

# Alaska Medicaid Strategy: Recommended Reform Principles and Savings Initiatives

## Final Report

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## I. EXECUTIVE SUMMARY

This paper is the culmination of work completed by Public Consulting Group (PCG) under a Medicaid Strategic Advising contract with the Department of Health and Social Services (DHSS) that began in September 2019. It is intended to provide recommendations for Alaska Medicaid budget savings and steps forward toward broader and more systematic Medicaid program reform.

Consistent with the scope of work, the paper proposes “guiding principles” to serve as the road map to reform. Specific initiatives to support the guiding principles are also proposed, with each initiative mapped to a guiding principle. The proposed initiatives have the potential to generate \$45.7 million in state savings, depending on the timing and scope of implementation.

### **Introduction and Methodology**

The paper begins by describing the methodology used to complete the scope of work. Between October 2019 and February 2020, PCG’s Strategic Advisor for this project, Rich Albertoni, completed four (4) one-week visits to Alaska to conduct stakeholder outreach and meet with DHSS staff. Mr. Albertoni traveled to Anchorage in October and January and to Juneau in November and February. Additional trips were planned but could not be completed due to COVID-19 pandemic travel restrictions. Mr. Albertoni continued to engage DHSS staff and stakeholders through video/audio conferencing.

PCG is a national consulting firm established in 1986 and focuses on policy and operational support in the public sector – primarily among state and local governmental programs and agencies. PCG has active contracts with approximately 35 state Medicaid agencies at any one time. PCG is involved in all dimensions of Medicaid operations – eligibility, benefits, policy, long-term care, financing, information technology and program integrity. As such, we brought our knowledge of national best practices to this engagement and applied them to shape the recommendations in this paper.

### **PCG Strategic Advising Scope of Work**

- Assist DHSS in creating a global roadmap that redesigns the Medicaid and public assistance system at a lower cost.
- Assist and work with appropriate internal and external entities to offer budget initiatives and cost reduction ideas across the DHSS system.
- Assistance transitioning Alaska’s Medicaid model to one that provides programmatic flexibility while limiting the exponential growth in costs that is seen in other state systems.
- Create policy reforms that offer greater self-sufficiency and independence, reduce the burden on government dependence, improve quality, and lower expenditures in Alaska’s health and social services system.
- Assist in preparation of reform proposals and negotiation of federal approvals .
- Assist in implementation of reforms.



It is important to note that by the time the PCG Strategic Advisor began working on this project in September 2019, Alaska Medicaid had already adopted a series of significant budget cuts required by the decline in state general revenues that occurred due to reductions in oil prices. Further, Alaska Medicaid was already implementing a major behavioral health transformation waiver. This waiver is aimed at achieving higher quality care and efficiencies that are consistent with the principles of health reform this paper will espouse. Therefore, recommendations made in this paper are intended to supplement and build on work Alaska has already begun.

The paper is intended to provide a framework that permits ongoing dialogue between Alaska DHSS and external stakeholders regarding program reform and cost containment. Principles outlined in this paper represent broad reform categories that structure future areas of focus. The most significant cost containment initiative – implementation of a global spending cap – is intended to establish a structure to support Alaskans engaging Alaskans on this important issue for years to come.

The recommendations have also been made with the awareness that the tribal health system plays a much more expansive role in Alaska than in any other state Medicaid program. We recognize that healthcare delivery and payment in Alaska plays out across existing governance agreements between tribal nations and the state and federal government.

### **Guiding Principles and Specific Initiatives**

This paper identifies five key principles to guide Alaska's Medicaid reform work into the future. These principles were established based on their consistency with the aims this study called for in the scope of work and are identified below:

#### **Guiding Principle #1: Payment Reform**

Alaska should continue migrating away from its fee-for-service payment model. Alaska remains an outlier among states regarding the extent to which its Medicaid program relies on fee-for-service. This paper suggests a next step in moving provider reimbursement toward value-based purchasing and pay-for-performance.

#### **Guiding Principle #2: Delivery System Reform**

Relative to other states and to Medicaid best practices, Alaska remains lean on an infrastructure of care coordination entities charged with and incentivized to better coordinate and manage care for identified populations. This paper proposes a gradual move toward delivery system reform that builds on progress already made in Alaska.

#### **Guiding Principle #3: Cost Containment**

Health care costs in Alaska have been historically high when compared to other states. This trend has been forecast to continue by Evergreen Economics, which projects annual state spending on Medicaid to grow from \$770 million in 2020 to nearly \$1.9 billion in 2040. The Evergreen report indicates that 2/3 of Alaska Medicaid projected cost growth is not attributable to increased enrollment or higher utilization. It is due to rising prices of services themselves.

#### **Guiding Principle #4: Program Integrity**

At its core, program integrity involves deploying program oversight that assures accuracy in determining recipient eligibility and making the right payments to eligible providers. Medicaid continues to become more complex as federal rules change and grow, and this requires continuously adapting program oversight strategies.

## Guiding Principle #5: State Financial Stewardship

Medicaid is jointly financed by states and the federal government. Federal rules that govern federal matching rates for services are complex and continue to become more so. Operating a Medicaid program that maximizes state efficiencies requires assuring that the state claims all federal dollars for which it is eligible.

### PCG Strategic Advising Overall Reform Principles

- **Payment Reform:** Move toward value-based purchasing
- **Delivery System Reform:** Move toward coordinated care
- **Cost Containment:** Address inflationary pressures
- **Program Integrity:** Prevent fraud, waste and abuse
- **State Financial Stewardship:** Assure Alaska claims its fair share of Medicaid matching dollars

Paying for value and coordinating care advance mission of quality healthcare for all Alaskans

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To begin the process of implementing reforms based on these guiding principles, PCG is recommending five specific initiatives that have the potential to yield \$45.7 million in state savings. Each of the five initiatives maps to each one of the guiding principles. With the guiding principles serving as the road map, the initiatives set out Alaska's path toward reform. PCG recognizes that these initiatives are a starting point. They may require modification as circumstances change. They may be expanded upon after initial success. Future changes or enhancements to initiatives do not conflict with long term adherence to the principles of the road map.

The five key initiatives recommended in this paper are as follows:

**Initiative #1: One-Time Medicaid Eligibility Review for All Recipients (\$17.0 million state savings)** – This initiative **supports the principle of program integrity** and involves a one-time review of all current Medicaid case files, applying external and publicly available data sources to determine if the individual or family continues to meet financial and non-financial eligibility standards. Based on completing similar reviews in other states, PCG conservatively estimates that 3% of cases will be found ineligible. PCG is aware that under federal COVID-19 public health emergency rules, states are required to maintain continuous eligibility for individuals, regardless of any change in circumstance (except for moving out of state). For this reason, completing a review at the conclusion of the public health emergency is expected to result in a higher number of cases being determined ineligible.

**Initiative #2: Implement Section 1945 Health Homes (\$6.5 million annual state savings)** – Adoption of Health Homes authorized under Section 1945 of the Affordable Care Act is recommended as Alaska's next step in transforming its Medicaid delivery system and **supports**

**the principle of delivery system reform.** Health Homes provide states with 90% federal match for care coordination expenses over eight calendar quarters. Health Homes have proven very effective at reducing Medicaid spend through improved care and reductions in hospital admissions, especially readmissions. Savings have been modeled based on outcomes achieved for a similar initiative in Missouri.

Health Homes are a gradual step away from fee-for-service, adding care coordination elements without immediately moving to a full-risk bearing, capitated managed care model. Health Homes strengthen Medicaid's relationships with existing provider organizations and build on state healthcare strengths that exist today. They are already authorized under Senate Bill 74 and can be implemented with a state plan amendment.

This section also describes other delivery system reform entities, including Managed Care Organizations (MCOs), Accountable Care Organizations (ACOs), Coordinated Care Organizations (CCOs) and tribal managed care, which is referred to in federal law using the specific term, "Indian Managed Care Entity (IMCE)."

PCG recommends that Alaska work with tribal health officials to explore the option of establishing an IMCE to better leverage tribal care management services and to aim for efficiencies in claiming 100% FMAP without required care coordination agreements for IMCE members.

**Initiative #3: Hospital Rate Setting to Include Pay for Performance (\$3.5 million annual state savings)** – Under this item, it is recommended that Alaska carve out a small portion of its non-tribal acute care hospital budget to be paid out to these same hospital providers on performance-based provisions. This initiative **supports the principle of payment reform**. This would involve a multi-step process that achieves the following:

- ✓ Includes a "budget adjustment factor" to inpatient and outpatient rate setting
- ✓ Reassigns "savings" achieved by the factor to be distributed as "pay for performance."
- ✓ Savings result from improved patient outcomes
- ✓ Continues implementation of resource-based rate setting methods (DRGs and APGs)

The budget adjustment factor would provide an additional variable to Alaska's inpatient and outpatient hospital rate setting methodology for non-tribal, acute care providers. The factor would serve as a mechanism to better manage cost growth and prevent unanticipated fiscal outcomes due to unexpected changes in hospital cost. In this paper, the budget adjustment factor is modeled to generate a state share amount of \$3.2 million to be reinvested in hospital pay for performance. This is achieved by targeting budget cost growth at 3% for both inpatient and outpatient services.

These state share savings would then be reinvested in a Pay for Performance (P4P) fund. This initial step of hospital P4P is recommended as a path forward into Value Based Purchasing (VBP) for Alaska Medicaid without immediate disruptions that could occur with more far-reaching VBP initiatives. Improvements in patient outcomes resulting from an increased focus on quality is estimated to generate state savings of \$3.5 million annually once preventable hospital readmissions are reduced by 25%.

Longer term, Alaska's method of paying hospitals should be transitioned to a method that measures and accounts for the resources used to provide services. This would stand in contrast to current methods that pay "per day" for inpatient hospital and on a "percent of charges" for outpatient. Resource-based rate setting is recommended using Diagnostic Related Groupers (DRGs) for inpatient services and Ambulatory Patient Groupers or Enhanced Ambulatory Patient Groupers (APGs, EAPGs) for outpatient services. During the stakeholder outreach performed for

this engagement, Alaska DHSS was already working with Alaska hospital providers to explore switching to DRGs for inpatient services.

**Initiative #4: Reform Medicaid School Health Services (\$4.1 million annual additional federal revenue)** – Under federal Medicaid rules, public that provide healthcare services are eligible for cost-based reimbursement of those services. This initiative **supports the principle of state financial stewardship**. Public providers are healthcare professionals employed by or retained under contract by a unit of government. In a public school district setting, they may include speech therapists, occupational therapists, physical therapists, nurses, psychologists, and special education aides who assist students with performing activities of daily living.

Where a governmental unit of a state is directly providing healthcare to Medicaid recipients, the local dollars expended to provide the service is effectively the “state share” that can be matched with federal dollars. As an example, a school district may provide speech therapy to a Medicaid eligible student at a cost of \$100. In this example, assume the state Medicaid program’s normal fee payment for this service is \$50 and that the federal match rate is 50%. Under a Certified Public Expenditure (CPE) authorized by the State Plan, this local district could document its \$100 cost of service and work through the state Medicaid agency to submit a claim to CMS for the federal share of the unreimbursed \$50. By doing this, the school district would receive \$25 in additional reimbursement from CMS.

In aggregate, CPE claiming for public providers generates millions in additional federal revenue for states. This represents a state’s accurate share of Medicaid claiming. States that do not cost settle for public providers are effectively underclaiming federal Medicaid matching dollars. Alaska does not currently cost settle Medicaid school services under a CPE. Further, Alaska does not claim Medicaid administrative dollars for the work done by school districts to support operations of Medicaid school-based services claiming.

Implementing Medicaid administrative claiming provides another revenue opportunity for Alaska. Medicaid Administrative Claiming provides a 50% federal match rate, meaning districts could be reimbursed \$50 by the federal government for every \$100 currently spent on Medicaid school-based services administration.

This paper will describe current claiming practices for school health provided by public schools, which is based on Intergovernmental Transfers (IGTs) and describe the logistics of moving to a CPE method.

Further, Alaska can and should modify the scope of health services provided by public school districts to optimize federal revenue claiming. Currently the Alaska State Plan limits the scope of school health to rehabilitative services such as speech therapy, occupational therapy, or physical therapy. This reflects prior federal rules that limited Medicaid school health to those services provided in the context of special education to students with an Individual Education Plan (IEP).

However, current Medicaid rules permit schools to bill for a wider range of services, including dental and behavioral health. Alaska is currently underclaiming federal revenue to the extent that schools are not leveraged as “place of service” settings for more comprehensive care to Medicaid and CHIP eligible student populations.

We estimate Alaska could generate an additional \$4.1 million in federal revenues per year by implementing a public-school health certified public expenditure and modifying the scope of Medicaid-reimbursable school health services. This estimate is based on the fact that Alaska today captures \$2.1 million in federal revenue on school-based services through the IGT claiming



methodology. Typically, states that move to a CPE cost settlement methodology inclusive of Medicaid administrative claiming double their federal revenues.

Further, states that have added services such as personal care, nursing services and specialized transportation, as well as making more children eligible by expanding beyond IEPs, have increased federal revenue by 50%. If Alaska is claiming \$4 million per year in total FED through a CPE methodology, the expansion in scope of services would add an additional \$2 million in FED from baseline funding. This would raise total school-based services federal funding from a baseline of \$2.1 million today to \$6.2 million, a net increase of \$4.1 million.

**Initiative #5: Impose a Global Spending Cap (\$14.6 million annual state savings)** – The broad challenge of Alaska Medicaid cost containment won't be solved without state collaboration with stakeholders, including providers, tribal entities, consumers and other interest groups. To that end, this paper focuses on a methodology for cost containment that can be sustained longer term.

To contain Medicaid cost growth, a “global Medicaid budget cap” is recommended for Alaska. This initiative **supports the principle of cost containment**. The cap draws from the model first implemented by New York State in 2012. Key to this model is an advisory group of stakeholders convened specifically to recommend policy actions that drive compliance with the cost growth cap. Another key element would be a provision that authorizes the Health Secretary to automatically take cost reduction actions consistent with CMS rules if the stakeholder process does not result in budget cap compliance.

PCG recognizes that certain provider rates cannot be reduced based on federal regulations such as tribal encounter rates and certain cost-based rates. These rates would be excluded from the budget cap process.

Because savings from a budget cap compound into the future, they grow large over time. The cap provides a working methodology for Alaska to confront cost containment in a way that both enhances stakeholder involvement and makes the process accountable to fiscal outcomes.

