2/6/07 MEDICAID PROGRAM REVIEW

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FILE

Senator Green 2/6/07

Housekeeping: As noted in this meeting's announcement, the full Medicaid report is available online for you to download. It can be found at http://www.aksenate.org and includes more than 250 pages. The complete Lewin Group forecast report is available on the Department of Health and Social Services' website. The handouts provided are summary pages from these two reports.

Medicaid Program Review Introduction

Like most of our offices, I too, receive a high percent of calls from Medicaid clients who are frustrated with their health care, and from health care providers who are frustrated with the growing paperwork requirements and varied reimbursement rates. Department staff are working diligently to run the Medicaid program as efficiently as possible and are equally frustrated with juggling an overwhelming amount of details that impact every client, provider, the agency's internal organization and the legislature.

I sympathize with how complex the Medicaid program is for clients, health care providers, program managers as well as for the budget staff. I also find it difficult to find a remedy through statute if all of us do not fully understand the implications of our actions.

The first step to better understanding came from the Department of Health and Social Services' fiscal forecast prepared by the Lewin Group and ECONorthwest. The key findings of this report were:

1. The Medicaid program will change fundamentally over the next 20 years from one focused on children to a program geared to caring for Alaska's growing senior and Alaska Native populations.
2. State matching funds will increase from approximately $500 Million per year to more than $2 Billion for a total program cost of more than $5 Billion.

ECONorthwest developed a computer program by which the department can continue to update data to develop more accurate program criteria and generate funding forecasts. The establishment of baseline data and developing the forecasting model is step-one in implementing program change.

Step Two – Program Change. After recovering from sticker shock of the projected costs for Medicaid, the Senate Finance Committee released an RFP for a program review consultant to help us understand Medicaid and make suggestions to improve Alaska's program. In April 2006, a contract was awarded to the Pacific Health Policy Group based out of Irvine, California. Their charge was to help establish the programmatic baseline so that the legislature and the administration could make program changes to improve Alaska's Medicaid program.

Issue:

I hear many opinions regarding the services provided and the eligibility criteria but it is very difficult to fully understand the implications of change because the program is so complicated and impacts so many varied stakeholders.

1. We are asked to make changes to Medicaid statutes, but how do we, as legislators, make sound recommendations when we may not fully understand the implications to the client, health care providers, agency staff or the budget?

- What program changes can be made to better serve Alaska's needy population? How can we make the changes based on sound research rather than assumptions?
- The Pacific Health Policy Group evaluated Medicaid eligibility and service coverage policies and provided an overview that defines the populations that Alaska is required to serve and the services it is required to cover under federal law.

- As legislators, we frequently want to know how our programs compare to those of other states. To help us make this comparison, the Pacific Health Policy Group reviewed Alaska's service coverage policies and eligibility criteria and ranked Alaska with the other 49 states and Washington DC. These rankings can be found under Appendix A in the report.

Issue:
Alaska's Medicaid State Plan was approved in 1974. Since that time, all changes have been made by amendment and create a difficult sequence of rules to follow.

2. If the Medicaid director or key staff positions turn over, how much knowledge is lost during the transition and, therefore, how much is dropped through the cracks?

- How can the legislature and agency program staff create a tool to better understand the relationship of the State Plan, statutes, and regulations?
- To this issue, The Pacific Health Policy Group completed a crosswalk of Alaska's State Plan, statutes, and regulations to help identify where, if any, pieces did not relate well with its counterparts. This information is provided in Appendix B of the final report.

Issue:
When there were optional services mandated to constrain the Medicaid program to spend within a limited budget, the restriction could not hold up to unanticipated growth in program costs and client needs.

3. It was frustrating to see very large supplemental requests come before the Legislature each year with relatively no option for legislators, except to pay for the cost of this important program.

- How do we create a program that is more predictable?
- Program reform options are outlined in Chapters 2 through 6. Many of these options are tried and true changes that have been proved successful in other states. Although Alaska has unique obstacles when compared to other states, the Pacific Health Policy Group has identified options that may create positive changes for Alaska.

Pacific Health Policy Group has shown great success in program reform most recently in the states of Arizona, Oklahoma, Vermont and West Virginia. With their work in Arizona and Oklahoma, PHPG worked extensively with the Indian Health Service and tribal providers. One of the reforms you will hear about was initiated by the PHPG in the states of New York, Oklahoma, Rhode Island and Vermont, and should prove to be an exciting prospect for Alaska.

I would now like to introduce Scott Wittman and Andy Cohen with the Pacific Health Policy Group to walk you through their report.

Scott Wittman is located in the mid-west and worked most specifically on the review of program compliance and development of reform options. **Andy Cohen** works out of California and worked specifically on the evaluation of program policies and the comparison of Alaska's policies to those of other states.

I now turn the presentation over to Scott Wittman and Andy Cohen.

Alaska
Medicaid Program Review

PRESENTATION OF FINDINGS

The Pacific Health Policy Group
February 2007

MEDICAID REVIEW
Introduction

Pacific Health Policy Group

- PHPG is a health care consulting firm, founded in 1994
- Offices in California and Illinois
- Our focus is Medicaid/SCHIP and other government-funded health care programs
- Have provided assistance to 20+ states
- We also have worked with counties, providers, foundations and private health insurers

MEDICAID REVIEW
Introduction

Project objectives:

- Evaluate the Alaska Medicaid program relative to other states ("50-state analysis")
- Ensure that program operations reflect current statutes, rules and policies ("regulatory review")
- Assess current program operations and identify best practices from other states ("operational review")
- Assist the legislature with the evaluation of short and long term program reform initiatives – identify strategies that enable the program to operate with the flexibility necessary to best serve Alaskans, recognizing budgetary realties
- Identify oversight priorities for the legislature

9:12:37 AM

MEDICAID REVIEW
Introduction

Potential reforms defined in RFP:

- Developing public/private partnerships between Medicaid and employers – adopting market-based reforms
- Introducing managed care, to the extent feasible
- Enacting cost sharing – premiums/co-pays, perhaps tied to benefits
- Containing costs through program caps
- Increasing federal financial participation by obtaining matching dollars for services funded with state dollars only
- Strengthening the tribal health system

9:16:11 AM

MEDICAID REVIEW
Introduction

Work Steps:

- Interviewed provider representatives and beneficiary stakeholders
- Consulted with DHSS and other state agency staff
- Reviewed recently-issued reports examining Medicaid's long term growth; long term care system; and behavioral health system
- Compared Alaska enrollment and expenditure data to comparable data for the other fifty states
- Evaluated best practices and innovative approaches in other states for applicability to Alaska
- *Note: DHSS has not had the opportunity to review figures/assumptions*

9:21:49 AM

MEDICAID REVIEW
Introduction

Topics to be Covered Today

1. Summary findings from 50-state review
   - Demographics and Medicaid eligibility
   - Covered services & aggregate expenditures
2. Current operations & trends, by service type
   - Acute care
   - Long term care – elderly/physically disabled & MR/DD
   - Behavioral health
   - Tribal health (all services)
   - Administration
3. Recommendations for reform and oversight

9:23:38 AM

MEDICAID REVIEW
Introduction

"Executive Summary":

- Alaska is expensive, on a per beneficiary basis
- However, the state falls into the middle range in most areas, in terms of the populations and services covered
- The aging of the state's population is going to place significant pressures on the delivery system and Medicaid's budget
- There are a number of reforms within the existing Medicaid structure that can be taken to improve services and better control costs
- There also are structural reforms that the state should consider to ensure the program's long term sustainability

