

#4

**Person Centered Case
Management (PCCM)**

Medicaid Advisory Reform Group recommendation for analysis: Develop a Comprehensive Person Centered Case Management (PCCM) Payment Mechanism with Steerage

Background:

Alaska Medicaid currently has two types of case management:

- Care Management Program
- Case Management

Care Management Program:

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

Currently, Alaska's Care Management program can accommodate a maximum of 300 recipients. The program is administered by the fiscal agent, Xerox. Each month, Xerox ensures that each participating recipient receives special Medicaid coupons showing the Care Management providers to which the recipient has been assigned..

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

Case Management:

Case Management is utilized when a recipient is hospitalized and receives evidence-based case management practices. This function is performed by our contractor Qualis and it includes:

- Patient Activation Measure (PAM) assessment: Gauges the knowledge, skills and confidence essential to managing one's own health and healthcare.
- Motivational Interviewing for Healthcare (MI): A person-centered counseling style for addressing the common problem of ambivalence about change.
- Care Transitions to support patients with complex care needs, to receive specific tools and to learn self-management skills that will ensure needs are met during the transition from hospital to home.
- Medication reconciliation to prevent medication-related mistakes.
- Onsite visits to promote collaborative case progression toward meeting the nursing plan of care.

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

During fiscal year 2013 925 cases were referred of which 114 were opened. The reported savings was \$3,5 million for a return on investment of \$4.94:\$1.

Discussion:

There are many types of medical management models that could be introduced to Alaska Medicaid. Some are:

- **Managed Care** (traditional utilization management)
 - Pre-certification
 - Pre-admission call
 - Hospital review
 - Discharge Planning
 - Post-discharge calls
 - Retro-review
 - Steerage

This is currently the type of case management that our contractor Qualis provides.

- **Care Management**
 - Case Management
 - Medical Outreach Program
 - Dedicated Units

Part of this model is provided through our contractor Xerox, but true care management goes well beyond the 300 people that our current program can manage. Expansion of these services in Medicaid could be accommodated with contracts that range in cost from \$3.45 per member, per month up to \$1,600 per member, per month.

- **Disease Management**
 - Asthma
 - Congestive Heart Failure
 - Coronary Artery Disease
 - Diabetes
 - End Stage Renal Disease
 - Low back pain

- Alaska does not currently case-manage recipients in these categories unless they are hospitalized. This type of case management requires medical professionals and would have to be performed under contract. **Health Promotion**
 - Coaching/Advocacy
 - Wellness
 - Wellness counseling
 - Health Risk Assessment
 - Healthy Body, Healthy Weight

The Division of Public Health within the state provides some of these promotions but not all.

- **Internet**

- Member Empowerment Tools
 - Nurse Helpline
 - Information Web Site
 - Medical Doctor Lists
 - Pricing Transparency Tools
 - Hospital Comparison Tool
 - Evaluate Your Health Care Provider

At this time Alaska does not provide very much of this information. Information about Medicaid can be found on the Alaska Medicaid Health Enterprise website as well as a searchable listing of providers who will accept Medicaid. Alaska does not currently have an All Payer Claims Database to compare hospitals or pricing.

Currently Alaska Medicaid only requires plans of care for individuals that qualify for home and community based waiver services or behavioral health services. The types of case management listed above require Integrated Care and oversight under which each recipient would have a care plan from the time they started receiving services. Typically this type of case management is performed in retail clinics and sometimes using a medical home model.

Cost:

To provide these services to all Medicaid recipients at the lower end of the spectrum (mostly telephonically) would cost the state approximately \$6 million per year. The contractors that provide these types of services claim a return on investment of more than \$20:\$1 and state that they are able to do this through economies of scale.

To provide these services to all Medicaid recipients at the higher end of the spectrum would cost the state approximately \$1.5 billion (considering the lowest of recent bids to provide case management services). In other words, nearly the total amount of Medicaid spending in the state.

Conclusion:

Alaska cannot afford the all-inclusive medical management model but should contract for lower-level services where the per member, per month fee does not end up exceeding the amount Medicaid pays for medical care at present. The State is currently trying to procure these services for a smaller population through the new Super Utilizer program. Once that program has been in place for enough time, we will be able to draw valid numbers for estimates on the amount that this type of case management can save the state.

#5

**Comprehensive
Payment Reform**

Introduction

The Office of Rate Review (ORR) was tasked with analyzing innovation item #5: Comprehensive Payment Reform. The item specifically includes the following seven avenues for approaching payment reform: bundled payments; specialty management, pay for outcomes; DRG reimbursement system; cost sharing; cost methodology; and, acuity rates.

Unlike many of the other innovation items, the type of comprehensive payment reform being discussed equates to a total system overhaul for Alaska. For example, hospitals currently operate under a prospective payment system that assigns daily reimbursement rates for Medicaid inpatient services. Since Alaska is one of only a small number of states that does not use a DRG system to reimburse hospitals for inpatient services, projecting the impact of implementing such a system, especially from a cost savings/liability perspective, would require an extensive amount of resources since it would require not only stakeholder input but an administrative system overhaul and a computer system overhaul.

Although fully assessing and quantifying these payment reform measures is difficult, this is still an exercise that offers valuable returns. With a Medicaid budget at \$1.7 billion and growing, comprehensive payment reform is inevitable. Therefore, the purpose of this analysis is to further explore the different avenues for payment reform, analyze what they may look like in Alaska, and evaluate impact, to the extent possible, in other states that adopted similar measures. This discussion is intended to establish a foundation for further stakeholder engagement and study.

Analysis: Comprehensive Payment Reform

Bundled Payments

Policy Analysis:

Bundled payments are the reimbursement of health care providers on the basis of expected costs for clinically defined episodes of care. A bundled payment is a single, fixed compensation for a patient's treatment planning, treatment and potentially follow-up care. It is considered the middle ground between fee-for-service and capitation.

Bundled payments are typically better suited to certain types of services, such as inpatient procedures, that have clearly defined episodes of care and similar related usual expenses. Services that are currently being paid through bundled payments in the United States include hip and knee replacements for inpatient services, maternity services for outpatient services and diabetes management for chronic condition services.

Currently in Alaska Medicaid, a majority of services are paid via fee-for service. Inpatient and outpatient hospital services procedures are not paid in Alaska Medicaid using bundled payments. Several services that are paid under bundled rates include IHS behavioral and dental encounter rates and several behavioral health services.

The benefits of bundled payments include aligning incentives to avoid complications and to deliver care efficiently in a coordinated fashion across the continuum of care. Health care consumers like the simplicity of a single bill for all services in order to determine what services

they are buying and at what price. Bundled payments also provide clear accountability for care for a defined episode.

Difficulties of bundled payments include a potential lack of control by health care professionals in the post-acute phase of care and the lack of way to measure and address acuity. In recent years, the push on part of the federal government for some services is to de-bundle payment down a smaller unit, such as a fifteen minute unit for home and community based waiver services.

Fiscal Impact

In the past two decades, there have been several studies to determine monetary savings of bundled payments. Studies look at potential savings using a single type of care, such as a knee replacement. The savings found under several studies are shown in Table 1 below.

Table 1. Savings from bundled payments in various studies

Year	Type of Care	Study	Savings	Payer	Source
2011	Knee Replacement	PROMETHEUS	8-10%	Blue Cross and Blue Shield of North Carolina	http://healthaffairs.org/blog/2014/07/02/the-payment-reform-landscape-bundled-payment/
					http://www.fiercehealthpayer.com/story/bcbsnc-bundles-payments-better-coordination-quality-costs/2013-03-22
1991 - 1996	Heart Bypass	ACE Demonstration and Heart Bypass Center Demonstration	10%	Medicare	http://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/downloads/Medicare_Heart_Bypass_Summary.pdf
					http://www.urban.org/UploadedPDF/412655-Payment-Reform-Bundled-Episodes-vs-Global-Payments.pdf
1997	Heart Bypass	Cromwell, Dayhoff, Thourmaian	2-23%	Medicare	http://www.rand.org/pubs/technical_reports/TR562z20/analysis-of-bundled-payment.html
2006	Non-emergency CABG procedures	ProvenCareSM	5%	Geisinger Health System	http://www.rand.org/pubs/technical_reports/TR562z20/analysis-of-bundled-payment.html

Specialty Management

Policy Analysis:

Specialty Management seeks to create multidisciplinary groups that provide expertise and perspectives specific to the topic of discussion. These groups seek to use their expertise to offer insights into health care opportunities and payment models that improve health care quality while reducing the costs of specialty care. Together with stakeholders, these groups assess

findings and issues addressed in published literature to provide input on impacts to the health care field.

The Centers for Medicare and Medicaid Services (CMS) have formed Technical Expert Panels (TEP) under their Specialty Payment Model Initiative for oncology, cardiology and gastroenterology. These TEPs are comprised of payers, providers, patients, health services researchers, pharmaceutical companies, quality improvement representatives and social workers. TEPs do not provide advice or recommendations, merely a mechanism to discuss health care issues.

Alaska Medicaid currently does not utilize Specialty Management.

Fiscal Impact

In light of forming its own TEPS, the State can view summaries of CMS's TEPs at http://www2.mitre.org/public/payment_models/.

Pay for Outcomes

Policy Analysis:

Paying for Outcomes, also known as pay-for-performance, is a reimbursement strategy that attempts to provide financial incentives to health care providers to improve the quality, efficiency and overall value of health care. Incentive payments are made when a health care provider achieves measurable goals in areas such as outcomes, patient experience and resource use.

There are various versions of pay-for-performance. The “pay” in pay-for-performance may refer to a monetary payment for the achievement of a pre-specified goal or other non-monetary incentives such public reporting or referrals of members to a plan or provider. One common version is providing a monetary reward for limiting referrals to specialty providers. A second version of pay-for-performance is creating incentives to reduce Potentially Preventable Events (PPEs). There are five categories of PPEs:

1. Readmissions
2. Admissions
3. Complications
4. ER visits that lead to an inpatient admission
5. Unnecessary outpatient procedures

Currently in Alaska Medicaid, providers are not reimbursed via pay-for-performance.

A benefit of pay-for-performance is the potential to improve the quality and efficiency of care delivered by emphasizing outcomes of care. In addition, pay-for-performance could help encourage collaborations among health care providers by providing monetary incentives to improve efficiency across the continuum of care.

A difficulty in implementing pay-for-performance is defining how quality of care is measured. Data must be gathered in a manner that is cost effective as to not outweigh any monetary

incentives offered. Given that there are several models of pay-for-performance, choosing which model to adopt would pose a difficulty that would require stakeholder input. In addition, pay-for-performance could provide incentives for physicians to avoid high-risk patients and fire non-compliant patients.

Fiscal Impact

Literature on the impact of health care outcomes under pay for performance show mixed results. Fewer studies have attempted to estimate the monetary savings of pay for performance. Dr. Goldfield and Dr. Averill, in their study of New York and Maryland Medicaid, were able to estimate savings by limiting each category of potentially preventable events. The savings found under Dr. Goldfield & Dr. Averill’s study are shown in Table 2

Table 2. Estimated savings for pay-for-performance

Study	Savings	Payer	Source
Dr. Goldfield & Dr. Averill	3% for Reducing preventable readmissions	New York & Maryland Medicaid & Private Payers	http://www.kaiserhealthnews.org/Columns/2011/May/050911mcdonough.aspx
	8% for Preventing unnecessary readmissions		
	2% for Reducing preventable complications		
	2% for Preventing unneeded ER visits		
	3% for Deterring unnecessary outpatient procedures		

DRG Reimbursement System

Policy Analysis:

A Diagnosis Related Groups (DRGs) Reimbursement System is a statistical system of classifying an inpatient stay into groups for the purposes of payment. This is the reimbursement system by Medicare and 47 state Medicaid programs. Factors that are used to determine the level of payment for a DRG payment include the diagnosis, the geographic location and the hospital resources, or relative value units (RVUs), used to treat the condition. Components of RVUs include the geometric and arithmetic average length of stay for the diagnosis. The relative value units necessary for each group are determined three times a year by the Specialty Society Relative Value Scale Update Committee. Diagnoses are divided into more than 20 major body systems and then subdivided into around 500 groups for reimbursement to Medicare.

DRG Reimbursement Systems can be administered in a variety of ways. Reimbursement rates are generally calculated by multiplying a base rate by the assigned RVUs for that diagnosis and by the geographic factor. Many states adopt the RVUs and geographic factors utilized by Medicare. States have flexibility to create a single base rate for all hospitals, create tiers for hospital reimbursement, or determine a separate base rate for each hospital.

Currently Alaska Medicaid does not pay hospitals on a DRG Reimbursement System. Inpatient procedures are paid to a hospital on a per diem basis that is specific to each hospital.

A benefit of the DRG Reimbursement System is that it offers a high level of standardization for reimbursement rates. This standardization could decrease the incidence of rate challenges and

ligation as well as provide more predictability for budgeting. A DRG Reimbursement System would align Alaska Medicaid with the reimbursement methodology used by a majority of state Medicaid programs and potentially provide incentives for efficient care delivery.

A disadvantage of the DRG Reimbursement System is that providing a standardized payment for a specific diagnosis may be difficult for hospitals with patients that are significantly outside of the average for hospital resource use. Different DRG systems such as the All-Patient, Severity-Adjusted DRG system and the All Patient Refined DRG system have been created in response to this criticism. A DRG Reimbursement System may create incentives for ‘upcoding’ patients to high-paying DRGs. In addition, a single base rate DRG system may not best fit the needs of the State’s unique geographic landscape.

Fiscal Impact

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

Cost Sharing

Policy Analysis:

Cost sharing is how health plan costs are shared between the insurance agent and the consumer. Cost sharing can be done through copayments, coinsurance or deductibles. States Medicaid programs can impose copayments, coinsurance, deductibles and other similar charges on some Medicaid-covered benefits. The Affordable Care Act (ACA) modified the cost sharing rules for Medicaid effective January 1, 2014.

Alaska Medicaid currently utilizes cost sharing for inpatient hospital services, outpatient hospital services, physician services and prescription drugs. Currently in the State of Alaska, if a recipient informs a provider that they cannot pay a copay, then the recipient is not required to pay that copay; this could result in an increase in financial risk to the provider. The current cost sharing amounts for Alaska Medicaid are shown in Table 3 below.

Table 3. Alaska Current Cost Sharing Amount.

Services	Maximum Allowable Cost Sharing
Inpatient Hospital Services	\$50 per day up to a Maximum of \$200 per discharge
Outpatient Hospital Services	5% of allowable charges
Physician Services	\$3.00 per day
Prescription under \$50	\$.50 cents
Prescription over \$50	\$3.50 dollars

A benefit of cost sharing is that it promotes efficient use of health care resources by engaging the recipient in the health care process.

A difficulty associated with increases in cost sharing is the potential to incentivize a reduction in cost-effective prevention resources. This can be mitigated by creating exemptions from cost sharing for preventative services. In addition, if cost sharing lowers program participation it may lead to adverse selection of a population with more severe medical needs. Computer systems changes may need to be implemented.

Cost sharing is further explored in response to Innovation Item #18.

Fiscal Impact

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

Cost Methodology

Policy Analysis:

A cost methodology is a reimbursement methodology that is set using a health care provider's actual cost. A provider or group of providers' expenses are divided by their units of service or patient days to arrive at a reimbursement rate.

Several services in Alaska Medicaid are set using a cost survey methodology including inpatient services and nursing home services. Rates for these services are set specific to each provider. Several other Medicaid services, such as some behavioral health services and home and community based waiver services are potentially looking to utilize cost methodology to create a single rate for all providers instead of a specific provider rate.

A benefit of utilizing a cost methodology is that it allows reimbursement to a health care provider that is specific to their unique costs in the case of a provider specific rate or specific to their provider type in the case of a single rate for all providers.