### **Savings Summary**

The table on the following page summarizes cost savings associated with both the budgetary and road map recommendations:

<b>Initiative</b>	<b>Financial Impact (State Dollars)</b>	<b>Notes</b>
Medicaid Eligibility Redeterminations	\$17 million one-time	One-time savings based on approximately 3% individuals being determined to be ineligible <b>(Program Integrity)</b> .
Implement Section 1945 Health Homes	\$6.5 million annual	Modeled based on other state savings <b>(Delivery System Reform)</b> .
Hospital Payments to Include Pay for Performance	\$3.5 million annual	Savings achieved through improved care, reduced hospitalizations <b>(Payment Reform)</b> .
School Based Health Reform	\$4.1 million additional federal revenue	This addresses current underclaiming of school-based services and leverages schools as a place of service to optimize federal funding <b>(State Financial Stewardship)</b> .
Global Spending Cap	\$14.6 million in Year 1	Savings compounds by year, yielding \$208.8 million in savings by 2025 <b>(Cost Containment)</b> .
<b>Total – All Initiatives</b>	<b>\$45.7 million</b>	



**Additional Information: Optional Medicaid Eligibility Categories:** This paper also provides information on categories of Medicaid that remain “optional” under federal law. Beyond the Medicaid Expansion, 11 categories remain optional. The associated expenditures and total enrollment in each of these eligibility categories is also provided. This is done as a point of information as DHSS considers all of its options for stopgap budget initiatives in the face of any future budget crisis.

At the same time, PCG recognizes that these 11 categories provide coverage for vulnerable state residents who are elderly, disabled or facing an acute health condition. These categories also invest in preventative care for children. While providing information on optional categories, this paper does not recommend eliminating any of those categories due to the adverse outcomes it would have on community health.

This scope of work was aided by the generous availability of DHSS staff and community stakeholders. Their time and insights are greatly appreciated. While staff in the Commissioner’s Office were lead contacts for this project on a day-to-day basis, this work could not have been completed without staff support across DHSS divisions.

Finally, it is understood that Alaska and DHSS may wish to incorporate elements of these suggested reforms more slowly than is modeled here and over an extended period. Nothing precludes a more gradual approach, which is not inconsistent with a commitment to pursuing the guiding principles and road map identified.

## II. INTRODUCTION AND METHODOLOGY

The responsibilities of DHSS include acting as the single state Medicaid agency, administering public health programs, serving as Alaska’s behavioral health authority, and operating a wide range of state and federal social service programs, including the Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance to Needy Families (TANF).<sup>1</sup> For purposes of this paper, the specific focus of PCG’s Senior Strategist was Alaska’s Medicaid program.

The scope of work for this engagement was defined in Request for Proposal (RFP) 2020-0600-4325, issued July 8, 2019.<sup>2</sup> The RFP defined contractor responsibilities to include the following:

- Assisting DHSS in creating a global road map that redesigns the Medicaid and public assistance system at a lower cost. This will require aligning all respective agency programs and divisions to support service-delivery and business processes that achieve program goals within reform efforts. Because Medicaid interfaces with all aspects of the DHSS system, a plan providing maximum flexibility to reform Medicaid within the entire system is necessary.
- Assisting and working with appropriate internal and external entities to offer budget initiatives and cost reduction ideas across the DHSS system.
- Assistance transitioning Alaska’s Medicaid model to one that provides programmatic flexibility while limiting the exponential growth in costs that is seen in other state systems.
- Providing leadership and assistance in creating policy reforms that offer greater self-sufficiency and independence, reduce the burden on government dependence, improve quality, and lower expenditures in Alaska’s health and social services system.
- Assisting in preparation of reform proposals and negotiation of federal approvals.
- Assisting in implementation of reforms.

### Characteristics of Current Alaska Medicaid Program and State Healthcare Landscape -

While each of the 50 states has unique healthcare landscape features and customized Medicaid program elements, Alaska’s differences are especially notable and include:

- ✓ The lowest state population density by far, measured at 1.3 individuals per square mile, according to the 2013 US Census Bureau estimate<sup>3</sup>. This is 78% less dense than the 49<sup>th</sup> ranked state, Wyoming. More than half of all US states have population density that exceeds 100 people per square mile.
- ✓ 34% of Alaskans reside in rural areas, compared to 19% of all Americans<sup>4</sup>.
- ✓ 15.4% of Alaska’s population is American Indian/Alaska Native, compared to 1.3% for the US overall<sup>5</sup>.

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<sup>1</sup> [Services \(alaska.gov\)](https://www.alaska.gov/services)

<sup>2</sup> [RFP 2020-0600-4325 - Senior Advisor and Strategist - Alaska Online Public Notices \(state.ak.us\)](https://www.state.ak.us/rfp/2020-0600-4325-Senior-Advisor-and-Strategist-Alaska-Online-Public-Notices)

<sup>3</sup> [State Population Totals: 2010-2019 \(census.gov\)](https://www.census.gov/data/tables/2019/states/alaska/population.html)

<sup>4</sup> [2010 Census Urban and Rural Classification and Urban Area Criteria](https://www.census.gov/data/tables/2010/special/urban-rural.html)

<sup>5</sup> [The American Indian and Alaska Native Population: 2010 \(census.gov\)](https://www.census.gov/data/tables/2010/special/indian.html)

- ✓ 40% of all Alaska Medicaid recipients are tribal members, according to the 2017 Milliman Alaska Medicaid Data Book<sup>6</sup>.
- ✓ The Alaska Tribal Health System serves approximately 120,000 individuals per year and includes 180 small rural clinics, 25 subregional advance practice clinics and 7 hospitals<sup>7</sup>.
- ✓ Medicaid healthcare services provided to Alaska Natives in an Indian Health Services (IHS) or tribal facility, or under a care coordination agreement entered into by an IHS or tribal facility, are eligible for 100% Federal Medical Assistance Percentage (FMAP).
- ✓ Alaska Medicaid remains overwhelmingly a fee-for-service delivery system.
- ✓ Alaska's per capita healthcare expenditures are higher than any other state<sup>8</sup>.
- ✓ Alaska's public health system does not feature a statewide network of locally governed health departments, as is the case in most states.

These characteristics all combine to make for a unique state health profile. As Alaska looks ahead to reform, solutions that build on these features should be prioritized, and this report has been written with that goal in mind.

The PCG Senior Advisor and Strategist, Rich Albertoni, made 4 one-week site visits to Alaska to meet with DHSS leadership and Medicaid staff as well as external stakeholders. Visits to Anchorage occurred in October and January and visits to Juneau took place in November and February. The DHSS contract with PCG called for eight visits to occur during the first twelve months. However, this travel schedule was disrupted by the COVID-19 pandemic. Mr. Albertoni also maintained ongoing, regularly scheduled calls with the Commissioner, the Commissioner's Health Policy Advisor, and the Deputy Commissioner for Medicaid.

Throughout the engagement, DHSS Commissioner, Adam Crum, and his staff facilitated outreach between Mr. Albertoni and Alaska healthcare stakeholders. Internal and external stakeholders consulted for this engagement included:

- Alaska Primary Care Association
- Alaska Native Tribal Health Consortium
- Alaska State Hospital and Nursing Home Association
- Alaska Health Transformation Project
- Alaska Division of Insurance
- Providence Health System
- Evergreen Economics
- DOA Division of Employee Benefits
- State legislators and legislative staff
- DHSS Division of Behavioral Health
- DHSS Senior and Disability Services
- DHSS Division of Public Assistance
- DHSS Division of Public Health
- DHSS Division of Financial Management
- DHSS Division of Healthcare Services
- DHSS Office of the Commissioner

The Senior Strategist also read reports published to date by the Alaska Healthcare Transformation Project<sup>9</sup>, including their road map to state health reform. The road map focuses

<sup>6</sup> [Milliman Alaska Medicaid Data Book](#)

<sup>7</sup> <https://anthc.org/wp-content/themes/anthc/extras/2019YearInReview/2019ANTHCAnnualReport.pdf>

<sup>8</sup> [Health Care Expenditures per Capita by State of Residence | KFF](#)

<sup>9</sup> [NEW-2019-AK-HC-Tranformation-Project-vWEB.pdf \(secureservercdn.net\)](#)

on delivery system and payment reform, with an all-payer claims database seen as the starting point for change. Many of the concepts put forward by the Transformation Project align with areas of focus for this scope of work.

## Methodology



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Review of existing Medicaid data and reports has been a key part of this effort. Division staff have provided information on current expenditures, benefit policies, enrollment data by eligibility category and roles and responsibilities of each DHSS business unit. The DHSS Chief Medical Officer provided information about regional healthcare coordination efforts that exist today across Alaska. Information publicly available from other vendors, including Milliman's Medicaid Databook and Evergreen Economics' financial forecast<sup>10</sup>, have also been reviewed.

<sup>10</sup> [www.akleg.gov/basis/get\\_documents.asp?session=31&docid=59183](http://www.akleg.gov/basis/get_documents.asp?session=31&docid=59183)

### III. ROAD MAP PRINCIPLES AND RELATED SAVINGS INITIATIVES

Nationwide, state Medicaid programs are confronting rising costs by working to implement care systems that are well coordinated across providers and that promote positive patient outcomes and cost efficiency. With passage of Senate Bill 74<sup>11</sup> in 2016, Alaska laid the foundation for similar reforms. In the years ahead, Alaska can build on the framework of SB74 to incrementally take further steps away from its fee-for-service system.

Senate Bill 74 was signed into law in 2016 and created a framework for Alaska Medicaid delivery system innovations. The bill established a Coordinated Care Demonstration Project (CCDP) that authorized DHSS to contract with several possible care entities, including:

- ✓ Provider Led Entities
- ✓ Accountable Care Organizations
- ✓ Primary Care Case Managers
- ✓ Managed Care Organizations
- ✓ Prepaid Ambulatory Health Plans

During fiscal year 2017, DHSS released an RFP seeking MCOs or other care management entities to operate CCDP initiatives in specific areas of the State. Two proposals emerged as qualified, and DHSS issued Notice of Intent to award a contract based on these two proposals in 2018.<sup>12</sup>

The first was a proposal by United Healthcare to operate a managed care delivery system in Anchorage and Mat-Su. These communities have both sufficient population density and provider network capabilities to support commercial managed care. DHSS also issued a Notice of Intent to award a contract to Providence Family Medical Center (PFMC) to operate a program equivalent to a Patient Centered Medical Home model in the Anchorage area.

After entering negotiations with United Healthcare, DHSS declined to pursue the MCO model for Anchorage and Mat-Su due to the perceived complexities of optional tribal enrollment and the fiscal challenges that could result if 100% FMAP claiming for certain tribal members were to become disrupted, according to interviews with DHSS staff.

DHSS did contract with PFMC, providing a capitated per-member per month care coordination fee aimed at improving health outcomes for those who voluntarily enrolled in the program. Preliminary results during the first year of operation indicate PFMC reduced emergency room utilization by 21% among the approximately 5,000 individuals enrolled in the care coordination demonstration.

Despite bearing similarities to the Health Home model authorized under Section 1945 of the Affordable Care Act, the Providence care coordination project is not authorized under that federal authority. However, SB74 specifically provides DHSS with authority to seek Section 1945 Health Home approvals moving forward.

<sup>11</sup> <http://www.akleg.gov/basis/Bill/Detail/29?Root=SB%20%2074>

<sup>12</sup> [Notice of Intent to Award Contracts for the Medicaid Coordinated Care Demonstration Project - Alaska Online Public Notices \(state.ak.us\)](#)

Building on progress made to date, this paper identifies five key principles to guide Alaska's Medicaid reform work into the future. These principles were established based on their consistency with the aims of this study called for in the scope of work and are identified below:

**Guiding Principle #1: Payment Reform** - Alaska should continue migrating away from its fee-for-service payment model. The State began to do this in a significant way with implementation of its behavioral health waiver. The waiver designates key behavioral health care coordination elements and provider oversight to an Administrative Services Organization (ASO), Optum. Senate Bill 74 also provided Alaska with legal authority to implement a variety of reforms, including a voluntary Care Coordination Initiative in Anchorage, administered by Providence Alaska Medical Center.

Still, Alaska remains an outlier among states regarding the extent to which its Medicaid program relies on fee-for-service. This paper suggests a next step in moving provider reimbursement toward value-based purchasing and pay-for-performance.

**Guiding Principle #2: Delivery System Reform** – Relative to other states and to Medicaid best practices, Alaska remains lean on an infrastructure of care coordination entities charged with and incentivized to better coordinate and manage care for identified populations. Stakeholder outreach completed for this study found a wide variety of provider organizations interested in taking on greater care management responsibilities. This includes community health centers, tribal health organizations and hospital systems.

***Notably, both payment and delivery system reform advance the greater aim of quality healthcare for all Alaskans by establishing standards that improve patient outcomes.***

**Guiding Principle #3: Cost Containment** - Health care costs in Alaska have been historically high when compared to other states. This trend has been forecast to continue by Evergreen Economics, which projects annual state spending on Medicaid to grow from \$770 million in 2020 to nearly \$1.9 billion in 2040. Solving the cost containment challenge will be a multi-year endeavor that, to succeed, requires collaboration and buy-in across Alaska healthcare payers, providers, consumers, and governmental entities.

**Guiding Principle #4: Program Integrity** – At its core, program integrity involves deploying program oversight that assures accuracy in determining recipient eligibility and making the right payments to eligible providers. Medicaid continues to become more complex as federal rules change and grow, and this requires continuously adapting program oversight strategies.

**Guiding Principle #5: State Financial Stewardship** – Medicaid is jointly financed by states and the federal government. Federal rules that govern federal matching rates for services are complex and continue to become more so. In this environment, operating a Medicaid program that is efficient from a state budget perspective requires implementing strategies that assure that the state claims all federal dollars for which it is eligible. Establishing and adhering to this principle is significant to meeting the state cost reduction aims identified in the strategic advising scope of work.

The sections that follow provide significant detail on the five specific initiatives that have the potential to yield \$45.7 million in state savings. Each of the five initiatives maps to each one of the guiding principles. With the guiding principles serving as the road map, the initiatives begin the path to reform. PCG recognizes that these initiatives are a starting point. They may require modification as circumstances change. They may be expanded upon after initial success. Future changes or enhancements to initiatives do not conflict with long term adherence to the principles of the road map.

## ***Initiative #1: Medicaid Eligibility Redeterminations (Program Integrity)***

States consistently seek to make certain only eligible individuals receive taxpayer-funded services and benefits. Such program integrity is crucial to maintain the confidence of state taxpayers, especially when state budget dollars must serve so many competing priorities. Like Alaska, many states modified eligibility systems to become compliant with the Modified Adjusted Gross Income (MAGI) means-testing method prescribed by the Affordable Care Act. During these system modifications, recertifications were often pending, resulting in Medicaid enrollment rosters that may not reflect the most recent information of individuals who had previously applied.

