supply.

It is important to note that additional program costs would be incurred through the use of a physician consultant and may offset the direct monetary savings realized through a reduction in the number of prescriptions or through the use of quantity limits on psychiatric medications.

Quality improvement | This policy will improve the care of the most vulnerable children in Alaska and reduce the adverse effects of psychiatric medications in children.

Federal requirements | A Medicaid state plan amendment would not be required.

Experience of other states | Other states have implemented restrictions on these medications to protect the most vulnerable children.

Responsibility for/coordination | HCS and DBH have been working on a department policy. The HCS Pharmacy Unit is ready to implement this option when the policy is final. The Pharmacy Unit in

Options for Cost Savings

collaboration with the Systems Unit will write a work order to schedule the system changes. The Pharmacy Unit will also write a provider notice to be sent thirty days prior to the implementation date.

Timeline | Once the department policy is final, this option would take a minimum of three months to implement.

Legal requirements | A regulation change is not required.

ADDENDUM G

Psychiatric Medication Policy

Addendum G

Brief Description

An increasing number of children in Medicaid are receiving one or more psychiatric medications, to control disruptive behavior and to treat other mental health problems, including a class of strong medicines known as atypical antipsychotics. An emerging body of evidence shows that this class of medications is not without risks, including metabolic and endocrine disorders, weight gain, and elevated blood glucose levels that can lead to the development of type II diabetes. Obesity and type II diabetes are a growing health epidemic and can lead to expensive lifelong health problems. In addition, some concerns remain that the use of these medications by young patients with developing brains may result in long-term cognitive effects that are not yet fully understood.

The Department is developing a psychiatric medication policy to reduce the risks associated with these medications in children. We propose to review the use of atypical antipsychotics when other appropriate treatment options have not been tried and when beneficiaries are on multiple mental health drugs. The policy will include an informed consent process for children in state custody, a second-level psychiatric consultation for children on duplicate therapies or large numbers of psychiatric medications, and a prior authorization requirement for duplicate antipsychotic therapies. The policy will also include quantity limits for atypical antipsychotics to optimize efficiency without sacrificing safety or efficacy.

This primary goal of the proposed policy is to improve the quality of care for Medicaid recipients, but a secondary outcome may be a reduction in future program costs by decreasing secondary metabolic diseases.

Stakeholders

Stakeholders include: Pharmacists, Physicians, Nurse Practitioners, Physician Assistants, Residential Psychiatric Treatment Centers, Acute Child Psychiatric Facilities, and Tribal Health Programs.

Additional non-practitioner stakeholders include advocacy groups and the Pharmaceutical Research and Manufacturers of America (PhRMA).

Lead agency

The Division of Health Care Services within the Department of Health and Social Services would be responsible for the implementation of the edits.

| COST SAVINGS | Direct |
|--|------------------|
| Estimated cost savings from pharmacy initiatives | \$300,000 |
| | |
| BUDGET | Raw |
| Programmer and Systems costs (varies with each coding effort) | \$35,000 |
| Call Center (post-implementation – estimated annual cost) | \$25,000 |
| Provider Notification (one time cost – 3 mailings) | \$6,000 |
| Physician Consultation | \$50,000 |
| Stakeholder meetings (one time cost – 2 meetings) | \$2,000 |
| TOTAL – year one | \$118,000 |
| | |
| NET ESTIMATED SAVINGS (direct) | \$182,000 |
| <i>Note: direct cost savings is not the primary focus of this intervention</i> | |

| TIMELINE of KEY ACTIVITIES | |
|-----------------------------------|--|
| Dates | Tasks |
| 2-May 2011 | Internal kick-off meeting |
| 3-May 2011 | 1 st Provider notification |
| 17-May 2011 | 1 st Stakeholder meeting |
| 18-May 2011 | Begin evaluation of initial policy following 1 st Stakeholder meeting; |
| 15-June 2011 | 2 nd provider notification |
| 15-Sept 2011 | Completion of coding changes and internal policies; secure physician consultant for 2 nd level review |
| 19-Sept 2011 | 3 rd provider notification |
| 1-Nov 2011 | Implementation |

OPTION H

Community First Choice (PCA)

OPTION H- Community First Choice (PCA)

Definition | Under section 1915 (k) of the Social Security Act, states can provide home and community-based attendant services and supports for individuals who are eligible for Medicaid under the State plan whose income does not exceed 150% of the Federal Poverty Level or, up to 300% if they meet institutional level of care.

Description | The program is similar to the existing State Plan personal care attendant (PCA) services program in that a recipient must be financially eligible for services and has been found, upon assessment, to demonstrate a functional need significant enough to qualify according to established standards. The PCA service is delivered by a qualified attendant, either chosen by the recipient (self-directed) or agency-based employee. Under a fee-for-service model this would be billed out as payments per unit of service rendered according to an established payment rate.