A difficulty of utilizing a cost methodology is that it incentivizes providers to increase costs in order to increase reimbursement. A single provider specific rate can result in a high level of rate challenges and litigation. In addition, a cost methodology does not take into account the acuity of the recipients as a provider gets a single rate for all recipients.

Fiscal Impact

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

Acuity Rates

Policy Analysis:

Acuity measures account for the intensity of services that are necessary to address a recipient's condition. In order to reimburse providers on the basis of acuity, a measure of acuity must be determined.

Acuity rates are not prevalent in Alaska Medicaid. Inpatient services and nursing home services have no acuity rates. Home and Community Based Waiver and Personal Care Attendant services have an add-on acuity rate for assisted living homes and group home services for individuals that meet established criteria for an acuity rate but do not have adjustments to account for other levels of acuity. The Department contracted with Myers and Stauffer, LC to study acuity adjusted rates for Home and Community Based Waiver and Personal Care Attendant services as well as Clinical and Rehabilitative behavioral health services.

A benefit of an acuity rate is that the rate reimbursement will provide a more precise reimbursement for the intensity of the services; a more acute recipient will be reimbursed at a higher rate. Acuity rates incentivize providers to provide care to highly acute recipients who might be more difficult to serve under other reimbursement methodologies.

A disadvantage of an acuity rate is the difficulty in measuring recipient acuity. Stakeholders must agree on the measures of acuity for a range of services and the Department or health care provider must measure and track recipient acuity in order for correct reimbursement to be paid. The current Enterprise system will need to be able to accommodate tracking recipient acuity.

Fiscal Impact

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

Statutory and Regulatory Changes

Since many of these payment reform measures would constitute a total system overhaul for Alaska, it is expected that changes to both regulations and the State Plan would be required at a minimum. Again, given the level of change that would be involved in comprehensive payment reform, statutory changes would also likely be required.

Additional Changes

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

#8

**Cap Waiver Recipients
to Nursing Home
level of care annually**

8. Individual Cost Neutrality Cap for Medicaid Home and Community-Based Waivers

To receive approval to offer Medicaid Home and Community-Based Service under a 1915(c) Waiver, states must provide assurance to the federal Centers for Medicare and Medicaid Services (CMS) that the waiver is cost neutral compared to institutional care. States have two options to demonstrate cost neutrality: they can show that the approved waiver will be cost neutral in the aggregate (i.e., the average cost), or they can impose a requirement that people on the waiver do not exceed the average cost of an institutional recipient at the individual level. If a person is expected to exceed that cost, then the person would be barred entry to the waiver, or terminated from the waiver at annual renewal. A state must apply this limit to all people on the waiver equally. It cannot provide for exceptions. States can also impose individual limits that exceed average institutional costs or are less than average institutional costs. In the latter case, states must justify that the level of services provided are adequate to meet the needs of the target population.

Of the four waivers that Alaska currently operates, the most expensive is the waiver for people with intellectual and developmental disabilities. Many people have approved waiver service plans in excess of the average cost of institutionalization. In FY 13, 169 individuals had plan costs in excess of the average for a total cost of \$35.6 million. **If Alaska had imposed a cap at the average cost of institutional care for this waiver, \$162,736, it would have spent \$27.5 million, saving \$8.1 million, half of that General Funds.**

Even if Alaska capped the individual waiver cost at the highest cost for an individual in an institution, it would still achieve savings. In FY 13, 63 individuals had plans in excess of \$219,613, the highest institutional cost that year. Alaska spent \$16.6 million on these individuals. **If the plan costs were capped at \$219,613, Alaska would have spent \$13.8 million, for a savings of \$2.8 million, half of that General Fund.**

The cap could result in more people receiving institutional care, if they were not willing to accept reduced waiver service plans. While this would not impact costs (as their waiver plans would have been in excess of institutional costs), people generally prefer to receive services in their community. Therefore, those individuals may be less satisfied with the services they receive.

#10

**Cost Savings through
Contracted Services**

Cost Savings Estimate - Contracted Pharmacy Services

All Maintenance Medications

Some private health plans restrict their members to limited pharmacy networks, or mail order pharmacies, for prescriptions for recurring maintenance medications. Acute medications, like antibiotics, are still expected to be available to members through local community retail pharmacies and not restricted to the contract pharmacies. Restricting medications to a contract pharmacy, or small network of contract pharmacies, would be anticipated to yield savings through either a reduced reimbursement rate on the drug, a reduced dispensing fee, or both. The contract pharmacies accept the lower reimbursement, despite making a lower profit on individual claims, because the overall increase in prescription volume from the dedicated patient population results in increased net revenue.

Considerations for using contract pharmacy networks for all maintenance medications

Due to the relatively aggressive reimbursement rate used by Alaska Medicaid for covered outpatient drugs it would not be anticipated that there is a lot of potential for cost savings due drug reimbursement. Currently Alaska Medicaid reimburses the lower of:

- The Wholesale Acquisition Cost (WAC) plus 1%; or
- The State Maximum Allowable Cost (National Average Drug Acquisition Cost - NADAC); or
- The Federal Upper Limit (if applicable); or
- The submitted ingredient cost

The combination of the WAC+1% and the NADAC results in the reimbursement for most brand name covered outpatient drugs being in the WAC-2% to WAC-3% range. It could be possible that a large mail order facility would bid on a contract and propose an additional cost savings; however, it is unlikely that an additional overall 3% savings would be realized on the drug costs for brand name drugs. A larger potential savings percentage could be anticipated on generic medications; however, the overall drug spend on generic drugs is significantly lower than the drug spend on brand name drugs.

A potential cost savings exist with respects to the dispensing fees paid for a contract pharmacy, though it is not anticipated that an aggressive dispensing fee would be part of a contract pharmacy's reimbursement rate if an aggressive drug cost is negotiated.

Drawbacks of using contract pharmacy networks for all maintenance medications

While cost savings are possible through a contract pharmacy network there are significant drawbacks that should be addressed and evaluated before cost savings are pursued. Medicaid prescriptions account for about 15% of the prescriptions dispensed by community retail pharmacies in Alaska with some individual pharmacies servicing a much larger Medicaid volume than others. If Medicaid required all maintenance medications to be refilled at a contract pharmacy network the impacts on the existing pharmacy providers would be devastating.

Prescription refills are an important component of a pharmacy's business and are often more profitable than dispensing new prescription drug orders because they are less time intensive.

It is likely that if Medicaid required maintenance medications to be refilled through a contract pharmacy network, non-contract pharmacies would dis-enroll and not service Medicaid recipients needing acute prescriptions for medications, like antibiotics. It is also expected that the removal of this important revenue stream would force many independent pharmacy owners out of business, potentially leading the closure of 30%+ of the pharmacies in Alaska. Chain pharmacies would be impacted; however, the losses could be absorbed easier by chain pharmacies due to a diverse revenue stream and offsetting profitable stores in other states.

Another important consideration is the potential loss of FMAP if tribal recipients are required to obtain their maintenance medications through a non-tribal contract pharmacy network. If these recipients are not carved out of the contract pharmacy network the State could potentially lose 50% of the federal funds currently collected on tribal recipient's prescription claims through tribal pharmacy providers. Conversely, if tribal recipients are excluded from participation in the contract pharmacy network it is less likely that the contract pharmacy network would offer the most competitive rates because the recipient pool will be significantly smaller than if all recipients were included. The large tribal recipient population serviced by Alaska Medicaid threatens the viability of using a contract pharmacy network for all maintenance medications for Medicaid recipients.

Additional Considerations

- Dual Eligible Recipients – Recipients with Part D coverage would not be restricted to a contract pharmacy network and would further decrease the population of recipients serviced under the contract and reduce the likelihood of receiving a favorable bid from the pharmacy providers.
- Access issues – If pharmacies close their doors to Medicaid recipients or go out of business the state will be limited in the options available to provide pharmacy services to Medicaid beneficiaries in the future. It should be expected that pharmacies financially harmed by this initiative will not be willing to provide services to Medicaid recipients in the future if the State wishes to return to an any willing provider delivery model unless the state pays a premium for their participation.
- Freedom of choice waiver – the state will need to obtain a freedom of choice waiver from CMS to restrict services to a contract of network pharmacies. While it is not anticipated that this couldn't be obtained it is a factor that needs to be considered during the planning and evaluation stages.

Recommendation

The risk of harming the Alaska pharmacy providers far outweighs the small potential cost savings available through restricting all maintenance prescriptions to a network of contract pharmacies. If contract pharmacy services are desired it is recommended that the state explore the option of securing a contract pharmacy provider for limited number of specialty drugs. Additional discussion regarding this recommendation follows.

Specialty Drugs

Some health plans and fee for service Medicaid programs utilize contract pharmacies to provide their recipients with pharmacy benefits. Few plans limit their recipients to a single pharmacy, chain, or network of pharmacies for all pharmacy services. It is more common for a payer to restrict “specialty drugs” to a contract “specialty pharmacy”. Surprisingly, there is not a nationally recognized definition of a “specialty drug” or “specialty pharmacy” so for the purposes of this analysis the definition of a “specialty drug” and “specialty pharmacy” will be as follows:

A specialty drug is a high cost drug that is not routinely stocked at a majority of community retail pharmacies or a drug that is prescribed for a person with a complex, chronic, or rare medical condition. Complex, chronic, or rare medical conditions include disorders such as; cancer, chronic renal failure, Crohn’s disease, cystic fibrosis, endocrine disorders, growth hormone deficiency, hemophilia and blood clotting diseases, hepatitis, immune deficiency, inflammatory conditions, iron toxicity, multiple sclerosis, pulmonary hypertension, respiratory syncytial virus prevention, rheumatoid arthritis, and organ transplantation.

A specialty pharmacy is a pharmacy that routinely stocks and dispenses specialty drugs.

Payers utilize specialty pharmacy contracts to achieve favorable pricing of high cost specialty drugs relative to the price the payer would pay through the open market. Specialty pharmacies accept lower reimbursement for specialty drugs through these contracts because they gain a larger patient pool to service when they are designated the sole supplier of specialty drugs for a payer. While the specialty pharmacy will receive a lower reimbursement on an individual claim, they achieve a higher annual revenue stream by increasing the volume of specialty drugs dispensed.

Universe of Specialty Drug Claims – SFY 2014

In SFY 2014 there were 3,582 claims with a total payment amount of >\$1,500. These 3,582 claims accounted for \$13,437,676.34 in payments. While this simple query may not include some lower cost specialty medications it is good estimate of the number of claims potentially subject to a specialty contract because nearly all specialty drugs cost several thousand dollars per claim.

Tribal Specialty Drug Claims

In SFY 2014 there were 840 claims for specialty drugs from tribal providers (23.5% of specialty drug claims). These 840 claims accounted for \$3,013,808.26 in payments with 100% Federal match. If these claims were diverted to a specialty pharmacy outside of the tribal system the net impact to the state would be a **cost increase of \$1,506,904.13**. It is not anticipated that there would be an offsetting cost savings through the specialty pharmacies because tribal providers purchase medications through a federal drug discount program and their reimbursement is capped at the Wholesale Acquisition Cost minus 15%.

Non-Tribal Specialty Drug Claims

In SFY 2014 there were 2,742 claims for specialty drugs from non-tribal providers (76.5% of specialty drug claims). These 2,742 claims accounted for \$10,423,868.08 in payments with 50% federal match. Alaska Medicaid already utilizes a relatively aggressive reimbursement at the lesser of the Wholesale Acquisition Cost plus 1% or NADAC (if applicable) for outpatient drugs and there is little room for further discounts; however, it would not be implausible to estimate that the state could achieve no more than an additional overall 5% savings, at a reimbursement rate of the Wholesale Acquisition Cost minus 4%, on the drug costs could be realized through a specialty drug contract. This could result in a **savings of up to \$500,000 a year**, with the actual savings depending on the specialty pharmacy contract rate and specialty drugs included.

Impact on Alaska Pharmacies

In SFY 2014 there were claims for specialty drugs from 97 different pharmacies. While some pharmacies filled a small number of claims for specialty drugs, others filled a moderate to high volume of claims for specialty drugs. It is important to weigh the potential cost savings of this initiative against the possibility of removing the reimbursement for specialty drugs that is currently going to the community pharmacies and potentially threatening the sustainability of their businesses.

Recommendation

One subgroup of specialty drugs where a disproportionate cost savings potential exists with minimal impact to the Alaska pharmacy provider community is hemophilia clotting factor. In SFY 2014 there were 64 claims for clotting factor, which accounted for \$1,889,612.25 in payments (\$1,307,807.45 from non-tribal providers). Currently, Alaska Medicaid reimburses providers the Wholesale Acquisition Cost plus 1% (or minus 15% if purchased through a drug discount program); however the Medicare rates for clotting factor are significantly lower and creates the potential for significant cost savings. Examples:

- Humate-P, used for the treatment of Von Willebrand Disease, is currently reimbursed at a rate of about \$1.07 per factor unit while the Medicare rate is \$0.95 per factor unit.
- Advate, used for the treatment of Hemophilia A, is currently reimbursed at a rate of about \$1.44 per factor unit while the Medicare rate is \$1.14 per factor unit.

A contract pharmacy providing clotting factor for Medicare's rate, or less than Medicare's rate, would be expected to yield at least a **20% savings of about \$260,000 a year on non-tribal claims**. Seeking a contract pharmacy to provide clotting factor to non-tribal Alaska Medicaid recipients presents the greatest benefit/risk ratio for the Medicaid program without creating significant impacts to the Alaska pharmacy community. While the risks to the pharmacy community are minimal it would be expected that one Alaska pharmacy would see a significant reduction in their Medicaid payments if they were not the contract pharmacy and the reduction could threaten their ability to do business.

The following administrative actions would need to be taken to secure a contract with a contract pharmacy for hemophilia clotting factor:

- A regulation change to allow the department to designate one or more enrolled pharmacies as the source of hemophilia clotting factor through a contract for services under AS 36.30.

- Obtain a freedom of choice waiver from CMS to require recipients to receive hemophilia clotting factor only through the contract pharmacies.
- Submit and gain approval for a State Plan Amendment to require recipients to receive hemophilia clotting factor only through the contract pharmacies.
- Issue a Request For Proposal (RFP) and issue a contract to the successful bidder.
- Notify prescribers, pharmacies, and recipients of the restriction on hemophilia clotting factor.
- Make system changes to restrict hemophilia clotting factor claims to the contract pharmacies.
- Implement the contract.

10 b. Contracting out for Medicaid Home and Community-Based Waiver and Personal Care Assessments.

As a condition for eligibility for Medicaid Home and Community-Based Waivers and the Personal Care program, applicants must be assessed and recipients must be reassessed annually. That results in the need for approximate 8,200 assessments annually; about 13% are initial assessments, the remainder are reassessments. The demand for these services and therefore the number of assessments is expected to increase with projected growth in the senior population over the next two decades. Ensuring that eligibility standards are applied correctly is absolutely critical to controlling the expense of these programs, as many people perceive that they would benefit from the services available even if they do not meet the eligibility criteria for them.

Currently, all assessments and reassessments are performed by nurses employed by the State; it is difficult to hire and retain nurse assessors. DHSS believes that contracting out at least a portion of the assessments to other nurses is a way to keep up with demand at a lower cost rather than continuously recruiting and training full-time employees. It would be easier to tap into the pool of nurses looking for part-time or seasonal work. At least initially, DHSS would use the contract nurses for reassessments in urban areas: urban because that is where we think the available labor force is located and reassessments because maintaining the consistency of the initial intake decision is critical.