Because of this, some states have employed a process to redetermine the eligibility of all Medicaid enrollees at one time. This is a one-time review of all current Medicaid enrollment files and involves applying external data sources to determine if the individual or family remains eligible.

Alaska added more than 60,000 new Medicaid beneficiaries since 2015<sup>13</sup>, and also implemented the ARIES eligibility system<sup>14</sup>. Further, passage of the Families First Coronavirus Response Act in March 2020 prevented states from ending Medicaid coverage for any recipient (unless they moved out of state) as a condition of enhanced federal match rates. This means that for the past 14 months, Alaska has not been permitted to end Medicaid coverage for any individual, even if they are known to no longer meet program eligibility.

Therefore, a one-time review of membership will find many ineligible cases and bring Medicaid enrollment to a more accurate level.

The following information provides an approach to accomplishing a one-time Medicaid eligibility redetermination:

As a first step, the vendor would obtain a Medicaid eligibility file from DHSS of all current clients. For each client provided, the following data elements would be included:

- ✓ Case Number
- ✓ Client ID
- ✓ Eligibility Start Date
- ✓ Eligibility End Date
- ✓ Name
- ✓ Date of Birth
- ✓ Current Address
- ✓ Phone Number
- ✓ Previous Address
- ✓ Social Security Number
- ✓ Category of Assistance
- ✓ Household Size
- ✓ Income Limit
- ✓ Asset Limit (if applicable)
- ✓ Known/Reported Employer(s)
- ✓ Known/Reported Owned Property; and
- ✓ Known/Reported Bank Account(s) (if applicable).

<sup>13</sup> [Medicaid Dashboard \(alaska.gov\)](https://www.alaska.gov/medicaid/)

<sup>14</sup> [ARIES Self Service Portal \(alaska.gov\)](https://www.alaska.gov/aries/)



To maximize the effectiveness of the redeterminations, case information should be matched against as much data as is available from the following third-party data sources to support eligibility redetermination:

- ✓ Department of Labor wage and employment files
- ✓ Department of Labor unemployment files
- ✓ SNAP and TANF raw income data
- ✓ Office of Child Support Enforcement unemployment, child support and new hire data
- ✓ PARIS Federal, VA, and Interstate Match files
- ✓ Vital Statistics data
- ✓ Department of Motor Vehicles data
- ✓ Social Security Administration death, SSN, incarceration, residency, household composition out-of-state benefits eligibility, and marital status data
- ✓ Equifax The Work Number data (via the Federal Data Services Hub, as available)
- ✓ TransUnion Identity, Death, Household Composition, Undisclosed Earner, Best Address, Premium Employment, Incarceration, Criminal History and Property data; and
- ✓ Accuity Asset Verification data (Long Term Care clients only)

Using this data, the redeterminations would involve matching information from each source to identify beneficiaries exhibiting potentially disqualifying characteristics. Continued client eligibility could be reviewed by comparing program eligibility policy with findings from State, federal and commercial data sources, including a review of the following eligibility criteria:

- ✓ Identity – confirm each client is who they say they are and are not presenting someone else's identity to obtain benefits.
- ✓ Age – confirm each client's age is inclusive of Medicaid eligibility requirements.
- ✓ Death – confirm each client is not currently deceased nor using the identity of someone who is currently deceased.
- ✓ In-State Residency – confirm each client currently resides in the State of Alaska.
- ✓ Out-of-State Benefits Eligibility – identify any client currently receiving public assistance in another State.
- ✓ Household Composition – confirm each client's household matches the household composition records the State currently maintains.
- ✓ Income – verify that each client's income is below program eligibility limits.
- ✓ Employment – identify any client with new employment unknown to the State.
- ✓ Incarceration – identify any clients who are currently incarcerated and/or were previously incarcerated during an eligibility segment.
- ✓ \*Financial Assets – identify any LTC clients maintaining assets exceeding program limits and any institutional clients with potentially disqualifying asset transfers.
- ✓ \*Property Assets – identify any LTC clients maintaining property assets, which when combined with their financial assets, cause them to exceed program limits and any institutional clients with potentially disqualifying asset transfers.

To prevent unnecessary disruptions to client services, the State could provide advance notice of the pending eligibility redeterminations to prepare enrollees to respond to the data match. Alaska could also employ its vendor to work with customers whose information needs to be manually verified after the initial data match. A program-wide eligibility redetermination effort can be

successfully completed within 75 days and client follow-up operations within 45 additional days.

## Potential Cost Savings

Population	Est. Average Annual Spend (State Share)	Est. Enrollment	Est. Disenrollments @3% Ineligibility	Est. Cost Savings @3% Ineligibility
Adults	\$2,068	48,436	1,453	\$3,004,969
Children	\$1,541	119,101	3,573	\$5,506,039
Aged, Blind and Disabled	\$8,228	34,972	1,049	\$8,632,488
<b>Total</b>		<b>202,509</b>	<b>6,075</b>	<b>\$17,143,497</b>

Sources:

- <https://www.kff.org/medicaid/state-indicator/medicaid-spending-by-enrollment-group/?currentTimeframe=0&sortModel=-%7B%22colid%22%22Location%22%22sort%22%22asc%22%7D>
- [http://dhss.alaska.gov/HealthyAlaska/Documents/redesign/FY-2018\\_Annual\\_Medicaid\\_Reform\\_Report\\_with\\_Appendices.pdf](http://dhss.alaska.gov/HealthyAlaska/Documents/redesign/FY-2018_Annual_Medicaid_Reform_Report_with_Appendices.pdf)



## Initiative #2: Implement Health Homes (Delivery System Reform)

A “delivery system” is, as its name suggests, the method through which a payer organizes the way healthcare will be delivered to recipients. Historically, Medicaid was organized as a “fee for service” delivery system in which state health agencies directly adopted fee schedules for provider services. These agencies directly paid hospitals, physicians, pharmacies, and other providers a fee for every service provided to a Medicaid recipient using their own claims adjudication systems. Critics of fee-for-service healthcare point to a simple fact – providers generate more revenue to the extent they bill for more health care services. Financial incentives are tied to the volume of healthcare provided, not to the quality of patient health outcomes.

In Medicaid, healthcare may be delivered through a health plan similar to the way health plans “deliver” commercial coverage in the private market. However, Medicaid is authorized under Title XIX of the Social Security Act and, as a program, has many features that distinguish it from private health insurance. The most salient category of Medicaid health plans is designated as “Managed Care Organizations” or “MCOs” in federal rules.

**Managed Care Organizations (MCOs):** The practice of Medicaid managed care involves states paying a capitated “per member per month” amount to a commercial or non-profit entity that contracts with healthcare providers. The MCO is, therefore, incentivized to assure that healthcare costs are contained within the monthly PMPM amount. MCOs “manage” through established of utilization controls, prior authorization, enhanced care coordination and competitive contracting.

States have increasingly turned to Managed Care Organizations (MCOs) to be their central delivery system partner. According to a CMS report published in Winter 2020, *Medicaid Managed Care Enrollment and Program Characteristics, 2018*,<sup>15</sup> 70% of all Medicaid recipients in the United

<sup>15</sup> <https://www.medicaid.gov/medicaid/managed-care/downloads/2018-medicaid-managed-care-enrollment-report.pdf>

States were enrolled in comprehensive managed care programs. Another 13% were enrolled in non-comprehensive managed care. Under this model, at least one major benefit category, such as pharmacy, is carved-out of the managed care benefit and administered directly by the state. Finally, 17% of Medicaid recipients were enrolled in fee-for-service delivery systems.

Nationwide, Medicaid long-term care enrollees are less likely to be in managed care than those who are not disabled or elderly. This is in part due to the complexity of the long-term care benefit structure, which includes extensive home-based care and personal care.

Medicaid MCOs are extensively governed by the Code of Federal Regulations (MCOs) at 42 CFR Part 438.<sup>16</sup> Implementation of state Medicaid MCO delivery systems are usually authorized under a waiver that permits MCOs to limit recipient “freedom of choice” in selecting a provider. This enables MCOs to form their own provider networks through competitive contracting. Managed care may be authorized under two waiver types:

- Section 1115 demonstration waivers can waive freedom of choice but more broadly encompass other reforms by waiving additional state plan rules that impact eligibility or payment methods.
- Section 1915(b) waivers are specific to limiting recipient “freedom of choice” of healthcare providers in order to permit commercial health plans to competitively negotiate contracts with healthcare providers.

States may also implement managed care without a waiver, but this option requires the MCO to follow all provisions of the Medicaid State Plan and limits the range of provisions MCOs may negotiate in their contracts with provider organizations.<sup>17</sup>

States are not permitted to require managed care enrollment for American Indian/Alaska Native (AI/AN) populations under a state plan, unless the MCO is an Indian Managed Care Entity (IMCE). While 1115 and 1915(b) waivers technically allow for mandatory managed care enrollment of tribal populations, CMS has historically never approved such a waiver due to the lack of interest and support from the tribes themselves. States may wholly exclude tribal populations from a managed care waiver. In many states, managed care enrollment is optional for American Indians and Alaska Natives.

States pay monthly capitation rates per member to MCOs, and MCOs are then responsible for paying providers. MCOs are at full financial risk for managing patient cost within the per member per month (PMPM) rate they are paid.

Alaska Medicaid operates under a fee-for-service (FFS) delivery system. While this is not consistent with what most states consider to be “best practice,” Alaska has unique characteristics that have made implementation of managed care especially challenging. Its geographic size, remote communities, and tribal health infrastructure shape Alaska’s unique healthcare delivery system needs. Most MCOs look to enroll thousands of members to smooth “risk” across higher and lower utilizers of health care services. In Alaska, there are few regions of the State with sufficient population to support a full risk managed care delivery system

However, stakeholder input gathered during this engagement has emphasized the need for improved coordination across the spectrum of care, especially for patients with more than one chronic condition who have complex care needs.

<sup>16</sup> [Electronic Code of Federal Regulations \(eCFR\)](#)

<sup>17</sup> [Managed Care Authorities | Medicaid](#)

Managed care has emerged as the dominant delivery system for state Medicaid programs for several reasons:

- ✓ **Budget Planning** – States pay MCOs using a fixed, monthly per-member per-month amount established at the start of the year. This reduces the number of variables for states that may change fiscal outcomes, narrowing the focus to the number of recipients enrolled.
- ✓ **Quality Metrics and Performance Management** – MCOs provide a centralized means for states to establish and collect performance data related to preventative care and care intervention outcomes.
- ✓ **Population Health Management** – States leverage MCOs as population health management partners. For example, states may create payment incentives for MCOs to achieve certain preventative care targets, such as increasing childhood immunization rates or controlling diabetes prevalence in a high-risk population.
- ✓ **Service Flexibility and Social Determinants of Health** – Federal rules permit managed care entities to utilize capitation dollars for healthcare-related services that are not traditionally covered benefits in Medicaid. This provides MCOs with greater flexibility to make investments in wellness and other preventative care measures deemed appropriate for reducing overall cost of care and improving member health. This may include investing to meet social service needs, such as housing or food insecurity.
- ✓ **Payment Reform** – MCOs can make it much easier for states to implement payment reform in Medicaid. State contracts with Medicaid MCOs may call for increasing shares of provider payments to be based on value, including care quality and outcomes. The MCO becomes the conduit for implementing such reforms.

Critics of managed care, however, cite the following downsides:

- ✓ **Conflicts with provider organizations over payment** – Transitions to managed care frequently involved disruption of established Medicaid payment protocols to provider organizations. MCOs may have different utilization control methods and/or different payment timelines than the state Medicaid agency did under a fee-for-service system. In many states, the initial launch of managed care generates a rash of provider complaints for this reason.
- ✓ **Medical loss ratio** – Per federal rules, MCOs should not retain more than 15 percent of capitation rates dollars for administrative expenses. However, when lower than expected medical spending occurs, as was seen in 2020 when non-essential medical services were delayed by many individuals due to COVID-19, states may spend more on capitated payments than they would have in a fee-for-service environment. Such excess payment would be considered by state actuaries and CMS in setting future capitation rates.
- ✓ **Potential for less transparency with medical spend, including pharmacy rebates** – States collect “encounter claims” from MCOs that do not reflect amounts paid to the provider. Receipt of encounter claims may lag, providing states with less timely data about medical expenditure trends. Some states face challenges getting complete and accurate encounter claiming data from MCOs.

Many states now competitively procure for MCOs, but others permit “any willing” MCO that meets state requirements to compete for members in a certain region. States have taken widely different approaches to managed long-term services and supports (LTSS). While some states have avoided it altogether, others have enlisted plans to manage dual-eligibles across both Medicaid and Medicare.

Connecticut is the only state that expanded to managed care but later reverted to fee-for-service.<sup>18</sup> Today, “Husky Care” describes itself as “self-funded,” akin to the coverage practice pursued by many larger employers.<sup>19</sup> Connecticut enlists four Administrative Service Organizations (ASOs) to pay claims and provide utilization controls and care coordination efforts. But Connecticut, rather than an MCO, bears claims risk and directly receives claims information. Connecticut’s transition from managed care to “managed fee-for-service” occurred in 2010.

Most states include pharmacy in the managed care benefit to assure coordinated care across major services. However, states are increasingly looking to pharmacy carve-outs to achieve enhanced rebates and greater cost transparency. California is carving pharmacy out of its managed care benefit effective January 1, 2021.<sup>20</sup> New York is pursuing a pharmacy carve-out as part of its FY22 budget.<sup>21</sup>

**Accountable Care Organizations:** While states have steadily embraced managed care delivery systems in Medicaid over the past 20 years, they’ve not all done it the same way. Some states have adopted a variation of “managed care” that is led by a group of healthcare providers. This may include hospitals, physician groups, Federally Qualified Health Plans (FQHP) or a combination of these providers who form an entity that is primarily owned or governed by them.

On a spectrum, an MCO would be closer to an insurance company. It is a business entity paid to “manage” providers by establishing utilization controls and payment incentives that advance efficient and effective care. Because an ACO is led by a group of providers, their chief goal is to maintain “accountability” for delivering efficient and effective care. They do so by using data to document healthcare outcomes and demonstrate compliance with spending caps. In Medicare and some state Medicaid programs, ACOs share the savings they generate when they control costs, as long as they generate savings in ways that maintain quality care.

State Medicaid ACO initiatives are authorized under Section 1115 demonstration waivers. ACOs are not subject to federal regulations that govern MCOs, namely 42 CFR Part 438. However, the Special Terms and Conditions of 1115 waivers may apply some of the provisions of 42 CFR Part 438 to Medicaid ACOs.