Prior experience | The existing PCA program has been a fertile ground to learn about pitfalls and successes in managing a PCA program. The 1915 (k) option has not been attempted previously in Alaska. This is a proposed replacement for the existing state plan service.

Relationship to other options | None identified at this time.

Anticipated reaction of providers and other potentially affected parties | There is a higher level of quality improvement/oversight and accountability built into this option that may impact providers. This plan requires individuals who need not only hands-on assistance but also supervision or cueing to qualify. Back-up systems or mechanisms to ensure continuity of services and supports must be offered (e.g., Lifeline). Stakeholders must be involved in the program design. This involvement fosters building supportive working relationships from the inception.

Cost containment | CMS allows for a 6% FMAP enhancement because this is a more robust service package. Currently an estimated \$2,000,000 is spent on PCA services weekly. Over the course of 52 weeks, the 6% enhancement equals \$6,240,000. State expenditures for the first full fiscal year of implementation for Medicaid services provided to individuals with disabilities or elderly must not fall below the prior year's level.

Quality improvement | Program participation requires the state to establish and maintain a quality assurance system with respect to community-base attendant services and supports that includes standards for agency-based and other delivery models for training, and appeals for denials and reconsideration procedures of an individual plan. The quality assurance system must incorporate feedback from individuals and their representatives, disability organizations, providers, families of disabled or elderly individuals and members of the community, and maximize consumer independence and control. The quality assurance system must also monitor the health and well-being of each individual who received these services, including a process for the mandatory reporting, investigation, and resolution of allegations of neglect, abuse, or exploitation in connection with the provision of such services and supports. States must collect and report this information.

Options for Cost Savings

This option affords the state the opportunity to redesign the existing PCA program, add efficiencies, and develop clear functional criteria for eligibility. This program will serve to keep individuals out of the higher cost institutional care setting.

It also provides an opportunity to address gaps in current delivery system. There are individuals who do not currently meet the level of care for the PCA program because their needs are limited to the need for supervision or cueing to manage their activities of daily living. These individuals often suffer from moderate to severe dementia such as Alzheimer's Disease. This state plan option requires that eligibility thresholds include the need for supervision and cueing and may help to cover the existing gap.

Federal Requirements | A Medicaid state plan amendment will be required.

Experiences of other states | This is a new option thus there is no reportable experience.

Unintended consequences | This option promotes consumer based models of delivery thus de-emphasizing the agency-based providers.

Difficulty | It will take a concerted effort between the managing Medicaid division, stakeholders, Office of Rate Review, Fiscal Agent and others to develop and maintain the program.

Timeline | The enhanced rate is effective as of October 1, 2011.

Responsibility for coordination | The Medicaid agencies mentioned above will be involved.

Legal requirements | A statute change and regulations are required.

Costs | There will be state costs to develop and implement and manage the program however, it is anticipated that costs will be offset by a portion of the savings resulting from the FMAP enhancement. An administrative burden of maintaining the requirements of this option will remain after the enhanced FMAP ends. One (1) FTE will be needed to lead program development and implementation.

ADDENDUM H

Community First Choice (PCA)

Addendum H

Brief Description

This option is being proposed as a redesign of the existing State Plan Personal Care Attendant program. This program would allow the state to develop an assessment process and service array that is more aligned with the needs of Alaskans and has greater integrity as to service utilization, quality assurance and oversight.

Individuals must be Medicaid eligible at no greater than 150 percent of poverty level (greater if they demonstrate an institutional level of care need upon assessment). The services must be available statewide and based on need rather than age, disability, or type of support required. Services must be provided in the most integrated “home and community-based setting” but may not be in a nursing facility, institutional for mental diseases, or intermediate care facility for the mentally retarded.

The service array must include the following:

- Assistance with Activities of Daily Living, Instrumental Activities of Daily Living and health related tasks; skills development; back-up systems/mechanisms; and voluntary training on how to select, manage, and dismiss attendants.

The State may not pay for:

- Room and board costs, special education and related services; vocational rehabilitation services; assistive technology and services (except emergency back-up devices); medical supplies and equipment; and home modifications with this program.

The personal care attendant services and supports may be provided through an agency-based or other model but in any case, services are controlled to the maximum extent possible by the recipient or their representative.

The system component of this model include:

- Functional needs assessments;
- Person-centered plans;
- Qualified attendants/services
- Comprehensive Quality Assurance System; and
- Annual evaluate, data collection and reporting.

Stakeholders have expressed initial support for the program.