Currently, it costs DHSS approximately \$464 for each assessment or reassessment, considering only the assessor's cost (excluding travel). **If DHSS is able to contract out 2,500 urban reassessments at \$200/assessment (assuming \$40/hour x 5 hours), it would be able to save up to \$660,000 per year over the current cost of state employee assessors, half of that in General Fund.** And it would help keep up with the increasing demand for services.

10 c. Contracting out for Medicaid Home and Community-Based Waiver Care Coordination

Historically, Medicaid Home and Community-Based Waivers were permitted to offer care coordination (or case management, as CMS refers to it) as a waiver service, as separate state plan service under the Targeted Case Management option, or administratively, either through state employees or through contracts with private entities. However, CMS no longer permits states to offer waiver case management administratively.

Case management can include a number of functions, including screening and intake, assessment, level of care determination, plan of care development, service monitoring, and assistance with service crises. States do not have to provide all of these functions through the service of case management, particularly the functions associated with application and eligibility determination. For example, Alaska provides assessment and level of care determination directly through state employees, not through care coordinators. It is piloting the provision of screening and intake through Aging and Disability Resource Centers, reducing the role of the care coordinator at the front end of the process. If the pilot proves successful, we hope to implement it statewide by the end of 2015. This would largely produce administrative cost avoidance, by improving the effectiveness of intake and screening and reducing the number of unnecessary assessments performed. Given that applications for waiver and personal care services expected to keep growing with the aging population over the next two decades, more effective screening will serve to flatten that growth somewhat.

Based on preliminary data from the Aging and Disabilities Resource Center pilot project, DHSS may be able to reduce initial assessments by 434 per year. Using the average assessment cost of \$464, this translates into a reduction of \$215,296/year, half of that in General Fund. If overall demand grows, then savings would grow as well.

There is probably not much opportunity to expand provision of other functions of case management administratively. Recent changes to CMS regulations will probably make it difficult to take on plan of care development administratively, as CMS is looking to separate service planning for home and community-based services from both payor and provider. The other remaining functions are difficult to separate from one another, and CMS expects core case management services to be offered as a service, not administratively.

Both waiver case management and targeted case management are subject to the Medicaid freedom of choice requirement that recipients be allowed to choose any qualified provider enrolled in Medicaid and offering the service. This limits states' ability to contract for waiver care coordination/case management. States can restrict freedom of choice using separate waiver authority under 1915(b) of the Social Security Act. Specifically, under 1915(b)(4), states can limit the number of providers of a service or group of services and contract with one or more providers directly. This requires CMS approval of the waiver, and the state must assure that services are adequate to provide timely access, provide adequate utilization and quality monitoring, and demonstrate efficiency and cost effectiveness.

This option offers some potential long term. However, recent changes to CMS regulations will require that Alaska substantially change its model of care coordination to come into compliance with new

person-centered planning requirements, including conflict-free care planning and case management. Alaska is currently in the process of analyzing what changes will be required to comply fully with the new regulations. Until that analysis is completed in early 2015, it is difficult to determine how use of a 1915(b) waiver to contract for care coordination would impact the program or analyze potential cost savings. It is likely that the majority of cost savings would come from improved control of service utilization, as care coordination itself represents a very small percentage of waiver expenditures.

#12

**Reduce benefits to
essential benefit plan
(or state plan benefits
only)**

Essential Health Benefits Comparison

The Affordable Care Act mandated a list of essential health benefits. Each State is required to establish and select a benchmark plan to represent that state's compliance with the ACA. Medicaid programs across the nation are now reviewing their benefit plan design comparing coverage with the ACA and benchmark plan. By doing so, Alaska like other states may improve benefit plan design and better control costs to more effectively improve the health and wellness of the Alaska populations served.

Alaska Statute 47.07.036 requires the Department to first ensure that they have complied with prescribed cost containment measures prior to the elimination or reduction in optional services. Under this statute the cost containment measures may include:

- New utilization review procedures,
- Changes in provider payment rates,
- Precertification requirements for coverage of services; and
- Agreements with the federal officials under which the federal government will assume responsibility for coverage of some individuals or some service for some individuals through such federal programs as the Indian Health Service or Medicare.

If these cost containment measures are insufficient to reduce costs then the state may, to the extent federally authorized, reduce optional service or reduce eligibility to optional Medicaid groups.

Medicaid Advisory Reform Group recommendation for analysis: Reduce benefits to essential benefit plan (or state plan benefits only)

Alaska's elected benchmark plan is Premiera Blue Cross Blue Shield of Alaska. When comparing the Alaska benchmark plan services with Alaska Medicaid services the following services, shown in Table 1 below, were identified as being provided by Medicaid and not by the benchmark plan. While services may be offered under both the benchmark plan and Medicaid, which does not mean that they are equal services. They may have different limits on amount of services offered. A full review/comparison of all benefit rules for each service could not be conducted within the timeline required of this project.

Some of the benefits, while optional under Medicaid, are currently required by State Statute. Some benefits are offered under Medicaid because they have been identified as cost saving measures. And, certain benefits are subject to Early Periodic Screening Diagnostic Treatment (EPSDT) rules which state, "Any Medicaid eligible child under 21 years of age pursuant to 1905 (r) (5) of the Social Security Act has access to necessary health care, diagnostic services, treatment and other measures described in 1905 (a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by screening services, whether or not such services are covered under the state plan". For reference to which services are impacted by the above requirements please see benefit rules (column F) in Table 1 below.

Table 1. *Alaska Benchmark plan v. Medicaid (Fee for Service)

AK Essential Health Benchmark Plan				AK Medicaid Program		
A Benefit	B Covered Y/N	C Benefit Rules	D Covered Y/N	E Adults &/or Children	F Benefit Rules	
Routine Dental Services (Adult)	N		Y	Adults	Limit: \$1,150 per recipient (combined limit); 7 AAC 110.145 – Garner v. State, DH&SS (2003)	
Long-Term/ Custodial Nursing Home Care	N		Y	Adults & Children	Other Rule(s): Requires service authorization and determination of level of care. Mandatory Medicaid covered service.	
Private-Duty Nursing	N		Y	Adults & Children	Limit: Private Duty Nursing services are limited to recipients less than 21 years of age – Mandated under Early and Periodic Screening, Diagnostic and Treatment (7 AAC 110.200)	
Routine Eye Exam (Adult)	N		Y	Adults	Limit: One vision exam per calendar year, any vision exam if medically necessary as determined by service authorization, one pair of glasses per calendar year, one additional pair of glasses if medically necessary as determined by service authorization. (7AAC 110.705 (c))	
Bariatric Surgery	N		Y	Adults & Children	Other Rule(s): Medical justification & service authorization required	
Routine Foot Care	N		Y	Adults & Children	Limit: Podiatry services are limited to: - recipients less than 21 years of age and only if rendered by a podiatrist; or - recipients less than 21 years of age or who are Medicare recipients and only if rendered by a physician Mandated under Early and Periodic Screening, Diagnostic and Treatment (7 AAC 110.200)	
Weight Loss Programs	N		Y	Adults & Children	Coverage: Medical treatment of obesity excluding supplements and food	
**Personal Care Assistance	N		Y	Adults & Children		
Targeted Case Management	N		Y	Adults & Children	Case Management is currently utilized as a cost savings tool	

AK Essential Health Benchmark Plan				AK Medicaid Program		
A Benefit	B Covered Y/N	C Benefit Rules	D Covered Y/N	E Adults &/or Children	F Benefit Rules	
Non-Emergent Transportation & Accommodations	N		Y	Adults & Children	Mandatory Medicaid covered service	

*Attached is a complete list of benefits offered by both Medicaid and the Essential Health Benefit Plan – Tab 1.

**Personal Care Assistance (PCA) is considered a less restrictive alternative to a nursing facility. PCA services were excluded from the fiscal impact analysis – removal as a Medicaid benefit would require a comprehensive evaluation of all long term care services and thus was deemed as being beyond the scope of this project

Fiscal Analysis: For those services identified the Department must determine if modifications in services to the Medicaid benefit package will both improve health care quality and lower costs in the program. Medicaid's annual expenditures on the following services are listed below: Adult Dental, Vision benefits for Adults, Bariatric Surgery. The expenditures are shown separating non-Indian Health Services and Indian Health Services. Federal Financial Participation for Indian Health Services is 100%.

Additionally, the State would benefit from leveraging their partnership with the Medicaid Evidence based Decision project (MED) to examine the latest cost-effectiveness research and value-based benefit design initiatives to see what lessons can be gleaned for Alaska Medicaid.

Table 2. FY2013 Adult Dental Services

Population	Summed Payment Amount
Non-Indian Health Services	\$18,084,120.87
Indian Health Services*	\$4,622,364.88
Grand Total	\$22,706,485.75

* includes IHS Adult settlement payments

Table 4. FY 2013 Bariatric Surgery+

Population	Summed Payment Amount
Non-Indian Health Services	\$86,082.30
Indian Health Services	\$17,326.36
Grand Total	\$103,408.66

Table 3. FY2013 Adult Vision Services

Population	Summed Payment Amount
Non-Indian Health Services	\$2,188,924.88
Indian Health Services	\$761,250.37
Grand Total	\$2,950,175.25

There are no services in Medicaid specifically called weight loss services. A recipient may have a physician visit covered under Medicaid with a diagnosis of morbid obesity. Under most circumstances a person with the diagnosis of morbid obesity also may have other diagnosis that justifies a physician visit, such as diabetes, or heart disease. Therefore no fiscal analysis could be done to reflect costs for a specific weight loss program. Medical treatment of obesity is covered; however supplements and food are not.

#13

**Eliminate loophole
allowing responsible
relatives refusing to
financially support
relative so the relative
can obtain Medicaid**

Medicaid Reform Advisory Group

Medicaid Innovation List:

#13 “Eliminate the loophole that allows for legally responsible relatives (spouse, parent) to refuse to financially support them in order for the other relative (spouse, child) to obtain Medicaid.”

Exceptions to Medicaid Eligibility Requirements

AS 47.07.020 Eligible Persons

(b)(3): persons under 21 years of age who are under supervision of the department, for whom maintenance is being paid in whole or in part from public funds, and who are in foster homes or private child-care institutions;

(b)(5): persons under 21 years of age who are in an institution designated as an intermediate care facility for the mentally retarded and who are financially eligible as determined by the standards of the federal program designated as the successor to the aid to families with dependent children program;

(b)(7): persons under 21 years of age who are receiving active treatment in a psychiatric hospital and who are financially eligible as determined by the standards of the federal program designated as the successor to the aid to families with dependent children program

(b)(10): persons under 21 years of age not covered under (a) of this section who the department has determined cannot be placed for adoption without medical assistance because of a special need for medical or rehabilitative care and who the department has determined are hard-to-place children eligible for subsidy under AS 25.23.190 – 25.23.210; and

7 AAC 100.112

(b): if a dependent child or caretaker relative is absent 30 days or more for a reason listed in (a) of this section, that child or caretaker relative may not be included as a member of the Family Medicaid household.

Children in Residential Treatment

Prior to implementation of the Affordable Care Act (ACA) and the new Modified Adjusted Gross Income (MAGI) test, if a child was in an institution for 30 days, Medicaid policy was to disregard the income of the other household members and only considered the income of the child when determining Medicaid eligibility (AS 47.07.020(b)(3) above). With the implementation of the new MAGI rules related to this population household income is now counted toward the child’s eligibility and this “loophole” was effectively closed.

The Division of Health Care Services indicates expenditures of approximately \$31 million in Medicaid costs for children in residential treatment facilities in FY2013. The Division of Behavioral Health indicates 622 children were served in psychiatric residential treatment during that time period.

Of this amount, 165 children qualify under rules for foster care or were not in treatment over 30 days. Of the remaining 457 children, the Division of Public Assistance estimates that 10% (5 children) will lose eligibility over the course of the year (FY2014) as their eligibility renewal date comes up. The 457ⁱ children represent \$25.9 million in Medicaid expenditures. The 10% that will lose their eligibility represent \$2.6 million of that amount. This represents a potential savings of \$1,105,000 in General Fundsⁱⁱ.

The potential for change:

The Department of Health and Social services could potentially submit a State Plan Amendment (SPA) to go back to the exemption that used to apply to this category of children. This is both a financial issue and a family preservation issue as the child is no longer considered a member of his/her family's household and becomes a ward of the state under the exemption. Such a request would, once again, disregard the income of the family when it comes to determining eligibility for the child. The effect would be to make the children that lost eligibility under MAGI once again eligible for Medicaid. If this course of action was taken; these are the potential positive and negative effects.

Possible Positive:

- Re-establish Medicaid reimbursed services for the children that lost eligibility due to MAGI.

Possible Negative:

- Effects family preservation in that children would no longer be counted in the household of their family and would become wards of the state;
- Effects length of stay as families have a vested interest to shorten the length of stay when they are financially reasonable for the care;
- Decreases family involvement in the ongoing health of their child; and
- Ignores the question of cost of care. If a family has the capacity to pay for care for their child, should they be paying? Under the exemption ruling, families could simply have their children committed to residential care and the financial burden of care was passed to the state.

ⁱ Average cost per child in residential treatment is \$56,768 annually.

ⁱⁱ A blended match rate of 57.5% was used as some children are eligible under Title XXI at 65% match and others are eligible under Title XIX at 50% match.

#15

**Utilization Limits for
Physical Therapy,
Occupational Therapy,
Speech Therapy &
Speech-Language
Pathology**

Alaska Medicaid Coverage for PT, OT and ST: Background Information and Recommendations for Utilization Limits

Background: Outpatient treatments such as physical, occupation and speech therapy help some patients improve function, but long-term benefits may be limited. A recent MED analysis found little evidence that ongoing PT following knee or hip replacement improves outcomes, while another found that many young children with speech problems are likely to do as well with parent-directed care as with professional ST.

Such treatments are expensive. Reimbursements for “Therapy and Rehabilitation” have accounted for up to 2% of Alaska Medicaid spending, or roughly \$30M annually. Placing tighter limits on coverage could produce significant savings, though an exact amount is hard to predict. While some of services are optional (e.g., post-operative therapy for adults) others may be required under EPSDT. Also, limiting treatments for some beneficiaries could in theory increase other cost—for example, a waiver client whose ongoing home based therapy may be allowing him or her to remain in a lower cost, non-SNF setting.

Current Coverage: HCS currently has only modest limitations on the types and frequency of therapy covered. State regulations specify which beneficiaries are eligible for services, who must prescribe them, and who may provide them. Therapists or facilities are required to be enrolled, treatment plans need to be approved by prescribers, and renewals are required every 6-12 months for children and monthly for adults. However, so long as treatment plans are current and recipients are improving, ongoing therapy is usually covered.

Alternative Policy Approaches: Coverage limits for therapy in other plans varies, both in the public and private sector. While some insurers use medical necessity criteria to authorize initial outpatient treatment, most seem to limit utilization through benefit design. For example, many carriers allow a set of initial visits based just on a prescribed therapy plan—typically six hours (e.g. six hour-long visits or 12 half-hour visits) or unlimited visits for 60 days. Beyond these initial visits some plans allow no extra therapy while others require PA for ongoing treatment.

In terms of other Alaskan coverage, the state’s DOA plan (AlaskaCare) allows an unlimited number of visits annually with minimal prior authorization. Likewise, traditional Medicare in Alaska has few if any utilization limits for therapy once a treatment plan is prescribed or renewed. Premera Alaska’s Bronze and Silver Exchange plans both allow 25 visits per year for each therapy, apparently with minimal medical necessity review.

QUALIS previously performed medical necessity determinations for some Medicaid plans to PA initial therapy, but it reports that that most clients found that savings were limited by the extra

administrative work, and have generally moved to manage the benefit—at least initially—through plan design.

