

The Menges Group

Strategic Health Policy & Care Coordination Consulting

Assessment of Medicaid Expansion and Reform

Initial Analysis

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Table of Contents

I. Introduction	1
II. Medicaid Expansion Assessment	4
a) Potential Cost Reductions in Other Areas Attributable to Medicaid Expansion	4
Disproportionate Share Payments.....	4
Reductions in Non-Medicaid Behavioral Health Costs	4
Criminal Justice Health Costs	4
Medicaid Spending Reductions.....	5
State Taxation on Increased Provider Revenues	5
Chronic and Acute Medical Assistance (CAMA) Program.....	5
b) Woodwork Effect	6
c) Provider “Crowd-Out” Assessment.....	7
d) Estimated Cost Impacts of Medicaid Expansion	7
Overview	7
Estimated Cost Per Medicaid Expansion Enrollee	8
III. Medicaid Reform: An Analysis of Proposed Legislation	12
Controlling Expansion Coverage Costs.....	12
Increased Use of Tribal Health Services.....	12
Personal Health Savings Accounts	14
Managed Care Demonstration Project	15
Emergency Department (ED) Usage Reduction Demonstration Project	17
Instituting Provider Taxes	17
Privatization of State Facilities.....	18
Medicaid Provider Audits.....	18
False Claims.....	18
Fraud/Abuse Report to Legislature.....	18
Computerized Eligibility Verification System	19
Telemedicine.....	19
Medicaid Reform Program.....	20
IV. Pharmacy Savings Assessment	21
V. Assessment of Frequently Hospitalized Persons.....	23
Appendix A. Review of Medicaid Expansion Estimates	26

Table of Exhibits

Exhibit A. Medicaid Enrollment Trajectory for Non-Expansion Eligibility Groups	6
Exhibit B. Medicaid Expansion Population Costs Relative to “Already Covered” Adults.....	8
Exhibit C. Estimated Annual Per Capita Medical Costs for Alaska Medicaid Expansion Enrollees	9
Exhibit D. Estimated Medicaid Expansion Costs.....	10
Exhibit E. Estimated State Fund Costs Attributable to Medicaid Expansion	11
Exhibit F. Medicaid Eligibility Dynamics in Alaska (source: tabulations of 2011 MSIS data)	14
Exhibit G. Medicaid Cost Per Prescription and Generic Mix, FFY2014	21
Exhibit H. Therapeutic Classes With Promising Potential for Drug Mix Savings	22
Exhibit I. Distribution of Alaska Medicaid Beneficiaries by Number of Non-Maternity Hospitalizations 23	
Exhibit J. Initial Savings Estimate, Focused Care Coordination Program.....	24
Exhibit K. Projected Care Team Configuration and Costs.....	25

I. Introduction

Alaska is in the midst of a concerted effort to achieve Medicaid reform. An array of legislation has been proposed, and multiple consulting contracts are in place – all working towards the same objective of strengthening and modernizing Alaska’s Medicaid program. The following report provides an independent analysis of Medicaid expansion as well as areas of reform initiatives that need focused and targeted attention.

“Medicaid reform” is a broad umbrella under which a wide array of program design changes might occur. The types of changes being discussed are ambitious, including many of the following components:

- Restructuring provider compensation to pay for outcomes and quality, rather than simply paying for a service being rendered.
- Improving the integration of physical health, behavioral health, and long-term care services such that a whole person focus is achieved, and persons with complex needs are no longer fragmentally treated through multiple silos.
- Achieving Medicaid savings through optimal preventive care and early detection to both prevent health crises from occurring and through utilizing the lowest-cost, clinically effective treatment option to address identified health needs.
- Facilitating access to needed care by identifying and addressing beneficiary gaps in care, attracting providers to fill delivery system shortfalls, expanding the use of telemedicine, and other mechanisms.
- Maximizing federal revenues through introduction of provider tax mechanisms, and enhanced use of the tribal health delivery system.
- Linking all Medicaid beneficiaries to a “medical home,” which can take accountability for identifying and addressing (directly and through appropriate referrals) each individual’s health needs.
- Improve utilization of the prescription drug database to assist providers in countering opiate medication abuse.

In our view, these objectives are all excellent “nice to haves” with regard to improving Alaska’s program – and every other state’s Medicaid program, for that matter. However, Alaska is faced with pressing “must have” improvements that need to occur as soon as possible. These imperatives are listed below:

- Alaska’s economy is highly dependent on the price of oil, which has dropped from over \$100 per barrel during the first half of 2014 to \$60 in mid-2015 and is now approximately \$30. Over half of the state government’s revenue comes from oil-related sources (production taxes, corporate income taxes, petroleum property taxes, etc.) and these revenues have dropped significantly.

Alaska's fiscal situation¹ necessitates that the State secure – as soon as possible – all available Medicaid savings that can be achieved at no clinical or quality of care detriment.

- Alaska's Department of Health and Social Services (DHSS), which administers the Medicaid program, needs bolstering to adequately administer the State's growing Medicaid program. The program's basic operational functions – maintaining current and accurate eligibility records, processing claims, assuring compliance with all program rules and requirements, and paying providers promptly and accurately for the services they render – have posed significant challenges during the past few years. At the same time, a struggling economy and Medicaid expansion are fueling increases in the size of Alaska's Medicaid program while budget challenges threaten to lower the resources available to DHSS to administer the program.

The wide-ranging efforts taking place to assess and then potentially implement “Medicaid reform” further dilute DHSS' seemingly stretched resources. While our work over the coming year will assess broader Medicaid reform options, in this initial document we are striving to identify program modifications that are relatively easy to implement (in terms of state staff burden, timeframe, and cost) but which nonetheless can generate substantial near-term and ongoing savings. We specifically recommend the following short-term action steps to yield state fund savings in Medicaid – none of which involve imposing “cuts” on the program:

1. Modify the preferred drug list and corresponding prior authorization processes to steer volume to the lowest-cost, clinically appropriate medication. Alaska is among the states with the highest Medicaid costs per prescription (net of rebates) and the lowest usage of generic medications. Our report identifies several therapeutic classes where stronger management of the *mix* of drugs can yield savings at no clinical detriment. Access to all FDA-approved drugs, as required by federal law, will be maintained. We project annual savings of more than \$5 million to Medicaid from these efforts, which can be put in place quickly at a modest administrative cost and staff burden. This recommendation is detailed further in Section IV.
2. Create a care coordination program for persons who have been hospitalized more than 3 times during the past two years (excluding obstetrical admissions and persons dually eligible for Medicare). Alaska has 347 Medicaid beneficiaries who have been hospitalized at least 5 times during the time frame 2012-2015 (including at least one 2015 admission). These persons can be readily identified, as can all emerging beneficiaries reaching any selected threshold of multiple hospitalizations. These individuals' admissions *after* their 5th hospitalization cost approximately \$13 million during 2015. A care coordination team explicitly focused on outreach and care coordination for this subgroup is projected to have an annual cost of \$1.2 million and create a Medicaid inpatient cost savings of approximately \$5 million, yielding a net annual savings of approximately \$4 million. This approach creates significant clinical improvements, whereby all

¹ It is important to note that Alaska has some unique levers available that can help cope with fiscal downturn timeframes. Alaska's State government has accumulated savings funds collectively totaling more than \$60 billion. The State also imposes no personal income tax or general sales taxes.

savings would occur through reducing the degree to which these high-need beneficiaries continue to “down-spiral” into health crises. This recommendation is described in Section V.

3. Create a business plan to establish a set of additional tribal health nursing facilities as well as additional tribal health home and community based services. Alaska’s tribal health delivery system is nearly devoid of long-term care service capacity, and adding this component can yield substantial ongoing State fund savings given the 100% federal financing for tribal health providers’ services rendered to Alaska Native Medicaid beneficiaries. A 50% State fund savings will occur when an institutionalized Medicaid beneficiary is served in a tribal facility rather than a non-tribal facility. With Alaska’s nursing home costs per resident being extremely high, we estimate this 50% savings to potentially represent \$75,000 per institutionalized enrollee per year. If 120 beneficiaries received year-long nursing home care in a tribal health facility, in lieu of a non-tribal facility, annual State fund savings of approximately \$20 million would occur.

Our report also includes a detailed assessment of the costs of Alaska’s Medicaid expansion initiative, as conveyed in the ensuing section.

II. Medicaid Expansion Assessment

We have assessed the Medicaid expansion initiative by addressing the following questions:

- a) Are there aspects of Medicaid expansion that will result in lower State fund outlays in other areas?
- b) Is there a significant “woodwork effect” related to the Medicaid expansion that will result in increased Medicaid enrollment (and thus State costs) for non-expansion groups?
- c) Will a provider “crowd-out” occur due to Medicaid expansion increasing the mix of providers’ patient base served by the poverty program, making their businesses non-viable?
- d) What are the expected State fund impacts for Medicaid expansion?