Projections using existing PCA model

The following depicts the estimated costs for PCA using the FY2010 data and projecting forward to FY13, assuming:

- 6 percent/per year growth rate and stable utilization and provider rates
- FMAP changes resulting from the end of the ARRA enhanced funding effective July 1, 2011
- Minimal growth in Medicaid Admin

| | FY2010 | FY2011 | FY2012 | FY2013 |
|---|-----------------|-----------------|-----------------|-----------------|
| Unduplicated recipients | 4115 | 4362 | 4624 | 4901 |
| Total State Medicaid Service Cost for SFY10 and 6% growth and GF increase with ARRA loss thereafter | \$58,679,100.00 | \$65,720,592.00 | \$76,893,092.64 | \$81,506,678.20 |
| Total Federal Medicaid Service Cost for SFY10 and 6% growth and Federal share decrease with ARRA loss | \$94,885,600.00 | \$73,607,063.04 | \$76,893,092.64 | \$81,506,678.20 |
| Total State Admin Cost and projected growth | \$609,400 | \$1,096,920 | \$1,974,456 | \$3,554,021 |
| Total Federal Admin Cost and projected growth | \$609,400 | \$1,096,920 | \$1,974,456 | \$3,554,021 |
| Total State Medicaid Cost | \$59,288,500.00 | \$66,817,512.00 | \$78,867,548.64 | \$85,060,699.00 |
| Total Federal Medicaid Cost | \$95,495,000.00 | \$74,703,983.04 | \$78,867,548.64 | \$85,060,699.00 |

Community First Choice Option 1915k

The projections again start with the FY2010 known figures and the following assumptions were made:

- Increased initial growth related to service to expanded population in FY2012 with 6%/year growth rate in recipient population thereafter
- 6% FMAP increase over the non-ARRA rate
- Increased administrative costs of \$250,000 for 6 months of FY12 and \$500,000 12 months of FY13
- Increased service costs related to emergency back-up services required

| | FY2010 | FY2011 | FY2012 | FY2013 |
|--|-----------------|-----------------|-----------------|-----------------|
| Unduplicated recipients | 4115 | 4362 | 4624 | 4901 |
| Total State Medicaid Service Cost for SFY10 and 6% growth and GF increase with ARRA loss thereafter | \$58,679,100.00 | \$65,720,592.00 | \$72,379,507.08 | \$76,716,277.51 |
| Total Federal Medicaid Service Cost for SFY10 and 6% growth and Federal share decrease with ARRA loss | \$94,885,600.00 | \$73,607,063.04 | \$81,606,678.20 | \$86,497,078.89 |
| Total State Admin Cost and projected growth | \$609,400 | \$1,096,920 | \$2,599,456 | \$4,929,021 |
| Total Federal Admin Cost and projected growth | \$609,400 | \$1,096,920 | \$2,599,456 | \$4,929,021 |
| Total State Medicaid Cost | \$59,288,500.00 | \$66,817,512.00 | \$74,978,963.08 | \$81,645,298.31 |
| Total Federal Medicaid Cost | \$95,495,000.00 | \$74,703,983.04 | \$84,206,134.20 | \$91,426,099.69 |

Potential State General Fund Cost Savings

| | FY2010 | FY2011 | FY2012 | FY2013 |
|--------------------------------|---------------|---------------|----------------|----------------|
| Potential State Savings | 0 | 0 | \$5,152,237.40 | \$6,651,753.00 |

Stakeholders

Key stakeholders include interested/involved providers, Medicaid recipients, advocacy groups.

Lead agency

The lead agency in this effort is the Department of Health and Social Service, Division of Health Care Services, in conjunction with others involved: Division of Public Assistance, Division of Senior and Disabilities Services, Division of Behavioral Health, and the Pioneer Homes.

| TIMELINE OF KEY ACTIVITIES | |
|---------------------------------------|--|
| DATES | ACTIVITY |
| March 2011 | Medicaid Task Force presentation/determination to pursue program development. Identify project lead. |
| April 2011 | Identification of internal development team and external key stakeholders. Analyze models from other State Medicaid programs and prepare to present summary to key stakeholders. Develop detailed work plan. Present draft work plan to key stakeholders. |
| May 2011 | Develop a communication strategy for educational campaign on definition of Community First Choice Option in Alaska and implementation plan. Finalize Implementation plan. Begin implementation activities. Determine elements of program and submit required application to CMS. Draft regulatory changes. |
| June 2011 – October 2011 | Continue Implementation including draft regulatory language. |
| October 2011 (very optimistic) | Begin program enroll of recipients. |

