Medicaid Reform Options

Presentation to the 29th Alaska State Legislature:

House Finance Committee

March 29, 2016

The Menges Group

Overview of our Engagement

- The Menges Group was selected through a competitive procurement process to conduct an independent analysis of Alaska's Medicaid Reform and Expansion legislation and efforts.

- Our client is Alaska's Legislative Budget and Audit Committee.

- We conducted an extensive set of interviews with Alaska stakeholders during late 2015.

- To date we have completed two reports:
  "Assessment of Medicaid Expansion and Reform," January 15, 2016
  "Assessment of Medicaid Reform Options," March 24, 2016

Outline of Today's Presentation

Agenda

- Care Teams for Frequently Hospitalized Persons
- Prescription Drug Savings Opportunities
- Coordinated Care Model Recommendations
- Employment Supports
- Access to Care in Rural Settings

Presenters

- Joel Menges
- Emily Ricci
- Poornima Singh

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Care Teams for Frequently Hospitalized Persons

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Frequently Hospitalized Persons

- CSSB 74(FIN) am Section 29: Enroll individuals with multiple hospitalizations in a Primary Care Case Management (PCCM) program or with a Managed Care Organization (MCO)
- Create a care coordination program for persons who have been hospitalized more than three times during the past two years
- Alaska has 347 Medicaid beneficiaries who have been hospitalized at least five times during the time frame 2012-2015 (including at least one 2015 admission).

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

- This approach creates significant clinical improvements, whereby all savings would occur through reducing the degree to which these high-need beneficiaries continue to “down-spiral” into health crises.

A Tailored Care Coordination Approach Will Cost Alaska Very Little Relative to Savings Expected

- This team includes a set of physician advisors (supporting the team on an hourly consulting basis), five 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.), and conduct an assessment of the person's needs, caregiver situation, etc. (interviewing the enrollee, caregiver, and key physicians).
- For persons in the Anchorage Metropolitan Statistical Area (MSA), community outreach workers would seek to conduct a home assessment and establish a direct personal connection with the enrollee and/or 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.

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**
Team Caseload (persons with 5+ admits with 1+ during 2015)		347	
Caseload per Overall Care Team FTE		37	
Caseload per RN		69	
Caseload per Outreach Specialist		87	

Prescription Drug Savings Opportunities

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Cost Per Prescription Overview

Alaska's average cost per Medicaid prescription are among nation's highest and have been rising sharply relative to the US average.

Statistical Measure and Federal Fiscal Year	Alaska	USA	Alaska Rank Among States
Net Cost Per Prescription (initial cost less rebates)			
2013	$38	$33	16th highest
2014	$45	$37	9th highest
2015	$52	$41	7th highest
Percent Increase 2013 - 2014	18%	12%	
Percent Increase 2014 - 2015	16%	11%	

Alaska's costs per prescription in FFY2015, while 27% above the US average, are not that far out of line when considering that Alaska's cost of living is roughly 23% above US average (based on poverty line data).

Alaska has also made some important achievements with drug mix in recent years, moving from 3.6 percentage points behind the US average in use of generics in Q1 2013 to 1.7 percentage points behind in Q3 2015. Nonetheless, we have identified opportunities for savings that are important to pursue.

We Encourage Two Changes to Improve Medicaid's Drug Mix and Pricing

- Allow DHSS to more quickly/nimbly adjust its preferred drug list (PDL) to steer volume to clinically appropriate, lowest-cost alternative
  - DHSS responsiveness to new product introductions, patent expirations, etc. is inhibited by the Alaska Administrative Procedures Act – creates 6+ month delay in PDL changes
- Avoid above-market payments to large pharmacies
  - Dispensing fees seem to warrant lowering at chain drug stores
  - Medicaid shouldn't be a "high-end" payer to all pharmacies in order to support a relatively small number of critical access stores
- CSSB 74(FIN) am Section 28, Sec. 47.05.270
  - Other pharmacy initiatives

Legislation Focuses on Prescription Database Related to Controlled Substance Abuse

