Fiscal Note

State of Alaska
2016 Legislative Session

Bill Version:	HCS CSSB 74(FIN) am H
Fiscal Note Number:	63
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Identifier: SB74 CC HSS HCMS 5-3-16
Title: MEDICAID REFORM;TELEMEDICINE;DRUG DATABAS
Sponsor: KELLY
Requester: Conference Committee

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	12,032.2		9,277.8	(3,213.2)	(8,904.6)	(15,061.6)	(18,965.9)
Miscellaneous							
Total Operating	**13,919.7**	**0.0**	**9,814.3**	**(2,776.7)**	**(8,468.1)**	**(14,625.1)**	**(18,529.4)**
Fund Source (Operating Only)							
1002 Fed Rcpts	13,548.4		24,568.4	21,851.7	22,606.0	23,127.5	21,175.4
1003 G/F Match	228.9		(14,934.0)	(24,850.7)	(31,293.9)	(37,972.4)	(39,924.6)
1092 MHTAAR	7.5		2.5	2.5			
1247 MedRecover	134.9		177.4	219.8	219.8	219.8	219.8
Total	**13,919.7**	**0.0**	**9,814.3**	**(2,776.7)**	**(8,468.1)**	**(14,625.1)**	**(18,529.4)**
Positions							
Full-time							
Part-time							
Temporary							
Change in Revenues							

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If yes, by what date are the regulations to be adopted, amended or repealed? 07/01/17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:

CC Note: The House and Senate versions of the operating budget (HB256) included a reduction of $20.3 million of UGF and the addition of $7 million of Federal Receipts to reflect anticipated savings resulting from the new CMS policy change that broadened the range of services eligible for 100% Federal Medical Assistance (FMAP). The CC note removes the difference between what was included in the budget and the amount of funding needed to implement reforms that had been included in the latest fiscal note.

Prepared By: Conference Committee Date: 05/03/2016

APPROVED BY CONFERENCE COMMITTEE

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2016 LEGISLATIVE SESSION

Analysis

Section 18 (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, awards allowed, actions that are not allowed, limits on state liability, and protections for whistleblowers. Based on the Department's experience with whistleblower recoveries during the past two years, the Department is poised to recover approximately $500.0, in FY2015-FY2016. The new law is estimated to triple the recoveries to $750.0 *annually*. 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. In addition, the civil penalty provisions contained in Section 17 provides for civil penalties plus three times the amount of actual damages sustained by the State. A conservative estimate of $100.0 of recoverable overpayments subject to the treble damages provision equates to an additional $300.0 in recoveries annually. **Combined with above equates to $612.5 annually for FY2018-2019. The Private right of action for realtor or private citizens is repealed on 7-1-2019, reducing recoveries by an estimated $100.0 per year for FY 2020 through FY 2022. FY2017 is a phase in year and recoveries are estimated at $306.2, 50% of normal annual recoveries.** Recoveries will be categorized as *abatements of expenditures*.

AMFCA recoveries FY 2017	**$306.2**
AMFCA annual recoveries FY 2018-FY2019	**$612.5**
AMFCA annual recoveries FY 2020-FY2022	**$512.5**

Section 33 (a) decreases the number of required 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 34 (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. Recoveries will be categorized as revenue receipts, recorded under new fund code #1247, Medicaid Monetary Recoveries.

Amount of Interest Penalty Recoveries FY2017	**$ 84.9**
Amount of Interest Penalty Recoveries FY2018	**$127.4**
Amount for FY2019-FY2022	**$169.8**

Section 35 requires enrolled Medicaid providers to conduct an audit every two years unless they are subject to an audit under AS 47.05.200 to identify overpayment and report findings to the department. The DHSS currently receives an average of approximately $500.0 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 and increasing awareness of the requirement when it is codified in Alaska Law. Based on the Department's prior experience with self-disclosure recoveries, the State can expect to receive an estimated $500.0 in additional recoveries for the first two years, and then gradually decrease to $25.0 decrements for the remainder of the period.