**Coordinated Care Organizations:** Another variation, “coordinated care organizations,” may incorporate elements of both MCOs and ACOs. Oregon is an example of a state that uses CCOs as a major component of their Medicaid delivery system.<sup>22</sup> This model permits the lead regional care organization to be either provider-led or to be operated by an insurer or commercial health plan. Both types of organizations are required to abide by common governance features that includes structured provider and consumer participation in CCO policy making.

Because CCOs are authorized under Section 1115 demonstration waivers, they may not be subject to some the provisions of 42 CFR Part 438. However, as is the case in Oregon, the waiver may make them subject to most federal Medicaid managed care rules.

Medicaid CCO initiatives usually rely on regional governance models, in part to be more responsive to the health needs of the communities they serve. For this reason, states that pursue CCO models typically have pre-established regional healthcare governance structures. This may

<sup>18</sup> [Connecticut Moves Away from Medicare Managed Care \(governing.com\)](https://www.governing.com/story/news/health/2019/06/11/connecticut-moves-away-from-medicare-managed-care/1275256001)

<sup>19</sup> [Overview of HUSKY Health Program.pdf \(ct.gov\)](https://www.ct.gov/hhs/pressrel/2019/06/11/overview-of-husky-health-program.pdf)

<sup>20</sup> [The 2019-20 Budget: Analysis of the Carve Out of Medi-Cal Pharmacy Services From Managed Care](https://www.cdph.ca/Programs/OPA/Pages/P200004.aspx)

<sup>21</sup> [Pharmacy Carve Out \(ny.gov\)](https://www.ny.gov/newsroom/ny-announces-pharmacy-carve-out)

<sup>22</sup> [Oregon Health Authority : Coordinated Care Organizations \(CCO\) : Oregon Health Plan : State of Oregon](https://www.oregon.gov/oha/CCO/Coordinated-Care-Organizations-CCO/Oregon-Health-Plan-State-of-Oregon)

include public health regions or regional alliances of hospitals and physicians that operate as an integrated provider network.

The same state profile features that make MCO models incongruous for Alaska also apply to CCOs. This includes low population density and the unique characteristics of the tribal health system.

Arkansas provides another state-specific variation of managed care. In that state, Health Insurance Exchange Qualified Health Plans, through a branded Medicaid program called Arkansas Works, serve the role normally played by MCOs.<sup>23</sup> No other state has adopted this structure due to the high cost of commercial rates paid to providers. Arkansas has asserted that their delivery system is budget neutral to what it would have had to invest to incentivize an influx of providers necessary to care for 250,000 new enrollees.<sup>24</sup>

**Indian Managed Care Entities:** Section 5006<sup>25</sup> of the American Recovery and Reinvestment Act (ARRA) of 2009 established authority for “Indian Managed Care Entities (IMCEs), which were codified in rule at 42 CFR 438.14 and defined as a managed care entity that “is controlled (within the meaning of the last sentence of section 1903(m)(1)(C) of the Act) by the Indian Health Service, a Tribe, Tribal Organization, or Urban Indian Organization, or a consortium, which may be composed of one or more Tribes, Tribal Organizations, or Urban Indian Organizations, and which also may include the Service.”

PCG has used the term IMCE in this paper to reference the federal designation. However, we fully recognize and understand that the term “Indian” is incongruent with “Alaska Natives.”

New Mexico and North Carolina have both pursued creation of a Medicaid IMCE. In New Mexico, the Navajo Nation had planned to team with Molina Health provide this healthcare delivery system for its tribal members.<sup>26</sup> However, the planned stalled in late March 2020 due to a disagreement between the Navajo Nation President and its lawmakers.<sup>27</sup> In North Carolina, the state Medicaid program contracted with the Cherokee Indian Hospital Authority in October 2020 to create an IMCE option for 4,000 tribal members starting in April 2021.<sup>28</sup> Federal rules permit IMCE membership to be limited to tribal populations.

IMCEs provide the potential for a culturally relevant delivery system and greater tribal control over local healthcare administration. For states, IMCEs provide the potential for greater budgetary predictability through a capitated payment rate. For Alaska, formation of an IMCE or multiple IMCEs could be complicated by governance challenges. Alaska is home to 229 federally recognized tribes,<sup>29</sup> compared to just one in North Carolina.

It should also be noted that an IMCE can operate under a Primary Care Case Management (PCCM) model and need not be a full risk-bearing managed care organization. This means that an IMCE could be paid a PMPM just for care management activities without taking on a broader role as payer for all health care services.

<sup>23</sup> [Arkansas Works | Arkansas Works](#)

<sup>24</sup> [Arkansas Health Care Independence Program: Final Report | ACHI](#)

<sup>25</sup> [Section-5006-Protections-for-Indians-under-Medicaid-and-CHIP.pdf \(cms.gov\)](#)

<sup>26</sup> [Navajo Nation, Molina Partner on Medicaid Managed Care in New Mexico - AIS Health](#)

<sup>27</sup> [Plans for Navajo Medicaid Entity Stall in Leadership Dispute | New Mexico News | US News](#)

<sup>28</sup> [NCDHHS: NCDHHS and Cherokee Indian Hospital Authority to Create First-in-Nation Indian Managed Care Entity](#)

<sup>29</sup> [Microsoft Word - Alaska 229 Federally Recognized Tribes.doc \(akgenweb.com\)](#)



IMCEs may also provide a simplified way for claiming 100% FMAP for tribal members receiving services through tribal health organizations or under a care coordination agreement. Currently, the need for DHSS to collect care coordination agreements when a tribal member receives care outside a tribal health organization limits enhanced match claiming. Depending on final agreements with CMS, all members of an IMCE may be eligible for 100% FMAP for all healthcare services without the need for documentation through Care Coordination Agreements.

**Health Homes:** As authorized under Section 1945 of the Affordable Care Act, Health Homes are eligible for 90% FMAP for the care coordination services they provide over an 8-quarter period.<sup>30</sup> Health Homes are specifically designated for certain individuals with chronic health conditions. They differ from PCCMs in that specific way. The specific care coordination services that are eligible for 90% FMAP for eight quarters include:

- Comprehensive care management
- Care coordination
- Health promotion
- Comprehensive transitional care/follow-up
- Patient and family support
- Referral to community and social support services

States have flexibility to determine eligible Health Home providers, under Section 1945 and related guidance. States may set qualification standards and permit more than one existing provider type to be certified as a Health Home. This means Alaska could establish standards that permit both community health centers and hospitals to serve as health homes. It would be in Alaska's interest to convert the current Providence care coordination program in the Anchorage area to operate under Section 1945 health home authority in order to convert the current state-only spending on that program to 90% FMAP.

States may also establish health homes in select geographic areas and do not need to implement the program statewide to qualify for the enhanced federal funding. States may phase in health homes geographically throughout the State and begin the eight-quarter clock separately for each phase of the expansion.

Alaska can implement a Section 1945 using a State Plan Amendment. No waiver is needed. Health Homes specifically target delivery system reform to those perceived as needing it most – members with certain chronic health conditions.

Alaska Medicaid's unique program features have served as a barrier to implementation of managed care. Those barriers include lack of population density outside of Anchorage, Fairbanks, and coastal communities, including Juneau. Further, more than any other state, Alaska Medicaid relies on Indian Health Services and tribal clinics and more than a third of Medicaid enrollees are Alaska Native tribal members. This makes imposing a plan-based delivery system that requires providers to separately contract with a commercial carrier especially challenging.

Health Homes provide an alternative by incentivizing provider organizations to voluntarily participate in care coordination activities. It builds on initiatives already in place in Alaska and feeds off provider interest in expanding this delivery model. Section 1945 Health Homes are consistent with the Providence care coordination program DHSS is now running in Anchorage.

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<sup>30</sup> [health-homes-section-2703-faq.pdf \(medicaid.gov\)](https://www.medicaid.gov/health-homes-section-2703-faq.pdf)



A privately-run social care program – High Utilizers Mat-Su (HUMS)<sup>31</sup> – is provided by Mat-Su Health Foundation in collaboration with a non-profit, LINKS (Linking Information and Knowledge about Special Needs). The goal of this program is to address patient social determinants of health that contribute to emergency department (ED) utilization. According to the Foundation, in 2016 there were 685 patients who had five or more visits to the ED of the Matsu Regional Medical Center, with facility charges totaling \$22.6 million. Seventy-two patients had 10 or more visits and 23 had 15 or more visits.

Fifty-two patients were served in the first year of the program. These 52 patients saw an average decrease of 61.7% in emergency visits after one year of HUMS enrollment. The Foundation indicates that associated costs savings for these patients was \$1,141,493 as a result of reduced ED visits.

**Recommendation for Alaska – Section 1945 Health Homes:** Stakeholders engaged by the PCG Senior Strategist have expressed strong interest in better care coordination to make healthcare spending more efficient, and ultimately, to lower healthcare costs, in Alaska. Providence Health System has indicated its interest in continuing and potentially expanding the reach of its current care coordination program.

The Alaska Primary Care Association (APCA), which represents the State’s community health centers, has also said its members wish to play greater care coordination roles and, with locations throughout the State, are well positioned to do so. APCA has specifically proposed an initial care coordination pilot under which four community health centers would participate and that would enroll up to 200 Medicaid patients.<sup>32</sup> If the pilot demonstrates success in lowering patient cost, APCA recommends expanding it statewide.

DHSS could opt to implement health homes in specific locations of the state or, alternatively, promote the model statewide. DHSS may also wish to restrict health homes to certain provider types or, alternatively, set criteria that enables any willing provider to pursue health home certification.

By taking the incremental delivery system reform step to establish Section 1945 Health Homes, Alaska Medicaid can forge partnerships with care management entities, growing and diversifying the scope of those partnerships with time. This could include eventually transitioning to models in which the provider organizations are capable of bearing risk for performance outcomes, thereby furthering Alaska’s migration away from a fee-for-service model under a structure that works for Alaska.

PCG also recommends that Alaska work with tribal health officials to explore the option of establishing an IMCE in order to better leverage tribal care management services and to aim for efficiencies in claiming 100% FMAP without required care coordination agreements for IMCE members.

<sup>31</sup> [High Utilizer Mat-Su Program – LINKS Resource Center \(linksprc.org\)](https://linksprc.org/)

<sup>32</sup> [Patient Centered Medical Home \(alaskapca.org\)](https://alaskapca.org/)

## ACA Section 1945 Health Homes

Provides authority to pilot care coordination initiatives within fee-for-service payment system while engaging care entities to perform specific services at 90% FMAP for 8 quarters.

Community Health Centers (CHCs) say they are ready and willing partners to do this. Converting the Providence initiative to a Health Home would convert 90% of care fees to FED.

This is a state plan option and may be implemented regionally. The State may establish provider eligibility standards by region.

[www.publicconsultinggroup.com](http://www.publicconsultinggroup.com)



**Estimated Savings:** Savings related to the implementation of health homes have been computed based on an assumption of outcomes like Missouri Medicaid, which has two Health Home initiatives, one focused on primary care and one focused on community mental health. Both programs are focused on serving individuals with two or more chronic health conditions. The Primary Care Health Care (PCHH) program in Missouri served 23,800 individuals and achieved PMPM savings of \$98, or approximately 5%, for the population enrolled.<sup>33</sup> Savings in the Community Mental Health Center Health Home (CMHC HH) program was greater at \$284 PMPM, or about 10%, for the 24,800 individuals enrolled. PCHH served 2.6% of total Medicaid members in Missouri, with the CMHC HH program serving 2.8% of enrollees.

If Alaska achieved similar enrollment and savings, the State would enroll 6,000 individuals in a similar PCHH program and 6,500 individuals in a similar CMHC HH program. Assuming a PMPM of \$2,000 for PCHH enrollees who have two or more chronic conditions and \$2,500 for CMHC enrollees with two or more chronic conditions, savings would be \$100 PMPM and \$250 PMPM, respectively. PCHH would, therefore, save \$7.2 million All Funds, or about \$2.9 million in state funding (assuming a blended FMAP of 40% for a population that would disproportionately be represented in the non-expansion population). For CMHC HH, All Funds savings compute to \$19.5 million, or about \$7.8 million in state funds per year.

Note that these are gross savings, not inclusive of the spending investment in care coordination fees, which are \$63 PMPM for PCHH and \$83 for CMHC HH in Missouri, matched at a federal rate of 90% for the first 8 quarters. After the 8 quarters, the fees reduce gross state savings 64% on the primary care side and 30% on the mental health side. For Alaska, this means annual state PCHH net savings of \$1 million and CMHC HH net annual savings of \$5.5 million, totaling \$6.5 million combined.

<sup>33</sup> [2017\\_PCHH report\\_7.19.18\\_Final Draft\\_editedJHW \(mo.gov\)](#)

While it will take some effort within DHSS to launch a health home project, the effort would be less intensive than implementation of managed care. Health Homes also benefit from having the support of existing provider stakeholders eager to participate in the model.

### ***Initiative #3: Hospital Pay for Performance (Delivery System Reform)***

**Payment Reform Background:** Nationwide, Medicaid programs have been gravitating toward payment reforms using “value-based purchasing” arrangements. Broadly, Value-Based Purchasing (VBP) is a payment method that moves away from fee-based reimbursement of individual medical services. It is intended to change financial incentives for healthcare providers by shifting away from rewarding high volumes of services. Instead, providers are rewarded for achieving care outcomes or meeting clinical quality standards.

CMS has been steadily implementing value-based purchasing in Medicare for the past decade. The Centers for Medicare and Medicaid Innovations (CMMI) designed several Medicare VBP initiatives<sup>34</sup> under the authority of the Affordable Care Act, including:

- **End-Stage Renal Disease Quality Incentive Program (ESRD QIP)** – a pay for performance program for renal dialysis facilities.
- **Hospital Value-Based Purchasing (VBP) Program** – Among other things, withholds hospital Medicare payments by up to 2% if specific performance metrics are not met.
- **Hospital Readmission Reduction Program (HRRP)** – Engages hospitals to improve discharge planning and reduces payment for readmissions that occur within 30 days.
- **Value Modifier (VM) Program (also called the Physician Value-Based Modifier or PVBM)** – Established a modifier value to physician fees that adjusted payment based on quality. This program transitioned to become the Medicare Quality Payment Program.
- **Hospital Acquired Conditions (HAC) Reduction Program** – Reduces Medicare hospital payments to facilities that score lower in preventing hospital acquired infections or other adverse events that occur during inpatient stays.