- Sections 13-19
  - The Board of Pharmacy will be responsible for establishing the controlled substance prescription database
  - Require reports to be submitted by all pharmacies/pharmacists on a weekly basis
  - Grant access to the database to a wider group of professionals
  - Require specific functionalities within the prescription database
- CSSB 74(FIN) am Section 28, Sec. 47.05.270

Care Coordination and Payment Strategies

Care Coordination and Payment Strategies

- CSSB 74(FIN) am Section 28, Sec. 47.05.270
  - Enhanced care management
  - Redesign payment process
  - Develop a healthcare delivery model backed by evidence-based practices
  - Integrate behavioral health
- CSSB 74(FIN) am Section 29
  - Establish a PCCM program or a MCO contract to deliver care and define the services provided under each program and set expectations of any contractor chosen to perform the scope of any program
- CSSB 74(FIN) am Section 30
  - Apply for an 1115 waiver to establish innovative payment models and provider infrastructure
- CSSB 74(FIN) am Section 31, Sec. 47.07.039
  - Contract with an entity to carry out the scope of the coordinated care demonstration project

Capitation Contracting with Managed Care Organizations (MCOs) Has Many Strengths…

- Full-risk capitation contracting with MCOs is the most commonly-used approach by state Medicaid agencies.
  - During FFY 2015, 45.3% of all Medicaid spending occurred through capitation contracting with MCOs.
  - Forty states currently utilize the capitated MCO model, and additional states have announced intentions to move in this direction (e.g., North Carolina and Oklahoma).
- Key attractions of this model:
  - Dollar-for-dollar risk that MCOs accept
  - Administrative services MCOs deliver with economies of scale (member services, provider relations, etc.),
  - Opportunity to leverage competition among health plans – both at the point of selecting the best-qualified MCOs through a competitive procurement, and an ongoing basis as plans compete for enrollment and strive to operate in a financially successful manner
- The capitated MCO model does more to facilitate access, measure and improve quality, and contain costs than any other alternative.

….But We Do Not View the Multi-MCO Capitation Contracting Model to be a Good Fit for Alaska

- 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.
- Even Alaska's most urban areas have highly dispersed populations. 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 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.

Capitation Contracting with MCOs is Not Recommended – Additional Rationale

- There is very little existing MCO involvement in Alaska.
- Capitation contracting with MCOs in Medicaid requires at least two competing health plans for purposes of beneficiary choice in a mandatory enrollment setting. The Medicaid population across the two large MSAs, Anchorage and Fairbanks, 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, and would require years to put in place.
- A multi-MCO capitation model is poorly suited to serve Alaska's relatively small and extremely dispersed Medicaid population.

Contracting with Accountable Care Organizations is Another Option to Consider

- ACOs represent a “provider driven” approach to coordinated care.
- Under the ACO model, providers typically continue to be paid on a FFS basis, with the ACO contractors being given financial incentives to achieve the state’s care coordination objectives.
- ACO models vary widely with regard to the level of risk/reward that ACOs accept, and the degree of administrative services the ACOs perform.
- At the most sophisticated end of the ACO spectrum, this model can closely resemble the capitated MCO model (albeit with only provider-sponsored owner entities).

ACO Model Has Been Primarily Tested in Medicare – Without Much Operational Success

- The ACO model has been tested across a large array of participating organizations in the Medicare arena, a coverage setting where care coordination is likely to yield more favorable results than in Medicaid.
  - Medicare has stable eligibility and relatively high per capita costs, large proportion of which are tied to chronic conditions that can be managed more cost-effectively.
- During Year One, 54 of 114 Medicare ACOs achieved savings against estimated costs in the pure fee-for-service setting.
  - Expected statistical outcome, *if no ACO even tried to achieve savings*, would be 57 of 114
- A more recent evaluation of 32 "pioneer ACOs" (more longstanding ACOs) found collective savings of $11 per person per month in Year Two, or 1.5%.
  - 70% of these savings occurred in just 3 of the 32 ACOs (all in Massachusetts)