Coverage for Washington and Colorado Medicaid are examples of this approach—both allow 24 initial “units” (generally six hours) with a valid treatment plan, then require PA review for additional visits. In Washington, the medical necessity review for ongoing care is done in-house by nurses who approve a limited number of additional treatments (usually another six hours) if patients are continuing to improve function and are moving clearly toward a home based self-care program.

Recommendations and Discussion: Alaska Medicaid should transition to more tightly limit PT, OT and ST coverage, primarily through plan design. HCS should implement six hour annual outpatient limits for each of the therapies. Coverage for initial visits would continue to be based on a valid treatment plan, as is currently required. A medical necessity review to PA additional visits (e.g., another six hours) should be implemented for children 21 years or less and for adults on waiver.

The authorization process for additional visits could be administered within HCS using existing detailed InterQual type criteria sets, or using more general medical necessity rules such as those used in Washington State. Alternatively, if HCS has extra resources it could contract out the PA process for additional visits to a vendor such as QUALIS or to another private vendor who specializes in this type of review (e.g., Orthonet).

It would be difficult for HCS to develop its own detailed medical necessity criteria in-house due to the wide variety of specific indications for different therapies, each of which would likely need its own evidence review. Also, determinations based on standardized criteria sets may be easier to defend at fair hearing than criteria developed in house without specialty input. Nonetheless, the general type of medical necessity criteria such as that used by Washington State should suffice for Alaska as well.

Finally, regardless of whether the medical necessity determinations are done in-house or by an outside agent, the most cost effective approach would likely be to allow coverage for the first six hours of visits based just on current HCS requirements. This approach should minimize the staffing resources needed to process PAs, since many beneficiaries are unlikely to need or want additional treatment beyond the initial set. Also, this approach is consistent to that of other state Medicaid programs, and might therefore generate fewer appeals or legal challenges from advocacy groups.

NAMPI- 2014 take-aways:

OPTUM

Optum currently has a contract with Xerox for EFADS (this is the system which extracts SURS data to present to DHCS SURS. This was a separate "users" meeting before the conference started. They didn't have a PowerPoint presentation however I did get several copies of their booklet which describes a number of studies with methodologies and results. Some of these will be incorporated into SURS research in the future. Some of the topics discussed:

- Ambulance ALS vs BLS services
- Methadone – inappropriate prescribing
- Pharmacy refills in last week of month
- PCA's
- Chiropractor Upcodeing
- Unnecessary cardiac tests
- Chore providers
- Therapeutic ultrasounds & message therapy
- Hospital in focus (duplicate billing as the Dentists on same DOS)

PowerPoints from presentations given are saved to the N drive: N:\NAMPI\NAMPI 2014

I wasn't able to attend all sessions as they usually had five scheduled at the same time. I encourage everyone to look over the list for topics that may help you in your work.

#18

**Medicaid fee-for-
service increase co-
pays, add new co-pays,
increase annual cap**

Medicaid Advisory Reform Group recommendation for analysis: For Medicaid fee-for-service, increase co-pays, adds new co-pays, increase annual cap.

Policy Overview:

Literature on impact of cost sharing suggests, that even small incremental changes in co-payments can have unintended consequences in low income populations such as reducing utilization of important treatments and services. However modifying copayment to align prices with selective health benefits may add value to the Medicaid service design. For example, exemptions from copayment for primary care visits for adult with chronic diseases.

Federal Cost Sharing rules establish the criteria by which the state is allowed to set cost sharing amounts, and who is subject to the cost sharing amount. The Affordable Care Act (ACA) modified the cost sharing¹ rules for Medicaid effective January 1, 2014. The state may opt to establish, at or below the amounts shown below in Tables 1 and 3, cost sharing for any service (other than for drugs and non-emergency services¹¹ furnished in an emergency department).

When evaluating the impact of the ACA cost sharing rules to State Statute, Regulations and system design (MMIS/Enterprise), the department may waive the cost sharing charges otherwise required (AS 47.07.042 (c) if the department determines that the maximum allowable charges per service would either not reduce state expenditures, or would generate insignificant savings to the state in relation to the total cost containment possible. The State’s current cost sharing amounts are shown in Table 2 and 4.

Table 1. Affordable Care Act Cost Sharing Maximum Allowable Cost Sharing

Services	Maximum Allowable Cost Sharing		
	Individuals with family income at or below 100% of the FPL	Individuals with Family income 100 - 150% of the FPL	Individuals with family income above 150% of the FPL
Outpatient Services (physician visit, physical therapy, etc.)	\$4	10% of cost the agency pays	20% of cost the agency pays
Inpatient stay	\$75	10% of total cost the agency pays for the entire stay	20% of total cost the agency pays for the entire stay.

Table 2. Alaska Cost Sharing Rule

Services	Alaska Cost Sharing
	All Medicaid Eligible Individuals
Inpatient Hospital Services	\$50 per day up to a Maximum of \$200 per discharge
Outpatient hospital services	5% of allowable charges
Physician Services	\$3.00 per day

Table 3. Affordable Care Act Cost Sharing for Drugs

Services	Maximum Allowable Cost Sharing	
	Individuals with Family Income at or below 150% of the FPL	Individuals with Family income above 150% of the FPL
Preferred Drugs	\$4	\$4
Non-Preferred Drugs	\$8	20% of the cost the agency pays.

Table 4. Alaska Cost Sharing for Drugs

Services	Maximum Allowable Cost Sharing
	All Medicaid Eligible Individuals
Prescription under \$50	\$.50 cents
Prescription over \$50	\$ 3.50 dollars

Increase Co-Pays/Add new Co-Pays:

Policy Analysis:

In order to increase co-pays and add new co-pays the Department must first assure that they are in compliance with the new cost sharing rules. To comply with the new Federal cost sharing rules Alaska's cost sharing structure must undergo a number of modifications. Attached is spreadsheet that provides a detailed impact analysis. And below are a few examples of potential impact to Alaska.

Pharmacy:

Drug cost sharing rules in Alaska are based upon a 2 tier prescription drug cost. It is possible that a prescription cost could fall below the allowable cost sharing (prescription costing less than \$.50 cents) therefore the State would out of compliance with 42 CFR 447.52(c) "in no case shall the maximum cost sharing exceed the amount the agency pays."

Additionally the State must analyze the impact of 42 CFR 447.53(e) to see if the 2 tier cost sharing (based on cost of drug) is impacted by this preferred/non-preferred rule.

Provider payment:

Federal Regulations (42 CFR 447.56(c)) requires the agency to deduct cost sharing with 2 exceptions that exempt specific services from cost sharing. Implementation requires modifications to the States Enterprise system.

Fiscal Impact:

The State is actively analyzing the current cost sharing system. Increasing cost sharing for recipients can occur as long as the increase is complies with Federal Regulation and the costs to the State to change Statute, Regulation and systems do not exceed the benefit that the increase in cost sharing would bring to the Department. Additionally, the Department may consider how the application of co-pay rules could be modified to encourage such things as preventive services or use of very effective, low-cost drugs.

Increase the Cap for Co-Pays:

Policy Analysis:

The requirements for the annual cap on recipients cost sharing have changed with the implementation of the Affordable Care Act. New aggregate limits for cost sharing require the Department to make both systems and regulation changes. These changes include:

- (1) Medicaid premiums and cost sharing incurred by all individuals in the Medicaid household may not exceed an aggregate limit of 5 percent of the family's income applied on either a

quarterly or monthly basis, as specified by the agency.

(2) If the state adopts premiums or cost sharing rules that could place beneficiaries at risk of reaching the aggregate family limit, the state plan must indicate a process to track each family's incurred premiums and cost sharing through an effective mechanism that does not rely on beneficiary documentation.

(3) The agency must inform beneficiaries and providers of the beneficiaries aggregate limit and notify beneficiaries and providers when a beneficiary has incurred out-of-pocket expenses up to the aggregate family limit and individual family members are no longer subject to cost sharing for the remainder of the family's current monthly or quarterly cap period.

(4) The agency must have a process in place for beneficiaries to request a reassessment of their family aggregate limit if they have a change in circumstances or if they are being terminated for failure to pay a premium.

(5) Nothing in paragraph (f) shall preclude the agency from establishing additional aggregate limits, including but not limited to a monthly limit on cost sharing charges for a particular service.

The current Enterprise system does not have the capacity to meet this requirement. Thus increasing the Cap for Cost Sharing without the ability to accurately track 1) family income and 2) when they meet their cost sharing cap, could result in the state being out of compliance with Federal Regulations.

Fiscal Impact: The intention of the Department is to apply the maximum Cap for co-pay allowed by Federal Rules. The Department is not able to provide specific cost savings associated with this recommendation at this time.

ⁱ Co-pays for Medicaid are referred to as Cost Sharing.

ⁱⁱ Non-emergency services means any care or services that are not considered emergency services. The does not includes any services furnished in a hospital emergency department that re required to be provided as an appropriate medical screening examination or stabilizing examination and treatment.

#19

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

MEDICAID REFORM ADVISORY GROUP—Follow-up

Item 19--Allow aged and permanently disabled with fixed incomes to be automatically renewed based on cost of living increases.

Methodology:

- Identify 5-year average number of eligible individuals for programs that include permanently disabled and/or aged
- Multiply by the average amount of time to complete eligibility determination
- Multiplied by the average hourly wage for an Eligibility Technician

Auto-Renewals for Permanently Disabled and Blind:

PROGRAM	5-YR Avg Caseload	X 1.5 hrs. Length of Time for Renewal App	X \$21.46 Avg hourly rate for Eligibility Technician	Total Approximate Cost Reduction for Auto-Renewal
Adult Public Assistance	12,968	19,452	\$417.4	\$417.4
Supplemental Nutrition Assistance Program	6,465	9698	\$208.1	\$208.1
Medicaid	4,586	6,879	\$147.6	\$147.6
Senior Benefits	N/A	N/A	N/A	N/A
Temporary Assistance to Needy Families	69	103.5	\$2.2	\$2.2
			<u>TOTAL</u>	<u>\$775.3</u>

Auto-Renewals for Aged:

PROGRAM	5-YR AVG Caseload	X 1.5 hrs. Length of Time for Renewal App	X \$21.46 Avg hourly rate for Eligibility Technician	Total Approximate Cost Reduction for Auto-Renewal
Adult Public Assistance	5,610	8,415	\$180.6	\$180.6
Supplemental Nutrition Assistance Program	3,099	4,648	\$99.7	\$99.7
Medicaid	5,406	8,109	\$174.0	\$174.0
Senior Benefits	11,254	16,881	\$362.3	\$362.3
Temporary Assistance to Needy Families	N/A	N/A	N/A	N/A
			<u>TOTAL</u>	<u>\$816.6</u>

Total Approximate Reduction of Costs Associated with Auto-Renewal:

	Approximate Cost Reduction for Auto-Renewal
Permanently Disabled and Blind	\$775.3
Aged	\$816.6
<u>TOTAL</u>	<u>\$1,591.9</u>

#20

**Expand scope of
practice for RNs, LPNs
& Home Health Aids**

Brodie, Margaret C (HSS)

From: Christensen, Cindy L (HSS)
Sent: Thursday, August 21, 2014 9:36 AM
To: Brodie, Margaret C (HSS)
Subject: MRAG

Margaret,
Here is the response for the MRAG #20

Expand the scope of practice for RNs, LPNs and home health aides to improve access to services and decrease associated costs in delivering services.

The Medicaid program pays for services provided by RNs, LPNs, and home health aides, either directly or as rendering providers or to providers under whom the individuals are employed, to the fullest extent of their Alaska licensure and/or certification. Scope of practice expansion does not fall within the regulatory authority of the Medicaid program.

#21

**Limit total Medicaid
spending to no greater
than 4% annual growth**

Medicaid Advisory Reform Group recommendation for analysis: Limit total Medicaid Spending to no more than 4%

Background:

Alaska Medicaid spending has historically had a 7% growth rate and is projected to increase by 6.45% per annum.

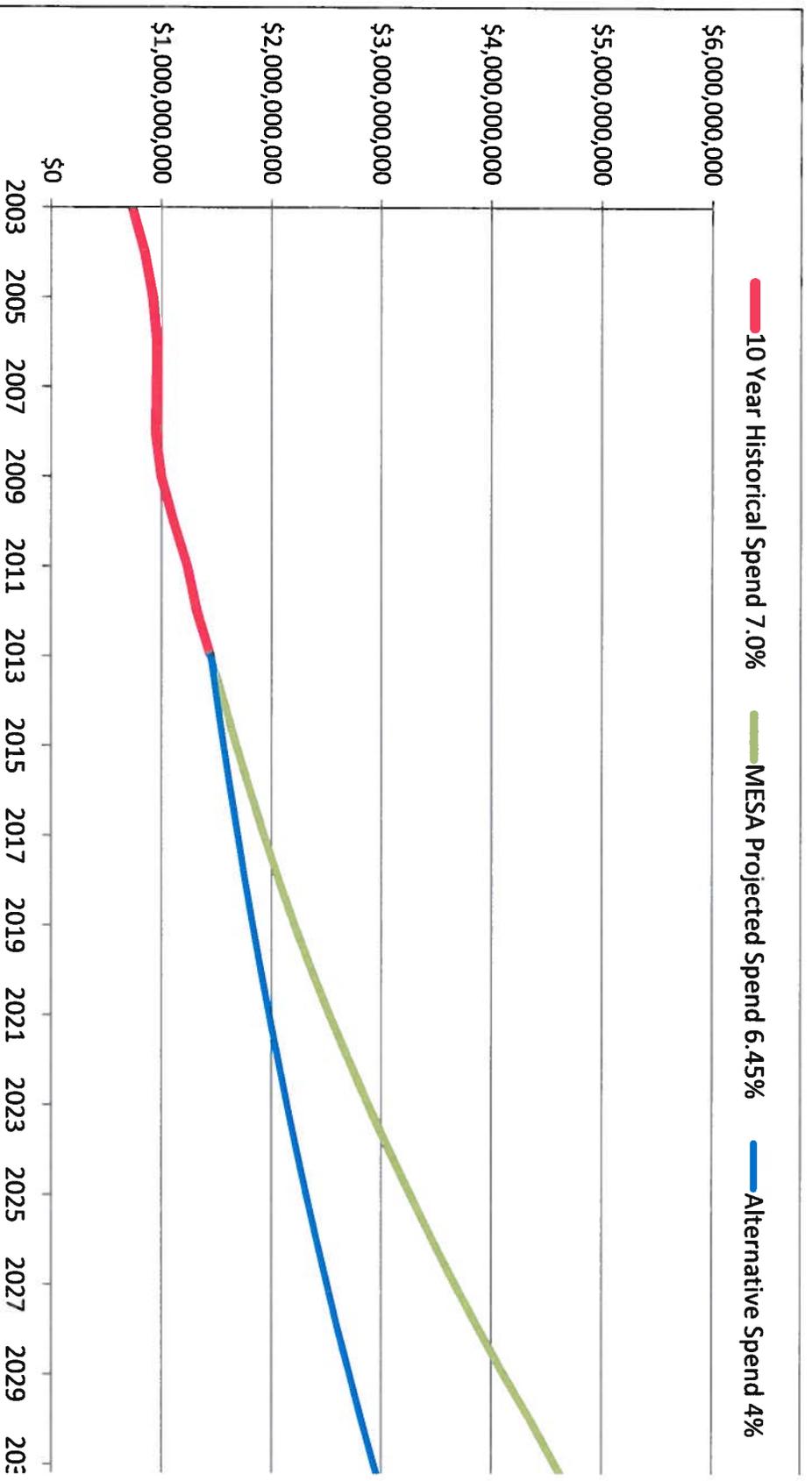
The numbers behind the spending:

Growth Rate: 4.0%

Calendar Year	10 Year		
	Historical Spend 7.0%	MESA Projected Spend 6.45%	Alternative Spend 4%
2003	\$735,088,329		
2004	\$846,729,560		
2005	\$921,771,345		
2006	\$957,948,057		
2007	\$953,638,057		
2008	\$947,427,035		
2009	\$998,133,090		
2010	\$1,111,501,197		
2011	\$1,237,537,630		
2012	\$1,323,775,378		
2013	\$1,447,522,807	\$1,447,522,807	\$1,447,522,807
2014		\$1,567,360,813	\$1,505,423,719
2015		\$1,681,022,937	\$1,565,640,668
2016		\$1,804,828,811	\$1,628,266,295
2017		\$1,932,988,788	\$1,693,396,947

2018	\$2,068,426,282	\$1,761,132,824
2019	\$2,213,103,316	\$1,831,578,137
2020	\$2,367,478,744	\$1,904,841,263
2021	\$2,532,062,637	\$1,981,034,913
2022	\$2,704,634,250	\$2,060,276,310
2023	\$2,884,193,256	\$2,142,687,362
2024	\$3,070,342,623	\$2,228,394,857
2025	\$3,264,821,364	\$2,317,530,651
2026	\$3,464,416,606	\$2,410,231,877
2027	\$3,672,384,635	\$2,506,641,152
2028	\$3,889,714,308	\$2,606,906,798
2029	\$4,116,822,770	\$2,711,183,070
2030	\$4,354,045,985	\$2,819,630,393
2031	\$4,577,695,924	\$2,932,415,609
2032	\$4,810,108,469	\$3,049,712,233
2033	\$5,050,277,215	\$3,171,700,722

Avg Annual Growth Rate: 7.01% 6.45% 4.00%



Spending Cap:

Medicaid is an entitlement program, so in order to keep the increase to only 4% we have to control utilization. This can be done through all the ideas that MRAG will be working on, by regulatory changes, prior authorizations, and by capping utilization. These changes have been unpopular but necessary to ensure that the program stays within budget.