Implementation of value-based purchasing in Medicaid has significantly lagged the pace of reform in Medicare. However, following passage of the Affordable Care Act, CMS funded several state VBP initiatives through Delivery System Reform Incentive Pool (DSRIP) waivers and the State Innovation Model (SIM) grant program.<sup>35</sup> DSRIP and SIM funding permitted states to invest in practice transformation and provider infrastructure needs that can be required for fundamental changes to payment structures. These expansive funding initiatives (New York leveraged \$8 billion in federal shared savings dollars over 5 years) focused on simultaneous delivery system and payment reforms.

**Stages of Medicaid Value-Based Purchasing:** As part of its Medicare value-based purchasing planning, CMS began participating in the Health Care Payment Learning and Action Network

<sup>34</sup> [Innovation Models | CMS Innovation Center](#)

<sup>35</sup> [State Innovation Models Initiative: General Information | CMS Innovation Center](#)

(HCP-LAN),<sup>36</sup> a group of public and private health care leaders who collaborate to design and structure payment reforms.

HCP-LAN established a four-category framework for “alternative payment methods” that are on a spectrum with pure fee for service at one end and pure population-based payments at the other end. The middle categories are gradually progressive steps away from fee-for-service.

Adoption of VBP is a critical component of Alaska Medicaid’s healthcare reform road map. The HCP-LAN categories can help guide Alaska’s forward progress and are explained as follows”

**Category 1: Fee-for-Service** – Reimbursement that pays providers using a fee schedule that delineates a separate rate for each healthcare service.

**Category 2: Fee-for-Service - Link to Quality and Value**

- ✓ Foundational payments for infrastructure and operations (e.g., care coordination fees and payments for HIT investments)
- ✓ Pay for reporting (bonuses for reporting data or penalties for not reporting data)
- ✓ Pay-for-performance (bonuses for quality performance)

**Category 3: Alternative Payment Methods Built on Fee-for-Service Architecture**

- ✓ Alternative payment methods with shared savings (e.g., shared savings with upside risk only)
- ✓ Alternative payment methods with shared savings and downside risk (e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk).

**Category 4: Population-Based Payment**

- ✓ Condition-specific population-based payment (e.g., per member per month payment for mental health or oncology)
- ✓ Comprehensive population-based payment (global budget to a provider)
- ✓ Integrated finance and delivery system (global budget to an integrated health system)

This framework is especially useful in determining an initial approach for Alaska as it migrates forward away from a fee-for-service system into value-based purchasing. Alaska remains overwhelmingly in Category 1, which limited exceptions, such as care coordination fees being paid to Providence Alaska under the Coordinated Care Demonstration Program.

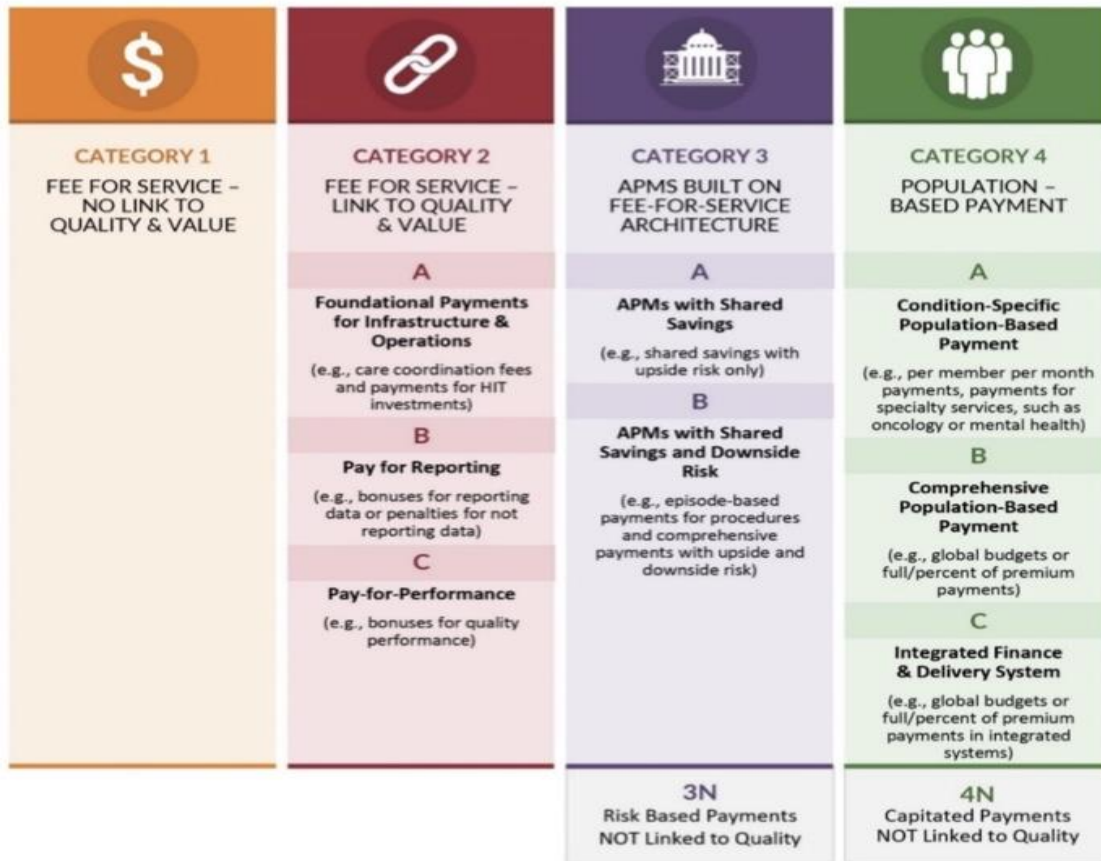
State Medicaid Director’s letter, SMD 20-004,<sup>37</sup> released September 15, 2020 provided information to states about methods that can use to pursue value-based purchasing arrangements.

SMD 20-004 also notes that implementation of VBP methods can require “significant change to provider business models.” The letter provides several suggested strategies states can use to facilitate provider transition to VBP models. This includes trying as much as possible to align VBP methods with Medicare and major commercial payers, which greatly simplifies provider transformation requirements.

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<sup>36</sup> [Health Care Payment Learning and Action Network - Health Care Payment Learning & Action Network \(hcp-lan.org\)](http://hcp-lan.org)

<sup>37</sup> [Value-based Care State Medicaid Directors Letter | CMS](#)



CMS further recommends selecting established performance metrics as the basis for value-based payments. They point to metrics already existing for Medicare Advantage plans, the Medicare Merit-Based Incentive Payment System (MIPS) or within CMS Innovation Center models.

**Recommendation for Alaska – Pay for Performance:** Initiating VBP in Alaska requires incremental steps forward. Given that Alaska continues to operate a fee-for-service delivery system, pay-for-performance (P4P) measures provide a logical entry point, moving from HCP-LAN category 1 to category 2. P4P can supplement the provider fee schedule without disruption. States often accomplish this by withholding a small percent of a benefit-specific budget line to be used to finance benefit-specific P4P.

Increasingly, State Medicaid agencies rely on MCOs to implement value-based purchasing arrangements with providers. MCOs typically rely on the Healthcare Effectiveness Data and Information Set (HEDIS) measures, designed by the National Committee for Quality Assurance, as the basis for VBP initiatives.

Specific examples of Medicaid P4P are indicated below:

**Nursing Home P4P:** In 2019, Oklahoma Medicaid implemented a nursing home P4P program.<sup>38</sup> The program leverages performance benchmarks already established by CMS as part of their Nursing Home Compare website. Specifically, Oklahoma includes the following four measures:

- ✓ Percentage of long-stay residents who lose too much weight
- ✓ Percentage of long-stay residents with high-risk/unstageable pressure ulcers

<sup>38</sup> [Pay For Performance \(oklahoma.gov\)](https://www.oklahoma.gov/pay-for-performance)

- ✓ Percentage of long-stay residents with a urinary tract infection
- ✓ Percentage of long-stay residents who received an antipsychotic medication but had no diagnosis of Schizophrenia, Huntington's Disease or Tourette's Syndrome

If a nursing home meets a specified level of improvement in performance across these categories, they are eligible for a lump-sum payment quarterly. Oklahoma has reported that, to date, about two-thirds of facilities have qualified for the P4P payments.

**Hospital P4P:** Preventable hospital readmissions are often a focus of VBP initiatives because they have the potential to provide significant improvements in care and cost. Notably, reducing preventable hospital readmissions is already identified as a state public health priority in Healthy Alaska 2020, with a goal of reducing the current 7.5 preventable readmissions per 1,000 adults to 6.7.

The Agency for Healthcare Research and Quality (AHRQ) estimates that about 15% of Medicaid hospitalizations are preventable.<sup>39</sup> In 2020, Alaska spent \$96 million in state funds on Medicaid Inpatient Hospital, according to Evergreen Economics. Using AHRQ data, this means Alaska spends \$14 million in state funds each year on preventable hospitalizations. Reducing this amount by 25% yields more than \$3.5 million in state savings per year.

To pursue this level of savings, while improving care outcomes for patients, it is recommended that Alaska adopt a potentially preventable readmission (PPR) P4P standard. The standard would compare the expected level of a hospital's rate of PPRs for a given year, based on historical averages, and compare it to actual PPR for the performance period. Hospitals that achieve reductions would receive bonus payments, with higher reductions receiving higher payments.

Across Medicaid programs, states are often more frequently involved in directly managing hospital VBP and quality payments than with other provider types. This is in part due to the distribution of hospital provider tax funded payments. CMS permits state directed payments to hospitals in a managed care environment only to the extent the payment is related to delivery system reform or value-based purchasing implementation. States generate political support for hospital provider assessments by directing a portion of the assessment into a lump sum payment back to the hospital.

To achieve compliance with its own Upper Payment Limit and to yield the savings associated with this initiative, it is recommended that Alaska finance the P4P initiative by withholding a specified amount of inpatient and outpatient hospital budget for the fiscal year. The amount would be established through implementation of a "budget adjustment factor" that limits final rate amounts to a 3% cost growth boundary.

Hospital performance-based payments are approved by CMS via state plan amendment. Below is an example of the extensive language in the Wisconsin Medicaid State Plan related to these payments. In Wisconsin, hospital P4P is categorized in two ways – the first by performance payments funded through the hospital assessment and the second by performance payments funded through the rate-setting withhold:

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<sup>39</sup> [Characteristics and Costs of Potentially Preventable Inpatient Stays, 2017 #259 \(ahrq.gov\)](#)



## **Assessment Based Performance Payments**

The Department reserves \$5 million (all funds) in each SFY for its Hospital Assessment Pay-for-Performance (HAP4P) program, which provides for payments to children's, rehabilitation, and acute care, including long term care, hospitals located in Wisconsin. Critical access hospitals are not included in the HAP4P program because they already receive cost-based reimbursement. Psychiatric hospitals are not included because they are paid under a different reimbursement methodology in the State Plan.

The HAP4P program is administered on a measurement year (MY) basis. Each MY runs from January 1 through December 31. Payments for each MY are made annually by the September 30 following the conclusion of the MY.

The remainder of this section describes the program's design and requirements for the current measurement year. In order to be eligible for HAP4P program payments, hospitals are required to report performance measure data and meet performance-based targets as specified in the Hospital Pay-for-Performance (P4P) Guide, which is effective January 1.

Hospitals receive payment for scoring at or above the averages published in the P4P Guide for the three Check Point measures, and their respective sub-measures, as listed below.

1) Perinatal Measures (\$2 million) - Hospitals are scored on two sub-measures (Cesarean Section and Newborn Screening Turnaround Time). A hospital can earn a 75% "partial share" of the \$2 million by scoring at or above the published average on one of the sub-measures or can earn a 100% "full share" of the \$2 million by scoring at or above the published average on both of the sub-measures.

2) Patient Experience of Care (\$1.5 million) - Hospitals are scored on 10 sub-measures drawn from the - 31 question Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey completed by patients. A hospital can earn a 100% "full share" of the \$1.5 million by scoring at or above the published average on at least three of the sub-measures.

3) Central Line Associated Blood Stream Infections (CLABSI) (\$1.5 million) - Hospitals are scored based on their performance on this standard infection ratio that is calculated for all Wisconsin hospitals. A hospital can earn a 100% "full share" of the \$1.5 million by scoring at or above the published average for this measure.

Only data submitted to Check Point as of the June 30 following the conclusion of the MY are included in the calculations of performance on these measures.

The Department determines the payment amounts and recipients for each measure separately. The Department calculates the "full share" payment amount for a measure by dividing the budget for the measure by the sum of ("partial" and "full") shares earned by hospitals; the "partial share" payment amount is the "full share" payment amount multiplied by the "partial share" percentage. For example, if, for the Perinatal Measures, 25 hospitals qualify for "full shares" and 20 hospitals qualify for 75% "partial shares," the sum of the shares is 40 ( $25 + (0.75 \times 20)$ ), so the 25 hospitals each earn \$50,000 ( $\$2 \text{ million} / 40$ ) while the 20 hospitals each earn \$37,500 ( $\$50,000 \times 0.75$ ).

HAP4P payments are limited by the federal UPL regulations at 42 CFR §447.272. All HAP4P payments are included in the UPL calculation for the MY regardless of when payments are actually made.

## **Withhold Based Performance Payments**

The Department has a Hospital Withhold Pay-for-Performance (HWP4P) program that provides for payments for acute care, children's, and critical access hospital services. Psychiatric, long term care, and rehabilitation hospitals are exempt from the HWP4P program.

The Department administers the HWP4P program on a measurement year (MY) basis. MYs are on a 12-month cycle, from January 1 through December 31.



*For each MY, the Department pays FFS inpatient claims at the rate of 97% of the reimbursement in effect during the MY. The HWP4P pool amount is the remaining 3% of the reimbursement in effect during the MY for those same FFS claims. Hospital supplemental payments made to eligible providers, including access payments, are excluded from the HWP4P pool amount. .*

*The Department makes HWP4P payments for each MY annually by the September 30 following the conclusion of the MY.*

*The remainder of this section describes the program's design and requirements for the current measurement year. In order to earn eligibility for HWP4P program payments, hospitals are required to meet performance-based targets as specified in the Hospital Pay-for-Performance (P4P) Guide, which is effective January 1.*

*Providers that meet the requirements are eligible to receive payments from the HWP4P pool as follows:*

- 1) If a hospital meets all of its performance targets for all applicable measures, it receives a payment equal to its individual HWP4P pool amount.*
- 2) If a hospital does not meet or surpass its performance targets, it receives either no return, or a partial return calculated in a graduated manner as specified in the Hospital P4P Guide.*
- 3) If all participating hospitals meet all of their individually applicable targets, no additional HWP4P pool funds are available and thus no bonus payments beyond those described above can be made to any hospital.*
- 4) If at least one participating hospital does not receive its full HWP4P pool amount, the Department aggregates all remaining HWP4P pool funds and distributes them as additional bonus payments to hospitals that met their performance targets, up to 10% of their total fee for service inpatient reimbursement.*

*HWP4P payments, including the additional bonus payments, are limited by the federal UPL regulations. All HWP4P payments, including the additional bonus payments, are included in the UPL calculation for the MY regardless of when payments are actually made.*

Alaska Medicaid currently utilizes a per diem prospective payment methodology for inpatient hospital services, according to the Alaska Medicaid State Plan<sup>40</sup>. Per Diem payment rates are intended to compensate hospitals based on cost, with cost elements discretely defined in the state plan. This methodology is executed by lifting cost components from Medicare cost reports and inflating them forward to the current year. Both capital and non-capital costs are included in the methodology. Smaller hospitals may choose an alternative per diem rate setting method that reflects some differences in cost inputs and inflation factors from the standard method. Finally, the Alaska Medicaid State Plan includes a separate rate setting method for psychiatric hospitals.

