#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 is model is provided through our contactor 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 t 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 requires 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 to 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 be 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 (ADA) 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 co-pay; this could result 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 is 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 furthered 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

MRAG Analysis #8

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 for special circumstances. 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 (IDD). Many people have approved waiver service plans in excess of the average cost of institutionalization. In FY 13, 169 individuals (about 9% of the IDD waiver) 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 (about 3.5%) 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 that level, Alaska would have spent $13.8 million, for a savings of $2.8 million, half of that General Fund.**

Some savings would be obtained by applying the cap to the other waivers, but the majority of expenditures on individuals over the average cost is on the IDD waiver, which accounts for 57% of total waiver expenditures.

The cap could result in more people receiving institutional care, if they were not willing or able to accept reduced waiver service plans. But that institutionalization would actually decrease costs. And given that people prefer to receive services at home or in community settings, we would anticipate that some people would choose to accept less extensive waiver service plans rather than go into an institution.

Imposing the cap might also ease the administrative burden on the waiver. Very high cost plans typically require extensive analysis of the plans by department staff to ensure regulatory compliance and reasonableness. Denials of high cost plans can also result in recipients pursuing the services through the Medicaid fair hearing process. A cap imposed by regulation is not subject to fair hearing.

#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 though 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 statue 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 Premera Blue Cross Blue Shield of Alaska. When comparing the Alaska bench mark 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	**Limits:** 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%.

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 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**

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**

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.

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."

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).

The new MAGI rules related to this population indicate that a child in residential treatment would fall under the MAGI filer rule if the parents claim the child as a tax dependent. The child would have the same household composition and income of the parent who claims them. This means we would count the child's income and any parents, siblings or children living with the child. Application of this policy may result in a denial of benefits. However if the parent is not planning to claim the child as a tax dependent in the following year the eligibility determination would default to non-filer rules. This means only the child's income would be counted. Application of this policy would likely result in approval of benefits.

The Division of Health Care Services indicates expenditures of approximately $31 million in Medicaid costs for children in residential treatment facilities. These costs are subject to 50% federal match. The Division of Behavioral Health estimates approximately 60 children or 10% of those served in residential treatment would lose coverage if the State eliminates the non-filer rule and requires eligibility to be determined on household income regardless of filing status.

This gap in coverage (impacting 10% of residential treatment cases) would result in a total savings of approximately $3.1 million or $1.5 million in general funds ($26,000 per child). However, this savings in Medicaid dollars will likely impact other state general fund programs as a result of the denial of residential treatment services. These children may require services from the Office of Children's Services or they may enter the Juvenile Justice System. They may be admitted to the Alaska Psychiatric Institute or their disorders may go untreated and escalate until acute treatment is the only service option.

#15

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

Alaska Medicaid Coverage for Physical, Occupational and Speech Therapy: Background Information and Recommendations for Possible Utilization Limits

Background: Outpatient treatments such as physical therapy (PT), occupational therapy (OT) and speech therapy (ST) can help patients improve function. Still, long-term benefits are often limited. A recent analysis by OHSU's Center for Evidence Based Policy found little data that prolonged PT following knee or hip replacement improves outcome, for example, and a second analysis found that young children with certain speech impediments appear to do as well with parent-directed care as with professional ST. (1, 2)

Still, cost and utilization of such treatments is considerable. Alaska Medicaid reimbursed $26M for "Therapy and Rehabilitation" services in 2013—roughly 2% of total spending. (3) Significant savings could certainly be realized by limiting coverage, though for a variety of reasons an exact amount is difficult to estimate. For instance, while some services are optional (such as post-op therapy for adults), others are effectively required and would be very difficult to reduce (e.g., some treatments delivered under EPSDT mandates).

Also, limiting therapy for certain beneficiaries could potentially increase other Medicaid costs. Ongoing outpatient therapy, for example, may be perceived by some waiver clients as allowing them to remain in home-based settings rather than requiring placement in higher-cost skilled nursing facilities. Still for many beneficiaries it seems that limiting coverage for some therapy services could generate savings without adversely affecting outcomes.

Current Coverage: Health Care Services (HCS) currently has only modest limits on the types and frequency of therapies covered. State regulations specify which beneficiaries are eligible for services, who must prescribe them, and who may provide them. (7 AAC 115.1-.4) Therapists or facilities are required to be licensed and enrolled, and their preliminary treatment plans need to be reviewed and signed by prescribers before coverage is approved.