APPENDIX A- Summary of Verbal Public Comment

| Subject | Commenter | Summary of Comments | Form & Date |
|---|--|---|------------------------------|
| Medicaid Task Force Draft Report- Options for Cost Savings | Mary Sullivan Alaska Primary Care Association | In support of Option A: Patient-Centered Medical Home Patient-driven, encourages patient responsibility in decision-making, reduces costs by reduction in ER visits as well as shorter and fewer hospital stays. Benefits all patients, not just Medicaid recipients. | Public Hearing 03.23.2011 |
| Medicaid Task Force Draft Report- Options for Cost Savings | Kate Burkhart Advisory Board on Alcoholism and Drug Abuse & Alaska Mental Health Board | Option C: Increase Substitution to Generic Medication Concerned that requirement of therapeutic failures/adverse reactions to two generics will put lives at risk. Need to define therapeutic failure. Grandfather in existing patients who have successful regimens that rely on brand name drugs. General Medicaid Task Force process did not include clear accommodations for Alaskans with disabilities. Every Alaskan that this affects should have access to information and be able to participate in this process. <i>For more details:</i> see written comment provided March 25 via letters signed Kate Burkhart. | Public Hearing 03.23.2011 |
| Medicaid Task Force Draft Report- Options for Cost Savings | Brenda Bogowith Alaska Primary Care Association | In support of Option A: Patient-Centered Medical Home Discussed the comprehensive nature of roll of PCMH. Team coordination/patient involvement. | Public Hearing 03.23.2011 |
| Medicaid Task Force Draft Report- Options for Cost Savings | Sandra Heffern Community Care Coalition (CCC) | Option A: Patient-Centered Medical Home CCC supports. Option B: Care Management CCC supports with concern that ROI will be calculated solely on improvement of condition and negate stabilization or maintenance of a condition. Options C & D Generic Medications CCC supports use of generics when they've been proven to be as effective as brand name | Public Hearing 03.23.2011 |

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| | | <p>counterparts. Concerned with “therapeutic failure with two generics.” Suggests waiver for individuals who have an established success with brand name regimen. Step-edit process should be reviewed by a third-party review panel, not a state panel.</p> <p>Option G: Psychiatric Medication Policy CCC support psych med policy in theory. Question duplicative nature of service if Option A is implemented.</p> <p>Option H: Community First Choice (PCA) CCC cautiously supports applying for 1915k waiver for PCA services. Concern that person-centered planning teams may result in possible undue administrative burden for providers and state personnel. This “redesign” needs more thoughtful activity before implementation.</p> | |
| Medicaid Task Force Draft Report- Options for Cost Savings | Mark Regan Disability Law Center of AK | <p>In support of Option H: Community First Choice (PCA) Fills a gap in current delivery system, as there are individuals who don’t meet the level of care requirements for PCA services, limited to the need for supervision or cuing to manage daily activities.</p> <p><i>For more details:</i> see written comment provided March 25 via letter signed Mark Regan.</p> | Public Hearing 03.23.2011 |
| Medicaid Task Force Draft Report- Options for Cost Savings | Steve Horn Alaska Behavioral Health Association | <p>Option A: Patient Centered Medical Home Keep the diversity of Alaskan communities in mind and allow communities flexibility to provide local solutions to their community health needs. Behavioral health providers should be included in funding for EHR.</p> <p>Option B: Care Management Careful consideration about how this will integrate with existing care management being undertaken at provider level. Want to be a part of workgroup that tackles details of this option before implemented.</p> <p>General: Forum should be developed to discuss/develop details/strategies for each recommendation.</p> | Public Hearing 03.23.2011 |

| | | | |
|---|--|--|------------------------------|
| | | Provider community should be involved. | |
| Medicaid Task Force Draft Report- Options for Cost Savings | Fred Kopacz Southcentral Foundation | <p>General Projected savings relatively small. Left out Long Term Care. Needs to be a more collaborative approach to plan.</p> <p>In support of Option A: Patient Centered Medical Home <i>with suggestions</i> (see written comment)</p> <p>Option B: Care Management Concerns with use of call center and potential lack of connection to beneficiaries' primary care provider (see written comment)</p> <p>Option C: Increase Substitution to Generic Medication Concerned with requirement of therapeutic failures.</p> <p>Option D: Increase Generic Medication Utilization Has potential to endanger beneficiary while adding a burden to practitioners.</p> <p>Option E: Enhanced Preferred Drug List Suggest dealing with outliers before adopting costly measures for all.</p> <p>Option F: State Maximum Allowable Cost no comment</p> <p>Option G: Psychiatric Medication Policy Does not agree with multiple assumptions made by this policy. This would also add to the administrative burden of practitioners. (see written comment)</p> <p>Option H: Community First Choice (PCA) no comment</p> <p>For more details: see written comment provided March 25 via letter signed Katherine Gottlieb.</p> | Public Hearing 03.23.2011 |
| Medicaid Task Force Draft Report- Options | Karen Perdue Alaska State Hospital & | <p>General Health facilities must do our part to bend the curve in Medicaid. Some areas that are</p> | Public Hearing 03.23.2011 |