7

9:24:30 AM

50-STATE SUMMARY
Demographics & Medicaid Eligibility

Overview

- Medicaid eligibility is segmented into mandatory and optional populations
- Mandatory groups have a "categorical" linkage to eligibility – e.g., children, pregnant women, disabled
- Optional groups typically are persons who meet mandatory/categorical criteria but whose income is too high
- Every state covers some optional groups, although the extent of the coverage varies widely
- Some states also cover "medically needy" persons through Medicaid – similar to Alaska's Chronic & Acute Medical Assistance (CAMA) eligibles

8

9:26:25 AM

50-STATE SUMMARY
Federally Defined Coverage Groups

Mandatory Group	Optional Group
1) Children under age 6 in households with income below 133 percent of FPL ($21,945 for a family of two in Alaska)	1) Children under age 6 in households at or above 133 percent of FPL
2) Children ages 6 and older in households with income below 100 percent of FPL ($18,500 for a family of two)	2) Children ages 6 and older in households at or above 100 percent of FPL
3) Parents at or below a state's AFDC cutoffs from July 1996, when welfare reform was enacted (75 percent of FPL for non-working parents, 81 percent for working parents)	3) Low-income parents above the state's AFDC cutoff
4) Pregnant women at or below 133 percent of FPL	4) Pregnant women above 133 percent of FPL
5) Aged, blind and disabled SSI beneficiaries with income below 75 percent of FPL ($9,188 for a household of one)	5) Aged, blind and disabled beneficiaries between 75 and 100 percent of FPL
6) Working disabled persons at or below SSI limits	6) Working disabled above SSI limits
7) Medicare eligibles above SSI limits qualifying for limited benefits (QMB, SLMB and Q1 groups)	7) Nursing home residents above SSI limits but below 300 percent of SSI
	8) Individuals at risk of needing nursing facility or ICF/MR placement but served through an HCBS waiver
	9) Women with breast or cervical cancer
	10) Medically needy individuals

9:29:36 AM

50-STATE SUMMARY
Alaska Optional Coverage Groups (sfy'05)

Alaska Optional Coverage Groups (sfy'05)

Group	Enrollment		Expenditures		
	Enrollees	Percent of Total Enrollment	Expenditures	Percent of Total Expenditures	Expenditures per Enrollee
Children (non-disabled)					
[illegible]	20,703	15.8%	$43,773,909	4.3%	$2,114
[illegible]	2,097	1.6%	$22,633,156	2.2%	$10,898
Pregnant Women					
[illegible]	978	0.8%	$1,919,096	0.2%	$1,966
Aged, Blind & Disabled					
[illegible]	8,904	6.5%	$129,883,255	12.7%	$14,586
[illegible]	1,762	1.4%	$26,169,130	2.6%	$14,854
Disabled Children					
[illegible]	423	0.3%	$4,843,210	0.5%	$11,450
[illegible]	288	0.2%	$2,075,519	0.2%	$7,206
BCC Women					
[illegible]	171	0.1%	$1,932,435	0.2%	$11,301
Working Disabled					
[illegible]	401	0.3%	$3,830,167	0.4%	$9,552
Subtotal - All Optional	35,405	27.0%	$235,960,135	23.0%	$6,664
All Mandatory	95,731	73.0%	$789,957,865	77.0%	$8,250
Grand Total - Medicaid	**131,136**	**100.0%**	**$1,024,918,000**	**100.0%**	**$7,816**

9:30:44 AM

50-STATE SUMMARY
Coverage of Optional Populations

Alaska is middle-range in coverage of major optional categories, such as children and pregnant women

	Under One Year	Ages 1 – 5	Ages 6 – 19	Pregnant Women
US Requirement	133%	133%	100%	133%
Highest State	[illegible]	300%	[illegible]	[illegible]
Lowest State	133%	133%	100%	133%
Alaska	175%	175%	175%	175%
Alaska Rank	*36th*	*19th*	*17th*	*36th*

Source: State Health Facts

[illegible]

11

50-STATE SUMMARY
Coverage of Optional Populations

Overall, Alaska's optional groups account for a smaller than average portion of enrollment and spending

Enrollment (2005)

Expenditures (2005)

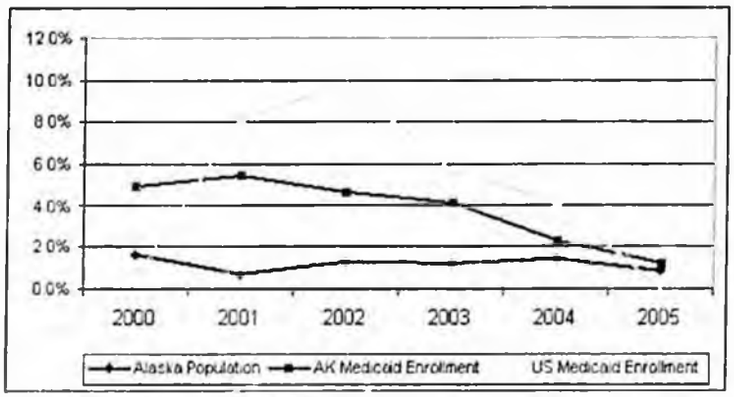
[illegible]

12

9:33:00 AM

50-STATE SUMMARY
Enrollment Growth

Total Medicaid enrollment until 2005 exceeded state population growth, but trailed the national rate



Sources: US Census Bureau, CPS Data and DHSS Fiscal Year 2007 Budget Overview

9:33:32 AM

50-STATE SUMMARY
Medicaid & Uninsured Populations

Medicaid covers a large percentage of Alaskans, but the percentage without insurance is also relatively high

Percent with Medicaid		
Rank	State	Percent
1	District of Columbia	21.9%
2	Mississippi	21.1%
3	Vermont	19.9%
4	Alaska	19.7%
5	Maine	19.6%
6	New York	18.4%
7	Rhode Island	17.2%
8	New Mexico	17.0%
9	Tennessee	16.4%
10	Arizona	16.1%
(tie)	Alabama	16.1%

Percent Uninsured		
Rank	State	Percent
1	Texas	24.2%
2	Florida	20.7%
3	New Mexico	20.4%
4	Arizona	20.2%
5	California	19.4%
6	Georgia	18.9%
7	Louisiana	18.8%
8	Oklahoma	18.6%
9	West Virginia	17.9%
10	Alaska	17.8%
(tie)	Arkansas	17.8%

Sources: US Census Bureau, CPS Data (2005)

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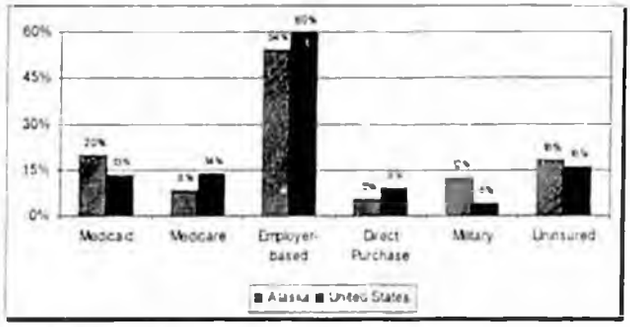
50-STATE SUMMARY
Distribution by Payor Mix

Relatively fewer Alaskans have employer-sponsored coverage, not surprising given the prevalence of small employers in the state



Source: US Census Bureau, CPS Data (2003)

15

50-STATE SUMMARY
Medically Needy & CAMA

Overview

- Medically Needy programs serve persons whose incomes exceed categorical limits, but who incur medical expenses sufficient to qualify on that basis
- Alaska is one of 16 states without a Medically Needy program
- The state's CAMA program is similar to a Medically Needy program, but is funded with state dollars only ($2.2 million in 2004)
- Some states have added CAMA-like populations to Medicaid through waivers, thereby capping the state's financial liability, while drawing down additional federal matching dollars

