2/08/11 OVERVIEW: NATIONAL AND STATE MEDICAID

<TARGET><BILL></BILL><SUBJECT>2-08-11 OVERVIEW NATIONAL AND STATE MEDICAID</SUBJECT><COMM>HFIN27</COMM></TARGET>

2/8/11

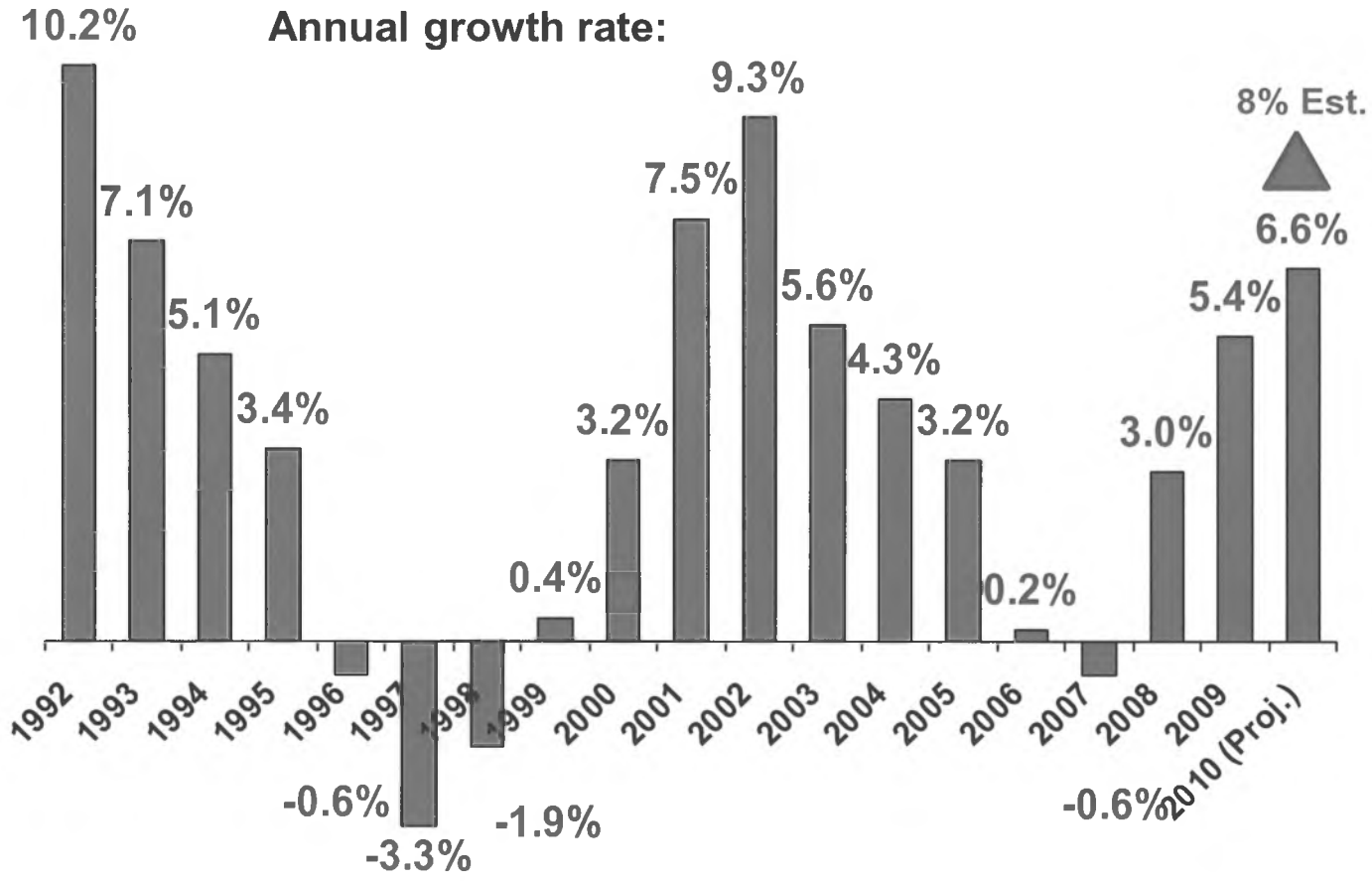
Figure 1

OVERVIEW OF NATIONAL AND STATE MEDICAID

William Streur, Commissioner
Alaska Department of Health and Social Services

Figure 2

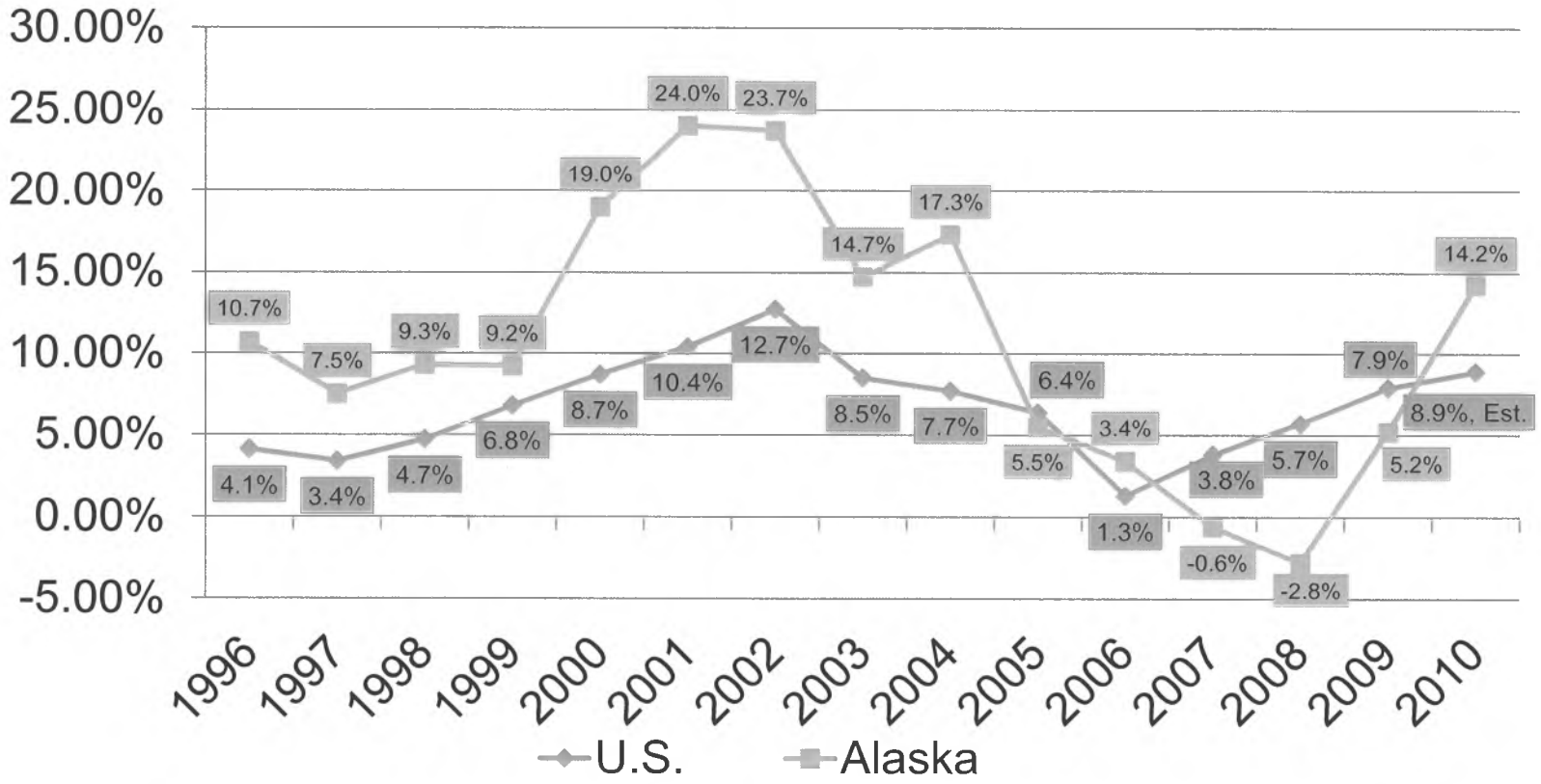
U.S. Medicaid Enrollment Increases in Economic Downturns: FY 1992- FY 2010



SOURCES: SOURCE: For 1998-2008: *Medicaid Enrollment in 50 States: June 2008 Data Update*, KCMU, August 2009. FY 2009 and FY 2010 based on KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, 2009. 1992-1997 data are from CMS for federal fiscal years. 1998-2010 are June-June state fiscal years.