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|--|--|---|--------------------------------------|
| <p>for Cost Savings</p> | <p>Nursing Home Association</p> | <p>currently being looked at: ER Usage, Re-Admission Issues, Transition issues from acute to community care, 340B program, EICU program. May want to look at innovations happening between Medicaid and Medicare.</p> <p>Option A: Patient Centered Medical Home Some members are interested and anxious to learn more about kinds of requirements to be a PCMH. Make sure private sector/practices are involved in pilots. Include hospitals in future input.</p> | |
| <p>Medicaid Task Force Draft Report- Options for Cost Savings</p> | <p>Millie Ryan Governor’s Council on Disabilities & Special Education (GCDSE)</p> | <p>In support of Option H: Community First Choice (PCA) Would recommend the back-up systems be defined broadly. Council has done research on technology used in smart-homes, which could be a viable option.</p> <p>Clarify that services don’t need to just be provided at home, but also at work and in the community. Voc Rehab/Supported Employment if allowable under federal law...may put it explicitly as a covered service.</p> <p>Option for consideration: Medicaid Buy In for working disabled. Kansas has a program that might be a good model.</p> | <p>Public Hearing 03.23.2011</p> |
| <p>Medicaid Task Force Draft Report- Options for Cost Savings</p> | <p>Ric Nelson GCDSE</p> | <p>Consumer for PCA program wants to see more involvement of consumers. MTF should get more input on what consumers have to say and be more specific about what kind of people the task force wants to hear from. Ric volunteered to be involved when stakeholder input is needed.</p> | <p>Public Hearing 03.23.2011</p> |
| <p>Medicaid Task Force Draft Report- Options for Cost Savings</p> | <p>Kathy Fitzgerald GCDSE</p> | <p>Parent of consumer. With regard to generic medications, there should be some consideration for people who are acutely sensitive to medication. Daughter has experienced sensitivity to meds entire life. Ensure those individuals aren’t unnecessarily exposed to other meds if they have already found what works best.</p> | <p>Public Hearing 03.23.2011</p> |
| <p>Medicaid Task Force Draft Report- Options</p> | <p>Marilyn Kasmar Alaska Primary Care Association</p> | <p>In support of Option A: Patient Centered Medical Home Top two reasons backed by evidence/research.</p> | <p>Public Hearing 03.23.2011</p> |

Options for Cost Savings

| | | | |
|---|--|---|------------------------------|
| for Cost Savings | | <ol style="list-style-type: none"> 1. Provides higher quality care and more patient and provider satisfaction. 2. Saves money by keeping people out of ER and reducing hospital stays. | |
| Medicaid Task Force Draft Report- Options for Cost Savings | Sonia Handforth-Kome Iliuliuk Family Health Services | In support of Option A: Patient Centered Medical Home Close to what Community Health Centers in AK already try to achieve. Makes sense to have an outcomes based model to measure effectiveness. Care is given in a coordinated and integrated fashion. | Public Hearing 03.23.2011 |

APPENDIX B- Summary of Written Public Comment

| OPTION A: Patient Centered Medical Home | | | |
|---|--|--|--|
| Subject | Commenter | Summary of Comments | Form & Date |
| Cost/Wait-time | Polly-Beth Odom Daybreak Inc. | Concerns: <ul style="list-style-type: none"> Increased costs to Medicaid Increased wait-time for services | Letter dated 3.24.11 |
| Support/Resource | Eric Britten | Supports: <ul style="list-style-type: none"> Is available as a resource | Email dated 3.25.11 |
| Comments | Jonathan Sugarman Qualis Health | Suggestions: <ul style="list-style-type: none"> Consider other options for payment method PCMH pilots suggest a more positive response by providers, than Task Force report indicates Technical assistance may be the key to the “urban/rural” issues implied in Task Force report | Letter dated 3.25.11 |
| Support/Comments | Brenda Friend Kodiak Community Health Center | Supports: Minimal investment for the end result, healthy people receiving quality care | Letter dated 3.25.11 |
| Seniors | Sharon Howerton-Clark & Denise Daniello Alaska Commission on Aging | Supports: <ul style="list-style-type: none"> Provides flexible, holistic patient-centered care Fits both urban and rural settings Recommendations: <ul style="list-style-type: none"> Patient choice Patient education/training Regular assessment of medical, social and support needs of PCMH patient | Letter dated 3.25.11 |
| Suggestions | Katherine Gottlieb Southcentral Foundation | Supports with suggestions: <ul style="list-style-type: none"> Pilot project Micro studies on costs and benefits Reimbursement methodology based on outcomes rather than processes | Written submission of verbal testimony dated 3.25.11 |
| Support with provisions | Pat Luby AARP | Supports: Provided... <ul style="list-style-type: none"> Home demonstrates voluntary patient selection of primary care provider Ease of access and communication (including non-business hours) | Letter dated 3.25.11 |