16

9:35:12 AM

50-STATE SUMMARY
Medically Needy & CAMA

Overview

- Example: Mississippi added a program in 2005 through a Section 1115a waiver covering most of the same groups as CAMA (cancer, diabetes etc.)
- Mississippi projected the program would be "budget neutral" by forestalling onset of disabling conditions requiring long term care
- Converting the CAMA program would likely not require legislation, unless the eligibility standards for the program were altered

50-STATE SUMMARY
Covered Services

Overview

- Medicaid-covered services are also segmented into mandatory and optional groups (children are entitled to a wider range of mandatory services than adults)
- Alaska is comparable to most other states in terms of the optional services offered
- Alaska spends more per beneficiary than other states and costs grew rapidly in the first part of the decade
- DHSS has taken a number of steps to contain costs, consistent with actions in other states
- Demographic trends are going to impose serious cost pressures in the next decade

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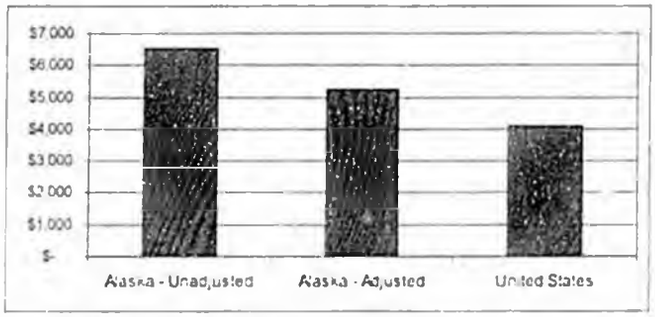
50-STATE SUMMARY
Expenditures per Beneficiary

Alaska spent more than the national average per beneficiary in 2003, even after adjusting for cost-of-living



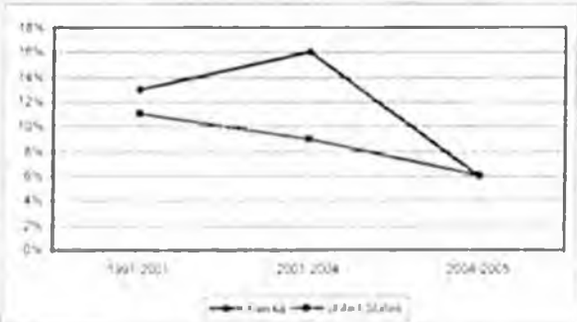
Source: State Health Facts. Adjustment made by applying ratio of FPL dollar values in the contiguous 48 states to Alaska's FPL and multiplying the unadjusted value by that ratio.

19

9:37:06 AM

50-STATE SUMMARY
Expenditure Growth

Alaska's Medicaid expenditures grew faster than the average annual rate early in the decade, but have since fallen back to the middle-range



20

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50-STATE SUMMARY
Expenditures by Beneficiary Type

Alaska ranked in the top 5 in every category (unadjusted dollars)

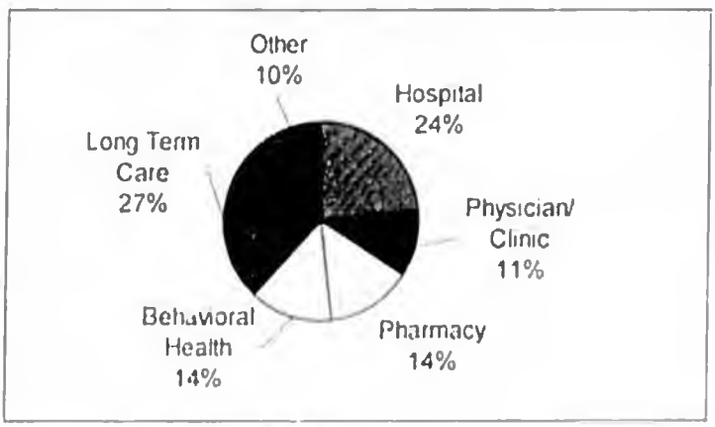
	Children	Adults	Elderly	Blind & Disabled	Total
United States	$1,467	$1,872	$10,799	$12,265	$4,072
Lowest State	$912	$813	$5,054	$5,623	$2,520
Alaska *Alaska Rank*	$3,504 2nd	$8,443 1st	$17,921 6th	$23,402 2nd	$6,512 3rd

Source: State Health Facts

21

ALASKA MEDICAID
Where Are the Dollars Spent?

Most spending falls into five major service categories



22

ALASKA MEDICAID
Acute Care

Hospital Services

- In 2003, Alaska spent $1,200 per beneficiary for inpatient services, fourth highest in the country
- Alaska spent $168 per beneficiary for outpatient services, second highest in the country
- The higher costs occurred despite lower than average utilization

9:40:25 AM

ALASKA MEDICAID
Acute Care

Physician/Clinic

- Alaska's physician payment rates are the highest in the country, partly because of the prevalence of tribal and cost-based providers
- Physicians perceive the fee schedule to be essential for supporting their practices – the reverse of what normally occurs
- The state faces a worsening physician supply shortage – one that could be exacerbated by cutting fees
- Telemedicine is a promising concept for stretching provider capacity. The state implemented payment regulations in 2002, but utilization remains low

9:42:26 AM

ALASKA MEDICAID
Acute Care

Pharmacy

- In 2003, prescription drug expenditures per beneficiary (before rebates) were $788, 13th highest in the country
- The state has taken a number of cost containment actions, including joining a purchasing pool and introducing a preferred drug list
- Alaska pays among the highest rates for drugs and dispensing fees - which to some extent supports critical access pharmacies
- The state should consider differential pricing strategies, targeting urban chains for discounts. This likely could be enacted through regulation, without the need for a statutory change

25

ALASKA MEDICAID
Long Term Care

Nursing Facilities/HCBS

- LTC accounted for one-quarter of Medicaid expenditures in 2005, but is projected to grow significantly as the state's elderly population grows in size (from 55,000 seniors in 2005 to 80,000 in 2015)
- Under current trend lines, Medicaid LTC spending is projected to increase from $273 million in 2005 to $877 in 2015
- Nursing home rates are highest in the country, but utilization is the lowest, partly due to a lack of beds
- Pioneer Homes, which are licensed as Assisted Living Facilities, are becoming de facto Alzheimer's providers, though in a relatively costly setting

26

ALASKA MEDICAID
Long Term Care

Nursing Facilities/HCBS

- The state has two HCBS waiver programs for elderly and physically disabled persons (OA and OPD), but neither are designed to serve persons with Alzheimer's/dementia.
- The waivers also offer limited in-home support services, encouraging many to seek Personal Care Attendant (PCA) services outside the waiver
- In 2005, PCA costs reached $80 million, while the two waivers amounted to only $42 million
- The state has introduced prior authorization rules for PCA, but a comprehensive pre-admission screen encompassing all community services (with PCA converted to a waiver service) would allow the state operate a more holistic system

9:45:49 AM

ALASKA MEDICAID
Long Term Care

Nursing Facilities/HCBS Recommendations

- Institute up-front, comprehensive pre-admission screening and care planning
- Convert PCA to a waiver service
- Add waiver services targeted to Alzheimer's/Dementia as less costly alternatives to Pioneer Homes (e.g., AFC) and/or establish case-mix adjusted payments for Pioneer Homes
- Also consider a provider tax on Nursing Facilities as a revenue source (also recommended by PCG in its report). Federal law permits up to a six percent tax
- The tax would require legislative action. The other recommendations would require federal approval

