

Fiscal Note

State of Alaska
2016 Legislative Session

Bill Version:	CSSB 74(FIN)
Fiscal Note Number:	44
(S) Publish Date:	3/9/2016

Identifier: SB074CS(FIN)-DHSS-HCMS-3-8-16
Title: MEDICAID REFORM/PFD/HSAS/ER
USE/STUDIES
Sponsor: KELLY
Requester: Senate Rules

Department: Department of Health and Social Services
Appropriation: Medicaid Services
Allocation: Health Care Medicaid Services
OMB Component Number: 2077

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below.

(Thousands of Dollars)

	FY2017 Appropriation Requested	Included in Governor's FY2017 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	FY 2017	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
Personal Services							
Travel							
Services	1,887.5		536.5	436.5	436.5	436.5	436.5
Commodities							
Capital Outlay							
Grants & Benefits	(1,550.3)		(4,304.9)	(16,795.7)	(22,487.1)	(28,644.1)	(32,548.4)
Miscellaneous							
Total Operating	337.2	0.0	(3,768.4)	(16,359.2)	(22,050.6)	(28,207.6)	(32,111.9)

Fund Source (Operating Only)

1002 Fed Rcpts	20,407.1	6,700.0	31,427.1	28,710.4	29,464.7	29,986.2	28,034.1
1003 G/F Match	(20,204.8)	(6,700.0)	(35,372.9)	(45,289.4)	(51,735.1)	(58,413.6)	(60,365.8)
1108 Stat Desig	134.9		177.4	219.8	219.8	219.8	219.8
Total	337.2	0.0	(3,768.4)	(16,359.2)	(22,050.6)	(28,207.6)	(32,111.9)

Positions

Full-time							
Part-time							
Temporary							

Change in Revenues

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Estimated SUPPLEMENTAL (FY2016) cost: 0.0 (separate supplemental appropriation required)
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2017) cost: 6,900.0 (separate capital appropriation required)
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? Yes
If yes, by what date are the regulations to be adopted, amended or repealed? 07/01/17

Why this fiscal note differs from previous version:

Corrected calculations for coordinated care demonstration project under Section 31 (47.07.039)(c).

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Agency: Health and Social Services

Phone: (907)334-2520
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Date: 03/08/16

REPORTED OUT OF
SFC 03/08/2016

FISCAL NOTE ANALYSIS

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Analysis

Section 10 (Chapter 58) (Sec. 09.58.010) establishes the Alaska Medicaid False Claim and Reporting Act (AMFCA) and includes several subsections related to liability for certain acts and omissions, civil actions, rights of participants in such actions, seizures of property related to Medicaid fraud cases, awards allowed, actions that are not allowed, limits on state liability, and protections for whistleblowers. The Department recovered \$250.0 per year for the last two fiscal years for whistleblower recoveries. Under the new law these recoveries are estimated to triple to \$750.0 *each fiscal year*. Whistleblowers will receive approximately 25% of the ultimate recovery, leaving 75% for the State, or \$562.5. Compared to current annual recoveries, this represents an increase of \$312.5 annually. A conservative estimate of \$100.0 of recoverable overpayments subject to the treble damages provision equates to an additional \$300.0 in recoveries annually. Receipt of these recoveries will be categorized as *abatements of expenditures*.

AMFCA recoveries FY 2017	\$306,250
AMFCA annual recoveries FY 2018-FY2019	\$612,500
AMFCA annual recoveries FY 2020-FY2022	\$512,500

Section 25 (a) decreases the number of required audits of Medicaid providers, conducted by an independent contractor, from at least 75 annually to at least 50 annually. Audits are conducted on a representative sample of all Medicaid providers in order to identify both overpayments and violations of criminal statutes. The department is directed to attempt to minimize concurrent state or federal audits of specific providers. This section of the bill will have no fiscal impact on the department. Any change in the cost of audits is estimated to be offset by a change in recoveries.