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|---|---|---|------------------------|
| | | <ul style="list-style-type: none"> • Period assessment of clinical needs • Education and training for patients and family caregivers in support of self-management • Receiving MH services should be voluntary | |
| Support | Kate Burkhart ABADA/AMHB | <p>Supports:</p> <ul style="list-style-type: none"> • Don't lose "patient-centeredness" in zeal for reducing Medicaid costs • Stress the need for careful implementation of the model depending on community need and capacity • Not one-size fits all- rural communities should have special considerations | Letter dated 3.25.11 |
| OPTION B: Care Management | | | |
| Subject | Commenter | Summary of Comments | Form & Date |
| Technology | Randi Sweet United Way of Anchorage | <ul style="list-style-type: none"> • Consider using the Turtle used by the feds in urban settings for biometric reading and transmission | Email dated 3.25.11 |
| History of providing similar services since 2000 | Polly-Beth Odom Daybreak Inc. | <p>Supports option</p> <p>Advantages (seen at Daybreak):</p> <ul style="list-style-type: none"> • Reduction in psychiatric hospitalizations • Lowering the overall cost of mental health services | Letter dated 3.24.11 |
| Maximizing benefit of option | Paul Stuve Care Management Technologies | <p>Care Management Interventions Offered:</p> <ul style="list-style-type: none"> • Comprehensive health profile • Specific/actionable notification system • Comprehensive review of pharmacy claims • Courtesy alerts for medication oversights • Significantly higher savings recognized | Letter dated 3.25.11 |
| Comments | Jonathan Sugarman Qualis Health | <p>Client provisions for successful CM programs include:</p> <ul style="list-style-type: none"> • Targeting the right patients • In-person contact • Access to timely information on hospital & ER visits • Close interaction between care coordinators and primary care physicians | Letter dated 3.25.11 |

| | | | |
|--------------------------------|--|---|--|
| | | <ul style="list-style-type: none"> • Specific services provided • Staffing <p>Call-center not widely accepted</p> <p>Budgeting of an appropriate amount of money for care management services is critical to support an effective program.</p> | |
| Concerns | Katherine Gottlieb Southcentral Foundation | Concerned with use of call center and potential lack of connection to beneficiaries' primary care provider. | Written submission of verbal testimony dated 3.25.11 |
| Support with provisions | Pat Luby AARP | Supports: Provided... <ul style="list-style-type: none"> • Must consider diversity in rural Alaska • Outreach and education should be adaptable to various languages and social/technological differences across the state | Letter dated 3.25.11 |
| Support | Kate Burkhart ABADA/AMHB | Supports: <ul style="list-style-type: none"> • Don't lose "patient-centeredness" in zeal for reducing Medicaid costs • Encourage reimbursement model that recognizes the value in maintenance of health status for those with most chronic conditions | Letter dated 3.25.11 |

OPTION C: Increase Substitution to Generic Medication

| Subject | Commenter | Summary of Comments | Form & Date |
|-----------------|--|---|--|
| Comments | Kathleen Fitzgerald Governor's Council on Disabilities & Special Education (GCDSE) | Supports: Recommendation: <ul style="list-style-type: none"> • "Grandfather" clause for people experiencing good results from established medication regimens reliant on brand name drugs, to avoid unnecessary and potentially life threatening health consequences. | Written submission of verbal testimony dated 3.25.11 |
| Concerns | Katherine Gottlieb Southcentral Foundation | Concerned with requirement of therapeutic failures. | Written submission of verbal testimony dated 3.25.11 |

| | | | |
|--|--|---|--|
| Concerns | Pat Luby AARP | Supports with concerns: <ul style="list-style-type: none"> Requirement of therapeutic failures Administrative burden for patients, prescribers and pharmacists Suggestion: <ul style="list-style-type: none"> Academic detailing, targeted to therapeutic classes | Letter dated 3.25.11 |
| Concerns | Kate Burkhart ABADA/AMHB | Concerns: <ul style="list-style-type: none"> Removes doctor's ability to make medical decision of one drug over another Therapeutic failure of two generic medications Define therapeutic failure Suggest "grandfather" provision for Medicaid recipients whose health is stable and improving with existing medication to continue their regimen | Letter dated 3.25.11 |
| Concerns | Sharon Brigner PhRMA | Substitution restricts patient access: <ul style="list-style-type: none"> AK already has 90% generic use. Healthcare providers should choose medications for patients; better outcomes. Patients should have unrestricted access. Unintended consequence--loss of rebates. | Letter dated 3.25.11 |
| OPTION D: Increase Generic Medication Utilization | | | |
| Subject | Commenter | Summary of Comments | Form & Date |
| Transition Period | Randi Sweet United Way of Anchorage | <ul style="list-style-type: none"> Don't require duplicative trial/failures if provider has already tried generics Allow for a transition period and for new patients to Medicaid | Email dated 3.25.11 |
| Comments | Kathleen Fitzgerald Governor's Council on Disabilities & Special Education (GCDSE) | Supports: Recommendation: <ul style="list-style-type: none"> "Grandfather" clause for people experiencing good results from established medication regimens reliant on brand name drugs, to avoid unnecessary and potentially life threatening health consequences. A third party determination of the therapeutic equivalency be used rather than one associated with the State's | Written submission of verbal testimony dated 3.25.11 |