9:46:47 AM

ALASKA MEDICAID
Long Term Care

Developmentally Disabled

- Alaska serves all DD beneficiaries through waivers, outside of institutional settings – one of only a handful of states to do so (making it a leader)
- In 2004, expenditures per waiver beneficiary were sixth highest in the country ($63,000 versus $37,000 average)
- DHSS should develop and introduce a mandatory, uniform cost reporting tool for providers (and audit requirements)
- Rates should be updated through application of a reasonable annual inflator and rebased periodically (e.g., every four or five years)
- This likely could be implemented at the regulatory level through changes to the principles of reimbursement

29

9:49:45 am

ALASKA MEDICAID
Long Term Care

Developmentally Disabled

- About 12 percent of the state's DD spending is through state-funded grants ($18 million in 2005) – average for the fifty states, but below states that have achieved close to 100 percent federally-matched programs
- Unmatched DD dollars are being spent, in part, on persons on the DD waiver waiting list and persons deemed not eligible under current screening criteria – the reverse of the elderly/physically disabled program
- The state could create a second waiver, with distinct eligibility criteria. Enrollment could be capped at the numbers served today with state dollars – and the dollars matched
- The new waiver would require federal approval and possibly legislative action, if the waivers are authorized in statute

30

9:50:56 AM

ALASKA MEDICAID
Behavioral Health

Overview

- Over 80 percent of behavioral health dollars in 2005 went toward treating children, with 90 percent of all spending split between Residential Psychiatric Treatment Centers (RPTCs) and general mental health
- The state spends very little on early intervention activities, to prevent or treat behavioral health conditions at an initial stage
- CMHC rates have been flat for over a decade – with most additional funding going to serve persons in crisis
- The "Bring the Kids Home" initiative is an important effort, though it will bring Alaska only to the stage many states reached years ago and will leave Alaska dependent on inpatient care
- Savings achieved through Bring the Kids Home should be at least partly invested in early intervention/community-based services, in line with trends in other states

9:51:43am

ALASKA MEDICAID
Tribal Health

Overview

- American Indian/Alaska Natives (AI/AN) represent 40 percent of the state's Medicaid population; tribal health is a $740 million delivery system
- The tribal system faces significant fiscal challenges, as IHS funding has been increasing at 1 – 2 percent per year
- The health status of Alaska Natives is significantly worse than that of the general population on many key measures, such as tuberculosis and diabetes
- The AI/AN population is younger than average, but its elderly segment is growing significantly and will require a tribal LTC provider infrastructure that does not exist today
- The state may have an opportunity to dramatically alter the fiscal landscape – and provider system – for AI/AN beneficiaries

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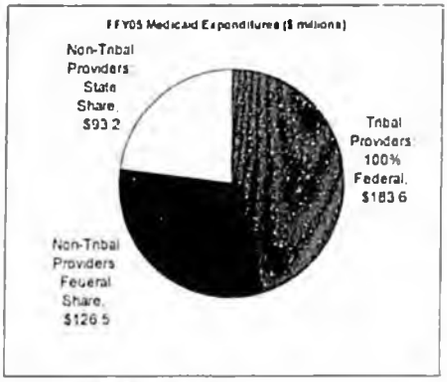
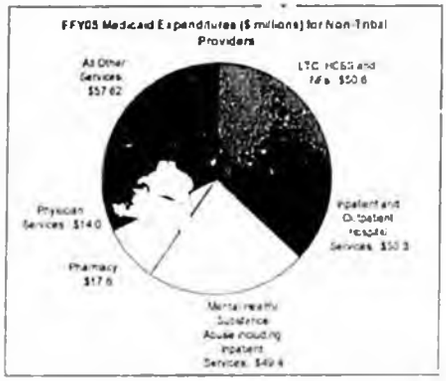
ALASKA MEDICAID
Tribal Health

AI/AN Current Medicaid Funding





Source: DHSS Tribal Funding Office

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ALASKA MEDICAID
Tribal Health

Tribal Health Recommendation

- Alaska spends about $19 million per year on nursing facility costs for AI/AN beneficiaries residing in non-tribal facilities ($8 million state dollars)
- The state should consider investing in development of tribal long term care capacity, to allow beneficiaries to be served closer to family/friends, while garnering 100 percent federal matching dollars. For example:

	State	Federal	Total
Nursing Facility Expenditures - Non-Tribal Provider			
Cost per nursing facility day	$170	$233	$403
Total annual Medicaid expenditures to serve 50 clients	$3 098 640	$4 253 345	$7 351 985
Ten-year Medicaid expenditures (5% annual growth)	$44 859 959	$61 591 947	$106 451 906
Investment in Tribal Provider Infrastructure			
State investment	$8 000 000		
Equal to estimated construction cost of 50 bed facility	—	$7 300 000	$7 300 000
Ten-year Medicaid expenditures (annual = 50)	—	$126 751 906	$126 751 906
Total Expenditures	$8 000 000	$126 751 906	$126 751 906
Potential State Savings Over Ten Years			
Single Facility	$36 859 959		

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ALASKA MEDICAID
Tribal Health

Tribal Health Recommendation

- Medicaid expenditures within the tribal health system receive 100 percent federal funding; services provided to AI/AN beneficiaries by non-tribal providers are matched at the regular rate
- Under a Section 1115a waiver, the state, in collaboration with tribal providers, could designate the tribal system as a managed care entity
- The entity would be funded for all care – including services furnished by non-tribal providers. However, the "capitation payment" would be submitted for 100 percent federal match
- The new entity would have flexibility to invest savings into areas of greatest need for AI/AN beneficiaries
- This initiative would require federal approval, which is not assured

9:56:18 AM

ALASKA MEDICAID
Administration

Overview

- DHSS was reorganized into four major divisions in 2003 – the department overall falls into the "super agency" structure adopted by many states to consolidate public health/behavioral health/ Medicaid
- In 2003 (pre-reorganization), Medicaid's administrative costs were $504 per beneficiary (or $403, adjusting for cost-of-living), versus a national average of $224
- Administrative costs represented 6.8 percent of total expenditures, closer to the national average of five percent
- Administrative spending also grew more slowly in Alaska from 1997 to 2004 than it did nationally

9:57:45 AM

ALASKA MEDICAID
Administration

Program Integrity/Provider Payments

- The federal government is phasing-in a new audit structure for states, known as the Payment Error Rate Measurement (PERM) process; Alaska's first audit is scheduled for 2008
- States that have error rates significantly above the national rate face disallowances and may be ordered to refund federal monies
- DHSS has established a Program Integrity and Analysis function and has re-codified service regulations, as a means of bringing better clarity and oversight to the payment process; the Department also has conducted test audits to prepare for PERM
- However, the PERM audit will overlap with implementation of a new MMIS – on a schedule which appears to be very ambitious
- The legislature should monitor both processes closely because of their fiscal implications for the program

37

9:58:13 AM

ALASKA MEDICAID
Administration

Regulations

- The updating of Medicaid regulations, beginning with HCBS waiver rules, was essential and is already yielding results
- The Department's recently-issued draft regulations for covered services comply with federal law and regulations, with only a few areas for potential follow-up by DHSS identified
- Of the 481 regulations reviewed, only 8 potential inconsistencies were detected, representing 1.66% of the total
- It appears that Alaska performed a very thorough review of applicable federal authorities when it sought to repeal existing state regulations and propose revised rules