We Do *Not* Recommend Using the ACO Model

- Saving money in Medicaid unavoidably means lowering the revenues providers, in the aggregate, receive. Enlisting providers – *and only providers* – to achieve this objective is conceptually counter-intuitive.
  - Medicare's experience bears out this concern
- Effective coordinated care requires making significant administrative investments that yield more than offsetting medical cost reductions.
  - ACOs are not explicitly paid for the administrative care coordination services that are needed to achieve medical cost reductions, access enhancements, and quality improvements. ACOs need to cover the costs for their administrative investments through the incentive payments they are hoping to earn (and which they often fail to earn – hence the frequent drop-outs Medicare has experienced). This leaves the ACOs poorly positioned to deliver the type of comprehensive coordinated care services that are needed.
- Nationally, the ACO model is overachieving in the political arena, and underachieving operationally.
- The ACO model is also a "huge lift" for Alaska to implement, and Alaska's provider community has little experience playing the role of identifying and achieving available medical cost savings.

What We *Do* Recommend: Contract with One MCO on an Administrative Services Only (ASO) Basis

- Tasks to be performed would include:
  - Access facilitation – systematically identify care gaps for each beneficiary and conduct outreach to beneficiaries, caregivers, and providers to help address these gaps.
  - Care coordination for high-need, high-cost beneficiaries whose cost trajectory is determined to be favorably impactable. The highest level of intervention would involve an intensive care management (ICM) approach – including clinicians and community outreach workers – similar to that used in Connecticut's ASO program.
  - Prior authorization of high-cost services (e.g., medical, surgical, and psychiatric admissions, certain diagnostic and surgical procedures, etc.).
  - Measuring and improving quality across several established metrics.

Advantages of Contracting with One MCO on an ASO Basis

- The ASO MCO approach enlists the involvement of a competitively procured contracting partner with vast relevant experience in Medicaid care coordination and cost containment.
- It does not require any new provider contracting or that providers re-organize themselves in any manner.
- The single MCO can operate with economies of scale, serving Alaska's entire beneficiary population. Under the ASO arrangement, beneficiaries would not "enroll" in the MCO.
- The MCO would not need to take on the roles of payer or negotiator of payment terms. The MCO would not create a provider network.
- The MCO would have incentives to coordinate care effectively and achieve cost savings for the entire Alaska Medicaid population.
- The ASO model dovetails well with any DHSS primary care case management (PCCM) initiative, dental home initiative, behavioral health home initiative, etc. that is put into place.
- The scope of work of the ASO contractor can be broadened to include fraud detection, member services functions, claims administration, etc. as desired by the State.

Linking Beneficiaries with a Medical Home

- We also recommend that Alaska implement a model whereby every Medicaid beneficiary is linked with a primary care provider (PCP), a dental provider, and where appropriate a behavioral health provider. These “provider homes” would serve as the beneficiary’s front-line point of access for routine care, with specialized care occurring through referrals from the beneficiary’s PCP.
- Primary Care Providers receive a very small percentage of Medicaid’s payments, but these front-line providers can favorably impact health status and spending across the entirety of the Medicaid benefits package.

Emergency Room Diversion

- CSSB 74(FIN) am Section 31, Sec. 47.07.038
  - Establish a hospital-based emergency room use reduction program
- States that have successful and promising emergency department (ED) utilization reduction programs built:
  - A strong relationship with providers, encouraging walk-in appointments and after-hours care.
  - Electronic Health Records (EHRs) and data sharing platforms to access information and divert care to the most appropriate setting
  - Patient outreach and education platforms
- Couple ER diversion programs within the scope of services provided by Alaska's MCO ASO contractor with a specific program for persons who have frequent ED visits.