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|-----------------|--|---|--|
| | | efforts to control cost. | |
| Concerns | Katherine Gottlieb Southcentral Foundation | Has potential to endanger beneficiary while adding a burden to practitioners. | Written submission of verbal testimony dated 3.25.11 |
| Concerns | Kate Burkhart ABADA/AMHB | Concerns: <ul style="list-style-type: none"> • Impact of the “step-edit” process on individuals with serious mental illness and other chronic conditions. • Suggest use of an objective third-party evaluator or committee to determine which drugs constitute the same “therapeutic class” | Letter dated 3.25.11 |
| Concerns | Sharon Brigner PhRMA | Opposes substitution as it may: <ul style="list-style-type: none"> • Disregard drug prescribed • Not the same active ingredient • Disruption may be serious and harmful • Medicaid patients may be dramatically upset and costly to the healthcare system | Letter dated 3.25.11 |

OPTION E: Enhanced Preferred Drug List

| Subject | Commenter | Summary of Comments | Form & Date |
|--|--|---|--|
| Alternative to consider | Paul Stuve Care Management Technologies | Alternative to consider: <ul style="list-style-type: none"> • “Audit & Feedback” Behavioral Pharmacy Management™ has been implemented by other State Medicaid programs (including AK) • 2008 Analysis for AK Medicaid showed cost avoidance of over \$2.2 million | Letter dated 3.25.11 |
| Concerns | Katherine Gottlieb Southcentral Foundation | Suggest dealing with outliers before adopting costly measures for all. | Written submission of verbal testimony dated 3.25.11 |
| Supports under specific circumstances | Pat Luby AARP | Supports under specific circumstances <ul style="list-style-type: none"> • There should also be the expectation that overrides may occur and prior authorization should not become an undue burden on the patient or provider. | Letter dated 3.25.11 |
| Comments | Kate Burkhart | Supports with comments: | Letter dated |

| | | | |
|--|--|---|--|
| | ABADA/AMHB | <ul style="list-style-type: none"> Encourages task force to examine the cause of the 15% drop in provider compliance with preferred drug list Concerned that “does optimization” effort will result in more accidental poisoning/overdoses | 3.25.11 |
| Concerns | Sharon Brigner PhRMA | Enhanced PDL and prior authorization may: <ul style="list-style-type: none"> Interfere with patient-physician relationship Be time-consuming for physician “Defense as Written” is an important safeguard and ensures needless suffering | Concerns |
| OPTION F: State Maximum Allowable Cost (SMAC) | | | |
| Subject | Commenter | Summary of Comments | Form & Date |
| Supports | Kate Burkhart ABADA/AMHB | Supports | Letter dated 3.25.11 |
| OPTION G: Psychiatric Medication Policy | | | |
| Subject | Commenter | Summary of Comments | Form & Date |
| Alternative to consider | Paul Stuve Care Management Technologies | Alternative to consider: <ul style="list-style-type: none"> Care Management Integration™ described in more detail in public comment to Option B: Care Management. Preliminary data for intervention shows decreased hospitalizations and ER visits, decrease in average number of different physicians prescribing behavior medications and modest ROI. | Letter dated 3.25.11 |
| Concerns | Katherine Gottlieb Southcentral Foundation | Does not agree with multiple assumptions made by this policy. This would also add to the administrative burden of practitioners. | Written submission of verbal testimony dated 3.25.11 |
| Supports | Pat Luby AARP | Supports | Letter dated 3.25.11 |
| Comments | Kate Burkhart ABADA/AMHB | Supports with comments: <ul style="list-style-type: none"> Primary care providers should be extended same oversight and support as mental health facilities | Letter dated 3.25.11 |

| | | <ul style="list-style-type: none"> No mechanism to track medication history | |
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| Concerns | Sharon Brigner PhRMA | <p>Restrictions on children's medications may:</p> <ul style="list-style-type: none"> Place unnecessary burden on physicians and takes time away from treating patients and running practice Unfair to add unnecessary requirements Could result in serious adverse events | Letter dated 3.25.11 |
| OPTION H: Community First Choice (PCA) | | | |
| Subject | Commenter | Summary of Comments | Form & Date |
| Long Term Care & Tribal Health Organizations | Kay Bunch for Liz Lee AK Native Tribal Health Consortium | <p>Promising option</p> <p>Concerns:</p> <ul style="list-style-type: none"> Tribal health organizations prefer the agency-based model which allows for more oversight and accountability of workers/services. Individual back-up plans should be flexible enough to meet unique needs in rural AK. Ensure more timely delivery of services QA/measures may cause additional costs to agencies without additional funding to comply with new regs for tracking/reporting. Speed that this option has been brought forward and ambitious timeline for implementation. <p>Suggestions:</p> <ul style="list-style-type: none"> Opportunities for savings through FMAP. Work with tribal health organizations to further enhance Medicaid savings. | Letter dated 3.25.11 |
| PCA program redesign | Alaska PCA Provider's Association | <p>Cautiously optimistic</p> <p>Encouraged by:</p> <ul style="list-style-type: none"> Expanded services Stakeholder input Greater quality assurance Potential for expanded service delivery models <p>Concerned about:</p> <ul style="list-style-type: none"> Avoiding design/implementation pitfalls by weighing provider and consumer input | Letter dated 3.25.11 |