Our analyses, findings, and opinions in these areas are conveyed below.

a) Potential Cost Reductions in Other Areas Attributable to Medicaid Expansion

Disproportionate Share Payments

Many arguments have been made that Medicaid expansion will reduce the need to maintain current budget levels for disproportionate share payments to hospitals. We see no consistent evidence that this has occurred in the expansion states. Phasing down of even the federal disproportionate share payments to hospitals, which were slated to occur as large numbers of previously uninsured persons moved into Medicaid coverage, has been postponed. While redeployment of funds to serve additional persons broadens the sphere of persons benefitting from public support, such dynamics cannot be appropriately referred to as “savings” being created by Medicaid expansion.

Reductions in Non-Medicaid Behavioral Health Costs

The FY2017 proposed budget from Governor Walker’s administration includes a reduction of \$5.8 million in behavioral health treatment and recovery grants, which seems directly attributable to Medicaid expansion with services currently being rendered to Medicaid expansion eligible individuals under Serious Mental Illness and Substance Use Disorders grants being converted to Medicaid. We have included this figure in our FY2017 projections, trending it upwards 3% per year thereafter.

Criminal Justice Health Costs

With Medicaid expansion, a much larger group of criminal justice-involved Alaskans will receive Medicaid coverage. In many Medicaid expansion states, nearly 100% of state prison inmates are enrolled in Medicaid upon release to the community. Nearly all state prison inmates are Medicaid

eligible under Medicaid expansion, whereas very few were eligible for Medicaid prior to implementing Medicaid expansion.

Medicaid will now cover these inmates' inpatient hospital costs that occur during an incarceration, and since nearly all of these individuals are eligible for Medicaid only due to Medicaid expansion, nearly all of these inpatient costs are now paid with Federal funds. Based on the size of Alaska's State prison inmate population and the State's reported health costs per inmate, we estimate an annual State fund reduction of *\$3 million per year* attributable to the implementation of Medicaid expansion.

We also encourage that a concerted re-entry effort occur to ensure that inmates receive the health services they need (including behavioral health supports). The health expenses incurred by these newly eligible Medicaid expansion recipients will overwhelmingly be covered by Federal funds. Reduced recidivism through better maintenance of this subgroup's behavioral health conditions could yield significant State savings (on corrections and correctional health costs), as well as important community safety benefits. We have not factored any such correctional health savings into our cost estimates, however, as the level of savings (if any) is not solidly quantifiable.

Medicaid Spending Reductions

Several states are experiencing reduced state fund outlays within Medicaid as a result of implementing their coverage expansion. However, this is due to these states having already covered persons in the Medicaid expansion eligibility corridor prior to 2014, and receiving greatly enhanced Federal match for these persons beginning in January 2014. Alaska has not previously covered the Medicaid expansion population and the state does not stand to benefit from this dynamic.

State Taxation on Increased Provider Revenues

The Medicaid expansion draws in a very large influx of new revenue to the state, predominantly from the Federal government due to the large matching rate for Medicaid expansion population's Medicaid medical costs. In most states, a source of state savings would be the state taxes levied on this additional provider and individual income. Alaska, however, has no sales tax nor an income tax and therefore does not stand to secure a state funds revenue increase by virtue of the influx of Federal Funds created by implementing the Medicaid expansion.

Chronic and Acute Medical Assistance (CAMA) Program

The Lewin Group has identified that approximately \$1.5 million in State spending on CAMA can cease to occur due to the Medicaid coverage expansion fulfilling this same role.² Based on the Governor's proposed FY 17 budget, the CAMA program is reduced but remains in existence resulting in a \$329,000 annual savings. We have not factored in a specific Medicaid expansion savings for CAMA – rather,

² The Lewin Group. *An Analysis of the Impact of Medicaid Expansion in Alaska* (2013). Funded by Alaska Department of Health and Social Services.

suggest that this program be formally reduced prior to attributing a state savings offset to the implementation of Medicaid expansion. Even full elimination of CAMA would create only a modest offset against the state share of Medicaid expansion costs.

b) Woodwork Effect

Implementing Medicaid expansion brings persons forward to seek Medicaid coverage, and some of these individuals (and/or their dependents) may qualify for traditional Medicaid coverage. To the extent additional persons, outside the expansion enrollees, come “out of the woodwork” in Alaska and obtain Medicaid coverage they would not otherwise have obtained, the State will pay a 50% match on their Medicaid costs.

Our analyses of the enrollment trajectory of states that have – and have not – implemented Medicaid expansion suggest that there is likely a “woodwork” effect increasing the volume of persons on traditional Medicaid coverage *related to the ACA overall*, but that there is no such impact directly attributable to implementing Medicaid expansion. These analyses, summarized in Exhibit A, indicate that the traditional (non-expansion) Medicaid population actually grew faster in non-expansion states than in expansion states between January 2014 and March 2015.

Exhibit A. Medicaid Enrollment Trajectory for Non-Expansion Eligibility Groups³

State Group	Non-Expansion Enrollees, Jan '14	Non-Expansion Enrollees, Mar '15	Percent Increase
22 States Expanding Medicaid	24,385,128	25,120,553	3.0%
22 States Not Expanding Medicaid as of Mar '15	21,817,164	23,698,154	8.6%

These figures suggest that the states expanding Medicaid have not experienced a woodwork effect (growth in their core Medicaid enrollment) as a result of implementing the coverage expansion. The Medicaid enrollment growth that has occurred since January 2014 is likely at least partially attributable to the ACA’s provisions requiring uninsured individuals to obtain health coverage or face tax penalties.

³ Note: Data in six states and DC were not deemed complete/usable across the timeframe assessed. Source: Menges Group analyses of CMS Medicaid enrollment data collected through the Medicaid Budget and Expenditure System (MBES); files are available at <https://www.medicaid.gov/medicaid-chip-program-information/program-information/medicaid-and-chip-enrollment-data/medicaid-enrollment-data-collected-through-mbes.html>

c) Provider “Crowd-Out” Assessment

Medicaid expansion pointedly increases the proportion of a state’s residents covered by Medicaid. Given that Medicaid is typically a low-end payer in terms of unit prices paid to providers, concerns have been raised that Medicaid expansion will worsen provider’s patient mix (a greater proportion of low-payment patients) and in some cases render provider practices non-viable. In the absence of Medicaid expansion, the argument has been made that this same population will largely be covered under the commercial insurance exchanges, where unit prices to providers will typically be well above Medicaid and where the crowd-out issue will not materialize.

While data evidence on this particular issue is sparse, we have not been aware of situations where providers have been harmed by Medicaid expansion. To the contrary, Medicaid expansion brings a large infusion of new revenue to the provider community. Providers throughout the country – including in Alaska – have been strong proponents of states implementing Medicaid expansion. This would not occur if they expected expansion to worsen their financial viability.

Hospitals in expansion states report less uncompensated care since Medicaid expansion was implemented, and the number of uninsured individuals has decreased substantially in these states.

In Alaska, Medicaid expansion creates hundreds of millions of dollars in revenue for the State’s providers, most of which will be for persons who would otherwise remain uninsured and therefore represents additional marginal revenue for the provider community. Medicaid is also a reasonably solid payer in Alaska in terms of unit prices, lessening any “crowd-out” concerns.

In summary, we do not anticipate that Alaska’s providers will become less financially viable due to Medicaid expansion. Our expectation is that the provider community will be made far better off by Medicaid expansion than had the state elected not to expand coverage.

We also note that Alaska has many underserved geographic areas where too little provider capacity currently exists. Providing Medicaid coverage to the expansion population in these areas will not, in and of itself, ensure that access to needed care will occur.

d) Estimated Cost Impacts of Medicaid Expansion

Overview

Our cost estimates of Medicaid expansion focus on whether implementing expanded coverage will require an investment in State funds, whether expansion creates a net reduction in State government outlays, and what the anticipated amount of this investment or savings will be each year through 2020. We seek to identify what the State fiscal impacts of Medicaid expansion will be, versus State costs had Medicaid expansion not been implemented. This involves attributing State fund savings that Medicaid

expansion will itself create. However, it does not involve attributing financial “credits” to the expansion for implementing a new Medicaid cost containment initiative (e.g., enhanced fraud detection, increased use of tribal health providers, “super-utilizer” care management, etc.) that could occur with or without Medicaid expansion.

It is important to note that the State government budget impact is not the only “lens” through which Medicaid expansion should be evaluated. We view implementation of the Medicaid expansion to be a highly attractive policy change financially due to the enormous influx of Federal dollars expansion is going to generate for Alaska’s economy. We also view Medicaid expansion to be an attractive policy programmatically and clinically due to the health coverage being provided to Alaskans who are not in a position to purchase health insurance (even under the ACA’s “mandate”), and who would otherwise remain uninsured or under-insured.

Financially, Alaska’s taxpayers are currently in the position of paying, through their Federal taxes, for all the other expansion states’ Medicaid coverage enhancements. We estimate this annual cost to Alaskans to be approximately \$90 million – without any corresponding benefit accruing to the State’s own residents. Through adopting the expansion and obtaining the Federal funds influx, we estimate that Alaska’s residents collectively move from experiencing an annual loss of \$90 million to an annual net gain of more than \$170 million.