The State's current inpatient rate methodology departs significantly from most other Medicaid programs nationwide. Most states utilize a diagnostic related grouper (DRG) method that measures the anticipated resource utilization of different inpatient hospital services. In this way, each DRG code is assigned a "weight" that measures its relative intensity. Codes with a weight of 1.0 reflect the precise average intensity level. Codes with weights of less than one or greater than one reflects a lesser or greater intensity of services. DRGs are not necessarily a lower cost rate setting method, but it does more accurately reimburse each service according to the intensity of that service. Alaska's per diem method only weights services based on the length of stay and no other factors.

This methodology puts Alaska Medicaid in the position of adjusting to externally driven hospital rate outcomes each year, based on each hospital's cost input variables. The method does not

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<sup>40</sup> [Medicaid State Plan: Section Four \(alaska.gov\)](#)

facilitate Alaska proactively managing rates to a budget or leveraging its payment methodology to incentivize quality and efficiency.

## **Payment Reform: States often begin with hospital pay for performance**

Current hospital inpatient “per diem” method incorporates hospital cost increases indiscriminately. As a result, the State reacts to cost adjustments rather than setting prices that drive hospital cost efficiencies.

Current outpatient method is based on a “percent of charges,” permitting hospitals to control their own prices by adjusting charges.

Neither method is acuity -based, meaning reimbursement is not based on the intensity of resource utilization. The method is also not value -based to align with quality outcomes.

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The Alaska Medicaid outpatient hospital rate setting method is even more misaligned with cost containment and quality promotion principles. The State uses a “percent of charges” method to adjudicate claims for these services. Hospital charges are not reflective of their costs, and arguably, have no relationship to resource utilization for services. Percent of charges methods effectively incentivize the provider to influence pricing by adjusting their chargemaster to achieve their desired price.

Alaska Medicaid has fewer supplemental hospital payments than other states<sup>41</sup>. This is primarily due to the State having no hospital provider tax authorized by CMS. Many states use hospital provider taxes as a financing mechanism. Revenue from a provider tax becomes state revenue that may be appropriated as the local match for Medicaid hospital payments, as long as the outcome advantages high-Medicaid utilization hospitals.

Over the past two decades, state hospital associations have generally moved toward supporting provider taxes as a better alternative for their members than rate cuts<sup>42</sup>. States typically have “room” under their Upper Payment Limits (UPLs) to increase hospital rates using provider tax revenue because most states were paying hospitals significantly below cost when they imposed the provider tax. Because Alaska hospital rates are already intended to pay based on cost, the State has very little room under federal UPL standards to increase payment rates further using provider tax revenue.

The most immediate way Alaska can better align its hospital rate setting methods with cost growth containment goals is to establish a budget adjustment factor. Such a factor would provide Alaska with leverage to proactively decide how much more it can afford to spend on inpatient hospital

<sup>41</sup> [EXHIBIT 24. Medicaid Supplemental Payments to Hospital Providers by State : MACPAC](#)

<sup>42</sup> <http://www.ashnha.com/wp-content/uploads/2012/11/Provider-Tax-Comprehensive-20152.pdf>

benefits. A budget adjustment factor is an allowable variable to insert in a Medicaid State Plan, and other states, such as Wisconsin, have done this for many years.

According to the Long-Term Forecast of Medicaid Enrollment and Spending in Alaska: FY2020 – FY2040 (completed by Evergreen Economics), the state share of inpatient hospital spending will increase from \$96.1 million in FY20 to \$119.5 million in FY25<sup>43</sup>. This is an average annual cost growth rate of 4.87%. Reducing this cost growth rate to 3.00% would generate \$1.8 million in state share savings in the first year.

The state share of outpatient hospital spending is projected to increase from \$60.8 million in FY20 to \$76.8 million in FY25. This is an average annual cost growth rate of 5.26%. Reducing this cost growth rate to 3.00% would generate \$1.4 million in state share savings in the first year.

***The total state share savings from this budget adjustment factor would, therefore, equal \$3.2 million in the first year of the initiative. Under this initiative, Alaska would reinvest this “savings” in a hospital pay for performance (P4P) fund.***

The P4P fund would facilitate hospitals earning performance-based revenue by meeting quality metrics, such as reducing preventable hospital readmissions. For Year 1, pay for reporting could be an initial method to claw back revenue. During site visits to Anchorage and Juneau completed for this engagement, DHSS staff indicated that some hospital claims are submitted with incomplete information, including diagnosis codes. Pay for reporting could provide the Department with more accurate information to assess what Medicaid is paying for and prepare for future quality measures. This paper assumes that all \$3.2 million in state funding assigned to the P4P Fund would be fully distributed to participating hospitals.

The following language from the Wisconsin Medicaid State Plan<sup>44</sup> illustrates the mechanics of how to implement a budget adjustment factor. This specific provision applies to non-IMD psychiatric, rehabilitation and long-term care hospitals. In Wisconsin, those classes of hospitals are paid on a per diem method that is similar to Alaska Medicaid inpatient payment methods. Therefore, this language shows how a budget adjustment factor can be applied to a per diem method. States can update their budget adjustment factor annually with a state plan amendment. The bolded language below is the specific language that imposes the budget factor:

*8220 All Other Psychiatric, Rehabilitation, and Long-Term Care Hospitals. Patient stays in a hospital covered by this section will be paid at a prospective per diem cost-based rate. The prospective per diem rate will be based on the rate setting Medicare cost report. A cost per day will be calculated for routine inpatient services using Medicare and Medicaid cost principles. WMP ancillary costs will be apportioned by deriving cost-to-charge ratios for each ancillary service. The total routine and ancillary WMP costs will be divided by total paid WMP days from the Medicaid Management Information System (MMIS). The cost per diem rate will be inflated to the current rate year by applying the “Hospital and Related Healthcare Costs Index” published by IHS. Final hospital-specific per diem payment rates are based on provider costs but are subject to a budget reduction factor to ensure compliance with the Department’s annual budget. **For rate year 2014 and subsequent years, the budget reduction factor used to ensure compliance with the Department’s annual budget is 85.08%.***

Language from Alaska’s current inpatient hospital rate setting state plan is provided below. The one-year adjustment factor added for 2018 (the 95% of the previous year) is shown in the last sentence. Alaska could update its State Plan to replace that single sentence with a specific

<sup>43</sup> [AK LongTermMedicaidFcast\\_FY2020-FY2040 \(akleg.gov\)](#)

<sup>44</sup> [Medicaid State Plan | Wisconsin Department of Health Services](#)

ongoing budget adjustment factor. The State could file a State Plan Amendment (SPA) annually update the factor. The SPA could also cite a process you will use annually to determine the budget adjustment factor:

*The prospective payment rate for inpatient hospital services rendered to Medicaid recipients is a per-day rate reflecting costs related to patient care and attributable to the Medicaid program. Prospective payment rates will be determined under one of three methodologies - Basic, Optional, and New Facilities...**For state fiscal year 2018, the payment rate will be 95% of the payment rate in state fiscal year.***

Alternatively, Alaska could identify a specific component of cost, for example, capital costs, and determine a reduction to the proportion of those costs that will be included in Medicaid rate setting. To the extent that a budget adjustment factor creates a gap in Medicaid reimbursement of full hospital cost, Alaska could permit hospitals to earn back the difference through quality payments. This will be discussed in greater detail in the payment reform section of this paper.

Other states pay for outpatient services using a resource-based measurement system similar to Diagnostic Related Grouping (DRGs). The DRG-equivalent for outpatient rate setting is the Ambulatory Patient Grouping (APG). Like DRGs, APGs measure the relative resource intensity of specific services and weights those services to pay more or less than the average accordingly.

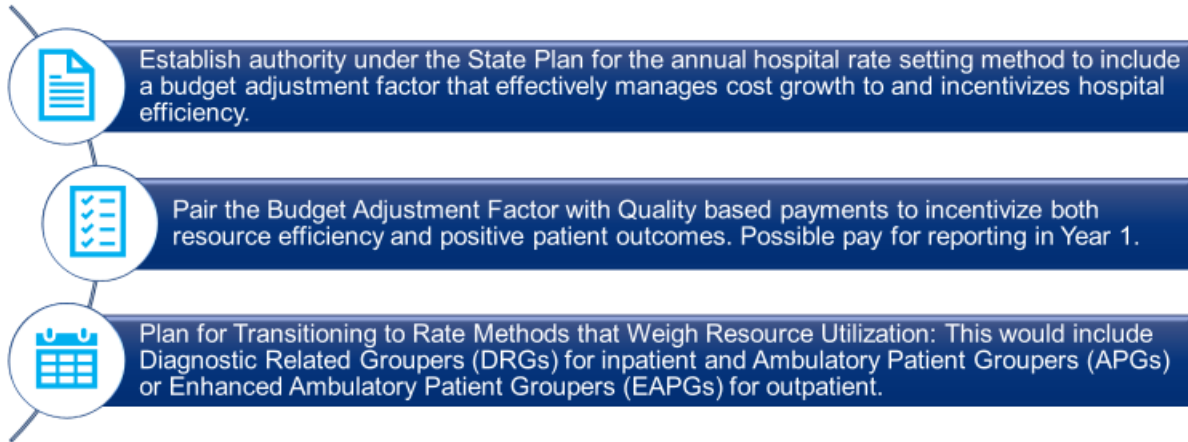
It should be noted that implementation of a DRG and/or APG system moves Alaska Medicaid in the direction of payment amounts that more accurately represent resource intensity, and in doing so, will create short term winners and losers among hospitals. Hospitals that typically provide more intensive services will gain revenue under these methods, and those providing fewer intensive services will see revenue declines, assuming the method is implemented in cost neutral fashion in aggregate.

It is recommended that Alaska eventually move toward hospital DRGs and APGs for inpatient and outpatient hospital rate setting since a resource-based payment methodology is more discreet in aligning payment and services.

Longer term, Alaska can take incremental steps toward adoption of a value-based hospital reimbursement methodology, consistent with Medicaid payment reforms that have been approved by CMS and/or initiated by managed care organizations in many states. Value-Based Purchasing methods can be complex to implement, such as the establishment of care episodes (a reimbursement method that pays a single fee for an entire care event, with the potential to adjust the fee based on the health outcome that results from the care episode). However, Alaska could take initial and simple steps forward in paying for value, which will be illustrated in the Value-Based Purchasing (VBP) section of this paper.

Given the lack of value-based reimbursement methods currently employed by Alaska Medicaid, it would be easy for the State to make some initial steps forward. Alaska Medicaid does not currently have a hospital readmission policy of any kind in its hospital provider manual. This is a departure from many states and most commercial health plans. Many states reduce reimbursement for a readmission if a clinical review indicates the readmission was preventable.

## Hospital Rate Setting Change: Value Based Purchasing



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Washington State's policy<sup>45</sup>, adopted in 2017, defines a readmission as preventable if there was a reasonable expectation that it could have been prevented by one or more of the following:

- The provision of quality care in the index hospitalization (a specific quality concern, knowable at the time of treatment, and resulting in the readmission, needs to be identified)
- Adequate discharge planning (as defined below under "provider responsibility")
- Adequate post-discharge follow-up

Washington's Health Care Authority (HCA) allows MCOs to deny payment for the readmission in these circumstances. However, the policy also notes that if issues with quality of care, discharge planning, or follow up occurred but cannot be reasonably considered the cause of the readmission, payment cannot be denied.

During stakeholder outreach for this paper conducted in late 2019, the Alaska State Hospital and Nursing Home Association (ASHNHA) revealed their interest in an Oregon-style "prioritization of services"<sup>46</sup> solution to cost containment, effectively limiting payment for low priority services. However, no other state that has pursued the Oregon model, in part because medical coding provides opportunities to bill for similar services in a variety of ways, thereby limiting the savings associated with a prioritized list. Even Oregon has not made the prioritization list a salient feature of its more recent set of reforms, instead relying on regional Care Coordination Organizations (CCOs)<sup>47</sup> that manage care within global budgets.

The following are incremental steps toward implementation of budget adjustment factors and migrating to broader hospital rate setting reforms:

<sup>45</sup> [Provider-Preventable-Readmissions-policy-and-use-of-PPR-data-110917.pdf \(wsha.org\)](#)

<sup>46</sup> [Oregon Health Authority : Prioritized List of Health Services : Health Evidence Review Commission : State of Oregon](#)

<sup>47</sup> [Oregon Health Authority : Coordinated Care Organizations \(CCO\) : Oregon Health Plan : State of Oregon](#)

### **Step 1: Establish a Budget Adjustment Factor**

Alaska would file a state plan amendment that inpatient per diems and outpatient percent of charges will be established consistent with an aggregate budget estimate that limits total expenditure growth to a budget adjustment factor. This would result in immediate savings for Alaska.

### **Step 2: Pair the Budget Adjustment Factor with Quality Payment Incentives**

Reinvest “savings” from Step 1 to facilitate hospitals earning performance-based revenue by meeting quality metrics, such as reducing preventable hospital readmissions. For Year 1, pay for reporting could be an initial method to claw back revenue. During site visits to Anchorage and Juneau completed for this engagement, DHSS staff indicated that some hospital claims are submitted with incomplete information, including diagnosis codes. Pay for reporting could provide the Department with more accurate information to assess what Medicaid is paying for and prepare for future quality measures. Eventual state savings of \$3.5 million accrue from a 25% decline in preventable readmissions.