Section 26 (b) allows the Department to assess interest on recoveries for audits performed under AS 47.05.200 as well as other audits and reviews conducted by the state and federal government. There is no additional cost to the department to implement interest penalties on identified overpayments, but recoveries will increase. The Department estimates it will take three years to reach the current volume of outstanding appeals subject to interest penalties. Interest penalty recoveries are calculated by taking the current amount of outstanding appeals and applying an estimated recovery percentage. The result is multiplied by the statutory rate for post-judgment interest of 3.75% and phased in over a period of three years, as shown below. (50% fed/50% GF match)

Amount of Interest Penalty Recoveries FY2017	\$ 84,910
Amount of Interest Penalty Recoveries FY2018	\$127,365
Amount for FY2019-FY2022	\$169,821

Section 27 requires enrolled Medicaid providers to conduct one biennial review, identify overpayment and report findings to the department within ten business days, and create a repayment agreement with the state. The DHSS currently receives an average of approximately \$500,000 in self disclosures annually. Although it is currently required by federal law, the DHSS estimates an increase in self-reporting of approximately 100% would result by requiring biennial audits. Based on the Department's prior experience with self-disclosure recoveries, the State can expect to receive an estimated \$500,000 in additional recoveries for the first 2 years, then decreasing \$25,000 annually to FY2022.

Regulations required to implement the provisions of the bill. Receipt of repayments will be categorized as abatements.

Amount of Self-Identified Recoveries FY2017	\$ 500,000
Amount of Self-Identified Recoveries FY2018	\$ 500,000
Amount of Self-Identified Recoveries FY2019	\$ 475,000
FY 2020	\$ 450,000
FY 2021	\$ 425,000
FY 2022	\$ 400,000

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Section 28 grants the Department of Health and Social Services the authority to assess civil fines against Medicaid providers. Fines are to be assessed within a range of from \$100 to \$25,000 per occurrence or offense. There is no additional cost to the department to implement fines under this section. Recoveries based on implementing fines in this section are calculated by taking the estimated number of civil fines and applying an average fine amount. It is estimated the amount of fines imposed per recovery will increase over time, but the number of fines assessed will decrease over time. The estimated amount of the recoveries would be \$50.0 per year. (50% fed/50% GF match). These recoveries are categorized as revenue receipts. This Section 11 also addresses overpayments and restitution from providers who are subject to Civil Forfeiture laws. During the past two years, overpayments and restitution amounts of \$5,650.0 were due from providers who may be subject to Civil Forfeiture laws. Annualized, this amounts to \$2,825.0. The DHSS estimates that 10% of this amount is recoverable through civil forfeiture or \$282.5 annually. Regulations will be required to implement these provisions of the bill. Receipt of these overpayments will be categorized as *abatements of expenditures*.

Annual recoveries from fines	\$ 50,000
Annual Recovery from Civil forfeiture	\$ 282,500
Annual recoveries for FY2017-FY2022	\$ 332,500

Section 28 47.05.270 Medical assistance reform program (a) (2) of this bill requires the department to provide an electronic distribution of an explanation of medical assistance benefits to recipients for health care services received under the program. It is the intent of the department to fully implement this section of the bill through the My Alaska Portal. It estimates that it will cost \$707,500 (90% federal/10% GF) to fully implement the electronic distribution of an explanation of medical assistance benefits in FY2017. After the initial set-up, estimated on-going costs are the concurrent user license, \$76,500, and the yearly maintenance fee, \$17,000, for a total of \$93,500 (50% federal/50% GF) annual costs.

Section 28 47.05.270(a)(9) directs the department to provide for stakeholder involvement in setting annual targets for quality and cost effectiveness. Existing department employees will staff this effort, and meetings of the workgroup will occur telephonically with no travel costs incurred. A consultant will be hired to facilitate the meetings and compile a report on the workgroup's findings and recommendations. **Services: \$5.0 annually for consultant contract**

Section 29 directs the department to implement the Primary Care Case Management system authorized under AS 47.07.030(d). This is a foundational component to other initiatives and projected savings. This system would assign Medicaid enrollees to a case manager in order to increase use of primary and preventive care, and decrease the use of specialty care and hospital services. The department proposes expansion of an existing case management contract, at \$500.0 across FY2017-2018 (50% federal\50% GF match). The contractor will case manage at \$3.85 per member per month to approximately 30,000 recipients. This approach would reduce implementation timelines.