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| | | <ul style="list-style-type: none"> Projected administrative costs | |
| Alzheimer's Disease and Related Disorders (ADRD) | Rosemary Hagevig Catholic Community Service | <p>Concerns:</p> <ul style="list-style-type: none"> Consumer-directed model is not appropriate for the ADRD population. <p>Support:</p> <ul style="list-style-type: none"> Concept of home and community-based care being available to ADRD population. | Letter dated 3.25.11 |
| Past mistakes & PCA Back-Up Systems | Graham Smith Priority Healthcare | <p>Cuing & Supervision</p> <ul style="list-style-type: none"> Provision will return elements of waste and abuse to PCA program <p>Back-up Systems</p> <ul style="list-style-type: none"> A functional PCA back-up system should be a comprehensive <i>service</i> rather than a device (such as Lifeline). | Email dated 3.25.11 |
| Comments | Mark Regan Disability Law Center of AK | <p>Supports:</p> <p>Fills a gap in current delivery system, as there are individuals who don't meet the level of care requirements for PCA services, limited to the need for supervision or cuing to manage daily activities.</p> | Written submission of verbal testimony dated 3.25.11 |
| Multiple Sclerosis related | Jim Freeburg National Multiple Sclerosis Society | <p>Supports:</p> <p>Community First Choice option is an important opportunity for the state to keep more people in their homes and community-based care- a cheaper long-term care option favored by many individuals who would otherwise be in residential care.</p> | |
| Alzheimer's Disease and Related Disorder (ADRD) | Sharon Howerton-Clark & Denise Daniello Alaska Commission on Aging | <p>Conditional support:</p> <ul style="list-style-type: none"> Falls short of array of services offered by waiver program <p>Recommendations:</p> <ul style="list-style-type: none"> Agency-based services (over consumer-directed) Increase number of rural persons served Allow for assistive technology devices (such as Lifeline) Establish a consumer advisory council | Letter dated 3.25.11 |
| Senior Citizen | Greg Brown Resident of Juneau | <p>Supports:</p> <ul style="list-style-type: none"> Provided the proposal does not repeat past mistakes Provided the proposal incorporates a | Email dated 3.25.11 |

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| | | comprehensive PCA back-up service | |
| Comments | Greg Schomaker Consumer Direct Personal Care | Supports: <ul style="list-style-type: none"> This will allow individuals who do not meet the level of care for PCA program due to need for cueing and supervision to remain in their homes. Recommendation: <ul style="list-style-type: none"> Consider how the compliance with requirements of 1915k will impact the lives of current and future consumers of Personal Care Services | Letter dated 3.25.11 |
| Comments | Kathleen Fitzgerald Governor's Council on Disabilities & Special Education (GCDSE) | Supports: <ul style="list-style-type: none"> Would recommend the back-up systems be defined broadly. Council has done research on technology used in smart-homes, which could be a viable option. Clarify that services don't need to just be provided at home, but also at work and in the community. Voc Rehab/Supported Employment if allowable under federal law...may put it explicitly as a covered service. Option for consideration: Medicaid Buy In for working disabled. Kansas has a program that might be a good model. | Written submission of verbal testimony dated 3.25.11 |
| Supports | Pat Luby AARP | Supports: <ul style="list-style-type: none"> Individuals transferred to the new state plan option should continue to receive the services that meet their full range of needs. Not described: Development and Implementation Council (required of states) AARP would like to participate on the above mentioned council | Letter dated 3.25.11 |
| General Comments | | | |
| Subject | Commenter | Summary of Comments | Form & Date |
| Stakeholders & Options not | Randi Sweet United Way of | <ul style="list-style-type: none"> Consider communication strategy and plan to engage stakeholders in | Email dated 3.25.11 |

Options for Cost Savings

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| covered | Anchorage | <p>changes.</p> <ul style="list-style-type: none"> • Include patients as stakeholders <p>Options not covered:</p> <ul style="list-style-type: none"> • Dual Eligible Medicaid-Medicare • Outreach • PFD/Annual payment for wellness | |
| Savings, LTC, Collaboration | Katherine Gottlieb Southcentral Foundation | <p>General</p> <ul style="list-style-type: none"> • Projected savings relatively small • Left out Long Term Care • Needs to be a more collaborative approach to plan | Written submission of verbal testimony dated 3.25.11 |
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