Subsequently, updated plans for adults need to be reviewed and renewed monthly. For those three and under renewals are required every six months, and for others 21 and under, yearly. Submitted plans are reviewed and authorized by our fiscal agent, Xerox, which is expected to use clinical nursing staff to oversee the reviews. Still, it seems that ongoing therapy is generally approved so long as treatment plans are appropriately updated and patients are improving.

Alternative Policy Approaches: Therapy coverage benefits vary widely in both public and private plans. While some insurers use medical necessity criteria to prior authorize (PA) initial therapy visits, most seem to limit utilization through benefit design. That is, they allow a set of

initial visits based solely on a prescription—typically six hours (e.g. six hour-long visits or 12 half-hour visits) or unlimited visits for 60 days. Beyond the initial visits some plans cover no additional therapy while others require PA for ongoing care.

In Alaska for example, the state's standard employee health plan (AlaskaCare) covers an unlimited number of visits annually with minimal PA requirements, and traditional fee-for-service Medicare has few limits for therapy once a treatment plan is prescribed. Premera Alaska's Bronze and Silver Health Exchange plans both allow 25 visits per year for each type of therapy, but apparently with minimal medical necessity PA requirements.

QUALIS, Alaska Medicaid's QIO, reports that it previously performed medical necessity reviews to PA initial treatment visits for some Medicaid plans, but that that most clients found that savings were limited by the extra administrative work required, and have generally moved to manage the benefit—at least initially—through benefit design.

Coverage for Washington and Colorado Medicaid exemplifies this design approach—both allow 24 initial "units" (generally six hours) with a valid treatment plan, then require PA review before approving 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 and are moving clearly toward a home based self-care program.

Recommendations, Discussion and Summary: Alaska Medicaid should consider policy changes to more appropriately limit PT, OT and ST coverage, primarily through benefit design:

- HCS should implement a standard six-hour annual outpatient limit for each type of therapy. Coverage for these initial visits would continue to be based on a valid, prescribed treatment plan, as under our current coverage process.
- A medical necessity review to authorize additional visits (in three or six hour increments) should be implemented for children 21 years old or less and for adults on waiver. In patients for whom long-term treatment is clearly warranted, longer coverage approval could occasionally be granted.
- The authorization process for additional visits should use broad medical necessity criteria such as those used by other Medicaid plans:
    - Beneficiary function has improved during initial therapy and is continuing to improve; and
    - Additional treatment visits are intended to help a beneficiary transition to a home-based self-care regimen in a specified timeframe, if at all feasible; and

    - Each PA request being submitted for additional treatment authorization has been reviewed and signed by a prescriber.

- PA requests for additional treatment should continue to be reviewed by Xerox clinical staff, perhaps with closer nursing or physician direction from the Division. It is unlikely that HCS could process these PA requests internally at the present time, without more clinical staff.

As noted, if Alaska Medicaid chooses to go forward with such a policy change it should be possible to more appropriately limit coverage for therapeutic services for many beneficiaries, without adversely affecting their outcomes. Also, the changes should not be too difficult to implement since the new approach would be somewhat similar to the processes currently in place.

The main effects of the changes would be: 1) only six hours of initial visits would be allowed for any given therapy type before a more focused PA review was required; 2) more frequent PA reviews would be required for children and waiver patients to assure they needed ongoing treatment; 3) some adults would no longer qualify for ongoing treatment; and 4) treatment plans would need to include the goal of ultimately transitioning a beneficiary to self-directed care, when at all appropriate.

Basing determinations on the more general medical necessity criteria would be preferable to using detailed algorithms for a few reasons. First, it would be difficult for HCS to internally develop more detailed PA criteria due to the wide variety of specific indications for different therapies, each of which would likely need its own evidence review. Second, while InterQual-type, comprehensive medical necessity criteria sets are available for such determinations, those proprietary algorithms can be expensive to use and complicated to administer.

Finally, if HCS chooses to go forward with policy changes around therapeutic services, it would be most efficient to continue allowing coverage for an initial set of visits without requiring detailed preliminary PA review. This is because realistically, most beneficiaries are likely to have their first set of visits approved regardless of review, and many are unlikely to need or want visits beyond the initial set in any case.

#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 can encourage utilization of primary care which prevents costlier utilization for later stage conditions.