Adopting the expansion is also of significant value and importance to Alaska’s low-income population (many of whom have no other affordable means of obtaining health insurance), to its provider community, and to the overall State economy. While none of these benefits accrue to the State budget, they are significant and in our view justify making a considerable state fund investment if necessary.

Estimated Cost Per Medicaid Expansion Enrollee

Substantial data are now available on expansion states’ medical costs for covering their Medicaid expansion enrollees. Exhibit B conveys these figures for seven states where both cost and enrollment data were available for the fourth quarter of 2014. Collectively, these states’ per capita costs for their expansion enrollees averaged approximately \$5,500 per person on an annualized basis.

We project that Alaska’s per capita costs for its Medicaid expansion enrollees will be 15% above the average of the other states, and that Alaska’s per capita costs will trend at 3% per year – a modest rate that assumes implementation of multiple Medicaid cost containment initiatives. These estimates, which place Alaska’s costs per capita above the observed costs in six of the seven expansion states in Exhibit B, are shown in Exhibit C.

Exhibit B. Medicaid Expansion Population Costs Relative to “Already Covered” Adults

State	Expenditures on Expansion Enrollees, Q4 2014	Expansion Covered Months During Q4 2014	Expansion Population's PMPM Cost During Q4 2014	Annualized Cost Per Expansion Enrollee, 2014	FY 2011 PMPM Medicaid Cost for Non-Expansion, Non-Disabled Adults	Expansion PMPM Q4 2014 Cost as % of Non-Expansion Adult FFY2011 PMPM Cost for Covered Adults
Arizona	\$523,452,643	1,046,919	\$500	\$6,000	\$498	100%
Connecticut	\$341,134,635	550,517	\$620	\$7,436	\$477	130%
Illinois	\$330,803,639	1,698,793	\$195	\$2,337	\$206	95%
Michigan	\$651,436,645	1,417,122	\$460	\$5,516	\$321	143%
Minnesota	\$505,865,823	548,846	\$922	\$11,060	\$439	210%
New Hampshire	\$43,385,097	80,462	\$539	\$6,470	\$382	141%
New Mexico	\$296,826,629	540,475	\$549	\$6,590	\$381	144%
7 State Total	\$2,692,905,111	5,883,134	\$458	\$5,493	\$351	130%

Note: To Derive average Medicaid expansion enrollment in each state during Q4 2014, divide the figure in the column titled “Expansion Covered Months, Q4 2014” by three. Also, PMPM signifies Per Member Per Month.

Exhibit C. Estimated Annual Per Capita Medical Costs for Alaska Medicaid Expansion Enrollees

Projections for Alaska Medicaid Expansion Population	
Average Cost Per Expansion Enrollee Across 7 States, FFY 2014	\$5,493
Alaska Cost Factor Relative to Other States	1.15
Estimated Cost Per Expansion Enrollee, FFY2014	\$6,317
Annual Per Capita Cost Inflation Factor	1.03
Estimated Expansion Cost Per Person, FY2015	\$6,506
Estimated Expansion Cost Per Person, FY2016	\$6,701
Estimated Expansion Cost Per Person, FY2017	\$6,902
Estimated Expansion Cost Per Person, FY2018	\$7,110
Estimated Expansion Cost Per Person, FY2019	\$7,323
Estimated Expansion Cost Per Person, FY2020	\$7,542

Enrollment Estimates

Alaska’s Medicaid expansion enrollment started slowly but we anticipate enrollment will steadily and significantly accumulate throughout federal fiscal year (FFY) 2016. We estimate average enrollment during FFY2016 will be approximately 20,000 persons. By the end of FFY2016, we anticipate that most persons who desire Medicaid coverage through the expansion initiative will have come forward and enrolled. Medicaid expansion enrollment is projected to reach a level of 40,000 persons. This figure represents roughly a mid-point of the projections made by The Lewin Group and the Urban Institute. We considered increasing these projections to depict an expectation of larger enrollment due to

Alaska’s oil industry and broader economic and employment challenges (not foreseeable at the point the prior reports were prepared), but we have continued to use these estimates. This is a potentially conservative aspect of our projections, and sensitivity analyses can easily be produced using different enrollment estimates.

Exhibit D estimates total Medicaid medical and administrative costs for the Medicaid expansion population by year. These figures use the per capita medical costs derived in Exhibit C, and assume the marginal administrative costs of covering the expansion population to be 2% of medical costs. Alaska’s current administrative costs as a percentage of Medicaid medical costs is much higher, but we anticipate that the majority of these administrative costs are fixed and that a much smaller percentage is appropriate for purposes of estimating marginal administrative costs.

As shown in Exhibit D Medicaid expansion is projected to create overall annual Medicaid expenditures (including medical and administrative costs, and Federal and State expenditures) of roughly \$300 million at an enrollment level of 40,000.

Exhibit D. Estimated Medicaid Expansion Costs⁴

Federal Fiscal Year	Average Expansion Population During Year	Average Annual Medical Costs Per Person	Administrative Costs Per Person (2% of medical assumed)	Total Medical Expenditures	Total Administrative Expenditures	Total Medicaid Expenditures
2015	262	\$6,506	\$130	\$1,703,545	\$34,071	\$1,737,616
2016	20,000	\$6,701	\$134	\$134,028,094	\$2,680,562	\$136,708,656
2017	35,000	\$6,902	\$138	\$241,585,639	\$4,831,713	\$246,417,352
2018	40,000	\$7,110	\$142	\$284,380,810	\$5,687,616	\$290,068,426
2019	40,000	\$7,323	\$146	\$292,912,234	\$5,858,245	\$298,770,479
2020	40,000	\$7,542	\$151	\$301,699,601	\$6,033,992	\$307,733,593

The State and Federal share of Medicaid expansion costs are statutorily determined by the ACA. These projected governmental shares of overall expansion costs are shown in Exhibit E, with the right-hand column presenting net estimated state fund costs in each fiscal year (after factoring in reductions in state correctional health outlays). Due to the 100% Federal match on medical costs through FFY2016, no investment in state fund costs to implement Medicaid expansion is expected to be needed until FFY2017.

⁴ Note: The 262 expansion enrollees during FFY2015 reflects somewhat of an odd average of no enrollees across the first 11 months of the fiscal year and 3,142 enrollees during the first month of implementation (September 2015).

Exhibit E. Estimated State Fund Costs Attributable to Medicaid Expansion

Federal Fiscal Year	Federal Share of Medical Cost	Federal Share of Admin. Cost	Total Federal Cost	State Share of Medical Cost	State Share of Administrative Cost	Total State Cost	Offset for Behavioral Health Grant Spending Reductions	Offset for Correctional Health Inpatient Savings	Estimated Net State Fund Impact of Medicaid Expansion
2015	100%	50%	\$1,720,580	\$0	\$17,035	\$17,035	\$0	\$0	\$17,035
2016	100%	50%	\$135,368,375	\$0	\$1,340,281	\$1,340,281	\$0	\$1,500,000	-\$159,719
2017	95%	50%	\$231,922,214	\$12,079,282	\$2,415,856	\$14,495,138	\$5,779,600	\$3,000,000	\$5,715,538
2018	94%	50%	\$270,161,769	\$17,062,849	\$2,843,808	\$19,906,657	\$5,952,988	\$3,090,000	\$10,863,669
2019	93%	50%	\$275,337,500	\$20,503,856	\$2,929,122	\$23,432,979	\$6,131,578	\$3,182,700	\$14,118,701
2020	90%	50%	\$274,546,637	\$30,169,960	\$3,016,996	\$33,186,956	\$6,315,525	\$3,278,181	\$23,593,250

However, the drop-off in the Federal share of the expansion population’s medical costs during FFY2017 (from 100% to 95%), coupled with a much larger average enrollment level, are expected to create a net state fund cost in that year of approximately \$6 million. As the Federal share of the expansion population’s medical costs continues to decrease (reaching 90% in 2020 and remaining at that level thereafter), Exhibit E conveys our projection that State fund costs related to Medicaid expansion will reach approximately \$24 million during FFY2020.

We believe large-scale opportunities exist to reduce state Medicaid costs over the longer term (e.g., through opening several tribal health nursing facilities) to offset Medicaid expansion costs at this level. However, it is also apparent that Alaska will be hard-pressed to achieve base Medicaid savings soon enough and large enough to finance the additional FFY2017 State costs created by covering the expansion population. We view the state fund investment required to implement and maintain Medicaid expansion to be of great benefit to Alaska’s economy, but a State fund investment does appear to be necessary from FFY2017 forward.

III. Medicaid Reform: An Analysis of Proposed Legislation

The following section provides a review of topics proposed in the following Medicaid reform legislative documents: House Bill 148, House Bill 190, Senate Bill 78, Senate Bill 74 and Revised Program Legislation # 06-2016-0056 and #06-2016-0057.

Controlling Expansion Coverage Costs

SB78A Section 1(1) and HB148b Section 1(1): “take all necessary action to capture federal revenues and offset state general funds and evaluate the most cost-effective method for revising expansion coverage, including more efficient benefit plans, cost sharing, utilization control, and other innovative health care financing strategies.”