38

9:59:16 AM

ALASKA MEDICAID
Broad-Based Reform

Planning for Reform

- The federal government in recent years has shown a willingness to grant states greater flexibility in running their Medicaid programs, if presented as part of a comprehensive reform model
- Vermont, Massachusetts and, to a lesser extent, Florida have undertaken major reforms under the aegis of 1115a waivers
- Under such waivers, states agree to operate their programs at no greater cost than would have occurred without reform. In return, the federal government agrees to "waive" traditional rules governing how the program operates and who can be served
- Denali KidCare operates under an 1115a waiver

39

9:59:58 AM

ALASKA MEDICAID
Broad-Based Reform

Reform Objectives

- Ensure the best use of public resources to meet Alaskans' health care needs
- Ensure the program is culturally appropriate and recognizes Alaska's unique demography
- Ensure the program is fiscally sustainable for the long term
- Encourage preventive care and early intervention
- Promote access to quality care
- Ensure the state has the necessary tools to quickly respond to client needs, changes in the delivery system and fiscal constraints

40

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ALASKA MEDICAID
Broad-Based Reform

Reform Steps

- Define Medicaid's top programmatic needs over the next decade
- Project likely spending authority over same period
- Draft waiver proposal seeking flexibility to restructure program
- Identify specific reforms to be undertaken
  - CAMA program
  - Tribal health
  - DD waiver
  - Long Term Care

41

10:04:27 AM

MEDICAID REVIEW
Summary

Program Area	Recommendation	Action Required
CAMA Program	• Convert to federally-matched model under a Section 1115a waiver	• Federal approval • Possible statutory action (if covered populations/services change)
Pharmaceutical Pricing	• Differential pricing strategies, by location	• Regulatory amendments
Personal Care Attendant (PCA)	• Comprehensive pre-admissions screening	• Regulatory changes • Possible statutory action (if covered populations/services change)

42

10:05:25 AM

MEDICAID REVIEW
Summary

Personal Care Attendant (PCA)	▸ Convert to waiver service ▸ Target alternatives for individuals with Alzheimer's/dementia	▸ Federal Approval
Nursing Facilities	▸ Provider Tax ▸ 6% tax allowed by Federal Law	▸ Statutory approval
Developmentally Disabled	▸ Mandatory, uniform cost reporting tool ▸ Fixed rate increases	▸ Regulatory changes

43

MEDICAID REVIEW
Summary

Program Area	Recommendation	Action Required
"Bring the Kids Home"	▸ Reinvest savings in early intervention/community based services	▸ Evaluate options for enhanced community based services
Tribal Health	▸ Designate tribal system as managed care entity ▸ Construct tribally-operated nursing facility	▸ Develop application for Section 1115a waiver ▸ Develop detailed cost-benefit analysis
PERM and MMIS	▸ Legislative monitoring	▸ Routine status reporting

44

The LEWIN GROUP

and

ECONorthwest

Long Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005-2025

Prepared for:

Alaska Department of Health and Social Services

Prepared by:

The Lewin Group and ECONorthwest

February 15, 2006

Long Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005-2025

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February 15, 2006

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Executive Summary

In April 2005 the Alaska Department of Health and Social Services (ADHSS) contracted with the Lewin Group and ECONorthwest to develop a long-term forecasting model of Medicaid spending for the State of Alaska. This document describes the steps undertaken in the development of the forecasting model and provides details on the projected growth in enrollment, utilization, and spending on Alaska's Medicaid program through 2025.

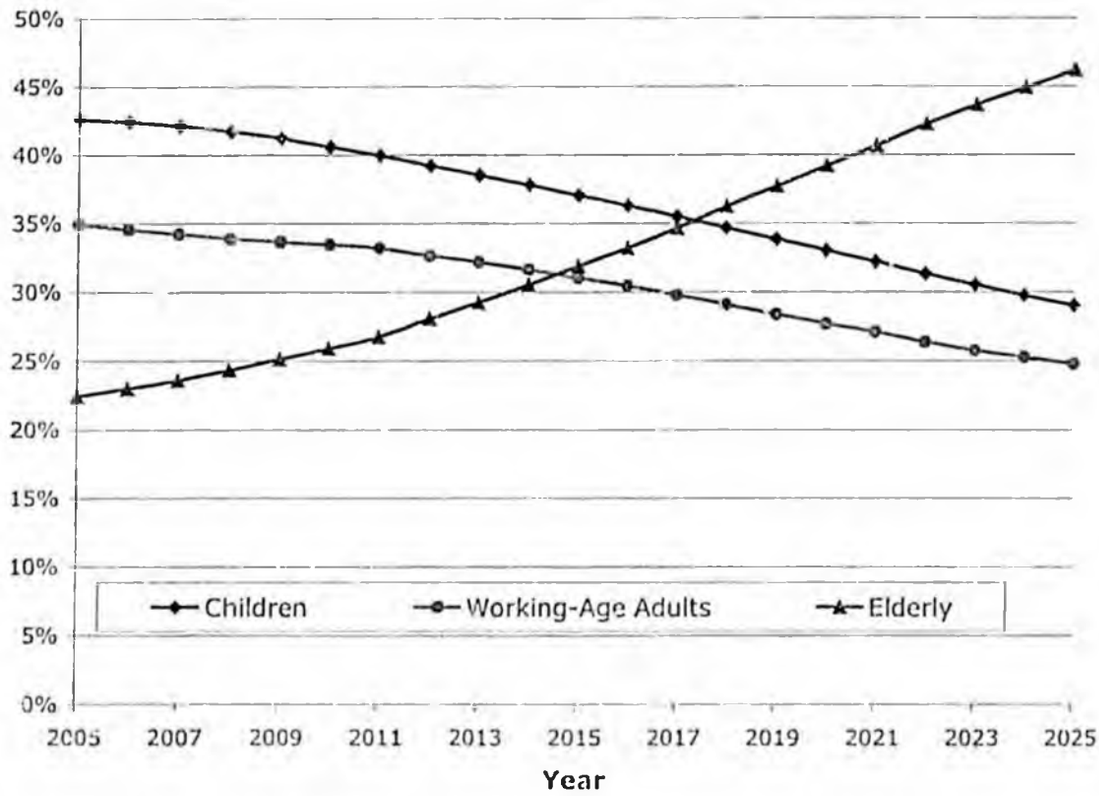
This report is intended to inform ADHSS executives and the Alaska State Legislature of the substantial projected growth in total spending on Alaska's Medicaid program and the projected growth in state matching fund spending on the Medicaid program. The projections of total and state matching fund spending presented in this report assume that the mix of Medicaid services remains constant and that eligibility criteria do not change in the future. These assumptions were necessary to show how Medicaid spending in Alaska would grow under the program's status quo. The statistical models developed for this analysis will be provided to ADHSS staff providing them the ability to update the Medicaid forecast as more timely data become available.

KEY FINDINGS

The Alaska Medicaid program will fundamentally change over the next 20 years from a program that centers on children to one that is dominated by seniors (age 65 and older). This is a result of changes in Alaska's demographic profile, which will include many more seniors. On a per-recipient basis, spending on Medicaid services for seniors is substantially higher than spending for children. As this portion of the population grows rapidly over the next 20 years, Medicaid spending will also grow rapidly. In calendar year 2005, approximately 42% of spending on Medicaid claims was devoted to children and 22% was devoted to seniors. By 2025, we expect that approximately 45% of Medicaid spending will be devoted to seniors and approximately 30% will be devoted to children. As Figure 1 shows, we expect spending on Medicaid claims for the elderly to surpass spending on the working-age population by 2015 and to surpass spending on children by 2018.

Figure 1: Spending on Elderly will Surpass Spending on Other Age Groups by 2018

Forecasted Proportion of Total Spending on Medicaid Claims by Age Group, 2005-2025



Source: Lewin Group & ECONorthwest analysis of Alaska Department of Health and Social Services data.
Note: Spending projections are on an incurred service basis.