### **Step 3: Plan for Transitioning to Rate Methods that Price Resource Utilization**

Alaska is already looking to implement Diagnostic Related Grouper (DRG) rates for inpatient hospital. PCG recommends a similar approach for outpatient services. The Ambulatory Outpatient Grouper (APGs) provides a more granular assignment of cost to the acuity of services. A variation of APGs is Enhanced Patient Ambulatory Groupers (EAPGs).<sup>48</sup> This is a proprietary product offered by 3M corporation that is in use in some states and considered by some to provide even more granularity than APGs.

## ***Initiative #4: Medicaid School Health Services Reform (State Financial Stewardship)***

### **School-Based Services as Part of an Individualized Education Plan (IEP)**

Schools must provide medically necessary services to students as part of their educational plans. The Individuals with Disabilities Act (IDEA)<sup>49</sup> ensures students with a disability receive an education that meets their individual needs. Children with disabilities have their specific needs identified in an Individualized Education Program (IEP).<sup>50</sup> The schools can bill Medicaid and receive payment for covered services provided to Medicaid eligible children. The services outlined in an IEP are uniquely different from services provided in a school-based health center because they are services that are specific to the child’s education.

State Medicaid agencies can cover services included in a child’s IEP as long if the following conditions are met:

- The services are medically necessary and covered in Section 1905(a) of the Social Security Act;
- All state and federal regulations governing the services are followed; and

<sup>48</sup> [3M™ Enhanced Ambulatory Patient Groups \(EAPGs\)](#)

<sup>49</sup> [Individuals with Disabilities Education Act \(IDEA\)](#)

<sup>50</sup> [Archived: Guide to the Individualized Education Program](#)



- The services are covered under the state plan or available through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit.<sup>51</sup>

Typically, the services consist of speech therapy, occupational therapy, physical therapy, counseling, behavioral health, nursing services, and transportation. Because costs vary across school districts, most Medicaid agencies carve these services out of Managed Care and utilize a cost settlement process to reimburse schools for the actual costs of services provided to Medicaid eligible children. Utilizing a cost-settlement process ensures the schools receive adequate funds to cover the costs of providing the services. In addition, the cost-settlement process is designed to reimburse schools at the correct amount and reduces the chances of underpayments and overpayments. Medicaid agencies typically use a contractor to perform cost settlement activities.

### **School-Based Administrative Services**

Schools can also receive Medicaid funding for administrative activities<sup>52</sup> that support the provision of Medicaid services to children in schools and activities related to outreach and enrollment. Schools can receive federal matching funds for activities including care coordination and transportation to and from school on a day a child receives a Medicaid-covered service, and transportation to treatment services if the service is provided on a day that school is in session and the service is delivered at a setting other than the school.

### **Financing School-Based Services**

The most common form of financing for the state share of school-based services is the use of certified public expenditures (CPE)<sup>53</sup> provided by state or local education agencies. When an education agency incurs expenditures that are eligible for federal financial participation (FFP) under the Medicaid state plan, the agency certifies those funds were used to support the cost of providing the Medicaid covered service or administrative activity. This certification allows the state to draw down the FFP for the services. It is important to note that some Medicaid agencies maintain a specific amount of withholding, such as 5% or other amount as determined by the state, from the CPE to cover the administrative expenditures incurred by the Medicaid program as it relates to administrative claiming.

### **School Based Services in Alaska**

The Alaska Medicaid State Plan<sup>54</sup> sets forth a methodology for reimbursing school-based rehabilitative services as follows:

*The division will reimburse an enrolled school district for those procedures identified in the United States Department of Health and Human Services, Centers for Medicare and Medicaid's (CMS) Healthcare Common Procedure Coding System (HCPCS) 2003 that are provided as a rehabilitative service. Payment is made at 85% of the rate identified in the State's fee schedule for all providers of physical therapy, occupational therapy, speech-language therapy, and hearing services, whether school-based or community-based. The maximum allowable rates for all services are calculated using the Resource Based Relative Value Scale (RBRVS) methodology described in 42 CFR 414. The relative value units used are the most current version published in the Federal Register.*

<sup>51</sup> [Early and Periodic Screening, Diagnostic, and Treatment | Medicaid](#)

<sup>52</sup> <https://www.cms.gov/research-statistics-data-and-systems/computer-data-and-systems/medicaidbudgetexpendsystem/downloads/schoolhealthsvcs.pdf>

<sup>53</sup> [Non-federal financing : MACPAC](#)

<sup>54</sup> [Medicaid State Plan \(alaska.gov\)](#)



Currently Alaska utilizes an Intergovernmental Transfer (IGT) process that requires school districts to front the state share in order to have their claims processed and receive reimbursement. Although Alaska communicated its intent to do this in writing to CMS through a response to a Request for Additional Information (RAI) in 2003, the Alaska State Plan document itself does not include language authorizing the IGT.

The IGT methodology does not capture federal revenue up to cost. For this reason, PCG recommends transitioning this IGT process to a CPE methodology. Other states, including Georgia and Kansas, have successfully transitioned from an IGT to a CPE. The CPE process is typically preferred by Districts, as it resolves the cash flow problems involved in fronting IGTs. Currently not all Alaska school districts are participating in the IGT program, meaning there is no Medicaid reimbursement at all for those rehabilitative services, even when performed for children on Medicaid or CHIP.

Transitioning from an IGT to CPE process does not have to require new state funding. An interim payment rate methodology can be established aimed at only paying out the federal share. This is a win-win for the State and school districts as reimbursement processes are made more user-friendly and new federal money flows into Alaska to promote healthy children in Alaska schools.

It is important to note that the current IGT methodology is authorized in state law. Converting to a CPE method will require a statutory change.

Thirty-two states also currently submit cost-based administrative claiming for school-based services to CMS. Alaska does not. PCG has requested a claims extract from DHSS to determine the potential amount of federal revenue the State could gain from a CPE methodology.

### **Statewide Cost Settlement**

Medicaid pays for health and related services provided to children in schools when the service is provided through an individualized education plan (IEP). Because the local school districts are public providers, their expenditures count as the “local match” for claiming the federal funds for medical claims and the Medicaid agency can draw down the Federal Medical Assistance Percentage (FMAP) to reimburse the districts for the additional costs of providing the services.

Approximately 32 states currently have administrative claiming processes that allow districts to claim costs associated with administration of Medicaid services to Medicaid eligible children. Schools can receive Medicaid funding for qualified administrative activities related to the delivery of Medicaid covered services to children in school. In addition to efforts that support the provision of Medicaid eligible services, administrative activities also include outreach and enrollment.

### **Modify the Scope of Alaska Medicaid School Based Services**

School-based health centers are simply clinics that are located in schools. School-based health centers typically have hours that can accommodate busy schedules and provide services to students and their families. Services include:

- Primary Care
- Behavioral Health
- Case Management
- Dental
- Vision

Services vary depending on the state and coverage provisions. School-based health centers typically operate as any other Medicaid provider. They must meet provider enrollment criteria and abide by Medicaid rules and regulations governing school-based health centers. They bill Medicaid for services provided to eligible members. In addition, if the state uses Managed Care Organizations (MCOs), school-based health centers will bill MCOs for Medicaid members assigned to them. School-based health services are generally reimbursed as any other Medicaid provider and are not subject to cost settlement activities. They are generally operated as a partnership between the school and a community health organization, such as a hospital, local health department, or community health center.

Alaska's current authorization of school health services as "rehabilitative" limits the reach of school-based clinics and risks underclaiming of federal funds.

## **Federal Revenue: Modify Scope of School Services**

### Additional Service to Consider:

- Nursing services
- Personal care or attendant services; and
- Specialized transportation services

Personal care and specialized transportation services have led to an increase in Medicaid funds of 20% to 30% in incremental revenues to school districts.

Historically, school-based services have been limited to students with an individual education plan or children enrolled in special education. This is no longer the case, and any state plan approved service can be provided in the school setting if services are medically necessary.

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PCG estimates that Alaska could generate an additional \$4.1 million in federal revenues per year by implementing a school health certified public expenditure and modifying the scope of Medicaid-reimbursable school health services. This estimate is based on the fact that Alaska today captures \$2.1 million in federal revenue on school-based services through the IGT claiming methodology. Typically, states that move to a CPE cost settlement methodology inclusive of Medicaid administrative claiming double their federal revenues.

Further, states that have added services such as personal care, nursing services and specialized transportation, as well as making more children eligible by expanding beyond IEPs, have increased federal revenue by 50%. If Alaska is claiming \$4 million per year in total FED through a CPE methodology, the expansion in scope of services would add an additional \$2 million in FED from baseline funding. This would raise total school-based services federal funding from a baseline of \$2.1 million today to \$6.2 million, a net increase of \$4.1 million.

## ***Initiative #5: Medicaid Global Spending Cap (Cost Containment)***

Alaska is not alone among states in terms of the challenge it faces in sustaining Medicaid cost growth. For many states, Medicaid consumes a high percentage of all new state revenues each year, leaving little room to grow other program areas, such as education or transportation. Finding ways to benchmark and enforce spending growth limits in Medicaid has been and continues to be pursued by both Republican and Democratic governors.

Over the past eight years, key spending limit models have emerged. Under Governor Andrew Cuomo, New York implemented a self-imposed global budget cap,<sup>55</sup> sharing the savings with the federal government that permitted investments in delivery system reform.

The Medicaid global budget cap is modeled after the Medicaid spending target mechanism that was first adopted by New York State in 2011. The New York Medicaid global budget cap has been governed by a 27-member “Medicaid Redesign Team (MRT),” consisting of providers and other stakeholders, to recommend and approve initiatives to reduce expenditure growth and increase healthcare quality. A primary strategy in appointing the MRT was to directly bring stakeholders into the process of establishing savings initiatives to get their buy in. Under the legislation authorizing MRT, automatic spending cuts would be imposed in the absence of MRT initiatives, thereby incentivizing members to reach agreement. The state has leveraged this process to successfully meet spending targets for many successive years.

CMS permitted New York to reinvest federal funds saved under some of the initiatives pursued as a result of the global cap to finance a Delivery System Reform Incentive Pool (DSRIP) initiative under an 1115 demonstration waiver.<sup>56</sup> The waiver was approved in April 2014. New York was able to document \$17.1 billion in federal savings through its Medicaid Redesign Team efforts. Of this amount, \$8 billion was authorized to be reinvested for delivery system reforms. The majority of the reinvestment targeted hospital transformation strategies aimed at reducing preventable hospital readmissions. New York invested one billion dollars for Health Home development and investments in long term care, workforce and enhanced behavioral health services and \$500 million in one-time funding will be used to assist safety net providers.

If Alaska were to choose to emulate this model, state legislation would authorize DHSS to establish an annual cap on the state share of expenditures that support the Medicaid program. The New York cap is tied to the 10-year rolling average of medical inflation as measured by the US Bureau of Labor Statistics. The current 10-year rolling average is 3.1%. This stands in contrast to forecasted state-share Alaska Medicaid expenditure growth of 5% between 2020 and 2025, or 4.6% between 2020 and 2040, based on work completed by Evergreen Economics for DHSS.

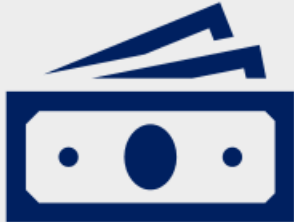
DHSS would then establish a governance committee comprised of a wide representation of Medicaid stakeholders, along with Medicaid program staff, charged with annually recommending a plan to the Commissioner that will result in compliance with the cap. It is recommended that the statute authorizing the global budget cap identify committee representation and set rules for state action should committee action fail to result in compliance with the growth cap. In that case, the statute should direct and empower the Alaska DHSS Commissioner to take action consistent with CMS rules as necessary to achieve cap compliance. This shapes the dynamics that drive the expenditure reduction efforts of key stakeholders.

<sup>55</sup> [Monthly Global Cap Updates \(ny.gov\)](https://www.ny.gov/newsroom/monthly-global-budget-cap-updates)

<sup>56</sup> [Delivery System Reform Incentive Payment \(DSRIP\) Program \(ny.gov\)](https://www.ny.gov/newsroom/delivery-system-reform-incentive-payment-dsrrip-program)

No waiver is required for implementation of the governance model itself, though initiatives that emerge from committee recommendations may require waivers or state plan amendments. Any rate reductions that emerge would also require approval from CMS via amendment of the State Plan. An 1115 waiver can also provide authority for sharing associated savings with the federal government to fund system reforms that can further improve care delivery and associated efficiency.

### Cost Containment: Global Spending Cap



New York Medicaid has had a CMS approved global spending cap in place since 2012.

Goal is to limit total Medicaid state-share spending growth to no greater than the ten-year average rate for the long-term medical component of the Consumer Price Index (currently estimated at 3.2 percent).

If cap is at risk of being exceeded, state works with advisory group on a spending reduction plan. If stakeholders are unable to agree on a plan, Commissioner authorized to take action.

The global budget cap is recommended because it provides a clear mechanism to drive cost containment. It also does so in a way that has the potential to advance greater support from the key stakeholder groups that would be impacted by cost containment initiatives.

**Estimated Savings:** Savings are measured as the difference between the 5% forecasted state share expenditure growth between 2020 and 2025 (see Evergreen Economics report) and a 3.1% annual growth rate to comply with established federal benchmark. This results in the following annual state savings amounts, which reflect reductions in compounding growth across years:

- \$14.6 million in 2021
- \$27.2 million in 2022
- \$40.8 million in 2023
- \$55.3 million in 2024
- \$70.9 million in 2025

Aggregate state savings total \$208.8 million over 5 years. Additional federal savings would result.

### *Information on Optional Medicaid Eligibility Categories*

While reform-based approaches that achieve savings through greater efficiency or improved care are clearly preferable, the following information is provided to clarify what is possible through “stopgap” budget cuts.

**Several Medicaid eligibility categories remain optional for Alaska.** Outside of the Medicaid expansion population, eleven other eligibility categories remain optional. Those covered under these optional categories primarily includes the elderly, individuals with disabilities and children, all of whom may have household income slightly higher than financial requirements associated with mandatory coverage categories.

Reducing enrollment by eliminating optional eligibility categories cannot not be implemented until the end of the federally declared coronavirus public health emergency, which is currently extended through January 20, 2021. Continuous Medicaid eligibility was established as a condition of the enhanced federal match provided to state Medicaid programs as part of the Families First Coronavirus Response Act.

Enrollment and expenditures associated with each of these eleven optional categories was provided by DHSS. While many of the individuals enrolled under each of these eleven categories have slightly higher incomes than mandatory enrollees, they generally reflect highly vulnerable, low-income Alaskans who may suffer significant harm from losing coverage. They are frail elderly whose long-term care needs would not be covered by Medicare. They are working disabled who may be incentivized to stop working to keep their Medicaid in the absence of coverage through a state option. They are children who otherwise may skip well-child visits and preventative care.