Commentary/Assessment: We suggest *not* focusing cost containment initiatives on the expansion population, where Medicaid’s costs for covered services are overwhelmingly being paid with Federal funds. At a 95% Federal match for expansion population care, a cost-containment initiative that yields an overall 4% cost reduction would achieve only a 0.2% State fund savings, with the other 3.8% going to the Federal government. Conversely, a 4% cost reduction in costs for any non-expansion population subgroup will yield a State fund savings of 2.0% at the regular 50% Federal match rate. Thus, any given broad-based cost containment initiative applied to all Medicaid populations will have roughly *ten times as much State fund savings value* for non-expansion populations (relative to achieving the same gross dollar Medicaid savings within the Medicaid expansion population).

Increased Use of Tribal Health Services

SB78A Section 1(2) and HB148b Section 1(2): “evaluate and implement meaningful Medicaid reform measures, including working with tribal and community partners to develop innovative practices leading to a sustainable Medicaid program available for future generations”

Commentary/Assessment: Approximately 40% of Medicaid recipients are Alaska Native. Increasing the use of tribal health providers has many complex dynamics that impact the benefits that accrue to the Medicaid program. In general, increasing the use of tribal health providers by tribal health members is of benefit to the State. Currently, two thirds of the funds spent on Alaska Native health care is paid to private sector providers. The opportunity to maximize Federal funds is not being realized.

A relatively straightforward and large-scale issue is that Alaska has almost no tribal health long term care providers at the present time. We encourage strong exploration of options for putting tribal health skilled nursing facilities into operation. We estimate annual state fund savings of approximately \$75,000 per bed will accrue as tribal health nursing home capacity is expanded and Medicaid eligible beneficiaries receive care in these facilities in lieu of a non-tribal nursing home. If a shift of 120 beds

occurs from general skilled nursing facilities to tribal nursing facilities, the annual State fund savings are estimated to be approximately \$10 million.

Additional opportunities exist to fill service gaps in Alaska by expanding the tribal health delivery system where a 100% Federal match will occur for care rendered to Alaska Natives who are Medicaid beneficiaries.

The Centers for Medicare and Medicaid Services (CMS) in its October 2015 “Medicaid Services Received Through an Indian Health Service/Tribal Facility: A Request for Comment” document is currently proposing a revision to its policies to address the lack of a full Federal match for services – varying on the provider and the type of service – provided by an IHS facility or tribe. CMS is proposing to change its policy to:

- Expand its definition of services “received through” IHS and tribal facilities to include transportation services, as well as emergency transportation (EMT) services and non-emergency transportation (NEMT) services, including related travel expenses (such as meals, lodgings, and cost of an attendant pursuant to Federal and State requirements).
- Include individuals or entities enrolled as a Medicaid provider and who provides items or services not within the scope of a Medicaid “facility services” benefit but within the IHS/ Tribal facility authority to serve AI/ AN members in IHS and tribal facilities.
- Provide IHS/tribal facilities a choice of specifying whether the facility would bill the state Medicaid program for the service or whether the contractual agent would bill the state Medicaid program directly.
- Adapt the fee-for-service (FFS) IHS facility rate set by the state plan to pay for services rendered in an IHS or tribal facility. For services not in the scope of the facility benefit, rates would be paid at the state plan rates.
- Ensure that the state can claim 100 percent FMAP for the capitation rate for AI/AN recipients enrolled in a managed care plan.⁵

It is important to Alaska that these Federal policy changes occur.

Further deliverables in our engagement will describe and assess opportunities for increasing the use of tribal health providers in detail.

⁵ FMAP, Federal Medical Assistance Percentages: the percentage rate the Federal government uses to determine the Federal matching funds available to Medicaid and other related programs.

Personal Health Savings Accounts

SB74A Section 3 –47.07.038: “The department shall develop and implement a personal health savings account program for the benefit of medical assistance recipients who elect to participate in the program.”

Commentary/Assessment: We do not see Health Savings Accounts (HSAs) as a good fit for Alaska’s Medicaid program for several reasons. First, this model is primarily used in commercial coverage settings where the core benefits package includes an array of deductibles, copayments, and other cost sharing occurs. Commercial plans also tend to provide no coverage for many services covered by Medicaid (e.g., non-emergency transportation, over-the-counter medications, etc.). Medicaid provides first-dollar coverage for a fairly comprehensive benefits package relative to commercial insurance. The costs that an HSA is typically used to cover are largely not applicable in Medicaid.

Second, Medicaid’s eligibility dynamics work against a HSA model’s efficacy. As shown in Exhibit F, Alaska’s Medicaid population has significant eligibility turnover with only 56% of the persons covered by Medicaid enrolled throughout the year. For dual eligibles, even where coverage stability is greatest, Medicare is the primary payer and the HSA model is particularly awkward.

Exhibit F. Medicaid Eligibility Dynamics in Alaska (source: tabulations of 2011 MSIS data)⁶

ALASKA 2011 Medicaid Eligibility	TANF CHILD	TANF ADULT	DISABLED NON-DUAL	DUAL ELIGIBLE	ALL OTHER	ALL BENEFICIARIES
Unique Eligibles	82,677	33,579	11,167	15,108	5,867	148,398
Full Year Eligibles	46,251	12,327	7,973	12,160	4,171	82,882
Percent of Persons Covered All Year	56%	37%	71%	80%	71%	56%
Average Covered Months Per Person	9.7	8.2	10.3	11.0	10.1	9.6

Third, an HSA arrangement would be a significant “lift” for an over-extended DHSS to implement. Substantial efforts will be needed to educate beneficiaries and their caregivers about these accounts, to configure systems to establish and track savings account balances, etc. We do not believe the administrative complexity involved in shifting to an HSA model is a worthy undertaking at this time given the myriad of other challenges DHSS is facing.

Fourth, the value proposition for the HSA approach is unproven in Medicaid. There is no assurance that this type of model will improve the program’s cost effectiveness, quality performance, or access performance.

⁶ TANF, Temporary Assistance for Needy Families: Provides temporary financial assistance for pregnant women and families with one or more dependent children | Dual Eligible: Individuals who are entitled to Medicare Part A and/or Part B and are eligible for some form of Medicaid benefit | Disabled Non-Duals: Aged, Blind, and Disabled individuals under 65 years who do not qualify for Medicare and typically receive assistance from the Social Security Administration. MSIS refers to the Medicaid Statistical Information System maintained by CMS.

In lieu of an HSA approach, Alaska could implement greater use of beneficiary copayments for various services (e.g., emergency department visits, prescriptions, physician visits, etc.). While this would not be burdensome administratively and has some value in ensuring that beneficiaries “give something to get something,” we are concerned that the copayments may pose a barrier to needed routine and maintenance care for the poverty population. This could easily more than offset the financial savings the copayments would otherwise yield. It will take very few hospitalizations to offset the full value of the all the copayments being collected. Also, states using copayments in Medicaid have found that their beneficiaries fail to pay (and/or providers are reluctant to ask for) the “required” copayments a considerable portion of the time, essentially resulting in a payment reduction for providers.

Managed Care Demonstration Project

SB74A Section 5(a), SB74B Section 5(a), SB74C Section 8(a), and HB190a Section 5(a): “The Department... shall design and initiate a managed care demonstration project for individuals who qualify for medical assistance.”

SB74A Section 5(b and c), SB74B Section 5(b and c), SB74C Section 8(b and c), and HB190a Section 5(b and c): The department shall contract with a third party to provide managed care or case management services.... The department shall enter into contracts with one or more third-party primary care case managers, managed care organizations.”

Commentary/Assessment: Alaska’s unique demographics need to be strongly considered in the effort to select optimal Medicaid care coordination approaches.

- Alaska has one of the nation’s smallest Medicaid programs in terms of spending (ranked 45th) and in terms of covered beneficiaries (ranked 47th). Alaska currently has approximately 130,000 Medicaid enrollees.
- Being the largest state in land area, Alaska’s Medicaid population is uniquely and widely dispersed. Alaska has only 0.2 Medicaid enrollees per square mile – far below every other state. The remainder of the United States has 18.6 Medicaid beneficiaries per square mile.
- Alaska’s most urban areas have highly dispersed populations. The population within Alaska’s Metropolitan Statistical Areas (MSA) is less concentrated than the *total population* in the remaining United States (including MSAs and non-MSAs)⁷. Anchorage is by far Alaska’s most populated MSA with roughly 400,000 residents. Anchorage is the 134th most populous MSA in the country, but is the nation’s second-largest MSA in terms of land area. The Anchorage MSA is larger in land area than ten other states’ square mileage. The Anchorage MSA has 15.2 persons per square mile overall, which is much more dispersed than the USA average (90.5) and the non-Alaska average (107.7). Fairbanks, the next-largest Alaska MSA with approximately 100,000

⁷ There are two metropolitan statistical areas (MSA). The Anchorage metropolitan statistical area is comprised of the Municipality of Anchorage and the Matanuska-Susitna Borough. The Fairbanks MSA is comprised of single boroughs. Alaska also has three micropolitan statistical areas (μSAs). The boroughs and census areas outside of the metropolitan and micropolitan statistical areas are considered to be entirely rural.

residents, is the 26th largest MSA in the nation with regard to land area. Fairbanks' population is also unusually dispersed for an MSA – its population per square mile (13.6) is smaller than the Anchorage MSA.