#22

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

22. 1915(k) Community First Choice Option for Home and Community-Based Services

Section 1915(k) of the Social Security Act gives states a different option for providing home and community-based attendant services and supports under the Medicaid program. Although the option references attendant services, the actual language and policy guidance suggests that a wide range of services now provided under home and community-based waivers could be included under the 1915(k) option, though not all. It can cover hands on assistance, supervision and cueing, and back-up systems or mechanism for continuity of care and support. It can't cover assistive technologies, medical supplies and equipment, or home modifications. It is limited to people who meet an institutional level of care (like our present waivers) and must include a strong self-direction component. In the first year, states must maintain or exceed their level of spending on home and community-based services and supports.

It also comes with an enhanced federal match rate: an additional 6%. This enhanced match represents an opportunity for Alaska to save General Funds while maintain the same level of service.

If Alaska were to adopt the 1915(k) option to replace as much as possible the service provided through the current 1915(c) waivers and the personal care program, the enhanced federal match would be significant. **Currently, 1215 individuals receiving personal care services are receiving waiver services. The average cost of personal care is \$23,811. If Alaska converted only personal care for waiver recipients, the additional 6% federal match on this cost alone would result in a General Fund savings of \$1.7 million.**

Not all waiver services could be converted to 1915(k), and given the small number of states using the option and the short amount of time it has been available, it is uncertain exactly how much of Alaska's waiver services could be converted to 1915(k). However, the waiver services of residential and day habilitation, chore, respite, adult day care, and residential supported living most closely fit the definition of hands on assistance, supervision and cueing. **In FY 13, DHSS spent \$221 million on these services. If they could be shifted to 1915(k), the additional 6% match would result in a General Fund savings of \$13.3 million. The General Fund savings obtained by converting both personal care and waiver services would total \$15 million per year.**

Developing the 1915(k) option could not be done overnight. To develop a state plan amendment for CMS approval, a state must establish a Development and Implementation Council. The majority of the Council's membership must be individuals with disabilities, elderly individuals, and their representatives. The state plan amendment must address a number of factors, including the specific services and supports to be covered, the provider qualifications, and the state's quality assurance plan. At the state level, regulations would be needed and a transition plan would need to be developed for how individuals transitioned from their current services to 1915(k) services. Modifications would need to be made to the MMIS to add the new service. Providers would need to be certified and enrolled in the new service categories. It would be comparable to the effort required to develop Alaska's 1915(c) waivers, which took approximately three years from inception to service delivery, with dedicated project staff.

#23

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



TO: Jared C. Kosin, Executive Director, ORR
FROM: Katherine Tompkins, Audit Supervisor, ORR
DATE: August 19, 2014

RE: Inflationary One Year Freeze (FQHC, Physician, HCB & PCA)

Analysis

<u>Category</u>	<u>State Savings</u>
Physician Services	1,466,948.70
FQHC/RHC	79,383.00
HCBW/PCA	4,508,644.86
TOTAL STATE SAVINGS	\$6,054,976.56

Below are the rate calculations for the savings to the state for the three categories.

1. Physician Services

Estimated Expenditures

The estimated expenditures are taken from the budget document titled Auth FY13 Final Recon.pdf. These expenditures exclude IHS expenditures.

Collocation Code	Total Projected Year End Expenditure
Physician Services	\$ 104,782,050.00
TOTAL PHYSICIAN	\$ 104,782,050.00

Inflation Factor

Per regulation 7 AAC 145.050(b)(3), the conversion factor portion of RBRVS is adjusted annually by the Consumer Price Index for all Urban Consumers (CPI-U). The most recent CPI-U for Anchorage are 3.1%, 2.2% and 3.2% for 2013, 2012 and 2011 respectively. This results in an average rate of 2.8% for the last three years.

**Consumer Price Index for Anchorage Municipality & U.S.
Not Seasonally Adjusted
All Items - All.1 Urban Consumers
(CPI-U) 1960-Present**

Year	1st Half (Jan-Jun)				2nd Half (Jul-Dec)				Annual			
	Anchorage		U.S.		Anchorage		U.S.		Anchorage		U.S.	
	Average	Percent Change From Same Half Previous Year	Average	Percent Change From Same Half Previous Year	Average	Percent Change From Same Half Previous Year	Average	Percent Change From Same Half Previous Year	Average	Percent Change From Previous Year	Average	Percent Change From Previous Year
2014	214.777	1.9	236.384	1.7								
2013	210.853	2.7	232.366	1.5	213.910	3.5	233.548	1.4	212.381	3.1	232.957	1.5
2012	205.215	2.5	228.850	2.3	206.617	2.0	230.338	1.9	205.916	2.2	229.594	2.1
2011	200.278	2.8	223.598	2.8	202.576	3.6	226.280	3.5	201.427	3.2	224.939	3.2

Savings Calculation

1. Calculate Projected Expenditures

2013 Estimated RBRVS Expenditures	Regular FMAP (50%)	\$ 104,782,050.00
3 Year Average CPI-U Anchorage		2.8%
Projected RBRVS Expenditures		\$ 107,715,947.40

2. Calculate Total Savings

Projected RBRVS Expenditures	\$ 107,715,947.40
Minus 2013 RBRVS Expenditures	\$ 104,782,050.00
Total Savings	\$ 2,933,897.40

3. Calculate State Savings

Total Savings	\$ 2,933,897.40
State Percentage (100%- FMAP)	50%
State Savings	\$ 1,466,948.70

2. FQHC/RHC

Estimated Expenditures

The estimated expenditures are taken from the budget document titled Auth FY13 Final Recon.pdf. These expenditures exclude IHS expenditures.

Collocation Code	Total Projected Year End Expenditure
Rural Health Clinic	\$ 1,560,277
Federal Qualified Health Ctr	\$ 6,498,904
TOTAL FQHC/RHC	\$ 8,059,181.00

Inflation Factor

FQHC/RHCs have two separate inflation factors depending on if they have a cost based rate or the MEI rate. Providers with a cost based rate receive an inflation factor from Global Insight's Skilled Nursing Facility Market Basket. Providers with an MEI rate receive the Medicare Economic Index inflation factor. In order to determine a single inflation factor to use, the following steps were taken:

1. Use a three year average to determine an estimated MEI rate.

2012	CMS MEI Inflation Factor	0.6%
2013	CMS MEI Inflation Factor	0.8%
2014	CMS MEI Inflation Factor	0.8%
	3 Year Average	<u>0.73%</u>

2. Determine the inflation factor for SFY2015 from Global Insight's Skilled Nursing Facility Market Based

2015:2 Global Insights Skilled Nursing Facility Total Market Basket CY	<u>2.4%</u>
--	-------------

3. Determine the percentage of UOS that are cost based and on the MEI using CY13 Claims data.

	CB	MEI
Alaska Island Comm. Services, DBA Wrangell Comm. Svs.		1,624
Anchorage Neighborhood Health Center	11,743	
Bethel Family Clinic	1,370	
Camai Community Health Center		159
Crossroads Medical Center	922	
Eastern Aleution Tribes, DBA Whittier		39
Illiuliuk Family & Health Center		239
Interior Community Health Center	5,871	
Kodiak Island Health Care Foundation	3,148	
Mat-Su Health Services, Inc		2,662
Municipality of Skagway, DBA Dahl Memorial Clinic		196
Peninsula Comm. Health Svs, DBA Cottonwood Health Ctr		3,755
Sunshine Community Health Center	1,589	
	<u>24,643</u>	<u>8,674</u>
	<u>74.0%</u>	<u>26.0%</u>

4. Calculate a single inflation factor using the percentages for cost based & MEI multiplied by their respective inflation factors.

3 Year Average MEI	0.73%
% of UOS MEI	<u>26.0%</u>
MEI Portion	0.19%
Cost Based 2015:2	2.4%
% of UOS Cost Based	<u>74.0%</u>
Cost Based Portion	1.78%
MEI Portion	0.19%
Cost Based Portion	<u>1.78%</u>
Mixed Inflation Factor	<u>1.97%</u>

Savings Calculation

1. Calculate Projected Expenditures

2013 Estimated FQHC/RHC Expenditures	Regular FMAP (50%)
	\$8,059,181
Mixed Inflation Factor	1.97%
<u>Projected FQHC/RHC Expenditures</u>	<u>\$8,217,947</u>

2. Calculate Total Savings

Projected FQHC/RHC Expenditures	\$8,217,947
Minus 2013 FQHC/RHC Expenditures	<u>\$8,059,181</u>
Total Savings	\$158,766

3. Calculate State Savings

Total Savings	\$158,766
State Percentage (100% - FMAP)	<u>50%</u>
State Savings	\$79,383

3. HCB Waiver & PCA

Estimated Expenditures

The estimated expenditures are taken from the budget document titled Auth FY13 Final Recon.pdf. These expenditures exclude IHS expenditures.

Acct	Total Projected Year End Expenditure
Total Adult Disabled Waiver	\$ 12,926,320
Total Children w/Med Compl. Cond. Waiver	\$ 11,149,888
Total Mentally Retard/Dev. Disabled Waiver	\$ 143,274,290
Total Older Alaska Waiver	\$ 83,991,155
Total Personal Care Services	\$ 126,703,079
Total HCB/PCA Expenditures	\$ 378,044,732

	Total Projected Year End Expenditure
IHS AD Waiver	\$ 4,973.00
IHS CCMS Waiver	\$ 126,287.00
IHS MRDD Waiver	\$ 1,576,783.00
IHS OA Waiver	\$ 466,252.00
IHS Personal Care	\$ 150,032.00
IHS HCB/PCA Expenditures	\$ 2,324,327.00
Total HCB/PCA Expenditures	\$ 378,044,732.00
Minus IHS HCB/PCA Expenditures	\$ 2,324,327.00
HCB/PCA non-tribal Expenditures	\$ 375,720,405.00

Inflation Factor

The inflation factor for Home and Community Based Waiver and Personal Care Attendant services is Global Insight's Home Health Agency Market Basket

2015:2 Global Home Health Agency Total Market Basket CY	2.4%
---	------

Savings Calculation

1. Calculate Projected Expenditures

2013 Estimated non-tribal HCB/PCA Expenditures	\$ 375,720,405.00
Inflation Factor	2.4%
Projected HCB/PCA Expenditures	\$ 384,737,694.72

2. Calculate Total Savings

Projected HCB/PCA Expenditures	\$ 384,737,694.72
Minus 2013 non-tribal HCB/PCA Expenditures	\$ 375,720,405.00
Total Savings	\$ 9,017,289.72

3. Calculate State Savings

Total Savings	\$ 9,017,289.72
State Percentage (100% - FMAP)	50%
State Savings	\$ 4,508,644.86

	Non-Capital Inflation	Capital Inflation	Combined
Inpatient	\$ 133,632,950	\$ 133,632,950	
% of Total Rate	91%	9%	
Average Inpatient	\$ 121,605,985	\$ 12,026,966	
Non-Cap Inflation	1,0260	1,013	
Less FY2013 I/P	\$ 124,767,741	\$ 12,183,317	\$ 136,951,058
Projected Savings			\$ (133,632,950)
State's Share			\$ 3,318,108
Projected Savings for State			\$ 50%
			\$ 1,659,054

	LTC	LTC	
Skilled	\$ 11,214,948	\$ 11,214,948	
Intermediate	\$ 77,238,529	\$ 77,238,529	
	\$ 88,453,477	\$ 88,453,477	
% of Total Rate	89%	11%	
Average LTC	\$ 78,723,595	\$ 9,729,882	
Non-Cap Inflation	1,024	1,011	
Less FY2013 LTC	\$ 80,612,961	\$ 9,836,911	\$ 90,449,872
Projected Savings			\$ (88,453,477)
State's Share			\$ 1,996,395
Projected Savings for State			\$ 50%
			\$ 998,198

Inpatient Psych - API	\$ 3,080,729	\$ 3,080,729	
% of Total Rate	96%	4%	
Average Inpatient	\$ 2,957,500	\$ 123,229	
Inflation	1,026	1,013	
Less FY2013 I/P Psych	\$ 3,034,395	\$ 124,831	\$ 3,159,226
Projected Savings			\$ (3,080,729)
State's Share			\$ 78,497
Projected Savings for State			\$ 50%
			\$ 39,249

Outpatient Surgical	\$3,820,157		
Average ASC			
Inflation	2,40%		
Projected savings	\$91,684	\$	\$ 91,684
State's Share			\$ 50%
Projected savings for State			\$ 45,842