Federal Cost Sharing rules establish the criteria for states to set cost sharing amounts, and establish who is subject to the cost sharing amount. The Affordable Care Act (ACA) modified the cost sharing [i]rules for Medicaid effective January 1, 2014. The state may opt to establish, at or below the amounts shown below in Tables 1 and 2, cost sharing for any service (other than for drugs and non-emergency services[ii] 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 1 and 2.

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

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

Services	ACA Maximum Allowable Cost Sharing			Alaska 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	All Medicaid Eligible Individuals
Outpatient Services (physician visit, physical therapy, etc.)	$4	10% of cost the agency pays	20% of cost the agency pays	$50 per day up to a Maximum of $200 per discharge
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.	5% of allowable charges

Table 2. Affordable Care Act vs. Alaska Cost Sharing for Drugs

Affordable Care Act			Alaska	
Services	Maximum Allowable Cost Sharing		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	All Medicaid Eligible Individuals	
Preferred Drugs	$4	$4	Prescription under $50	$.50 cents
Non-Preferred Drugs	$8	20% of the cost the agency pays.	Prescription over $50	$ 3.50 dollars

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

Increase Co-Pays/Add new Co-Pays:

Policy Analysis:

In order to increase co-pays, or 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 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.

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

Increase the Cap for Co-Pays:

Policy Analysis:

The requirements for the annual capitation of 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.

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. This does not include any services furnished in a hospital emergency department that are required to be provided as an appropriate medical screening examination or stabilizing examination and treatment.

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

#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
			TOTAL	**$775.3**

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 Eligiblity 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
			TOTAL	$816.6

Total Approximate Reduction of Costs Associated with Auto-Renewal:

	Approximate Cost Reduction for Auto-Renewal
Permanently Disabled and Blind	$775.3
Aged	$816.6
TOTAL	$1,591.9

#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:

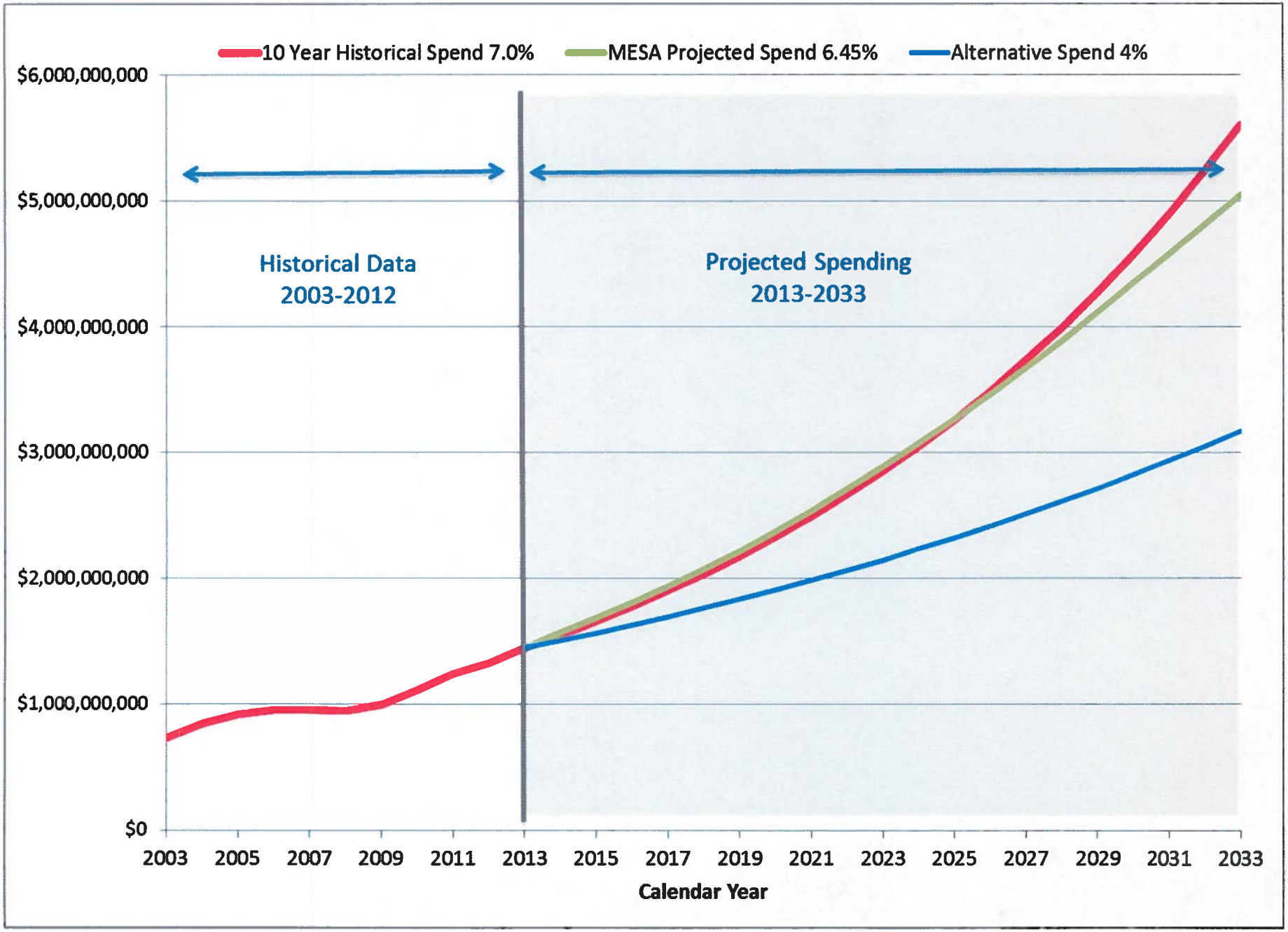
Alaska Medicaid spending has historically had a 7% growth rate and is projected to increase an average of 6.45% per annum.