These dynamics do not line up well for use of capitation contracting with Managed Care Organizations (MCOs) as a central vehicle for Medicaid reform. Capitation contracting with MCOs requires at least two competing health plans, for purposes of beneficiary choice in a mandatory enrollment setting. While a single plan model has been used for rural areas in a few states, many states prefer to ensure that at least three MCOs operate in each area. This assures that no MCO has leverage (e.g., with regard to the capitation rates being paid) to unravel the entire coordinated care program by terminating its contract with the state. The Medicaid population across the two large MSAs (Anchorage and Fairbanks) that totals fewer than 100,000 persons, which would need to be divided among at least two health plans. Introducing the MCO capitation model in Alaska would also be a massive and complex undertaking.

The challenges of redesigning Medicaid in this direction, coupled with the risks that a multi-MCO capitation contracting model will operate on too small a scale, led us to avoid recommending this approach in Alaska. Note that Alaska may nonetheless be well-suited to contract with an experienced Medicaid MCO organization. One of the options we believe warrants close consideration is contracting with a single MCO on a non-risk (or limited risk) administrative services only basis to deliver care coordination services on a program-wide basis. Note also that other forms of capitation contracting may be viable in Alaska, such as paying on a capitation basis for certain services (e.g., primary care) or possibly certain population groups (e.g., Alaska Native).

SB74A Section 5: Medicaid Managed Care Demonstration Project for individuals enrolled in Denali Kidcare; opt in for other recipients. (Note that this language was removed from later versions of bills SB74B and SB74C.)

Commentary/Assessment: We concur with the removal of this language and do not believe the state should seek to alter the core structure of Denali Kidcare at this time. Serving this population through a managed care model is a high-effort endeavor and the cost savings that will result are small and quite possibly even negative based on our recent national modeling of Medicaid capitation savings⁸.

Medicaid and CHIP children, other than infants and those with disabilities, have very low per capita costs. Coordinated care initiatives are better targeted at persons with significant, impactable health needs, high costs, and stable/lasting eligibility for coverage.

⁸ This October 2015 report, "Projected Savings of Medicaid Capitated Care: National and State-by-State" is available at: <http://www.communityplans.net/Portals/0/Policy/Medicaid/Projected%20Savings%20of%20Medicaid%20Capitated%20Care%20-%20October%202015.pdf>.

HB148b Section 16: Demonstration Project: Reducing Pre-Term Births

Commentary/Assessment: We concur with the goals of the reducing pre-term births demonstration project.

HB148b Section 17: Medicaid Managed Care Program for Super-Utilizers

Commentary/Assessment: We encourage the development of a program to address super-utilizers. We have outlined a specific opportunity, focused on frequently hospitalized individuals, in Section V.

Emergency Department (ED) Usage Reduction Demonstration Project

SB74A Section 6, SB74B Section 3 - 47.07.038, SB 74C Section 6 - 47.07.038, and HB190a Section 3 - 47.07.038: “The Department... shall design and initiate a demonstration project to reduce non-urgent use of emergency departments.”

Commentary/Assessment: In the near term, we encourage the State to focus on enrollees with the largest volume of ED visits during 2015, conducting outreach to these persons to assess the cause of the frequent ED usage and seek to establish an effective primary care provider relationship. If and when a broader Primary Care Case Management (PCCM) program is put in place, particular efforts can occur (including financial incentives for primary care physicians) to lower the use of ED visits in general and for high utilizers in particular. Another near-term option would be to lock-in beneficiaries to a single pharmacy, and a single prescriber, for opioids once their usage pattern signals probably abuse/ misuse of these drugs. These individuals could continue going to the ED, but would not be able to obtain opioid medications in conjunction with those visits.

Instituting Provider Taxes

SB78A Section 1(3) and HB148b, Section 1(3): “Submit to the legislature... a proposal to authorize a provider tax up to the maximum extent allowed by federal law to offset some of the cost of the Medicaid program.”

Commentary/Assessment: While efforts to explore provider tax options have been ongoing, The Menges Group has not been involved in them. One advantage of keeping the underlying FFS payment structure in place (versus moving to a capitated MCO model) is that new provider tax programs can more easily be put in place. We can comment on any specific proposal once it is submitted to the legislature.

Privatization of State Facilities

SB74A Section 8(a), SB74B Section 6(a), SB74C Section 9(a), HB190a Section 6(a): “The Department... shall conduct a study analyzing the feasibility of privatizing services delivered at Alaska Pioneers’ Homes, the Alaska Psychiatric Institute, and select facilities of the division of juvenile justice.”

Commentary/Assessment: We concur with this language. For federal matching funds purposes it is important that the assessment include the option of transferring ownership to a tribal health system – as compared to transferring ownership to a traditional private sector entity.

Medicaid Provider Audits

SB78A, Section 3: “The department shall annually contract for independent audits of a statewide sample of all medical assistance providers in order to identify overpayments and violations of criminal statutes... The number of audits under this section may not be less than 50 each year.”

Commentary/Assessment: We suggest not stipulating a minimum of 50 provider audits beyond the initial year of implementation of this provision. To the extent that the audits are not finding substantive concerns with certain provider types, geographic areas, etc., it would make sense to ramp down the audit volume in these provider sectors. Claims and trend analyses can be used to identify providers warranting an audit. However, it is important to note that a provider that has been operating at a steady fraudulent level will not be discernable in an adverse trend report. We encourage that one component of the provider audits involve contacting beneficiaries to verify that they in fact received the services that Medicaid was billed for.

False Claims

SB74B Section 1 - 47.05.202, SB74C Section 3 - 47.05.202, HB190a Section 1 - 47.05.202: Defines false claims and the penalties that will apply.

Commentary/Assessment: We concur with this language.

Fraud/Abuse Report to Legislature

SB74B Section 4 - 47.07.076 and HB190a Section 4 - 47.07.076: “The department and the attorney general shall annually prepare a report... The report must identify the amount and source of funds used to prevent or prosecute fraud, ... the actions taken to address fraud, etc.”

Commentary/Assessment: We concur with this language. A systematic effort to identify which types of fraud identification approaches are proving most effective and including ongoing efforts to keep up with new types of fraud (and new perpetrators of fraud) seems needed. The required report seems useful in

helping the legislature and other policymakers ensure that the investments being made are not excessive, inadequate, or misplaced.

Computerized Eligibility Verification System

SB74C Section 2 - 47.05.105: “The department shall establish a computerized income, asset, and eligibility verification system... The department shall enter into a competitive bid contract with a third-party vendor...”

RPL# 06-2016-0057: “Medical Assistance Administration and Public Assistance positions, space and equipment are needed to support the claims processing, and an increase in applications for eligibility determinations for Medicaid expansion. Additional federal receipt authority allows the department to claim 50 percent federal reimbursement for administrative costs for claims processing and eligibility determinations. Mental Health Trust Authority Authorized Receipts (MHTAAR) will be used as 50 percent match for the additional federal receipt authority.”

Commentary/Assessment: Typically, these basic functions of Medicaid program operations do not require legislation. However, in light of the challenges that have occurred in Alaska with Xerox Corporation, we understand the need for this language to explicitly appear in legislation.

Telemedicine

SB74C Section 4 – 47.05.260 and HB 190a Section 2 – 47.05.260: “The department shall identify the areas of the state where improvements in access to telemedicine would be most effective in reducing the costs of medical assistance and improving access to care for medical assistance recipients.”

Commentary/Assessment: We concur with this language, as expanded use of telemedicine holds promise in any state and particularly a rural state such as Alaska. We also encourage exploration of greater use of “telehealth” whereby the patient and established provider communicate by email, phone, text messages etc, (e.g., sending in a digital photo of how one’s rash is currently looking) in situations where an equally effective – and far more convenient – clinical interaction can occur in lieu of a face-to-face meeting or even in lieu of a more formal telemedicine event.

Medicaid Reform Program

SB74A Section 2 – 47.04.250, SB74B Section 2 – 47.05.260, SB74C Section 4 – 47.05.260, HB190a Section 2 - 47.05.260: “Medical assistance reform program. (a) The department shall adopt regulations to design and implement a program for reforming the state medical assistance program under AS 47.07...

Commentary/Assessment: Alaska’s Medicaid agency has been struggling to perform basic Medicaid operations, such as paying providers in a timely and accurate manner for the services they render. The implementation of Medicaid expansion, and a declining State economy are adding significantly to the program’s enrollment and to the size of the core program that must be administered.