Total Combined Projected Savings for State \$ 2,742,343

Name of Facility	Fiscal YE	I/P Rate	% of I/P		% of I/P		LTC		Non-Capital		% of LTC	
			Non-Capital	Rate	Capital	Rate	LTC	Capital	Rate	Capital	Rate	
Alaska Psychiatric Institute	6/30	\$ 1,288.72	\$ 1,231.08	96%	\$ 57.64	4%	n/a	n/a	n/a	n/a	n/a	n/a
Bartlett Regional Hospital	6/30	\$ 3,317.61	\$ 3,012.68	91%	\$ 304.93	9%	n/a	n/a	n/a	n/a	n/a	n/a
Central Peninsula Hospital	6/30	\$ 3,678.34	\$ 3,165.67	86%	\$ 512.67	14%	\$ 455.96	\$ 438.51	96%	\$ 17.45	4%	n/a
Cordova Community Medical Center	6/30	\$ 3,804.44	\$ 3,458.42	91%	\$ 346.02	9%	\$ 849.99	\$ 817.30	96%	\$ 32.69	4%	n/a
Peacehealth Kitchikan Medical Center	6/30	\$ 2,856.27	\$ 2,720.60	95%	\$ 135.67	5%	\$ 740.61	\$ 693.63	94%	\$ 46.98	6%	n/a
Petersburg Medical Center	6/30	\$ 4,522.16	\$ 4,241.47	94%	\$ 280.69	6%	\$ 653.17	\$ 621.30	95%	\$ 31.87	5%	n/a
Sitka Community Hospital	6/30	\$ 5,273.13	\$ 5,018.90	95%	\$ 254.23	5%	\$ 884.20	\$ 851.16	96%	\$ 33.04	4%	n/a
South Peninsula Hospital	6/30	\$ 3,856.30	\$ 3,408.66	88%	\$ 447.64	12%	\$ 753.13	\$ 681.88	91%	\$ 71.25	9%	n/a
Wrangell Medical Center	6/30	\$ 2,414.62	\$ 2,317.34	96%	\$ 97.28	4%	\$ 612.24	\$ 597.54	98%	\$ 14.70	2%	n/a
Norton Sound Regional Hospital	9/30	\$ 4,727.50	\$ 4,331.21	92%	\$ 396.34	8%	\$ 981.86	\$ 947.86	97%	\$ 34.00	3%	n/a
Prestige Care & Rehab Center of Anchorage	9/30	n/a	n/a	n/a	n/a	n/a	\$ 381.65	\$ 346.48	91%	\$ 35.17	9%	n/a
Alaska Regional Hospital	12/31	\$ 3,100.52	\$ 2,823.38	91%	\$ 277.14	9%	n/a	n/a	n/a	n/a	n/a	n/a
Fairbanks Memorial Hospital	12/31	\$ 2,809.93	\$ 2,456.43	87%	\$ 353.50	13%	\$ 652.29	\$ 526.03	81%	\$ 124.26	19%	n/a
Mat-Su Regional Medical Center	12/31	\$ 2,538.48	\$ 2,319.97	91%	\$ 218.51	9%	n/a	n/a	n/a	n/a	n/a	n/a
North Star Hospital	12/31	\$ 639.77	\$ 588.49	92%	\$ 51.28	8%	n/a	n/a	n/a	n/a	n/a	n/a
Providence Alaska Medical Center	12/31	\$ 2,652.30	\$ 2,483.35	94%	\$ 168.95	6%	n/a	n/a	n/a	n/a	n/a	n/a
Providence Kodiak Island Medical Center	12/31	\$ 4,197.90	\$ 3,791.52	90%	\$ 406.38	10%	\$ 602.70	\$ 541.94	90%	\$ 60.76	10%	n/a
Providence Seward Medical Center	12/31	\$ 8,297.11	\$ 7,789.30	n/a	\$ 507.81	n/a	\$ 720.49	\$ 656.63	91%	\$ 63.86	9%	n/a
Providence Transitional Care Center	12/31	n/a	n/a	n/a	n/a	n/a	\$ 465.31	\$ 456.69	98%	\$ 8.62	2%	n/a
Providence Valdez Medical Center	12/31	\$ 6,306.25	\$ 5,209.26	83%	\$ 1,096.99	17%	\$ 630.87	\$ 535.92	85%	\$ 94.95	15%	n/a
St. Elias Specialty Hospital	12/31	\$ 2,423.72	\$ 2,008.28	83%	\$ 415.46	17%	n/a	n/a	n/a	n/a	n/a	n/a
Wildflower Court	12/31	n/a	n/a	n/a	n/a	n/a	\$ 547.52	\$ 455.22	83%	\$ 92.30	17%	n/a

Average Percentages excluding API

I/P	Non-Capital	91%	I/P	Capital	9%	LTC	Non-Capital	89%	LTC	Capital	11%
W/O API	90.5441%		W/O API	9.4560%							
w/API	90.8210%		w/API	9.1791%							

Introduction

The Office of Rate Review (ORR) was tasked with analyzing innovation item #23: an across the board rate freeze for one year. Numerous Medicaid services experience a resetting of rates in a given year. This process is specifically known as “rebasings.” Rebasings is a critical function because it allows for reimbursement rates to be revised in a way that reflects current cost data. Both the methodology and schedule for rebasing vary from service to service.

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

Medicaid Services Subject to Rate Freeze

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

Projected Impact to the State

Based on ORR’s projections, if the Department were to take all necessary steps to enact an across the board rate freeze for one year for the six service groups that receive annual inflation increases, the State would realize savings in an approximate amount of **\$8,797,319.56** (General Fund).

<u>Category</u>	<u>State Savings</u>
Physician Services	1,466,948.70
FQHC/RHC	79,383.00
HCBW/PCA	4,508,644.86
Hospital Inpatient	1,698,303.00
Long Term Care	998,198.00
Ambulatory Surgical	45,842.00
TOTAL STATE SAVINGS	\$8,797,319.56 (GF)

Key Assumptions

Expenditures

This analysis is based on total expenditures made in State Fiscal Year 2013.

Inflation

The inflationary adjustments for each of the six service groups are described in regulation. Each inflationary adjustment is based on specific inflation factors. For example, physician services are adjusted using the consumer price index, while hospital inpatient services are adjusted using two types of factors: the Global Insight Hospital Market Basket for non-capital costs; and, the Global Insight Health Care Costs Building Cost Index for capital costs. Since the inflation index varies among services, and since ORR is tasked with projecting savings based on inflation schedules that have not yet been published, it is necessary to make assumptions to determine the fiscal impact to the State. The following is a list of key assumptions concerning inflation:

Service	Projected Inflation	Methodology for Projection
• Physician Services	2.8%	Avg based on past 3 yrs of inflation
• FQHC/RHC	1.97%	Mixed Avg based on 2 indexes
• HCBW/PCA	2.4%	Projected 2015 Global Insights Infl.
• Hospital Inpatient	2.6%*; 1.3%**	Avg based on past 3 yrs of inflation
• Long Term Care	2.4%*; 1.1%**	Avg based on past 3 yrs of inflation
• Ambulatory Surgical	2.4%	Avg based on past 3 yrs of inflation

* Inflation on Non-Capital Costs (non-capital costs are about 91% of total allowable costs)

** Inflation on Capital Costs (capital costs are about 9% of total allowable costs)

Federal Medical Assistance Percentage (FMAP)

The FMAP for services can vary. However, for purposes of this analysis, a 50% match was assumed. Accordingly, total savings were reduced by half to demonstrate the savings to the State General Fund.

It should be noted that savings would likely be about 1% to 2% higher than that reflected on page one. For purposes of simplicity, ORR staff did not consider any expenditures for services associated with either Breast Cancer and Cervical Cancer (BCC), or Title XXI recipients (i.e. CHIP). These expenditures make up a very small percentage of the total expenditures captured in the analysis. This is noteworthy because the FMAP for BCC and Title XXI services is enhanced, meaning the federal government pays for 65% of the expenditures and the State pays the remaining 35%, so the total savings associated with this already low expenditure amount would be multiplied by 35% (rather than 50%) to reflect State savings.

Statutory and Regulatory Changes

Since the inflationary adjustments for each of the six service groups are described in regulation, at a minimum, a change to regulation would be required to implement a year-long freeze on inflationary increases. Additionally, it is ORR's preliminary conclusion that a statutory change would not be required for this action. Finally, State Plan Amendments would likely need to be filed for at least one service group.

Supplements

Supplement A: SFY 2013 Expenditure Summary

Supplement B: Calculations for Physician, FQHC & RHC, HCBW & PCA Services

Supplement C: Calculations for Hospital Inpatient, LTC, Ambulatory Surgical Services

Supplement D: Capital v. Non-Capital Breakdown Hospital Inpatient & LTC

PHYSICIAN SERVICES (23881)

ACCT	MAIS	Revised	52	53	FY 13 YTD	Federal	State	FY13 YTD	FY13	Weekly	Number	Protected	Total
	Auth	FY13	CW	CW	Expenditure	Expenditure %	Expenditure %	Expenditure %	Auth	Average	Check	Surplus	Year End
		Authorization	25-Jun-13	conceded thru 8	60.00%	85.00%	60.00%	35.00%		FTD	Remainder	(Deficit)	Expenditure
Health Care Medical	0	0	0	0	0	0.00	0.00	0.00	0	0	0	0	0
HCS Medical Center	0	0	0	0	0	0.00	0.00	0.00	0	0	0	0	0
Total Physician Services	0	0	0	0	0	0.00	0.00	0.00	0	0	0	0	0

INPATIENT SERVICES (23882)

ACCT	MAIS	Revised	52	53	FY 13 YTD	Federal	State	FY13 YTD	FY13	Weekly	Number	Protected	Total
	Auth	FY13	CW	CW	Expenditure	Expenditure %	Expenditure %	Expenditure %	Auth	Average	Check	Surplus	Year End
		Authorization	25-Jun-13	conceded thru 8	60.00%	85.00%	60.00%	35.00%		FTD	Remainder	(Deficit)	Expenditure
Inpatient Hospital	141,600,000	137,000,000	2,291,158.71	(48,773,50)	133,632,849.65	68,818,478.83	33,408,237.41	97.54%	3,387,050	2,589,864	0	3,387,050	133,632,849.65
HCS Inpatient Hospital	90,000,000	43,000,000	1,275,138.38	(40,772,54)	40,772,548.89	40,772,548.89	18,932.32	86.45%	2,727,457	1,700,000	0	2,727,457	40,772,548.89
BCC Inpatient Hospital	228,000	228,000	234,385.81	2,357,277.00	1,527,220.00	538,280.00	102,495%	66.45%	78,869	3,251	0	78,869	171,131
XCI Inpatient Hospital	183,550,000	183,550,000	3,015,564.68	(48,773,50)	178,633,808.42	109,232,488.77	33,883,450.25	102.49%	(57,277)	45,332	0	(57,277)	2,972,277
Total Inpatient Hospital Services	400	400	4,506,147.57	(97,820,50)	362,967,426.96	219,864,765.91	86,144,118.98	97.54%	3,407,515	3,407,515	0	3,407,515	178,933,808

OUTPATIENT SERVICES (23883)

ACCT	MAIS	Revised	52	53	FY 13 YTD	Federal	State	FY13 YTD	FY13	Weekly	Number	Protected	Total
	Auth	FY13	CW	CW	Expenditure	Expenditure %	Expenditure %	Expenditure %	Auth	Average	Check	Surplus	Year End
		Authorization	25-Jun-13	conceded thru 8	60.00%	85.00%	60.00%	35.00%		FTD	Remainder	(Deficit)	Expenditure
Outpatient Hospital	78,000,000	71,000,000	1,450,266.22	(23,814.10)	65,260,942.15	32,630,021.08	18,315,010.54	91.93%	5,738,938	1,255,001	0	5,738,938	65,260,942.15
HCS Outpatient Hospital	4,000,000	4,000,000	51,501.53	(1,582.71)	3,820,197.45	1,910,078.73	955,039.38	85.30%	170,573	170,573	0	170,573	3,820,197.45
BCC Outpatient Hospital	52,500,000	56,780,000	888,908.70	(1,532.68)	51,738,428.85	29,578,515.38	14,844,475.87	87.40%	5,178,823	994,868	0	5,178,823	29,578,515.38
XCI Outpatient Hospital	900,000	900,000	69,547.71	8,320.57	8,320,571.00	12,480.37	6,720,200.00	87.80%	64,087	16,076	0	64,087	8,320,571.00
BCC Outpatient Surgical Centers	3,000,000	3,000,000	298,248.28	2,915,577.18	1,895,326.17	1,020,557.01	87.20%	87,205	30,789	389	0	87,205	1,895,326.17
XCI Outpatient Surgical Centers	500,000	500,000	25,098.46	305,265.00	198,427.25	108,642.75	91.05%	194,735	64,123	5,617	0	194,735	305,265.00
Total Outpatient Hospital Services	84	84	2,723,591.48	(26,102.47)	124,895,985.71	68,928,098.57	18,996,746.24	91.65%	11,314,104	2,401,000	0	11,314,104	124,895,985.71

PHYSICIAN SERVICES (23884)

ACCT	MAIS	Revised	52	53	FY 13 YTD	Federal	State	FY13 YTD	FY13	Weekly	Number	Protected	Total
	Auth	FY13	CW	CW	Expenditure	Expenditure %	Expenditure %	Expenditure %	Auth	Average	Check	Surplus	Year End
		Authorization	25-Jun-13	conceded thru 8	60.00%	85.00%	60.00%	35.00%		FTD	Remainder	(Deficit)	Expenditure
Physician Services	110,000,000	110,000,000	1,919,415.21	(108,488.78)	104,783,848.58	52,301,024.84	28,165,512.42	95.30%	5,217,950	2,015,039	0	5,217,950	104,783,848.58
Rural Health Clinics	2,500,000	2,500,000	1,560,277.28	(2,030.63)	1,558,277.28	780,138.65	390,089.32	47.21%	1,738,723	30,005	0	1,738,723	1,558,277.28
Federal Qualified Health Cr.	8,500,000	8,500,000	142,452.52	(2,030.63)	6,486,933.87	3,248,451.94	1,624,725.87	76.48%	2,001,096	124,879	0	2,001,096	6,486,933.87
EPSDT Physician Services	650,000	650,000	2,980.38	(344.08)	423,984.40	211,989.20	105,888.80	0%	0	0	0	0	423,984.40
HCS Clinic	70,500,000	63,000,000	63,000,000	141,071.33	58,070,058.42	58,070,058.42	1,055,381.21	91.31%	5,529,941	1,116,732	0	5,529,941	58,070,058.42
BCC Physician Services	1,500,000	1,500,000	1,580,000	141,071.33	1,623,678.76	1,055,381.21	1,281.75	102.76%	(43,878)	(43,878)	0	(43,878)	1,623,678.76
BCC Rural Health	20,000	20,000	3,695.50	10,029.24	5,400.00	2,800.00	28,956	28.95%	28,956	28,956	0	28,956	5,400.00
BCC Federal Qualified Health Center	4,000	4,000	1,877.37	15,434.22	10,029.24	10,029.24	100,000	0%	0	0	0	0	10,029.24
BCC EPSDT Physician Services	4,750,000	4,750,000	400,787.17	5,100,298.72	3,315,184.82	1,505,104.81	150,300	150.30%	(150,300)	0	0	(150,300)	3,315,184.82
XCI Physician Services	150,000	150,000	14,517.00	92,888.25	142,965.00	92,888.25	7,095	95.27%	7,095	7,095	0	7,095	142,965.00
XCI Fed Qualified Health Clinic	300,000	300,000	27,851.28	330,985.82	330,985.82	215,147.28	115,848.54	103.44%	(10,990)	6,365	0	(10,990)	330,985.82
XCI EPSDT Physician Services	60,000	60,000	2,739.82	37,488.77	24,317.20	13,124.57	0	0%	22,501	751	0	22,501	24,317.20
Total Physician Services	188,175,000	188,175,000	3,684,154	(120,980.38)	178,989,071.98	118,618,048.30	30,959,326.27	92.45%	14,585,288	3,434,417	0	14,585,288	178,989,071.98

PHARMACY (23885)