This initiative will require planning and development in SFY2017 with implementation in the 2nd quarter SFY2018 (on Oct 1, 2017). Activities will include determining regions/communities for which PCCM is practicable and determining populations/beneficiary groups to include in PCCM. It also includes drafting a SPA, regulations, revising beneficiary and provider manuals, provider education, evaluation and reporting plan, to compare before and after costs and patient outcomes, MMIS system changes to add per member per month payments.

Funding is also required to implement associated changes to MMIS, including one-time capital funds for systems changes, and additional contractual costs for on-going operations.

Capital Budget: One-time MMIS system changes: \$1,000.0 (90% federal/10% GF)

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Once primary care case management is fully implemented, the department projects an increase in expenditures for physician services, but a decrease in outpatient, inpatient, and pharmacy services to produce a net savings of:

FY2017	(\$596,389)
FY2018	(\$1,787,333)
FY2019	(\$4,375,526)
FY2020	(\$6,963,720)
FY2021	(\$9,517,530)
FY2022	(\$9,517,530)

Section 30 (d)(3) directs the department to implement the Health Homes option under section 1945 of the Social Security Act. Health Homes provide integrated and coordinated care for people with chronic health conditions. The federal government would provide a 90% enhanced Federal Medical Assistance Percentage (FMAP) reimbursement for the new Health Home services for the first eight quarters following their approval of the state's Medicaid State Plan Amendment.

The department would need approximately two years (SFY2017-2018) for planning and development prior to implementation in SFY2019, in order to determine eligibility criteria for recipients and providers, design the new payment methodology and required reporting systems, develop and receive approval on the State Plan Amendment and process associated regulations, and make required IT modifications to the Medicaid payment system.

Additional resources would also be required to support systems changes required in MMIS. A portion of these would be a one-time capital budget request, but the MMIS contract would also need to be increased on an on-going basis to support the new workload associated with payment reform.

Capital Budget: One-time MMIS system changes: \$1,000.0 (90% federal/10% GF)

The above planning and development work would move the department to an enhanced reimbursement/provider payment model and would follow 2 years after the Primary Care Improvement Initiative. This would lead to potentially paying enrolled Health Home providers per month for enrolled recipients (on top of regular fee-for-service reimbursement). Projected Savings would be assumed through utilization reduction factors specific to Health Homes and based on the above with a reduction in 0.25% of inpatient costs at \$5,230,000 (based on the FY 2016 budget line items) for the projected population of 10,000 recipients and offset by the projected 10,000 recipients X \$15.00 per member per month = \$150,000 X 12 months = \$1,800,000 for a **total projected future savings of \$3,430,000**

Section 30 (d)(5) directs the department to provide incentives for telehealth, including increasing the capability for and reimbursement of telehealth for recipients. The department's first step in implementing this new provision will be to convene a workgroup, including stakeholders from the health care community, for one year to identify legal, technical and financial barriers to increasing use of telehealth in Alaska.

Existing department employees will staff this effort, and meetings of the workgroup will occur telephonically with no travel costs incurred. A consultant will be hired to facilitate the meetings and compile a report on the workgroup's findings and recommendations. **Services: \$5.0 one-time cost in FY2017 for consultant contract.**

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FY2017 will be used to implement the final recommendations of the workgroup. Once those recommendations are fully implemented, the department expects the following savings:

FY2018	(\$1,300,000)
FY2019	(\$2,600,000)
FY2020	(\$5,800,000)
FY2021	(\$9,400,000)
FY2022	(\$13,300,000)

Section 31 (47.07.038) authorizes the department to support private initiatives designed to reduce non-urgent use of hospital emergency departments by Medicaid enrollees. The department's supporting role would include data sharing, support for the Prescription Drug Monitoring Program database, support for electronic health record sharing between participating hospitals' emergency departments, and development of a shared savings payment model reflected below.