The numbers behind the spending:

Growth Rate:	4.0%

Calendar Year	10 Year Historical Spend 7.0%	MESA Projected Spend	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	$1,548,849,403	$1,567,360,813	$1,505,423,719
2015	$1,657,268,862	$1,681,022,937	$1,565,640,668
2016	$1,773,277,682	$1,804,828,811	$1,628,266,295
2017	$1,897,407,120	$1,932,988,788	$1,693,396,947

2018	$2,030,225,618	$2,068,426,282	$1,761,132,824
2019	$2,172,341,411	$2,213,103,316	$1,831,578,137
2020	$2,324,405,310	$2,367,478,744	$1,904,841,263
2021	$2,487,113,682	$2,532,062,637	$1,981,034,913
2022	$2,661,211,640	$2,704,634,250	$2,060,276,310
2023	$2,847,496,454	$2,884,193,256	$2,142,687,362
2024	$3,046,821,206	$3,070,342,623	$2,228,394,857
2025	$3,260,098,691	$3,264,821,364	$2,317,530,651
2026	$3,488,305,599	$3,464,416,606	$2,410,231,877
2027	$3,732,486,991	$3,672,384,635	$2,506,641,152
2028	$3,993,761,080	$3,889,714,308	$2,606,906,798
2029	$4,273,324,356	$4,116,822,770	$2,711,183,070
2030	$4,572,457,061	$4,354,045,985	$2,819,630,393
2031	$4,892,529,055	$4,577,695,924	$2,932,415,609
2032	$5,235,006,089	$4,810,108,469	$3,049,712,233
2033	$5,601,456,515	$5,050,277,215	$3,171,700,722
Avg Annual Growth Rate:	7.01%	6.45%	4.00%


10 Year Historical Spend 7.0%
MESA Projected Spend 6.45%
Alternative Spend 4%
$6,000,000,000
$5,000,000,000
$4,000,000,000
$3,000,000,000
$2,000,000,000
$1,000,000,000
$0
Historical Data
2003-2012
Projected Spending
2013-2033
2003
2005
2007
2009
2011
2013
2015
2017
2019
2021
2023
2025
2027
2029
2031
2033
Calendar Year

Spending Cap:

Medicaid is an entitlement program, so in order to keep the increase to only 4% we have to control utilization. Many believe that a block grant will cap Medicaid spending but what it does over time is shift the costs to the states. This would result in the state being responsible for the ever increasing health care costs. Costs can be contained by reducing or freezing provider payments, controlling prescription drug costs, reducing benefits, reducing eligibility, managed care, disease management programs, long-term care initiatives, and by targeting fraud and abuse. These are incorporated in the ideas that MRAG is working on. These changes are 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, at an estimated annual cost of $28.9 million. The additional 6% federal match would be $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. The additional 6% federal match would be $13.3 million. In total, the General Fund savings obtained by implementing 1915(k) would be $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

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 "rebasing." Rebasing 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).

Category	State Savings
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