Among the key findings of this report are the following:

- More important than any of the other factors in our projection of the Alaska population, the 65 and older population is projected to grow rapidly, almost tripling from 43,000 to 124,000 between 2005 and 2025.

- Alaska's Medicaid program has been a program dominated by spending on services for children but it will change to one much more focused on the elderly. This change will affect the mix of benefits that Medicaid provides and, more importantly, the cost. Average per-recipient costs of Medicaid services are much higher for the elderly than for children.

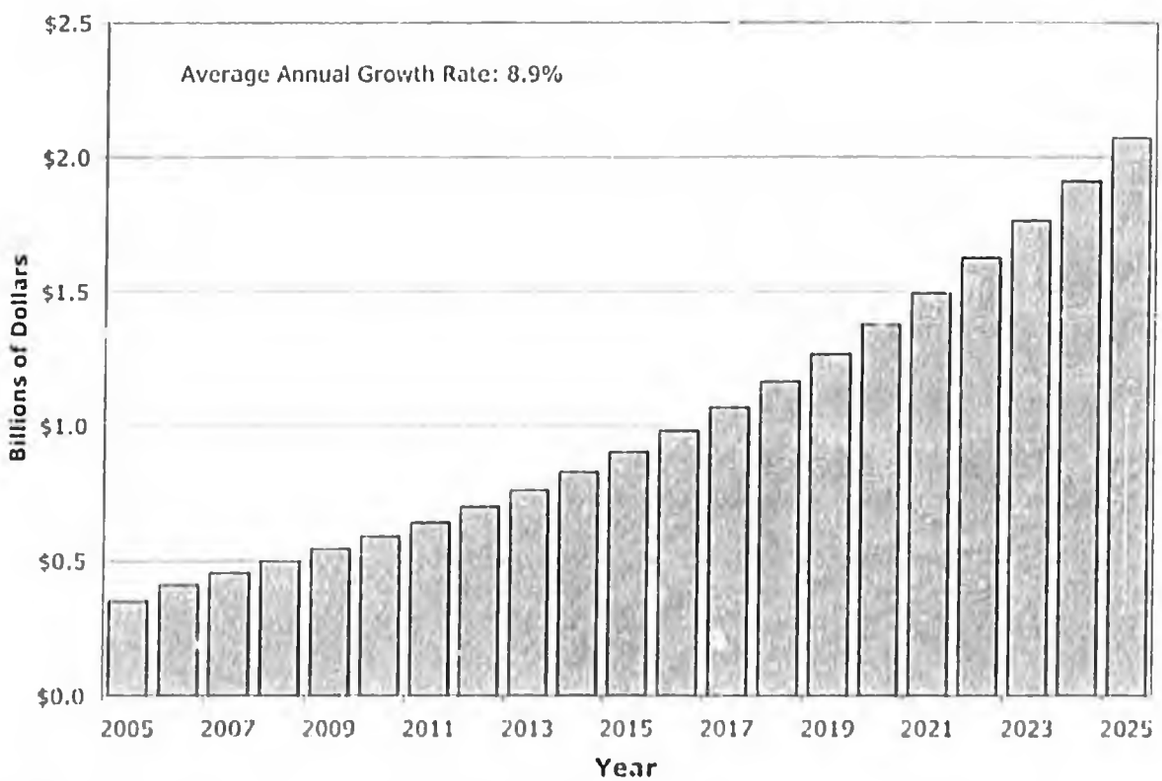
- Projected to grow a little faster than the state's population, we expect Medicaid enrollment—on a full time equivalent basis—to reach 131,000 by 2025 (compared to 95,000 in 2004).

- Total spending on Medicaid claims will increase from approximately $975 million in CY 2005 to approximately $4.7 billion in CY 2025.

- An increasing share of the Medicaid burden will be shifted away from the federal government to the state. State matching funds for Medicaid claims are projected to increase at a faster rate than the total Medicaid program—8.9% versus 7.6% for total funds (see Figure 2).

Figure 2: State Matching Fund Spending on Medicaid to Grow 8.9% Annually

Total Forecasted State Matching Funds for Medicaid Claims (in Millions of Dollars), 2005-2025



Source: Lewin Group & ECONorthwest analysis of Alaska Department of Health and Social Services data.
Note: Spending projections are on an incurred service basis. Not adjusted for inflation.

Table 1 and Table 2 show projected utilization and spending for the five fastest growing Medicaid service categories. With the exception of Vision Services, these categories are also expected to be among the most expensive Medicaid services provided in 2025. In fact, As Table 2 shows, over half of state matching funds will be spent on just two service categories—Personal Care and HCB Waiver. These are two of the most important Medicaid service categories for Alaska's seniors.

Table 1: Forecast of the 5 Fastest Growing Service Categories by Utilization, 2005-2025

Medicaid Service	Calendar Year					Average Annual % Change (2005-2025)	Rank by Avg. Annual % Change
	2005	2010	2015	2020	2025		
Personal Care	5,029	8,626	14,587	23,617	35,311	9.7%	1
HCB Waiver	4,167	7,00[illegible]	11,428	17,686	25,263	9.0%	2
Residential Psych./BRS	1,227	1,898	2,766	3,889	5,319	7.3%	3
Therapy/Rehabilitation	9,949	15,240	22,242	31,135	41,529	7.1%	4
Vision	24,288	35,006	47,669	61,614	75,190	5.7%	5
Unduplicated Count of Medicaid Recipients	113,953	130,047	141,184	148,117	150,743	1.4%	NA
Unduplicated Count of Medicaid Enrollees	132,344	151,036	163,971	172,022	175,073	1.4%	NA

Source: Lewin Group & ECONorthwest analysis of Alaska Department of Health and Social Services data.
Note: In this analysis we define service utilization as the annual unduplicated count of persons who used a particular Medicaid service during the fiscal year

Table 2: Forecast of the 5 Fastest Growing Service Categories by State Matching Funds (In Millions of Dollars), 2005-2025

Medicaid Service	Calendar Year					Avg. Annual % Change (2005-2025)	Rank by Avg. Annual % Change
	2005	2010	2015	2020	2025		
Personal Care	$48.7	$105.0	$200.6	$367.3	$629.1	12.8%	1
HCB Waiver	$49.0	$100.6	$181.8	$316.1	$520.4	11.8%	2
Residential Psych/BRS	$27.1	$52.9	$88.0	$141.1	$221.5	10.5%	3
Therapy/Rehabilitation	$11.5	$21.7	$35.4	$56.3	$85.9	10.0%	4
Vision	$0.4	$0.8	$1.2	$1.7	$2.4	8.6%	5
All Medicaid Services	$350	$591	$902	$1,377	$2,070	8.9%	NA

Source: Lewin Group & ECONorthwest analysis of Alaska Department of Health and Social Services data.
Note: Dollars are not adjusted for inflation.

- State matching fund spending on claims provided by the Alaska Medicaid program will grow from approximately $350 million in calendar year 2005 to just over $2 billion in calendar year 2025.

- The main factors responsible for growth in spending on Medicaid services are population growth, aging of the population, increasing utilization of Medicaid services by enrollees, and growth in the prices of medical services.

- Growth in total (federal and state funds) spending on claims will slow from the pace of the last decade. On an average annual basis, total spending on Medicaid claims is projected to increase by 7.8%. Comparatively, between 1998 and 2004, spending on Medicaid claims increased by 16.6%.

- In calendar year 2005, state-matching fund spending on Medicaid claims was approximately $500 per Alaskan citizen. We project this will grow to approximately $2,600 by 2025—an 8.0% average annual growth rate. Comparatively, per-capita personal income in Alaska is projected to grow by less than 3.0% per year over this same period.