The planning phase for this initiative would begin during FY2017, and the required data, reporting and information system infrastructure would be built in FY2018. The department would implement the shared-savings payment model in FY2019.

Resources would also be required to support Health Information Exchange interface and other changes related to payment reform for MMIS. A portion of these would be a one-time capital budget request.

Capital Budget: One-time MMIS system changes: \$1,000.0 (90% federal/10% GF)

The Prescription Drug Monitoring Program (PDMP) is an integral part of this initiative, as it is required to help prevent the misuse and abuse of opioids prescribed or administered through emergency departments. Access to the PDMP database by physicians and pharmacists could be improved if the current stand-alone system was integrated into the Health Information Exchange (HIE). The following costs are one-time in addition to \$20.0 annual operating costs:

FY2017 PDMP system and interface to the HIE is \$285.0 (90% federal/10% GF), and FY2017 costs to connect pharmacies is \$480.0 (90% federal/10% GF)

The projected DHSS savings from this would be calculated from reduced utilization in 2% of hospital outpatient services. **Total savings are estimated at \$3,200,000, including \$960,000 of shared savings paid to providers, for a savings to the department of \$2,240,000, with an increase of 0.5% to the savings in each subsequent year.**

Section 31 (47.07.039)(C) authorizes the department to contract with one or more entities to demonstrate the use of local, provider-led coordinated care entities that agree to monitor care across multiple care settings and that will be accountable to the department for the overall cost and quality of care. This demonstration project will be implemented in three regions of the state. Planning and development would begin in FY2017, with implementation starting in FY2019. An estimated 30,000 Medicaid recipients would be enrolled to receive services through this demonstration project. For purposes of estimation, the Department assumes the entities would be reimbursed on a fee-for-service basis plus shared-savings, with the entities receiving a portion of any savings accrued to the state Medicaid program, for the first two years. The department's best estimate at this time is approximately \$1,500,000 in GF savings. The state's fiscal agent will require an additional 3 staff members for the additional work in provider enrollment, claims processing, and telephone inquiries as a result of the change - **increase contract by \$318.0 (50% federal/50% GF)**. These individuals will provide support across the primary care case management project, health homes, and the hospital emergency room project as well.

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The estimated capital budget start up cost for FY2017 is **\$3,125,000** for technical development and consulting services, reimbursed at 90% federal, 10% GF. On-going annual maintenance costs is expected to be approximately \$318,000 to the fiscal agent for Medicaid reform activities. These costs are placed in the operating budget and are reimbursed at 50% federal, 50% GF.

Program staff support would be required for negotiation and contracting with such entities, and also for data systems and analysis. The positions established to develop (Sec. 30(d)(3) Health Homes; Sec 29 Primary Care Case Management system will staff this initiative as well.

Section 38 directs the Department to implement federal policy on tribal Medicaid reimbursement to collaborate with Alaska tribal health organizations. The Department will utilize the Centers for Medicare and Medicaid (CMS) recent proposed clarification of national policy to allow states to broaden the range of services eligible for 100% Federal Medical Assistance. However, the Department is cautious in projecting the impacts in the initial years of implementation.

Total Transportation to US TRAVEL for 2015 Payments

Total Monthly average reimbursement for AI/AN transportation claims = \$3,000,000

Monthly average X 12 months = \$3,000,000 x 12 = \$36,000,000 total costs. The refinancing from 50% federal/50% GF match to 100% federal results in **\$18,000,000 in GF match savings**, with a reciprocal increase to federal costs. This fund source change is to be equally spread at 20% per year for five years, or **\$3,600,000 in annual, cumulatively building GF match savings across each subsequent year from FY2017-2021**. The multi-year spread is because the cost shift to 100% federal is assumed to take several years. Full savings achieved in FY2021, year five of the effort.