Employment Supports

Employment Supports

- What are employment supports? For this report, that term will include, but is not limited to, those activities listed below:
  - Work search programs
  - Job training programs
  - Vocational rehabilitation programs
  - Training for older Alaskans
  - Educational supports
  - Vocational training

The Federal Regulatory Environment Limits States' Current Options

- The Center for Medicaid & Medicare Services (CMS) had repeatedly denied waivers for state's seeking to link employment support requirements to Medicaid eligibility.
- Federal law maintains that eligibility criteria is determined by the federal government, not the states. This has been tested and upheld repeatedly through past court cases.
- As a result, states interested in linking employment supports to Medicaid benefits have largely done so through passive referrals to work search and training programs that are fully state funded.
- Some states are beginning to experiment with employment support programs that link participation to certain incentives.

Alaska & Employment Supports

- The current CSSB 74(FIN) am includes a requirement that any reform program must include referrals to community and social services, including career and educational training services available through the Department of Labor & Workforce Development, the University of Alaska, or other sources. (Sec. 28, 47.05.270)

- This is in-line with other states' approaches to ensuring Medicaid beneficiaries are aware of -- and can access -- employment support services without running afoul of federal restrictions.

Indiana

- Indiana implemented Medicaid expansion through a Sec. 1115 waiver. The plan is called the Healthy Indiana Plan (HIP).
- The HIP requires all non-disabled adults receive a referral to the state's Department of Workforce Development. The referral is made based on an initial applicant screening.
- This is a watered-down version of what was first proposed, which tied participation in the workforce development program to HIP eligibility and was denied by CMS.
- Implementation began in 2015. An evaluation of the program is ongoing and will specifically seek to measure the impact of the referrals on:
  - 1) How many of the referrals resulted in full-time and/or part-time employment?
  - 2) Of those who received referrals, how long did they remain eligible for HIP?
  - 3) Do the referrals impact HIP enrollment?

Arizona

- The Arizona legislature passed a bill establishing the Arizona Health Care Cost Containment System (AHCCCS) Works program linking employment support services to Medicaid eligibility.
- Arizona then submitted a Sec. 1115 waiver that is currently pending response by CMS.
- The legislation linked participation in the AHCCCS Works program to Medicaid eligibility, but the waiver filed with CMS ties participation to incentives instead of eligibility.
- As proposed, the waiver requires certain adult beneficiaries to contribute up to two percent of their household income into something similar to a Health Savings Account (HSA).
- The account could be used to pay for things like vision and dental services, which are not covered by Medicaid.
- To access their account, beneficiaries would need to do the following:
  - 1) Maintain timely payment of their contributions
  - 2) Participate in AHCCCS Works
  - 3) Meet at least one wellness-related requirement

New Hampshire

- New Hampshire implemented Medicaid expansion in 2014, but only funded it through the end of 2016. The House passed legislation this month that would extend funding through 2018.
- The current version of the legislation contains a provision that would tie eligibility to work search requirements. Specifically it would require certain beneficiaries to engage in the following activities for a minimum of 30 hours per week to maintain Medicaid eligibility:
  - Employment
  - Work experience
  - On-the-job training
  - Job search & readiness assistance
  - Community service programs
  - Vocational education training
  - Job skills directly related to employment
  - Provision of child care services to an individual participating in a community service program
- The bill is currently being heard in the Senate. There is no reason to believe CMS will approve the proposed work requirement.

Rural Health Strategies

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Rural Health Strategies

- Alaska is at the forefront of addressing rural health and ensuring access to care. The State's tribal health network is a critical piece to the network infrastructure, especially in rural areas.
- Telehealth Practices
  - Telemedicine Licensure
  - Remote Monitoring
- Community Health Aides/ Practitioners
- Network and Data Infrastructure
- Non-Emergency Medical Transportation

Telemedicine Language in CSSB 74(FIN) am

- CSSB 74(FIN) am Section 1-7
  - Medical records are shared with the PCP, given patient's consent
  - Establish standards of care, training, confidentiality, etc.
  - Authorizes the Board to develop guidelines on how licenses are granted and administer applications
- CSSB 74(FIN) am Section 28, Sec. 47.05.270
  - Expand telehealth use for primary care, behavioral health, and urgent care
  - Reduce travel costs
- CSSB 74(FIN) am Section 30
  - Provide incentives for encouraging use of telehealth