In light of these growing challenges to operate Alaska Medicaid’s “current store,” we do not view this to be the appropriate time for Alaska’s staff resources to be spread even more thinly sorting through a wide array of potential large-scale transformations of its Medicaid program. We encourage the State to promptly implement a small number of relatively high-impact, low-burden initiatives such as those outlined in Sections IV and V, and to explore specific large dollar opportunities such as creating much larger nursing home bed capacity within the tribal health delivery system where a 100% federal payment can occur. We do not encourage that high-effort initiatives of limited/ questionable fiscal savings value – such as linking all beneficiaries to a primary care provider and creating new compensation structures through pay for performance, bundled payments, etc. – be further pursued until, at minimum, basic program operations are functioning successfully and consistently. Any such larger-scale reform endeavors should have clear and favorable fiscal savings value – and ensure that sufficient additional administrative resources are budgeted to successfully transform the program.

IV. Pharmacy Savings Assessment

We are confident that sizable savings can be achieved through strengthened management of the mix of drugs prescribed to Alaska’s Medicaid beneficiaries – with savings achievable in the short-term and continuing to accrue/accumulate over the longer term.

We performed extensive tabulations of Alaska and every other state’s Medicaid prescription drug usage and costs working with CMS State Drug Utilization data files. Exhibit G conveys Alaska’s Medicaid pharmacy cost statistics relative to the United States overall for federal fiscal year (FFY) 2014.

Exhibit G. Medicaid Cost Per Prescription and Generic Mix, FFY2014⁹

Medicaid Statistic	Alaska	USA	Alaska as Percentage of USA Average	Alaska’s Rank Among States
Pre-Rebate Cost Per Prescription	\$79.94	\$72.40	110%	28 th highest
Rebates Per Prescription	\$34.76	\$35.09	99%	19 th highest
Post-Rebate Cost Per Prescription	\$45.19	\$37.32	121%	9 th highest
Generics as % of All Prescriptions	77.7%	80.7%		43 rd highest

Alaska’s prescription drug costs have trended upwards sharply into calendar year (CY) 2015. Across the first two quarters of CY2015, Alaska’s average cost per Medicaid prescription was \$90.73 pre-rebate, and \$53.16 post-rebate. These figures are 14% and 18% above the State’s corresponding FFY 2014 figures.

With Alaska being among the nation’s highest-cost states in terms of net costs per Medicaid prescription, and (relatedly) being among the states with the lowest generic proportion of Medicaid prescriptions, significant opportunities exist for Alaska to achieve Medicaid savings through strengthened management of its mix of drugs. Substantial price differences typically exist (post-rebate) between medications that can effectively treat a given condition. Exhibit H identifies a list of therapeutic classes that we believe hold significant promise for Alaska to achieve savings through enforcement of a modernized Preferred Drug List (PDL) and corresponding prior authorization processes, in line with those commonly used in Medicaid and other health coverage arenas around the country.

⁹ Note: The ACA requires drug manufacturers to pay significant rebates to Medicaid for Medicaid-paid prescriptions. Nationally, these rebates averaged approximately 50% of the initial amounts Medicaid paid to pharmacies during 2014.

Exhibit H. Therapeutic Classes With Promising Potential for Drug Mix Savings

Therapeutic Class - 3rd Tier	Alaska Statistics, Q1 & Q2 of 2015				Estimated Net Cost Per Prescription		Alaska Net Cost Per Prescription as Percentage of US Average	Estimated Annual Savings if Alaska's Net Costs Per Prescription Were 20% Above USA Average	Therapeutic Class Priority Rank
	Prescriptions	Paid Amount, Pre-Rebate	Estimated Rebates	Estimated Paid Amount, Post-Rebate	Alaska	USA			
Adrenergic bronchodilators	16,435	\$1,608,658	\$536,153	\$1,072,506	\$65	\$31	209%	\$912,415	1
5HT3 receptor antagonists	7,755	\$738,432	\$102,646	\$635,785	\$82	\$23	357%	\$844,360	2
Nonsteroidal anti-inflammatory agents	17,204	\$566,061	\$80,088	\$485,974	\$28	\$8	343%	\$632,334	3
Narcotic analgesics	15,903	\$1,458,976	\$496,377	\$962,599	\$61	\$38	161%	\$488,509	4
Glucocorticoids	7,423	\$314,223	\$66,448	\$247,776	\$33	\$11	298%	\$296,270	5
Antiadrenergic agents, centrally acting	6,485	\$544,984	\$103,549	\$441,435	\$68	\$41	166%	\$243,306	6
Macrolides	6,107	\$322,851	\$91,819	\$231,031	\$38	\$17	229%	\$219,474	7
Vitamins	2,121	\$168,957	\$58,128	\$110,829	\$52	\$6	847%	\$190,249	8
Natural penicillins	1,646	\$204,725	\$103,027	\$101,698	\$62	\$10	639%	\$165,179	9
Cardioselective beta blockers	6,721	\$180,197	\$52,209	\$127,988	\$19	\$8	237%	\$126,227	10
Local injectable anesthetics	740	\$122,137	\$25,391	\$96,746	\$131	\$41	317%	\$120,312	11
Interferons	37	\$360,705	\$198,388	\$162,317	\$4,387	\$2,358	186%	\$115,207	12
Third generation cephalosporins	2,708	\$260,480	\$35,337	\$225,143	\$83	\$53	157%	\$106,222	13
Aminopenicillins	11,007	\$206,371	\$49,068	\$157,303	\$14	\$8	170%	\$92,737	14
Anticholinergics/antispasmodics	766	\$76,566	\$11,984	\$64,582	\$84	\$22	380%	\$88,354	15
Benzodiazepines	5,184	\$144,310	\$44,915	\$99,394	\$19	\$9	209%	\$84,897	16
Antihistamines	1,702	\$72,645	\$11,520	\$61,126	\$36	\$10	367%	\$82,330	17
Recombinant human erythropoietins	75	\$100,230	\$55,127	\$45,104	\$601	\$47	1271%	\$81,691	18
H2 antagonists	5,106	\$102,552	\$15,925	\$86,628	\$17	\$8	202%	\$70,150	19
Selective serotonin reuptake inhibitors	18,296	\$294,888	\$72,923	\$221,965	\$12	\$9	140%	\$62,241	20
Calcium channel blocking agents	3,882	\$73,803	\$11,888	\$61,916	\$16	\$7	231%	\$59,418	21
Topical acne agents	1,091	\$218,181	\$83,365	\$134,816	\$124	\$82	151%	\$55,994	22
Non-sulfonylureas	5,532	\$84,086	\$13,292	\$70,794	\$13	\$7	193%	\$53,442	23
Iron products	800	\$76,404	\$41,907	\$34,497	\$43	\$9	481%	\$51,795	24
Selective immunosuppressants	346	\$512,091	\$266,835	\$245,256	\$709	\$530	134%	\$50,740	25

An initial estimate of the annual savings opportunity, if Alaska’s overall net cost per prescription in each class were *lowered* to represent 120% of the US average is presented in the right-hand column of Exhibit H. Note that these projected savings entirely represent better management of the mix of drugs – they do not involve any revised pricing on any specific drug. Collectively across the 25 therapeutic classes, an annual Medicaid savings of more than \$5 million is deemed to be achievable.

In a subsequent deliverable, we will provide a detailed comparison of the mix of drugs within each of the therapeutic classes shown in Exhibit H between Alaska and the US overall. These tables can be used to guide clinical deliberations regarding appropriate PDL content revisions in Alaska.

V. Assessment of Frequently Hospitalized Persons

We assessed the degree to which Alaska Medicaid beneficiaries are being hospitalized repeatedly and quantified the savings opportunity of a case management team focused on selected subgroups of these members. Exhibit I shows the distribution of Alaska Medicaid enrollees by their number of medical/ surgical/ psychiatric hospitalizations during the timeframe 2012 through 2015 (partial year including claims paid through November 18, 2015). Note that maternity-related and newborn admits were removed, as were “admissions” on the file that occurred simultaneously or on consecutive days to another admission for the same person.

Alaska had 652 Medicaid beneficiaries with 5+ hospitalizations across the roughly 45-month timeframe, over half of whom had at least one admission to date during CY2015. This population’s claims patterns strongly suggest that programs that are in place to keep these members stable when they go back to the community are not working, despite the hospitals’ work to address the clinical crises as they occur.