ACCT	MAIS	Revised	52	53	FY 13 YTD	Federal	State	FY13 YTD	FY13	Weekly	Number	Protected	Total
	Auth	FY13	CW	CW	Expenditure	Expenditure %	Expenditure %	Expenditure %	Auth	Average	Check	Surplus	Year End
		Authorization	25-Jun-13	conceded thru 8	60.00%	85.00%	60.00%	35.00%		FTD	Remainder	(Deficit)	Expenditure
Pharmacy	85,000,000	53,500,000	741,213.14	(2,219,800.72)	48,465,527.35	23,232,763.68	23,232,763.68	86.65%	7,034,473	893,568	0	7,034,473	48,465,527.35
Pharmacy - Allotment	5,000	5,000	-2,219,800.72	1,819,870.52	(28,528,672.78)	(10,268,473.38)	(5,058,417.50)	62.85%	20,528,471	(384,740)	0	20,528,471	(20,528,471)
State Prescriber D Buy-In Premium	22,000,000	22,000,000	34,964.87	4,504,718.04	28,622,207.89	34,964.87	665	0%	20,435	665	0	20,435	34,964.87
HCS Pharmacy	13,000,000	13,000,000	227,872.52	(5,718.52)	11,001,408.91	11,001,408.91	28,822,208	116.73%	(3,822,208)	511,966	0	(3,822,208)	28,822,208
HCS Drug Rebate Allotment	0	0	17,370.61	182,280.58	125,051.88	67,336.70	54.87%	157,809	157,809	3,700	0	157,809	182,280.58
BCC Pharmacy	350,000	350,000	174,544.18	(418,212.00)	2,261,958.40	1,431,887.76	772,082.84	88.24%	284,050	42,422	0	284,050	2,261,958.40
XCI Pharmacy Drug Rebate Allotment	2,500,000	2,500,000	(418,212.00)	(2,492,547.00)	(2,492,547.00)	(2,492,547.00)	(2,492,547.00)	55.27%	28,209,420	1,268,148	0	28,209,420	(2,492,547.00)
Total Pharmacy	102,850,000	82,295,000	1,059,890	(2,979,010.48)	50,985,903.33	25,529,658.83	40,465,720.50	55.27%	28,209,420	1,268,148	0	28,209,420	50,985,903.33

DENTAL SERVICES (23886)

ACCT	MAIS	Revised	52	53	FY 13 YTD	Federal	State	FY13 YTD	FY13	Weekly	Number	Protected	Total
	Auth	FY13	CW	CW	Expenditure	Expenditure %	Expenditure %	Expenditure %	Auth	Average	Check	Surplus	Year End
		Authorization	25-Jun-13	conceded thru 8	60.00%	85.00%	60.00%	35.00%		FTD	Remainder	(Deficit)	Expenditure
NR Adult Prev Dental	0	0	0	0	0	0.00	0.00	0.00	0	0	0	0	0
Adult Dental	10,000,000	10,000,000	185,808.53	(1,998.87)	8,753,528.52	4,378,784.38	4,378,784.38	87.54%	1,246,471	180,317	0	1,246,471	8,753,528.52
EPSDT Dental Services	25,000,000	25,000,000	1,485,287.00	(2,287.00)	22,717,713.00	11,485,675.82	90,036	90.03%	2,528,648	441,757	0	2,528,648	22,717,713.00
HCS Dental Care	18,000,000	18,000,000	185,820.80	(5,114.88)	18,145,400.20	19,145,400.20	0	91.17%	1,454,600	388,181	0	1,454,600	18,145,400.20
BCC Dental Care	10,000	10,000	0	0	0	0.00	0.00	0.00	0	0	0	0	0
XCI EPSDT Dental Care	4,500,000	4,500,000	372,120.18	(41,508.48)	4,073,609.72	3,037,848.32	1,635,763.40	102.88%	(173,810)	88,877	0	(173,810)	4,073,609.72
Total Dental Services	56,010,000	61,010,000	850,056	(24,828.33)	55,543,990.27	29,045,986.89	17,499,203.58	91.04%	5,488,110	1,088,152	0	5,488,110	55,543,990.27

TRANSPORTATION (23887)

ACCT	MAIS	Revised	52	53	FY 13 YTD	Federal	State	FY13 YTD	FY13	Weekly	Number	Protected	Total
	Auth	FY13	CW	CW	Expenditure	Expenditure %	Expenditure %	Expenditure %	Auth	Average	Check	Surplus	Year End
		Authorization	25-Jun-13	conceded thru 8	60.00%	85.00%	60.00%	35.00%		FTD	Remainder	(Deficit)	Expenditure
Transportation & Accommodation	60,000,000	60,000,000	1,131,345.95	(31,752.45)	61,583,178.32	30,791,588.16	30,791,588.16	98.51%	916,822	1,184,292	0	916,822	61,583,178.32
Special Travel	2,000,000	2,000,000	39,451.18	(1,312.48)	1,857,315.55	928,658.28	1,457,317	142.65%	142,658	35,718	0	142,658	1,857,315.55
HCS Transportation	1,500,000	50,000	28,568.90	0	4,288.44	4,288.44	0	0%	41,401	165	0	41,401	4,288.44
HCS Transportation & Accommodation	3,100,000	3,100,000	16,933.82	0	1,413,717.82	151,477.30	81,563.09	46.50%	1,888,282	27,187	0	1,888,282	1,413,717.82
XCI Transportation													

AUTH1
FY2013 MINS TOTAL EXPENDITURE AND NET AVAILABLE BALANCE
AS OF 06-30-13 CHECKWRITE: Reconciled thru 03/11/13
Fiscal Year Lapse

98.83%
ACCT

VISION SERVICES (238812)

ACCT	MINS	Revised	52	53	FY 13 YTD	Federal	State	FY13 YTD	FY 13 Net	52	Number	Projected	Total
	Amended	23,900,000	25-Jun-13	CV	Expenditure	65.00%	35.00%	of FY13 Available	1,649,004	Weekly	Checkwrite	Surplus	Year End
			313,124		22,250,186.21	11,166,418.00	11,083,778.21	83.10%		Average	Remaining	0	1,649,004
										FYTD			22,250,186

CHIROPRACTIC & SPEECH/PHYS/OCCUPATIONAL THERAPY (238881)

ACCT	MINS	Revised	52	53	FY 13 YTD	Federal	State	FY13 YTD	FY 13 Net	52	Number	Projected	Total
	Amended	23,900,000	25-Jun-13	CV	Expenditure	65.00%	35.00%	of FY13 Available	1,649,004	Weekly	Checkwrite	Surplus	Year End
			313,124		22,250,186.21	11,166,418.00	11,083,778.21	83.10%		Average	Remaining	0	1,649,004
										FYTD			22,250,186

HOME HEALTH & HOSPITALS (238883)

ACCT	MINS	Revised	52	53	FY 13 YTD	Federal	State	FY13 YTD	FY 13 Net	52	Number	Projected	Total
	Amended	23,900,000	25-Jun-13	CV	Expenditure	65.00%	35.00%	of FY13 Available	1,649,004	Weekly	Checkwrite	Surplus	Year End
			313,124		22,250,186.21	11,166,418.00	11,083,778.21	83.10%		Average	Remaining	0	1,649,004
										FYTD			22,250,186

OTHER SERVICES (238881)

ACCT	MINS	Revised	52	53	FY 13 YTD	Federal	State	FY13 YTD	FY 13 Net	52	Number	Projected	Total
	Amended	23,900,000	25-Jun-13	CV	Expenditure	65.00%	35.00%	of FY13 Available	1,649,004	Weekly	Checkwrite	Surplus	Year End
			313,124		22,250,186.21	11,166,418.00	11,083,778.21	83.10%		Average	Remaining	0	1,649,004
										FYTD			22,250,186

NON-MINS (238821)

ACCT	MINS	Revised	52	53	FY 13 YTD	Federal	State	FY13 YTD	FY 13 Net	52	Number	Projected	Total
	Amended	23,900,000	25-Jun-13	CV	Expenditure	65.00%	35.00%	of FY13 Available	1,649,004	Weekly	Checkwrite	Surplus	Year End
			313,124		22,250,186.21	11,166,418.00	11,083,778.21	83.10%		Average	Remaining	0	1,649,004
										FYTD			22,250,186

MEDICAL FINANCE (238831)

ACCT	MINS	Revised	52	53	FY 13 YTD	Federal	State	FY13 YTD	FY 13 Net	52	Number	Projected	Total
	Amended	23,900,000	25-Jun-13	CV	Expenditure	65.00%	35.00%	of FY13 Available	1,649,004	Weekly	Checkwrite	Surplus	Year End
			313,124		22,250,186.21	11,166,418.00	11,083,778.21	83.10%		Average	Remaining	0	1,649,004
										FYTD			22,250,186

MEDICAL - STATE ONLY (238841)

ACCT	MINS	Revised	52	53	FY 13 YTD	Federal	State	FY13 YTD	FY 13 Net	52	Number	Projected	Total
	Amended	23,900,000	25-Jun-13	CV	Expenditure	65.00%	35.00%	of FY13 Available	1,649,004	Weekly	Checkwrite	Surplus	Year End
			313,124		22,250,186.21	11,166,418.00	11,083,778.21	83.10%		Average	Remaining	0	1,649,004
										FYTD			22,250,186

AUTH13
FY2013 MARS TOTAL EXPENDITURE AND NET AVAILABLE BALANCE
AS OF 06-30-13 CHECKWRITE: Reconciled thru 03/31/13
Fiscal Year Lapse

ACT	98.83%	MARS FY13	Revised FY13	52 CW	53 CW	FY 13 YTD	Federal	State	FY13 YTD	FY 13 Net	52 Weekly Average	Number	Projected	Total
		Authorized	Authorization	25-Jun-13	concluded thru 9	Expenditure	50.00%	50.00%	50.00%	35.00%	of FY13 Available	Checkwrite	Surplus	Year End
		9,537,400	9,537,400	0	482,418.50	4,984,205.34	3,134,548	1,848,657	50.18%	4,953,195	95,630	0	4,953,195	4,984,205

Children's Medicaid BTRH (23102)

IHS BTRH No-Care BRS	70,000	70,000	30,288.00	3,344,688.00	1,672,348.00	1,672,348.00	86,070	0	7.0%	65,050	0	0	65,050	4,950
KIM BTRH Medicaid	3,735,000	3,735,000	30,288.00	3,344,688.00	1,672,348.00	1,672,348.00	86,070	0	0%	172,000	0	0	172,000	3,344,688
BTRH Reimbursed cost	175,000	175,000	0	0	0	0	0	0	0%	0	0	0	0	175,000
Total Children's Medicaid BTRH	4,680,000	4,680,000	30,288.00	3,344,688.00	1,672,348.00	1,672,348.00	86,070	0	0%	65,050	0	0	65,050	3,344,688
TOTAL CHILDREN'S SERVICES	13,937,400	13,937,400	-	763,066.50	0,333,051.34	4,811,048	3,922,005	180,265	59.78%	5,603,549	180,265	0	5,603,549	8,333,651

SENIOR & DISABILITY SERVICES (23580)

IHS AD Waiver	1,500,000	1,500,000	(81,413.08)	4,973.12	4,973.12	328,717.78	164,358.89	0.33%	1,485,027	95	0	0	1,485,027	4,973
AD Waiver Care Coordination	1,700,000	1,700,000	1,067.85	657,435.55	328,717.78	1,042,564	38,676	0.33%	1,042,564	12,648	0	0	1,042,564	657,435
AD Waiver Residential Services	20,000,000	10,200,000	158,957.27	4,385,375.42	2,192,687.71	1,429,249	188,688	63.98%	1,429,249	188,688	0	0	1,429,249	8,770,151
AD Waiver Day Services	2,300,000	2,300,000	42,867.78	1,928,619.27	864,409.64	482,204.82	83,865	83.86%	371,181	37,093	0	0	371,181	1,928,619
AD Waiver SWE & Environmental Modification	800,000	800,000	5,915.00	149,598.32	74,799.16	37,399.58	16,627	16.63%	728,215	27,207	0	0	728,215	149,598
AD Waiver Chw Services & Respite	6,000,000	2,700,000	35,998.63	1,414,794.34	707,397.17	353,698.59	52,404	52.40%	1,285,215	27,207	0	0	1,285,215	1,414,794
XXI AD Waiver Coordination	0	0	0	0	0	0	0	0%	0	0	0	0	0	0
XXI AD Waiver Residential Services	0	0	0	0	0	0	0	0%	0	0	0	0	0	0
XXI AD Waiver Day Services	0	0	0	0	0	0	0	0%	0	0	0	0	0	0
XXI AD Waiver SWE/Environmental Modification	0	0	0	0	0	0	0	0%	0	0	0	0	0	0
XXI AD Waiver Chw Services & Respite	0	0	0	0	0	0	0	0%	0	0	0	0	0	0
Total Adult Disabled Waiver	33,700,000	19,300,000	171,333	12,828,320.03	6,485,648.59	3,230,338.73	66,998	66.99%	6,373,680	248,583	0	0	6,373,680	12,828,320

Children with Medically Complex Condition Waiver (23581)

IHS CMCC Waiver	500,000	500,000	3988.81	129,327.43	129,327.43	150,161.52	75,080.76	25.26%	373,713	2,429	0	0	373,713	129,327
CMCC Waiver Care Coordination	1,000,000	1,000,000	6,028.28	600,646.09	300,323.05	1,57,580.55	60,604	60.60%	389,354	11,551	0	0	389,354	600,646
CMCC Waiver Residential Services	1,320,000	1,320,000	132,898.47	3,515,166.10	1,757,583.05	1,488,668	115,199	87.1%	1,488,668	115,199	0	0	1,488,668	2,938,312
CMCC Waiver Day Services	2,500,000	2,500,000	38,142.70	1,041,150.22	520,725.11	416,580	40,678	28.14%	416,580	40,678	0	0	416,580	2,938,312
CMCC Waiver SWE & Environmental Modification	300,000	300,000	(40.00)	84,415.38	42,207.69	21,103.85	28,142	28.14%	215,585	1,623	0	0	215,585	84,415
CMCC Waiver Chw Services & Respite	1,600,000	1,600,000	22,348.06	1,225,168.50	612,584.25	306,292.13	60,607	60.60%	576,684	23,507	0	0	576,684	1,225,168
XXI CMCC Waiver Care Coordination	10,000	10,000	0	0	0	0	0	0%	10,000	0	0	0	10,000	0
XXI CMCC Waiver Residential Services	10,000	10,000	0	0	0	0	0	0%	10,000	0	0	0	10,000	0
XXI CMCC Waiver Day Services	10,000	10,000	0	0	0	0	0	0%	10,000	0	0	0	10,000	0
XXI CMCC Waiver SWE/Environmental Modification	10,000	10,000	0	0	0	0	0	0%	10,000	0	0	0	10,000	0
XXI CMCC Waiver Chw Services & Respite	10,000	10,000	0	0	0	0	0	0%	10,000	0	0	0	10,000	0
Total Children With Medically Complex Condition Waiver	14,550,000	14,650,000	185,108	11,149,088.03	5,639,087.73	2,755,900.15	76,13%	3,900,112	214,421	0	0	3,900,112	11,149,088	

Medically Fragile/Developmentally Disabled Waiver (23582)

IHS MRDD Waiver	2,000,000	2,000,000	68,206.73	1,578,742.64	1,578,742.64	1,124,862.32	88,008	88.01%	1,423,217	30,323	0	0	1,423,217	1,578,742
MRDD Waiver Care Coordination	5,000,000	5,000,000	1,717,447.73	88,428,214.66	44,714,607.33	22,357,304.67	98,872	98.87%	1,070,785	86,537	0	0	1,070,785	4,498,928
MRDD Waiver Residential Services	85,000,000	44,300,000	887,682.75	21,859,183.95	10,929,541.87	8,318,318	83,045	83.05%	9,816,782	83,045	0	0	9,816,782	43,318,318
MRDD Waiver Day Services	500,000	500,000	40.00	60,827.80	30,413.90	15,141.80	1,165	12.11%	438,432	1,165	0	0	438,432	60,827
MRDD Waiver SWE & Environmental Modification	5,500,000	5,500,000	66,785.67	4,305,580.69	2,182,790.35	1,091,385.17	58,784	58.78%	1,134,419	58,784	0	0	1,134,419	4,305,580
XXI MRDD Waiver Care Coordination	10,000	10,000	0	5,975.68	3,624.18	1,812.09	136	13.6%	1,812.09	136	0	0	1,812.09	5,975
XXI MRDD Waiver Residential Services	25,000	25,000	8,725.32	8,725.32	4,362.66	2,181.33	168	16.8%	4,362.66	168	0	0	4,362.66	8,725
XXI MRDD Waiver Day Services	10,000	10,000	0	0	0	0	0	0%	10,000	0	0	0	10,000	0
XXI MRDD Waiver SWE/Environmental Modification	10,000	10,000	0	0	0	0	0	0%	10,000	0	0	0	10,000	0
XXI MRDD Waiver Chw Services & Respite	10,000	10,000	0	0	0	0	0	0%	10,000	0	0	0	10,000	0
Total Medically Fragile/Developmentally Disabled Waiver	135,550,000	148,650,000	2,832,241.89	143,274,980.34	72,429,119.63	35,428,765.89	96,25%	5,964,610	2,755,215	0	0	5,964,610	143,274,980	