STATE OF ALASKA **BILL NO.** CSSB074(FIN)
2016 LEGISLATIVE SESSION

Analysis Continued

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

Amount of Self-Identified Recoveries FY2017	**$ 500.0**
Amount of Self-Identified Recoveries FY2018	**$ 500.0**
Amount of Self-Identified Recoveries FY2019	**$ 475.0**
FY 2020	**$ 450.0**
FY 2021	**$ 425.0**
FY 2022	**$ 400.0**

Section 36 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. These recoveries are categorized as revenue receipts, under new fund code #1247, Medicaid Monetary Recoveries. Regulations will be required to implement these provisions of the bill.

Annual recoveries for FY2017-FY2022 $ 50.0

Section 36 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 $707.5 (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, $76.5, and the yearly maintenance fee, $17.0, for a total of $93.5 (50% federal/50% GF) annual costs.

Section 36 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 (Mental Health Trust Funded from FY2017 through FY2019)**

Section 37 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 FY2017 with implementation in the 2nd quarter FY2018 (on Oct 1, 2017). Activities will include determining regions/communities for which Primary Care Case Management is practicable and determining populations/beneficiary groups to include in Primary Care Case Management. It also includes drafting a state plan amendment (SPA), regulations, revising beneficiary and provider manuals, provider education, evaluation and reporting plan, comparison of before and after costs and patient outcomes, and Medicaid Management Information System (MMIS) changes to add per member per month payments.

STATE OF ALASKA **BILL NO.** CSSB074(FIN)
2016 LEGISLATIVE SESSION

Analysis Continued

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)

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	($596.4)
FY2018	($1,787.3)
FY2019	($4,375.5)
FY2020	($6,963.7)
FY2021	($9,517.5)
FY2022	($9,517.5)

Section 38 (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 (FY2017-2018) for planning and development prior to implementation in FY2019, 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 $5,230.0 (based on the FY2016 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 = $150.0 X 12 months = $1,800.0 for a **total projected future savings of $3,430.0.**

Section 38 (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 (Mental Health Trust Funded).**

STATE OF ALASKA **BILL NO.** CSSB074(FIN)
2016 LEGISLATIVE SESSION

Analysis Continued

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	($1,300.0)
FY2019	($2,600.0)
FY2020	($5,800.0)
FY2021	($9,400.0)
FY2022	($13,300.0)

Section 39 (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 $3,200.0, including $960.0 of shared savings paid to providers, for a savings to the department of $2,240.0, with an increase of 0.5% to the savings in each subsequent year.**

Section 39 (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 $1,500.0 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.

STATE OF ALASKA **BILL NO.** CSSB074(FIN)
2016 LEGISLATIVE SESSION

Analysis Continued

The estimated capital budget start up cost for FY2017 is **$3,125.0** for technical development and consulting services, reimbursed at 90% federal, 10% GF. On-going annual maintenance costs is expected to be approximately $318.0 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. 38 (d)(3) Health Homes; and Sec 37 Primary Care Case Management system will staff this initiative as well.

Section 48 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 = $3,000.0
Monthly average X 12 months = $3,000.0 x 12 = $36,000.0 total costs. The refinancing from 50% federal/50% GF match to 100% federal results in **$18,000.0 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 $3,600.0 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 = $3,100.0

Total quarterly at $3,100.0 X 4 quarters = $12,400.0 total costs. Results in **$6,200.0 GF match savings** and a reciprocal increase in federal costs. Assume a two-year spread to shift costs to 100% federal. $3,100.0 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 $20,000.0 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 $20,000.0 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)

STATE OF ALASKA **BILL NO.** CSSB074(FIN)
2016 LEGISLATIVE SESSION

Analysis Continued

Section 49 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 FY2017 for consultant contract (Mental Health Trust Funded).**

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.