- By 2025, more than half of state matching fund spending on Medicaid claims is expected to be for Personal Care and HCB Waiver. In CY 2005 these two service categories account for less than 30% of the state's spending on Medicaid claims.

- Medicaid enrollment will grow at almost twice the annual rate of Alaska's population (1.4% vs. 0.86%).

- For the elderly, Medicaid enrollment is also projected to grow at a greater annual rate than the population (6.3% vs. 5.3%).

- Medicaid utilization will grow by approximately 4.3% per year between 2005 and 2010, but this rate of growth will decline to approximately 2.1% between 2020 and 2025.

- We project relatively slow growth in the enrollment rates of eligibility categories specific to children (e.g. Title XIX Kids), but high rates of growth in eligibility

categories geared more heavily toward the elderly (e.g. Long Term Care Non-Cash).

- The elderly population in Alaska will almost triple between 2005 and 2025 from 43,000 to 124,000; while the child population will remain relatively stable growing only from 205,000 to 245,000 in 20 years.

- The Native population will increase on average by 1.71% per year, while the Non-Native population is expected to increase by only 0.67%. The difference between the two growth rates is expected to result in the Native proportion of the population increasing from approximately 17% in 2005 to approximately 21% by 2025.

- Currently, Natives are almost three times as likely to be enrolled in Medicaid as are non-Natives.

- The enrollment of males into the Medicaid program is projected to grow slightly faster than females. Still, due to greater life expectancies, higher rates of poverty, and pregnancy and related needs, we expect the proportion of females in the Medicaid program to remain higher than males.

- The Anchorage/Mat-Su region, with almost half of all Medicaid enrollees in 2005, is expected to increase its Medicaid population by 2.0% per year—the fastest growth of any of the regions.

Introduction—Alaska Medicaid Spending Projection

In this study, we develop long-term forecasts of Medicaid program spending from 2005 through 2025. We project spending for 20 categories of services provided under the Alaska Medicaid program. Although results are presented at state level for all residents, analysis is conducted on a regional basis for demographic subgroups of the population.

In addition to this report, the models constructed for and used in the analysis will be installed on Alaska Department of Health and Social Services (ADHSS) computers. This will provide ADHSS staff the ability to update the forecast as more timely data become available. The models were developed in the Statistical Package for the Social Sciences (SPSS) at the request of agency staff. The SPSS modeling syntax serves as documentation of the analysis, allowing ADHSS staff to operate and, if necessary, modify the models. Indeed, the primary contributions of this project are the development of a methodology and set of statistical models that will allow ADHSS staff to prepare long-term forecasts of Medicaid spending into the future. Neither the demographic profile of Alaska's population, nor the administrative aspects of the Medicaid program are static. It is important, therefore, that ADHSS staff has the ability to inform Medicaid administrators and policy makers about fiscal issues related to the Medicaid program. ADHSS now has a tool that they can use to project the impact of proposed changes to the Medicaid program.

This report presents the findings from our analysis of long-term Medicaid spending in Alaska. It is based on the most currently available data and represents a benchmark for future forecasts, but does not reflect changes in Alaska's Medicaid program made since the last year of historical data (fiscal year 2004). We recognize that changes to the Medicaid program ADHSS has implemented since FY 2004 already have had—and will continue to have—an impact on enrollment, utilization, and spending.[1] With the new long-term forecasting model in hand, these changes will be reflected in ADHSS' future updates of the forecast. Revised projections will have the same validity as the benchmarking projection because they will be based on the same model.

[1] Examples of changes made to the Medicaid program since FY 2004 include numerous changes implemented to contain costs, the Bring the Kids Home initiative to return children in out-of-state residential psychiatric treatment centers to Alaska, changes to the Personal Care Attendant program, and the launch of Medicare's prescription drug benefits.

SUMMARY OF METHODOLOGY

The main factors responsible for growth in spending on Medicaid services are population growth, aging of the population, increasing utilization of Medicaid services by enrollees, and growth in the prices of medical services. Our methodology, therefore, entailed detailed analysis of each of these factors in order to formulate a series of statistical models to project total spending on Medicaid services. The statistical models of Medicaid enrollment, and service utilization and spending were developed using historical enrollment-level data provided by ADHSS. Population forecasts for five regions of Alaska were based on historical Census population estimates and statewide population forecasts developed by the Alaska Department of Labor and Workforce Development.

The forecast of total spending on Medicaid services depends on the following key demographic, economic, and program-related factors:

- Growth in Alaska's resident population and changes in demographic composition
- Changes in the Medicaid enrollment rate
- Changes in the utilization of Medicaid services by Medicaid enrollees
- Personal health services specific price inflation

The creation of the long-term Medicaid forecasting model for Alaska required the development of five separate modeling tasks. These include:

- **Task 1: Project population of Alaska by regional-demographic grouping:** The first step in determining the demand for Medicaid services in future years is to understand the size of the Medicaid eligible population, its demographic characteristics, and its regional distribution. We do this by projecting Alaska's population through 2025 by the following four characteristics:
    - Region (5)
    - Age Cohort (11)
    - Gender (2)
    - Native/non-Native (2)

This results in 220 subpopulations (5 * 11 * 2 * 2 = 220) that we project for each year from 2005 to 2025. The purpose of projecting Alaska's population at such detail is that eligibility for and consumption of Medicaid services differs greatly by age and gender; the federal match rate varies between Medicaid service categories and by Native/non-Native status; there may be regional differences in the eligibility and participation rates for Medicaid, as well as in the costs of service.

Task 2: Project Medicaid enrollment rate for each of the 220 subpopulations: Using Medicaid enrollment data provided by the Alaska Medicaid program for fiscal years 1997-2004, we estimated regression equations of Medicaid enrollment rates for children (0-19 years of age), working-age adults (20-64 years of age), and the elderly (65+ years of age). These equations included a range of demographic variables designed to measure differences in enrollment for these groups, including age, gender, Native/non-Native status, and region of residence.[2] Coefficient estimates from the regression equations were used to project the proportion of each of the 220 subpopulations enrolled in Medicaid through 2025. Medicaid enrollment is then allocated across the 11 eligibility classes based on historic trends. Medicaid eligibility classifications were determined by ADHSS staff.

Task 3: Project utilization by Medicaid service class for each of the 220 subpopulations: Using historic Medicaid data on utilization of Medicaid services for each of the 20 service classes, we project Medicaid utilization for each of the 20 service classes within each of the 11 eligibility groups and the 220 subpopulations. Service utilization is modeled using logistic regression, a statistical modeling technique used for estimating the probability of an event occurring. For our purposes, the event is the utilization of a particular service within a given year.

Task 4: Forecast the average and total cost per year of Medicaid services by subpopulation: Using linear regression analysis, average spending per recipient of each Medicaid service category was regressed on demographic and other explanatory

[2] In addition, we examined statewide economic data, including total personal income, per capita personal income, and employment. The statewide data provided no explanatory power in the enrollment rate models and was, therefore, dropped from the models. Regional economic data were not examined because we know of no available long-term forecasts of such data. Statewide economic data from the University of Alaska's Institute for Social and Economic Research (ISER) were also considered in the regression models. The economic data, however, did not provide additional explanatory power and were, therefore, dropped from the models.

variables.[3] One regression model was developed and estimated for each of the 20 service categories. The results obtained from the 20 models were used to project total *real* spending *per Medicaid recipient* through 2025. Using national-level forecasts of medical inflation, we then project total annual *nominal* spending per recipient through 2025.