Total Ground and Air Ambulance for 2015

Total quarterly average reimbursement for AI/AN claims = \$3,100,000

Total quarterly at \$3,100,000 X 4 quarters = \$12,400,000 total costs. Results in **\$6,200,000 GF match savings** and a reciprocal increase in federal costs. Assume a two-year spread to shift costs to 100% federal. **\$3,100,000 in annual, cumulatively building GF match savings across the two-year span, FY2017-2018**. Full savings achieved in FY2018, year two.

To aggressively pursue the new Centers for Medicare and Medicaid Services (CMS) policy and realize an additional \$20 million in savings in FY2017, the Department is requesting a Tribal Federal Liaison section, staffed with 4 positions in the Commissioner's Office. This section will focus on achieving these additional savings as referrals and care plans are approved by CMS. **This additional \$20 million in savings for FY2017 has also been proposed in the House and Senate Finance subcommittee recommendations for the DHSS operating budget.**

US Travel	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022
fed	\$ 3,600.0	\$ 7,200.0	\$ 10,800.0	\$ 14,400.0	\$ 18,000.0	\$ 18,000.0
GF match	\$ (3,600.0)	\$ (7,200.0)	\$ (10,800.0)	\$ (14,400.0)	\$ (18,000.0)	\$ (18,000.0)
ambulance	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022
fed	\$ 3,100.0	\$ 6,200.0	\$ 6,200.0	\$ 6,200.0	\$ 6,200.0	\$ 6,200.0
GF match	\$ (3,100.0)	\$ (6,200.0)	\$ (6,200.0)	\$ (6,200.0)	\$ (6,200.0)	\$ (6,200.0)
Addn'l Savings	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022
fed	\$ 20,000.0	\$ 20,000.0	\$ 20,000.0	\$ 20,000.0	\$ 20,000.0	\$ 20,000.0
GF match	\$ (20,000.0)	\$ (20,000.0)	\$ (20,000.0)	\$ (20,000.0)	\$ (20,000.0)	\$ (20,000.0)
Total	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022
fed	\$ 26,700.0	\$ 33,400.0	\$ 37,000.0	\$ 40,600.0	\$ 44,200.0	\$ 44,200.0
GF match	\$ (26,700.0)	\$ (33,400.0)	\$ (37,000.0)	\$ (40,600.0)	\$ (44,200.0)	\$ (44,200.0)

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Section 39 directs the department to develop a health information infrastructure plan to support transformation of the healthcare system in the state by providing data health care providers require for care coordination and quality improvement, and the information support required by the department and providers to enable development and implementation of other provisions of this act.

The department's existing Health Information Technology program will staff this effort, and meetings of the workgroup will occur telephonically at minimal cost with no travel costs incurred. A consultant will be hired to facilitate the meetings and compile a report on the workgroup's findings and recommendations. **Services: \$5.0 one-time cost in FY 17 for consultant contract.**

Capital Costs:

Health Information Infrastructure Plan development to improve health care outcomes through:

OUTCOMES:

- Outcome I - Provide Personal Health View
- Outcome II - Provide Population Data Analytical view
- Outcome III - Provide Health Care Provider View

ASSUMPTIONS:

Assumption I - The Plan will include the use of the existing Health Information Exchange (HIE)

Assumption II - The Plan will provide a communication infrastructure plan that will utilize new and existing systems that include Electronic Medical Record Systems, Electronic Health Record Systems, Personal Health Record Systems, Registries and Data interchange capabilities.

Assumption III –The plan will provide:

- "As-Is" view of the existing systems.
- Gap analysis of what is missing.
- "To-Be/Desired" view of the future state.
- Design roadmap with milestone investment targets to incrementally achieve "To-Be" state.
- Implementation plan to achieve To-Be state.

PHASES:

- Phase I - Requirements Gathering/Define As-Is environment.
- Phase II - Development To-Be/Desired state roadmap with Gap analysis of what is missing.
- Phase III - Design/Engineering Implementation Plan with phases and achievement goals to implement the Health Information Infrastructure Plan.

The estimated capital budget cost to implement these changes is **\$775.0**, 90% federal, 10% GF.