Exhibit I. Distribution of Alaska Medicaid Beneficiaries by Number of Non-Maternity Hospitalizations

Number of Hospitalizations 2012-2015	Total Persons with this Number of Admits	Total Number of Persons with at Least One Admit to Date in 2015	Total Paid Across All Admits	Total Paid Across 2015 Admits	Total Admits	Total 2015 Admits	Cost per Admit
1	11,826	2,500	\$114,836,414	\$26,398,174	11,826	2,500	\$9,711
2	2,722	803	\$67,123,355	\$13,483,219	5,444	1,070	\$12,330
3	987	371	\$41,026,750	\$8,112,143	2,961	592	\$13,856
4	497	206	\$28,371,465	\$6,869,676	1,988	399	\$14,271
5	272	133	\$19,499,154	\$3,649,699	1,360	247	\$14,338
6	114	62	\$11,358,535	\$2,257,352	684	140	\$16,606
7	80	44	\$8,918,864	\$1,698,391	560	101	\$15,927
8	56	23	\$6,962,288	\$1,175,229	448	57	\$15,541
9	37	24	\$5,029,687	\$1,013,265	333	67	\$15,104
10	23	12	\$2,874,863	\$722,989	230	45	\$12,499
11	13	9	\$2,026,094	\$308,538	143	35	\$14,168
12	10	6	\$1,639,864	\$158,203	120	17	\$13,666
13	12	9	\$2,473,175	\$290,224	156	19	\$15,854
14	10	7	\$2,880,633	\$579,727	140	28	\$20,576
15	6	3	\$1,340,776	\$173,902	90	14	\$14,898
16	5	4	\$1,972,122	\$231,626	80	9	\$24,652
17	2	2	\$307,973	\$108,011	34	14	\$9,058
18	4	2	\$1,210,783	\$190,597	72	10	\$16,816
20	1	1	\$327,337	\$167,489	20	7	\$16,367
22	2	2	\$288,943	\$52,939	44	7	\$6,567
23	1	1	\$305,638	\$14,630	23	1	\$13,289
26	1	1	\$221,617	\$159,647	26	16	\$8,524
30	1	-	\$486,230	\$0	30	-	\$16,208
33	1	1	\$145,321	\$22,639	33	5	\$4,404
53	1	1	\$1,122,138	\$284,141	53	18	\$21,172
Total	16,684	4,227	\$322,750,020	\$68,122,451	26,898	5,418	\$11,999
Persons with 3+ Admits	2,136	924	\$140,790,252	\$28,241,058	9,628	1,848	\$14,623
Persons with 5+ Admits	652	347	\$71,392,037	\$13,259,239	4,679	857	\$15,258
Persons with 10+ Admits	93	61	\$19,623,508	\$3,465,303	1,294	245	\$15,165

These persons' additional admissions during 2015 after their 5th hospitalization represented 5.3% of all Alaska Medicaid med/surg/psych admits during the assessed timeframe and collectively cost \$13 million during 2015, as shown in Exhibit J. We estimate that a pointed case management program would eliminate 25% to 50% of the additional admissions these types of enrollees have, which would reduce medical costs by approximately \$3.3 million to \$6.5 million for persons with 5 or more admits and \$6.8 million to \$13.5 million for persons with 3 more admits.

Exhibit J. Initial Savings Estimate, Focused Care Coordination Program

Threshold	# of Persons Reaching This Level	# of Persons with at Least One Hospitalization in 2015	% With at Least One Hospitalization in 2015	Subsequent Admits Above Threshold	Subsequent Admits as % of All Non-Maternity, Non-Newborn Admits	Estimated 2015 Cost of Subsequent Admits	Savings at 50% Reduction	Savings at 25% Reduction
Persons with 3+ Admits	2,136	924	43%	3,220	12.0%	\$27,023,305	\$13,511,653	\$6,755,826
Persons with 5+ Admits	652	347	53%	1,419	5.3%	\$13,076,079	\$6,538,040	\$3,269,020
Persons with 10+ Admits	93	61	66%	364	1.4%	\$3,715,425	\$1,857,712	\$928,856

The care management effort can focus on the highest-cost and most frequently hospitalized persons, then expand to other members, as value is being achieved/demonstrated with the initial target population.

The cost of providing the tailored care coordination team would be low relative to the expected savings. Exhibit K conveys a draft care team to focus initially on the 347 identified beneficiaries with 5+ hospitalizations (including at least one during CY2015). This team includes a set of physician advisors (supporting the team on an hourly consulting basis), 5 full-time RNs, and four full-time community outreach staff.

The team would assess each individual's Medicaid claims history (diagnoses, providers seen, medication regimens, etc.), conduct an assessment of the person's needs, caregiver situation, etc. (interviewing the enrollee, caregiver, and key physicians). For many of these persons in the Anchorage area, one of the community outreach workers would seek to conduct a home assessment and establish a direct personal connection with the enrollee and/or the key caregivers. The assessment and care coordination work would occur primarily telephonically, and through email if desired, outside of the Anchorage MSA. An individualized plan of care would then be developed to support the enrollee and seek to improve her/ his clinical trajectory.

Exhibit K. Projected Care Team Configuration and Costs

Position	Salary	FTEs	Annual Cost
Physician Consultant Advisors	\$400,000	0.5	\$200,000
Supervisory RN	\$100,000	1	\$100,000
Behavioral Health RN	\$72,500	1	\$72,500
Staff RN	\$72,500	3	\$217,500
Community Outreach Specialist	\$50,000	4	\$200,000
Total Salary		9.5	\$790,000
Loading Factor for Benefits, IT Support, Office Space, Local Travel, etc.			0.5
Non-Salary Costs			\$395,000
Total Annual Cost for Care Team			\$1,185,000
Caseload (persons with 5+ admits with 1+ during 20:		347	
Caseload per Overall Care Team FTE		37	
Caseload per RN		69	
Caseload per Outreach Specialist		87	

Note that if the enrollee/caregiver refuses to participate in the care coordination efforts, this case would nonetheless remain active and the care team would remain responsible for supporting this person working with providers, sending educational information, etc.

This team’s annual costs of operation are estimated at approximately \$1.2 million. The annual medical cost savings for this subgroup, created by the care team’s efforts, are estimated at \$3.3 million to \$6.5 million. Only a 9% reduction in subsequent admissions would be needed for the care team to cover its costs and for Alaska Medicaid to reach breakeven. At a 37.5% reduction in subsequent hospitalizations (our midpoint estimate), inpatient costs would be lowered by \$4.9 million creating a net savings of \$3.7 million (with the return on investment being 4.1 to one).

Appendix A. Review of Medicaid Expansion Estimates

Study: Fiscal and Economic Impacts of Medicaid Expansion in Alaska

Funded by: Alaska Native Tribal Health Consortium

Prepared by: Northern Economics

Date: February 2013

Description of the Study:

This study looked at multiple scenarios: low participation expansion, mid participation expansion, and high participation expansion. It was a follow-up to a prior analysis conducted. This study placed significant emphasis on the economic impact of the expansion (direct and indirect). The population estimates were based on the Urban Institute's estimates. This analysis estimates that the State can achieve savings during the first three years of expansion. For the low participation model, the report estimates that savings could continue through 2020. For the mid and high participation, the study estimated costs to the State starting in 2017. Estimates in this report reflect direct, indirect, and induced economic effects of Medicaid spending.

This study estimates the woodwork effect will cost the State around \$174.4 million and the Federal government \$268.7 million in all scenarios.

- Low participation expansion: The cost from 2014 to 2020 would be around \$17.4 million in total. The report estimates an additional 2,600 jobs will be added to the economy.
- Mid participation expansion: This report primarily focuses on the mid participation scenario. This scenario assumes the newly eligible population and incremental increase in currently eligible participation will result in an increase in 19,390 individuals in 2014 to 39,340 individuals in 2020. The State cost would be \$90.7 million in total from 2014 to 2020. It is estimated to generate \$12 in Federal funds for every \$1 in State funding related to Medicaid (not accounting for savings in other programs). The report estimates an additional 4,000 jobs will be added to the economy.
- High participation expansion: This scenario is estimated to cost the State \$115.8 million from 2014 to 2020. The report estimates an additional 4,500 jobs will be added to the economy.¹⁰

This report provides cost offset analyses for three programs: Chronic and Acute Medical Assistance Program (\$1.4 million), Department of Corrections (\$5 million), and Immunizations (\$0.9 to \$1.1 million). All of these estimates assumed a 2.5 % rate of annual inflation.

This report also takes into account the higher health care spending and higher economic activity that is anticipated to occur. As a result, this report takes into account the increased corporate income taxes:

¹⁰ Northern Economics (2013). *Fiscal and Economic Impacts of Medicaid Expansion in Alaska*. Funded by: Alaska Native Tribal Health Consortium

For the low participation model, the additional revenue is estimated at \$9 million. The mid participation model would result in \$11.9 million in revenue. The high participation model is anticipated to generate \$13.1 million.

Population Estimates: N/A

Assumptions:

This study recognizes there are potential offsets to the Medicaid expansion that they were unable to quantify at the time. These include: reductions in the Adult Public Assistance Interim Assistance, municipal expenditures for health care, behavioral health service grants, and the costs of the State’s employee and retiree health care (refer to page 15 of the study for more info).

The report also acknowledges that it excludes “additional economic benefits that may result from reductions in uncompensated care and bad debt paid by people with no health insurance, or improvements in the health status of people who would acquire coverage.”