Task 5: Forecast total state matching fund spending on Alaska's Medicaid program: The State's obligation to cover the cost of an individual's Medicaid costs differs according to the individual's Medicaid eligibility group, category of Medicaid service, provider of Medicaid-related service, and Native/non-Native status. Based on cost share information from ADHSS and our projections of total Medicaid spending by service category, we forecast total state matching fund spending through 2025 by the State of Alaska.

Task 6: Forecast the cost of other payments and offsetting recoveries: This final component of Medicaid spending is not directly tied to individual claims and, therefore, cannot be forecasted by the same methods described above. Rather, for projections of Offsetting Recoveries, future credits are assumed to grow at approximately the same rate as in the past. For the forecasts of Medicare Part A & Part B Premiums, the historical relationship between spending on this program and growth in the elderly population (65 and older) was statistically measured and used as a basis for projecting future spending by ADHSS on Medicare Part A & Part B Premiums. Finally, for the Supplemental Hospital Payments program, the relationship between spending on this program and spending on the Inpatient and Outpatient Hospital services categories was statistically measured and used as a basis for projecting future spending on the Supplemental Hospital Payments program.

MODEL ASSUMPTIONS AND LIMITATIONS

The Lewin Group and ECONorthwest realize that the value of economic analysis depends on the quality of the data and assumptions employed. We have worked carefully to ensure the quality of our work and the accuracy of our data. Throughout this report we identify our sources of information and the assumptions used in the analysis. We have undertaken considerable effort to validate the forecast and to confirm the reasonableness of the data and assumptions on which the forecast is based.

[3] Note: Annual Medicaid spending for each of the historical years of data is inflation adjusted into 2004 dollars.

Nonetheless, we acknowledge that any forecast of the future is uncertain. The fact that we view the forecasts in this report as reasonable does not guarantee that actual enrollment in, utilization of, and spending on the Alaska Medicaid program will equal the projections in this report. ADHSS administrators and the Alaska's elected representatives must recognize the inherent uncertainty that surrounds forecasts in considering the long-term Medicaid spending projections. The primary benefit of this report to Medicaid administrators and Alaska's policy makers is information on the direction and approximate magnitude of changes in the Medicaid program.

There are many assumptions underlying the forecast, which the Lewin Group and ECONorthwest have deemed to be reasonable. ADHSS established a steering committee of program and financial managers experienced in Medicaid policy to provide guidance throughout the process of developing the forecast models. The steering committee provided valuable feedback on the suitability of our assumptions and the reasonableness of our results. Throughout the analysis, we relied upon the best available information, including historic Medicaid claim data, the State of Alaska's official population forecast, and nationally recognized information on trends in medical prices. In addition, in no instances do we impose any speculation on future Medicaid policies or procedures. Rather, we develop the long-term forecast as if the policies and practices of today will be the status quo throughout the forecast period. Assumptions of particular importance, include, but are not limited to, the following:

- The mix of currently available Medicaid services is assumed to be constant throughout the forecast period. The State of Alaska currently provides Medicaid services not mandated by the federal government. We assume the State will continue to provide these services throughout the forecast period.

- Medicaid eligibility requirements will not change throughout the length of the forecast period.

- With respect to gender and age cohort, Alaska's population will grow at approximately the rate forecasted by the Alaska Department of Labor and Workforce Development in their February 2005 report. Relative population growth by region of the state and by Native/non-Native status will be similar to that experienced between 1990 and 2000.

- The growth rate in the prices of Alaska's Medicaid services will be the same as the projected growth rate in the prices of personal health care services, embodied

in the Center for Medicare and Medicaid services' national personal health care deflator.

- Neither the historical data nor the spending forecast will directly correspond to the ADHSS accounting or budget systems. Additionally, the claims data is based on date of service while the accounting and budget systems are based on dates of payment. There are three reasons for this:

  1. The data used in the forecast of total spending are based on date of service and not on date of payment;

  2. The payment amounts include only claim payments processed through the Medicaid Management Information System (MMIS) and do not included any payments or accounting adjustments not made through MMIS (i.e., the data do not directly correspond to accounting records);

  3. The historical data are based on the State's fiscal year, but the forecasts are on a calendar year basis. This was done to remain aligned with the population forecast.

- Claim data for Fiscal Year 2005 are used as a benchmark for the long-term forecast. These data were not, however, used in the development of the forecast. The reason for this is that the statistical models used in this analysis were developed in Q2 and Q3 2005, and the earliest the FY 2005 claim data became available was a month or more into Q3 2005. Further, because this analysis is on an incurred basis and many claims are not paid for several months or more after the service is incurred, there is currently and will continue to be for several months much missing cost data in the FY 2005 claim data.

- Data for years 1997, 1999, 2001, and 2003 are not shown in historical tables of utilization and spending because of limited space. Average annual growth rates are slightly lower when considering the period 1997-2004.

- Forecast data are only shown for 2005, 2010, 2015, 2020, and 2025. The model, however, forecasts each year from 2005 through 2025.

- The enrollment and claims data provided by ADHSS were from their Juneau Claims and Enrollment (JUCE) database. JUCE contains Medicaid enrollment records and claim-level data on paid claims, adjustments, and voids. JUCE does not include denied claims, claims pending adjudication, payments not processed through MMIS, or administrative costs. For the long-term forecasting model, ADHSS summarized enrollment and paid claims data into one record for each individual enrolled in the Medicaid program for each complete fiscal year available (1997-2004) using the following 10 criteria.

1. Claim date is based on the date the service was provided (incurred), not the date the claim was paid.

2. Only complete fiscal years are included in the data file. Data for fiscal year 2005 are excluded because there is a lag between providing the service and paying the claim. Many of the claims incurred during fiscal year 2005 will not be paid until fiscal year 2006.

3. There is one record per individual for each fiscal year he/she is enrolled in Alaska's Medicaid program, regardless of whether he/she is enrolled for one month during the fiscal year or for the entire fiscal year.

4. Data were grouped so that classifications are consistent with those typically used by ADHSS in budgeting analyses and financial reporting. The list of variables include ID, year, region, gender, race (Native/non-Native), age, months in program, eligibility classification, and service classification.

5. To protect the privacy of clients, no personally identifying information (i.e., name, birth date, social security number) was included in the data file. The Medicaid client identification numbers were recoded by ADHSS to create the ID variable and cannot in any way be used to identify individuals.

6. The race variable is one of two values: Native or non-Native. The Native category includes anyone identified as Alaska Native or American Indian. Race is a self-identified optional field on the enrollment application. Natives who left this item blank would be counted as non-Native.

7. The Months-in-Program variable is the number of months during the fiscal year in which the individual was enrolled in Medicaid. Eligibility is determined on a monthly basis. If a person is eligible for one day in the month, they are eligible for the whole month.

8. When summarizing enrollment data, if multiple values were encountered in the region, gender, race, or age variables, one of the values was chosen randomly by assigning an integer between 1 and 12 (inclusive). The integer represented the month of the fiscal year in which to determine the individual's value for the entire fiscal year.

9. The 11 eligibility classifications are based on groupings of eligibility subtype codes (See Appendix A). If a client's situation changes over time, he/she is reassigned to the eligibility code that best fits. Consequently, there is a great deal of movement between classifications and it is common

for individuals to have more than one eligibility code during the year. If multiple eligibility codes were encountered during a fiscal year, the last value was chosen.

10. Claim data were aggregated into 20 service classifications based on ADHSS categories of service (See Table 9) The net amount of claims paid, including debits, credits, and voids, was summarized for each individual enrolled for each fiscal year. Not all enrollees had claims in all service classifications. In fact, some enrollees did not have any claims at all for a fiscal year.