Other Waiver Services (23587)

Waiver Determination	600,000	600,000	20,184.46	280,930.97	144,015.49	144,015.49	48,015	48.01%	311,869	5,539	0	0	311,869	280,931
----------------------	---------	---------	-----------	------------	------------	------------	--------	--------	---------	-------	---	---	---------	---------

Personal Care Services (23588)

IHS Personal Care	120,000,000	120,000,000	2,827,975.86	128,445,027.43	63,222,514.72	63,222,514.72	98,79%	1,554,973	2,431,635	0	0	1,554,973	128,445,027
BCC Personal Care	800,000	800,000	1,948.40	150,031.56	41,702.78	23,532.26	33,63%	449,968	2,445	0	0	449,968	150,032
XXI Personal Care	200,000	200,000	3,330.91	40,735.31	28,519.65	14,259.83	40,71%	59,215	1,233	0	0	59,215	40,735
Total Personal Care Services	120,800,000	120,800,000	2,832,255.17	128,535,793.34	63,281,756.13	63,281,756.13	98.39%	2,185,681	2,435,589	0	0	2,185,681	128,535,793

Nursing Homes (23589)

Nursing Home Skilled	15,000,000	15,000,000	41,180.43	11,214,948.24	5,607,474.12	2,803,737.06	74.77%	3,785,952	2,185,612	0	0	3,785,952	11,214,948
Nursing Home Intermediate	82,000,000	80,100,000	1,186,199.65	77,238,528.02	38,618,284.51	19,309,632.26	96.43%	2,881,471	1,445,356	0	0	2,881,471	77,238,528
Intermediate Care Facility/Minutely Referred	3,500,000	4,000,000	18,050.40	3,413,324.87	1,706,862.48	853,131.24	65.33%	588,675	288,675	0	0	588,675	3,413,324
BCC Nursing Home - Skilled	7,500,000	8,200,000	15,282.24	7,555,978.43	7,555,978.43	7,555,978.43	92.18%	944,024	143,307	0	0	944,024	7,555,978
XXI Nursing Home - Skilled	10,000	10,000	0	0	0	0	0%	100,000	0	0	0	100,000	0
XXI Nursing Home - Intermediate	100,000	100,000	0	0	0	0	0%	7,887,221	1,811,977	0	0	7,887,221	99,423,719
Total Nursing Home Services	108,110,000	107,410,000	1,210,682.72	120,990,000	63,422,776.86	32,266,766.86	62.56%	5,363,358	2,627,265	0	0	5,363,358	120,990,000

TOTAL SENIOR & DISABILITY SERVICES

508,318,900	508,318,900	8,741,634.61	(25,084.35)	47,755,542.48	24,333,709.20	189,548,480.82	63.93%	30,503,358	9,187,607	0	0	30,503,358	47,755,542
10,500,000	10,500,000	170,856.88	(1,802.89)	10,185,227.23	5,092,813.82	5,092,813.82	97.00%	314,773	186,870	0	0	314,773	10,185,227

ADULT PREVENTATIVE DENTAL MEDICAD (23300)

Adult Prev Dental	10,500,000	10,500,000	170,856.88	(1,802.89)	10,185,227.23	5,092,813.82	5,092,813.82	97.00%	314,773	186,870	0	0	314,773	10,185,227
-------------------	------------	------------	------------	------------	---------------	--------------	--------------	--------	---------	---------	---	---	---------	------------

AUTH13
FY2013 MMS TOTAL EXPENDITURE AND NET AVAILABLE BALANCE
AS OF 06-30-13 CHECKWRITE: Recorded thru 03/01/13
Fiscal Year Update

FY2013 Annual Growth Factor
 Weekly Growth Factor

ACCT	98.83%	MMS FY12	Revised FY12	52 CW	53 CW	FY 13 YTD	Federal	State	FY13 YTD	FY13 Net	Weekly	Number	Projected	Total
		Authorized	Authorization	25-Jun-13	completed thru 8	Expenditure	80.00%	80.00%	Expenditure % of FY13 Auth	FY13 Net Available	Average FYTD	Checkwrites Remaining	Surplus (Deficit)	Projected Year End Expenditure
115 Adult Prev Dental		2,038,700	2,038,700	18,909.03	(2,978.77)	1,488,960.45	0.00%	0.00%	0.00%	1,488,960.45	26.242	0	598,140	1,488,960.45
Adult Dental Prev Dental		12,538,700	12,538,700	189,868.88	(2,102.48)	6,561,172.07	80.00%	80.00%	82.86%	6,561,172.07	324.111	0	482,812	11,653,788
TOTAL ADULT DENTAL MEDICAL		12,538,700	12,538,700	189,868.88	(2,102.48)	11,653,788.52	80.00%	80.00%	82.86%	11,653,788.52	224.111	0	682,912	11,653,788

HCMS MEDICAL SERVICES (23301)

ACCT	98.83%	MMS FY12	Revised FY12	52 CW	53 CW	FY 13 YTD	Federal	State	FY13 YTD	FY13 Net	Weekly	Number	Projected	Total
		Authorized	Authorization	25-Jun-13	completed thru 8	Expenditure	80.00%	80.00%	Expenditure % of FY13 Auth	FY13 Net Available	Average FYTD	Checkwrites Remaining	Surplus (Deficit)	Projected Year End Expenditure
Health Care Services (Medical) (23301)		0	0	0	0	0	0.00%	0.00%	0.00%	0	0	0	0	0
Inpatient Hospital Services (23389)		193,950,000	182,550,000	3,815,595	(48,773.58)	178,933,906	100.232,489	33,983,450	98.92%	5,818,094	3,407,575	0	5,018,094	178,933,906
Outpatient Hospital Services (23389)		138,950,000	138,210,000	2,723,591	(26,482.47)	124,895,888	89,829,100	18,989,746	91.63%	11,314,104	2,401,844	0	11,314,104	124,895,888
Physician Services (23441)		198,972,000	193,175,000	3,644,154	(120,950.39)	178,589,702	118,418,043	30,655,352	92.45%	14,585,298	3,434,417	0	14,585,298	178,589,702
Pharmacy (23482)		102,855,000	92,205,000	1,079,050	(2,970,010.48)	50,985,803	25,529,860	40,685,720	55.27%	26,209,420	1,281,166	0	26,209,420	50,985,803
Dental Services (23483)		56,010,000	61,010,000	650,058	(41,008.46)	55,543,890	38,045,887	17,498,204	91.04%	5,466,110	1,061,152	0	5,466,110	55,543,890
Transportation (23484)		68,160,000	70,800,000	1,481,989	(44,588.88)	88,044,282	35,223,354	32,680,838	86.07%	2,815,708	387,786	0	2,815,708	88,044,282
Lab & X-Ray Services (23485)		3,420,000	3,420,000	45,015	(1,222.87)	3,032,234	1,528,714	1,503,520	88.88%	387,786	54,312	0	387,786	3,032,234
Diag & Audiology (23487)		23,800,000	23,800,000	318,124	(13,889.81)	22,250,188	11,108,418	11,083,778	83.10%	1,649,804	428,778	0	1,649,804	22,250,188
Chiropractic & Speech/Phys/Occup. Therapy (23487)		6,405,000	6,878,261	98,634	(3,890.38)	6,590,370	3,390,000	3,180,181	94.04%	418,180	128,156	0	418,180	6,590,370
Home Health & Hospice (23489)		15,545,000	18,070,000	578,571	(20,883.17)	14,577,748	7,457,626	7,120,123	80.71%	1,492,251	280,341	0	1,492,251	14,577,748
Other Services (23491)		3,137,000	3,137,000	9,585	-	1,133,785	586,892	586,892	38.14%	2,003,215	21,804	0	2,003,215	1,133,785
Non - MMS (23492)		45,021,000	46,464,739	(50,439)	1,991,839.99	43,088,639	22,314,395	7,921,150	92.72%	3,376,099	878,628	0	3,376,099	43,088,639
Medical Financing (23493)		500,000	500,000	0	-	130,429	65,215	65,215	50.40%	498,040	6,892	0	498,040	500,000
Medical - State Only (23494)		97,500	97,500	0	-	97,489.59	0	97,500	100.00%	0	1,815	0	0	97,500
Med Svcs MMS-Tobacco (23495)		878,350,700	853,350,700	12,247,239	4,654,278.09	758,043,682.79	413,298,507	207,519,175	88.83%	80,277,598	14,661,137	0	80,277,598	758,043,683
TOTAL HCMS MEDICAL SERVICES		1,471,000	1,471,000	7,628	(316.18)	1,073,531	0	1,073,531	73.17%	393,448	20,684	0	393,448	1,073,531

CHRONIC ACUTE MEDICAL ASSISTANCE (23305)

ACCT	98.83%	MMS FY12	Revised FY12	52 CW	53 CW	FY 13 YTD	Federal	State	FY13 YTD	FY13 Net	Weekly	Number	Projected	Total
		Authorized	Authorization	25-Jun-13	completed thru 8	Expenditure	80.00%	80.00%	Expenditure % of FY13 Auth	FY13 Net Available	Average FYTD	Checkwrites Remaining	Surplus (Deficit)	Projected Year End Expenditure
Behavioral Health Medicaid (23305)		0	0	0	0	189,239	0	0	0.00%	-189,239	3,233	0	-189,239	189,239
Mental Health Services (24010)		113,484,100	125,454,100	2,181,103	(84,441.94)	111,448,380	64,885,721	23,878,195	88.83%	14,007,740	2,143,199	-	14,007,740	111,448,380
Psychiatric Hospital Services (24011)		27,500,000	25,000,000	182,308	-	10,632,346	5,189,278	61,596	61.59%	4,620,149	393,459	-	4,620,149	20,659,851
Residential Care Services (24012)		54,700,000	45,150,000	393,345	120,598.43	17,243,180	18,618,100	75,21%	11,880,740	11,880,740	-	11,880,740	33,659,280	
RPT/PRN Walker (24013)		6,200,000	6,200,000	0	-	977,888	0	977,888	15.77%	5,222,112	18,898	0	5,222,112	977,888
Total Behavioral Health Medicaid SF		201,684,100	201,684,100	2,756,756	1,718,426.48	188,525,718	92,841,228	45,782,534	83.48%	33,358,392	3,240,879	0	33,358,392	188,525,718
Behavioral Health Medicaid ADPT (23305)		1,500,000	1,500,000	125,000	-	335,000	0	335,000	22%	1,165,000	6,442	0	1,165,000	335,000
TOTAL BEHAVIORAL HEALTH MEDICAL		203,184,100	203,184,100	2,881,756	1,718,426.48	188,860,718	92,841,228	46,117,534	83.07%	34,523,392	3,247,321	0	34,523,392	188,860,718

CHILDREN'S SERVICES (23300)

ACCT	98.83%	MMS FY12	Revised FY12	52 CW	53 CW	FY 13 YTD	Federal	State	FY13 YTD	FY13 Net	Weekly	Number	Projected	Total
		Authorized	Authorization	25-Jun-13	completed thru 8	Expenditure	80.00%	80.00%	Expenditure % of FY13 Auth	FY13 Net Available	Average FYTD	Checkwrites Remaining	Surplus (Deficit)	Projected Year End Expenditure
Children's Services (24101)		4,000,000	4,000,000	0	301,288.00	3,349,646	1,877,289	1,877,289	81.74%	850,354	64,416	0	850,354	3,349,646
Children's Medicaid BTRH (24102)		13,937,400	13,937,400	0	793,868.50	8,333,851	4,811,848	3,222,005	59.79%	5,603,349	180,298	0	5,603,349	8,333,851
TOTAL CHILDREN'S SERVICES		13,937,400	13,937,400	0	793,868.50	8,333,851	4,811,848	3,222,005	59.79%	5,603,349	180,298	0	5,603,349	8,333,851

SENIOR & DISABILITY SERVICES (23350)

ACCT	98.83%	MMS FY12	Revised FY12	52 CW	53 CW	FY 13 YTD	Federal	State	FY13 YTD	FY13 Net	Weekly	Number	Projected	Total
		Authorized	Authorization	25-Jun-13	completed thru 8	Expenditure	80.00%	80.00%	Expenditure % of FY13 Auth	FY13 Net Available	Average FYTD	Checkwrites Remaining	Surplus (Deficit)	Projected Year End Expenditure
Adult Disabled Walker (23352)		33,700,000	19,300,000	171,389	-	12,828,329	6,465,647	3,230,337	66.81%	6,373,680	248,583	0	6,373,680	12,828,329
Children with Medically Complex Conditions Walker		14,650,000	14,650,000	185,108	(444.00)	5,638,088	2,755,900	2,755,900	79.1%	3,500,112	314,421	0	3,500,112	11,148,888
Mentally Retarded/Developmentally Disabled Walker		135,558,900	146,858,900	2,825,242	(10,861.86)	143,274,280	72,429,120	35,428,788	98.25%	5,984,610	2,753,275	0	5,984,610	143,274,280
Older Alaskan Walker (23358)		88,800,000	88,800,000	1,428,848	(3,821.34)	83,981,195	42,228,784	41,787,451	94.82%	4,808,645	1,619,115	0	4,808,645	83,981,195
Other Walker Services (23357)		800,000	800,000	20,184	-	298,031	144,015	144,015	48.01%	311,989	5,538	0	311,989	288,031
Personal Care Services (23356)		128,900,000	128,900,000	2,832,356	(157,411)	128,703,078	63,442,759	63,280,321	88.97%	2,186,921	2,435,398	0	2,186,921	128,703,078
Nursing Homes (23359)		108,110,000	107,410,000	1,270,693	(20,000.00)	99,422,718	53,489,378	22,989,701	92.58%	7,887,221	1,811,817	0	7,887,221	99,422,718

AUTH13
 FY2013 MMIS TOTAL EXPENDITURE AND NET AVAILABLE BALANCE
 AS OF 04-25-13 CHECKWRITE: Rescinded thru R21113
 Fiscal Year Lapse

FY2013 Annual Growth Factor
 Weekly Growth Factor

ACCT	MMIS Fiscal Year Lapse	Rescinded Auth Lapse	25-Jun-12 CNY	31 CNY	FY 11 YTD Expenditure	Federal 50.00%	State 50.00%	FY12 YTD Expenditure % of FY13 Auth	FY 13 Mt Available	25 Weekly Average FYTD	0 Number Checkwrites Remaining	Projected Surplus/ (Deficit)	Total Projected Year End Expenditure
ADULT PREVENTAL MEDICAL - GF (22300)	98.83%												
			508,318,800	508,318,800	477,755,542	243,837,709	189,548,491	93.89%	30,563,358	9,187,607	0	30,563,358	477,755,542
			12,539,700	12,539,700	11,653,788	6,591,174	5,092,814	92.98%	882,912	224,111	0	882,912	11,653,788
			12,539,700	12,539,700	11,653,788	6,591,174	5,092,814	92.98%	882,912	224,111	0	882,912	11,653,788
			1,617,998,800	1,592,998,800	1,423,723,143	821,448,483	432,843,370	88.59%	152,248,248	27,709,138	0	152,248,248	1,423,723,143