Cost Estimates: N/A

Study: An Analysis of the Impact of Medicaid Expansion in Alaska

Funded by: Alaska Department of Health and Social Services

Prepared by: The Lewin Group

Date: April 2013

Description of the Study:

This study was probably the most comprehensive study conducted. The report compares a non-expansion model to various design models under expansion, as well as a one- and two- year delay of Medicaid expansion. This study also highlights various mechanisms Alaska can use in redefining the population previously covered by State funds to the Health Benefits Exchange. At the time of this report, adult pregnant women up to 175% FPL were covered by Medicaid funds. The Lewin report suggests placing an eligibility cap at 138% FPL and moving the remainder of these women into the Health Benefits Exchange (and would thus be covered by federal dollars). The study also explores the transitioning of the Breast and Cervical Cancer Program eligibles into the Health Benefits Exchange. Similarly, the program looked at Denali KidCare Program, CAMA Program, and the State Employee Health Benefits Exchange. The study also examined other changes from the ACA including rebates for prescription drugs, changes in payment levels for PCPs, reductions in DSH payments, and modification to Denali KidCare Program.¹¹

Non-expansion summary: There are several provisions of the ACA that will impact Medicaid enrollment, even if the State opted to not expand. These include the individual mandate, simplified Medicaid

¹¹ The Lewin Group (2013). *An Analysis of the Impact of Medicaid Expansion in Alaska*. Funded by: Alaska Department of Health and Social Services

eligibility procedures, larger employer mandate, and the increase in CHIP FMAP. 779 individuals would move into Medicaid by 2020 and would cost the State (inclusive of admin costs) an estimated \$39.9 million. It would cost the federal government \$40.5 million. If the State caps Medicaid eligibility at 138% FPL for pregnant women, 242 enrollees would be moved into the HBE. Over the 2014-2020 period, the State would save \$28.8 million with this eligibility cap.

- Expansion scenario 1: The Lewin Group used enrollment levels estimated by the CBO assuming enrollment would reach 76% the first year, 88% in the second year, and 100% in the third year. Lewin also estimated that 2400 children and adults will leave Medicaid for private insurance. Lewin did not include estimates for individuals who may take steps to spend down to 138% FPL because they would now be receiving federal subsidies. With these assumptions, Lewin estimates that Medicaid enrollment would increase by 43,300 individuals by 2020 and would cost the State \$240 million (7.7% of total costs). This includes the administrative costs, as the federal government will only pay the pre-ACA admin matching rate on these costs.
- Expansion scenario 2: The 2nd scenario assumes all ACA provisions and ultimate enrollment are achieved by 2014. The State could anticipate a net enrollment of 56,000 individuals and a cost of \$306 million.
- Expansion scenario 3: Lewin illustrated 2 delayed scenarios. Delaying to 2015 would result in covering 30,000 fewer people and a savings of \$9.9 million. The federal government would save \$387.6 million. Delaying to 2016 would reduce the State cost by \$21.9 million as opposed to implementing in 2014 and would save the Federal government \$782.7 million.
- Expansion scenario 4: Lewin estimated what it would cost to move current eligibles above 138% FPL to the exchange (pregnant women) and transition of enrollees out of the breast and cervical cancer program to Medicaid (assuming most of these individuals are under 138% FPL). This would result in the State saving \$42.3 million.

Administrative costs: Lewin estimated that admin costs for FFS was 8.2% of annual costs (from CMS 64 data). The federal government would match most admin roles at 50%, with some higher match rates for specific functions. There are expected costs to integrate the HBE and current systems, however the State Health Reform Assistance Network proposes these may be offset with enhanced match rates (90% for building eligibility system and 75% for systems operations). Similarly, DHSS may need significant staffing to accommodate the expansion. Finally, these are some of the administrative roles that will need to be considered: updating technology systems that support eligibility, review of current eligibility categories (and how this will interface with the HBE), the implementation of MAGI methodologies, a review of the application process, and a renewal process to increase retention. Lewin also notes some states have seen decreases in admin costs over time with the elimination of the income certification process and the asset test.

Lewin also qualitatively explores the opportunity for other cost control measures including patient centered medical homes, prevention and wellness interventions, quality incentives, drug benefit management, and behavioral health telemedicine.

Population Estimates:

The Lewin Group Health Benefits Simulation Model was used to estimate the number of newly eligible individuals in the State. Lewin used the Current Population Survey data from the Bureau of the Census for the simulation. Lewin also simulated “crowd-out” in the participation models.

Assumptions:

The report took the following into consideration in the analysis:

- Costs of health care benefits for Medicaid enrollees enrolled between 2008-2012 (including demographic categories, type of service, and Federal and State shares, as provided by Alaska DHSS)
- Eligibility counts between 2008 and 2012
- Estimated cost of the Medicaid program without ACA implementation from 2008 to 2012
- Cost effects of ACA mandates
- Costs for population that will be eligible under Medicaid expansion.

Cost Estimates:

Without Medicaid expansion, this report projects \$39.9 million in costs to the State due to ACA effects. At various participation scenarios, the State spending would vary from \$198 million to \$306 million between 2014 and 2020.

Study: Medicaid in Alaska Under the ACA

Funded by: N/A

Prepared by: The Urban Institute

Date: February 2013

Description of the Study:

The Urban Institute assumes if Alaska opts to expand Medicaid in 2014, there will be a “ramp up” of enrollees from 60,500 nonelderly adult enrollees in 2014 to 81,500 in 2020 (during an average month). Without Medicaid expansion, Urban estimates that there would be an average of 42,300 adults enrolled in Medicaid in 2014 and would increase to 44,000 in 2020. Of those newly enrolling, Urban estimates that 14,000 would be Alaska Natives or American Indians.¹²

Urban estimates that most of the enrollment of children with expansion and in absence of expansion would only be a difference of 1,200 enrollees in 2014 and 1,900 enrollees in 2020 (largely due to the “no wrong door” policy).

¹² The Urban Institute. *Medicaid in Alaska Under the ACA* (2013).

The study estimates that the acute care for nonelderly adults under full expansion would be \$1.3 billion in 2014 and \$1.9 billion in 2020. Without expansion, total spending would be \$1.2 billion in 2014 and \$1.6 billion in 2020. The report used an average of Medicaid enrollment take-up to produce the analysis (refer to pg. 16 of report).

Administrative costs: Urban estimated that Alaska currently spends 2% of total spending on administrative costs (according to Alaska's FY 2011 Budget Summary). The report notes that while there is a 50% match, the ACA allows for the federal government to match the development costs at 90% and maintenance costs at 75%. For this analysis, however, Urban estimates the match to be 50%. According to this report, Alaska would spend \$12 million more from 2014 to 2020 (excluding State savings).

Population Estimates:

The Urban Institute used three years of Alaskans in the American Community Survey integrated with the Urban Institute's Health Insurance Policy Simulation Model.

Assumptions:

This analysis did not take offset estimates into account.

Cost Estimates:

Urban estimates there would be \$1.1 billion in additional federal spending and \$78 million in State spending for the nonelderly adult population. Cost data are based on three years on the Medical Expenditure Panel Survey-Household Component.

Study: Projected Population, Enrollment, Service Costs, and Demographics of Medicaid Expansion
Beginning in 2016

Funded by: Alaska Department of Health and Social Services

Prepared by: Evergreen Economics

Date: February 2015

Description of the Study:

This analysis was prepared to develop a six-year analysis of the number of new eligibles and total spending on this new population. The analysis presents three components: projection of the expansion population for FY 2016 to FY 2021, estimates of the per-enrollee costs of providing Medicaid services for the expansion population, and estimates of the total spending and states' spending on services for the Medicaid expansion.¹³

¹³ Evergreen Economics. *Projected Population, Enrollment, Service Costs, and Demographics of Medicaid Expansion Beginning in 2016 (2015)*. Alaska Department of Health and Social Services

The report acknowledges the differing population estimates in the Lewin report and the Urban Institute report. The Lewin report estimates the Medicaid enrollment eligible to newly enroll as well as estimates of those predicted to actually enroll. Urban only estimates the number of newly eligible that actually enroll. Further, the Lewin Group projects the average growth rate to be 1.4% (which is greater than the 0.4% growth rate projected by the Alaska Department of Labor and Workforce Department).

Using the BRFSS and ADLWD data (see below in population estimates for acronym definitions), the lower and upper bounds of the estimates of the expansion population are 34,833 and 48,988 individuals, respectively. The report also breaks down the demographic features of the population, including based on geographic areas, health insurance status, gender, age, and employment status.

The report estimated the weighted cost of service per newly eligible Medicaid enrollee to range from \$7,248 in 2016 to \$8,433 in 2021. In estimating the costs of Medicaid expansion, this report uses the Lewin's Group progression of the take-up rate from 2016 to 2021. The overall annual spend for Federal spend would range from \$145,435,000 to \$204,928,000 between 2016 and 2021 and the State spend would range from \$0 to \$19,587,000.

**This estimates that 29% of newly eligible Medicaid enrollees will be either Alaska Native or American Indian based on data from the Medicaid Budget Group. An average of 44% of Medicaid expenses incurred by AN/AIs occur at tribal health facilities (with a 100% match).

***It does not appear that administrative costs were taken into account.

Population Estimates:

Evergreen used the Behavioral Risk Factor Surveillance System (BRFSS) for 2012 and 2013 and the population estimates from the Alaska Department of Labor and Workforce Development.

Assumptions:

None

Cost Estimates:

Overall annual Federal spending would range from \$145 million to \$205 million between 2016 and 2021; annual State spending would range from \$0 to \$20 million.