Telehealth Strategies

- Live Telehealth Video Calls
  - Most state Medicaid program reimburse for telehealth, however states vary their terms of where the video calls must occur from and the type of equipment used
  - Traveling to an approved telehealth site can still be challenging
- Store and Forward
  - 9 States, including Alaska, allow for store and forward
- Alaska's Medicaid telehealth program is quite robust and reimburses for initial visits, follow-up visits, consultations to confirm diagnoses, diagnostic, therapeutic, or interpretive services, psychiatric or substance abuse assessment, psychotherapy, or pharmacological management services.
- While "regular" patient/provider telephone calls are not included in the definition of telehealth, the PCCM model could include a pilot whereby all primary care services are paid via a monthly capitation.
  - This would promote addressing patient needs in the least costly, most convenient manner where appropriate (e.g., face to face visits would occur only when there is clinical value)

Telemedicine Licensure

- Cross-state Licensure – Telemedicine providers located in a different state as the patients they serve provide care for these individuals
  - Helps address provider shortages
  - Moves Alaska dollars out of state
- While Alaska's telemedicine allows for limited telemedicine practice, the licensing rules require that the provider have an Alaska Medical license and have generated concern over ambiguity regarding the State Medical Board's ability to sanction providers practicing telemedicine.
  - This limits the State's ability to secure a stronger provider network.
- The CSSB 74(FIN) am currently being heard in the House Finance Committee authorizes DHSS to identify areas where telemedicine policies can be improved – specifically addressing licensure barriers and board sanctions – and put these programmatic changes in place to give the State greater opportunity to leverage telemedicine.

Additional Telehealth Programs

- Home Health Monitoring
  - Alaska allows for remote monitoring within its telehealth programs
- Community Health Aides/ Practitioners
  - Alaska has a strong community health aide program, which can still benefit from improvement in when the CHA/Ps are utilized
    - There are currently 550 community health aides/practitioners (CHA/Ps) serving over 170 villages in Alaska
    - An estimated 50,000 residents receive care from a CHA/P annually, representing around 25,000 clinical encounters
  - States are repurposing Emergency Medical Services staff to address gaps in care in rural communities. Specifically, several states have authorized these professionals to receive additional training and certification programs to address non-urgent medical needs (health assessments, immunizations and vaccinations, chronic disease monitoring and education, lab collection, follow-up visits, routine care, etc.)

Developing "Information Sharing" Infrastructure

- Promoting access to care in rural areas requires infrastructure that promotes access to care, including access to timely information.
  - Idaho has been transitioning from its FFS model by building clinical infrastructure capacity through Patient Centered Medical Homes and a medical neighborhood as well as data sharing to ensure access to information, not just access to care
  - North Dakota specifically built Rural Health Centers (RHCs) as it is defined under Federal law, allowing for special and more favorable billing rates to these providers
- Alaska has strong clinical infrastructure via the tribal health centers. The information infrastructure, however needs to be further assessed and developed.

Non-Emergency Medical Transportation

- Given the combination of high rural NEMT needs, particularly among Alaska Native Medicaid beneficiaries, and the recent expansion of 100% FMAP for transportation services for Native beneficiaries by the Center for Medicaid and Medicare Services (CMS), it makes sense that Alaska covers NEMT travel (as a medical cost).
- States rely on a variety of management tools for NEMT services including:
  - Prior Authorization
  - Co-Payments
  - Service Limits
  - Administrative Service Organizations
  - Brokerage Firms
- A number of states seeking section 1115 waivers for covering the adult Medicaid expansion population have specifically asked to carve out and exclude coverage for NEMT services for the expansion population.
  - Arkansas considered applying for such a waiver, but decided against excluding NEMT services after they were provided evidence that covering NEMT delivered a cost benefit ratio of 11:1 and 10:1 based on previous studies looking at inpatient cost avoidance as a result of improved outpatient care access.

Questions

The Menges Group