The eleven categories – along with current associated enrollment and expenditures – are as follows:

1. **“TEFRA” Option (Subtype DK)** – Disabled children living at home who, if not living at home, would require an institutional level of care. For children who meet this requirement, financial eligibility is determined based on the income of the child, not the household.
  - ✓ 740 children enrolled as of September 2020
  - ✓ FY20 Spend: \$9.1 million AF (\$4.0 million GR, \$5.1 million FED)
  - ✓ Unlikely to qualify for Medicaid under another eligibility category as household income would be too high
2. **Working Disabled (Subtype DW)** – Individuals who have a disability determination but are employed and have income that makes them ineligible for SSI. Under federal law, states have the option to provide Medicaid coverage for these individuals up to 250% of the federal poverty level (250% FPL)
  - ✓ 305 individuals enrolled as of September 2020
  - ✓ FY20 Spend: \$7.2 million AF (\$3.1 million GR, \$4.1 million FED)
  - ✓ Unlikely to qualify for Medicaid under another eligibility category as household income would be too high
3. **Individuals Eligible for but not Receiving Cash Assistance (Subtype RC)** - Receipt of Supplemental Security Income (SSI) or an SSI State Supplement guarantees eligibility for Medicaid. However, there are some individuals who meet the income and resource requirements for cash assistance but who do not want to apply for those benefits.
  - ✓ 2,221 individuals enrolled as of September 2020
  - ✓ FY20 Spend: \$11.6 million AF (\$4.6 million GR, \$7.0 million FED)
  - ✓ Many may qualify under standard SSI cash assistance eligibility if this category is eliminated.

4. **Individuals Who Would Be Eligible for SSI if They Were Not in an Institution (Subtype NH)** - If an individual is in a medical institution, the person's SSI cash benefit will be considerably reduced (to no more than \$30 a month) or even eliminated. By adopting the Individuals Eligible for Cash Except for Institutionalization eligibility group, states can extend Medicaid eligibility to individuals who are only ineligible for cash assistance because of their institutionalization.
  - ✓ 219 individuals enrolled as of September 2020
  - ✓ FY20 Spend: \$64.9 million (\$22.9 million GR, \$42 million FED)
5. **Breast and Cervical Cancer Eligibility (Subtypes BC, BI)** - The CDC National Breast and Cervical Cancer Early Detection Program (NBCCEDP) provides screening, diagnostic evaluation, and treatment referrals but does not pay for treatment services. Congress established a Medicaid optional eligibility group for uninsured individuals who were screened through the NBCCEDP and require treatment for breast or cervical cancer.
  - ✓ 22 individuals enrolled as of September 2020
  - ✓ FY20 Spend: \$573,000 AF (\$166,000 GR, \$407,000 FED)
6. **Individuals Receiving Home and Community Based Services under Institutional Rules (Subtypes MC, MD, DA, AG and IS)** – Provides coverage for individuals who would be eligible for Medicaid if they were living in an institution and who, were it not for the receipt of home and community-based services (HCBS), would require the level of care furnished in an institution.
  - ✓ No data on enrollment
  - ✓ No data on expenditures
7. **Reasonable Classifications of Individuals under Age 21 (Subtypes TO, TI)** – States may cover all individuals under the age of 21, or a reasonably defined subset of these individuals, up to the higher of the state AFDC eligibility income standard that was in effect in 1996 or the highest income level already in effect for individuals under the age of 21 in the Medicaid state plan.
  - ✓ 5,682 enrolled in September 2020
  - ✓ FY20 Spend: \$20.7 million AF (\$5.3 million GR, \$15.4 million FED)
8. **Children with Non-IV-E Adoption Assistance (Subtype SO)** - Children for whom an adoption assistance agreement is in effect under Alaska authority and not through Title IV-E,
  - ✓ 342 enrolled in September 2020
  - ✓ FY20 Spend: \$3.4 million AF (\$1.3 million GR, \$2.1 million FED)
9. **Optional Targeted Low-Income Children (Subtypes CP, CI, H2, S2)** – This is Title XXI, Children's Health Insurance Program (CHIP), administered as a "Medicaid Expansion." This category is inclusive of children up to 175% FPL. Title XXI comes with a significantly higher federal match rate.
  - ✓ 13,639 children enrolled in September 2020
  - ✓ FY20 Spend: \$55.4 million AF (\$6.6 GR, \$48.8 FED)
10. **Optional State Supplement Recipients (Subtype ST)** – Many states supplement federal SSI cash assistance payments with an optional state payment. This category of Medicaid eligibility covers individuals who would be eligible for Medicaid on the basis of SSI



eligibility, except their incomes are too high, presumably at least in part due to receiving the optional SSI state supplement.

- ✓ 10,674 individuals enrolled in September 2020
- ✓ FY20 Spend: \$201.5 million AF (\$78.6 GR, \$122.9 FED)

**11. Institutionalized Individuals Eligible under a Special Income Level (Subtypes AS, IN)** – Optional coverage for certain individuals who are in an institution for at least 30 consecutive days and have a higher income level, up to three times the federal SSI cash assistance benefit amount.

- ✓ 1,111 individuals enrolled in September 2020
- ✓ FY20 Spend: \$98.7 million AF (\$40.9 million GR, \$57.8 million FED)

It should also be noted that because many of the individuals enrolled in these eleven categories are either younger than 18 or older than 64, they cannot be transitioned to coverage under the Medicaid expansion at a higher federal matching rate. Further, federal rules prevent states from claiming a higher federal match rate if they transition an optional eligibility group that was covered prior to January 1, 2009 to the Medicaid expansion population. Some individuals between the ages of 18-64 who are living with a disability may otherwise be eligible for coverage under the Medicaid expansion, but that would provide no financial gain for Alaska since the enhanced federal matching rate would not apply.

## IV. CONCLUSION

Alaska has already begun to make significant steps forward toward systematic Medicaid reform and cost containment. The Behavioral Health 1115 waiver provides a foundation for enhanced care coordination for people with complex healthcare needs. DHSS has managed recent budget reduction targets with a deep commitment to supporting the provider community and enlisting as partners in forging Medicaid's future. This paper is intended to reflect the input received by many as Alaska navigates its way forward to continued healthcare reforms.

The PCG Senior Strategist, Rich Albertoni, acknowledges and wishes to thank the many staff of the Department of Health and Social Services (DHSS) and the associated community stakeholders who provided generous contributions of time to provide critical information and important insights.

## V. APPENDIX: FEEDBACK ON PRELIMINARY REPORT

This appendix summarizes feedback received by key stakeholders that were provided a “preliminary” version of this report. The DHSS Commissioner’s Office began distributing a preliminary version of this report to stakeholders on June 4, 2021. These groups included:

- Alaska Primary Care Association
- Alaska State Hospital and Nursing Home Association
- Alaska Native Tribal Health Consortium/Alaska Native Health Board
- Alaskans Together for Medicaid
- Alaska Behavioral Health Association
- Alaska Division of Public Health (Internal Stakeholder)
- Agencies Serving Alaskan Senior and Disabilities Populations

During the months of June and July 2021, DHSS arranged online meetings in which the PCG Senior Strategist briefed stakeholder groups assembled by these organizations. The meetings also provided opportunities for stakeholders to ask questions and offer comments and perspectives on both the overall road map itself and the initiatives associated the road map principles.

During the sessions, DHSS leadership emphasized that no decisions had been made to move forward with recommendations made in the report, nor had a timeline been established for possible implementation.

This summary of the feedback received during those sessions is organized by initiative.

### **Initiative 1: One-Time Medicaid Eligibility Redetermination**

Some stakeholders expressed concern that this initiative would result in healthcare coverage gaps for individuals. Stakeholders suggested that to the extent this initiative moves forward, it should be accompanied by a plan to provide outreach and navigation services to help impacted individuals enroll in other coverage, such as the Health Insurance Marketplace. In general, stakeholders emphasized the need for a strong communication plan and outreach campaign to create awareness surrounding a one-time, program-wide redetermination effort. Some stakeholders expressed concern that this initiative was simply an effort to reduce Medicaid enrollment.

It was suggested that a portion of the estimated savings be reinvested in an outreach/healthcare navigator campaign to assist affected individuals and help them enroll in other coverage.

Questions about the basis of computed savings were posed during the briefing sessions. Some stakeholders asked if savings based on average spend was an accurate method of reflecting savings. These stakeholders indicated their belief that the individuals most likely to be found no longer eligible would not likely have as much associated healthcare utilization.

Others articulated concerns about indirect negative impacts on Alaska’s healthcare system overall. The initiative was cited as having the potential to increase hospital uncompensated care, thereby putting more financial pressure on hospitals and resulting in cost-shifting to other payers throughout the system. Some said that a one-time redetermination that resulted in coverage losses could trigger higher utilization of hospital emergency rooms, which can be the least efficient place of care for non-emergency conditions.

Several stakeholders asked questions about DHSS staff capacity and readiness to successfully run the redetermination in a way that provided support for re-enrollment and timely submission of new verification documents. One stakeholder expressed concern that a one-time effort did not align with ongoing eligibility tasks that DHSS should be maintaining per State Health Officer letter 20-004 published by CMS in December 2020.

During conversations about this initiative at the stakeholder meetings, DHSS leadership added that the Department maintains a responsibility to assure accuracy in using public dollars to award eligibility and the cost of associated benefits.

### **Initiative 2: Implement Section 1945 Health Homes**

In general, across stakeholders, broad support was expressed for the idea of strengthening care management through implementation of Section 1945 Health Homes. This support was consistent with stakeholder input provided to PCG in late 2019 and early 2020. That input has emphasized the potential to reduce healthcare cost by improving coordination and efficiency.

Beyond the general support, however, several stakeholders offered additional perspectives. Hospital stakeholders indicated a concern about their ability to participate as health home providers based on capacity challenges that result from annual rate cuts imposed by the Department.

Rural stakeholders said it may be challenging to establish health homes in communities where care coordination resources are currently scarce. Other stakeholders said it would be important that patients be given the ability to “opt in” to the health home since the individual’s willingness to participate would be an important determiner of success.

Stakeholders provided suggestions for chronic conditions to focus on as part of the health home effort. Some thought less intensive behavioral health conditions not within the scope of the current Alaska 1115 waiver would be worthwhile. Others suggested focusing on neurological diseases such as dementia and Alzheimer’s. A focus on autism was also mentioned.

The Health Home passage of the preliminary paper also noted related methods DHSS should consider over time to enhance care coordination in ways that synch with Alaska healthcare system strengths. Specifically, federal authority to establish what CMS refers to as “Indian Managed Care Entities” (IMCEs) was noted in the paper. Stakeholders reacted positively to this idea, especially tribal stakeholders. Stakeholders noted their appreciation that the paper called out use of the term “Indian” as not appropriate for Alaska despite the need to express it in citing federal legal authority.

Finally, some stakeholders expressed concern that DHSS lacked bandwidth to successfully implement the health home initiative.

### **Initiative 3: Hospital Payments to Include Pay for Performance**

Comments on this initiative included the perspective that reducing preventable admissions would require new investments in primary care. Others noted that the paper appeared to consider and address that need by pairing hospital pay for performance with a concurrent focus on health homes.

Tribal stakeholders expressed openness to participating in a pay-for-performance model and in moving to value-based purchasing overall. However, tribal stakeholders noted that metrics applied to tribes would need to be aligned with the unique features of the tribal health system. Consideration of “tribal system only” pay-for-performance indicators was suggested.

Other feedback included the need to reduce barriers to timely discharge from hospitals. Hospital providers cite the lack of appropriate community placements as a factor that impacts length of stay and readmissions and said that this is a factor hospitals are not able to control and should be accounted for in any pay-for-performance initiative.

Additional input included the point of view that value-based purchasing funding should not entirely come from the current pool of rate funding. Reference-based pricing was cited as a hospital rate setting methodology that could generate significant savings. Other stakeholders asked for more clarity on how performance and quality metrics would be established and who would generate them. The ability of smaller hospitals to adapt to being paid for complying with specific metrics was also noted as a concern. -

#### **Initiative 4: School Based Health Services Reform**

There was general support for this concept across stakeholders as an initiative that advanced bringing care to sites where patients are most likely to access that care. Healthcare providers expressed strong interest in teaming with schools to offer more health services in the school setting. The focus on preventative care was cited as having the potential to reduce overall healthcare costs.

At the same time, stakeholders expressed concern about the mechanics of implementation and associated risks that come with it. As a Medicaid finance methodology that requires significant cost documentation from school districts, the potential administrative burden to school districts was noted. The elaborate cost methodologies required by CMS to comply with a Certified Public Expenditure (CPE) was also noted for bringing possible audit exposure.

As with other initiatives, stakeholders also questioned if DHSS had adequate staff resources that would be required to implement this scope of work.

#### **Initiative 5: Global Spending Cap**

Several concerns were expressed by stakeholders about imposing a global spending cap on the non-federal share of Medicaid funding. However, the level of stakeholder participation envisioned to be part of the cap process was noted as a positive. Throughout stakeholder conversations about the recommended cap, DHSS leadership provided the perspective that the conversation about cost containment would not be going away either with or without adoption of the cap.

Stakeholder indicated concern that the cap would consistently result in implementation of rate cuts that providers would not be able to sustain. To the extent the cuts resulted in restrictions on services, stakeholders said patient care could also be negatively impacted. This could include negative impacts on the continuum of behavioral health care, said one stakeholder.

Other stakeholders said the cap could put cost pressure on other payers in Alaska's healthcare system and result in cost shifting overall. These stakeholders said a system-wide focus on cost-containment is needed. Concern was raised that the initiative does not clearly tie to reductions in cost but instead just reduce payments.

Tribal stakeholders expressed concern that even if tribal expenditures are exempt from the cap, other cuts across Medicaid could have an indirect negative impact to tribes and their members given the many connection points between tribal and non-tribal providers.

The need for better data was suggested as something that should precede any move to toward a global cost management effort. Better understanding cost drivers would be important to the task of effective program-wide cost management.

Finally, some stakeholders indicated that, to the extent the State decides to move ahead with this, they would favor asking CMS to permit reinvesting a portion of the federal savings similar to the Delivery System Reform Incentive Pool (DSRIP) waiver that New York initiated in parallel to their global spending cap.

DHSS staff noted that among the initiatives in the paper, the global spending cap was one that would require state legislation to implement.

Separate from any one initiative, most stakeholders expressed appreciation to DHSS leadership for the opportunity to provide reaction and comment prior to publishing of a final paper. DHSS also expressed its appreciation for the time stakeholders took to offer feedback and indicated a commitment to include feedback in the final version of the paper, which is provided in this appendix.