Figure 3

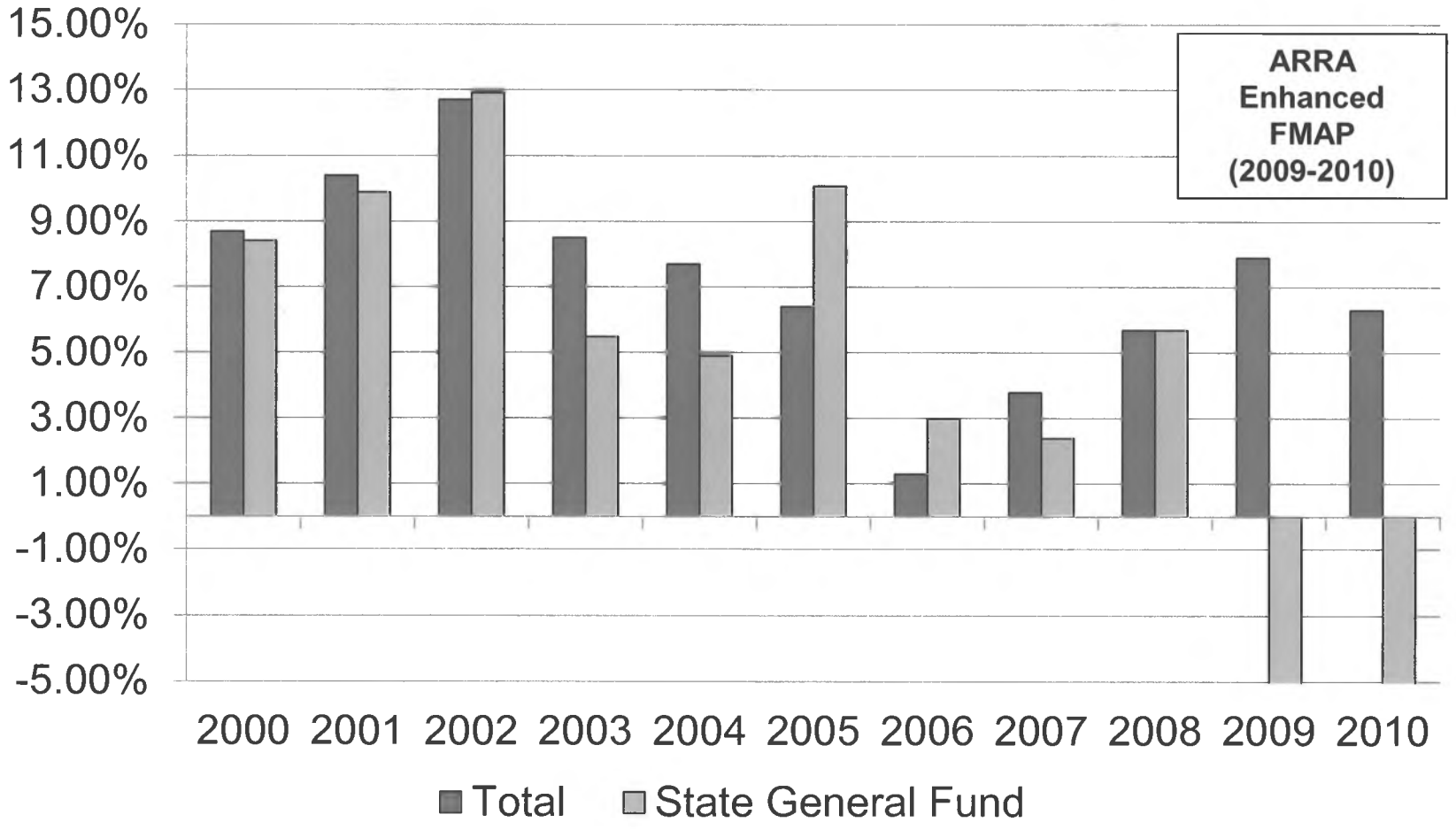
Medicaid Spending Growth, U.S. and State of Alaska, 1996 - 2010



Source for U.S.: KCMU Analysis of CMS 64 Data, FY 2008, 2009, and 2010 based on KCMU survey of Medicaid officials in 50 states and D.C. conducted by Health Management Associates, 2009.

Figure 4

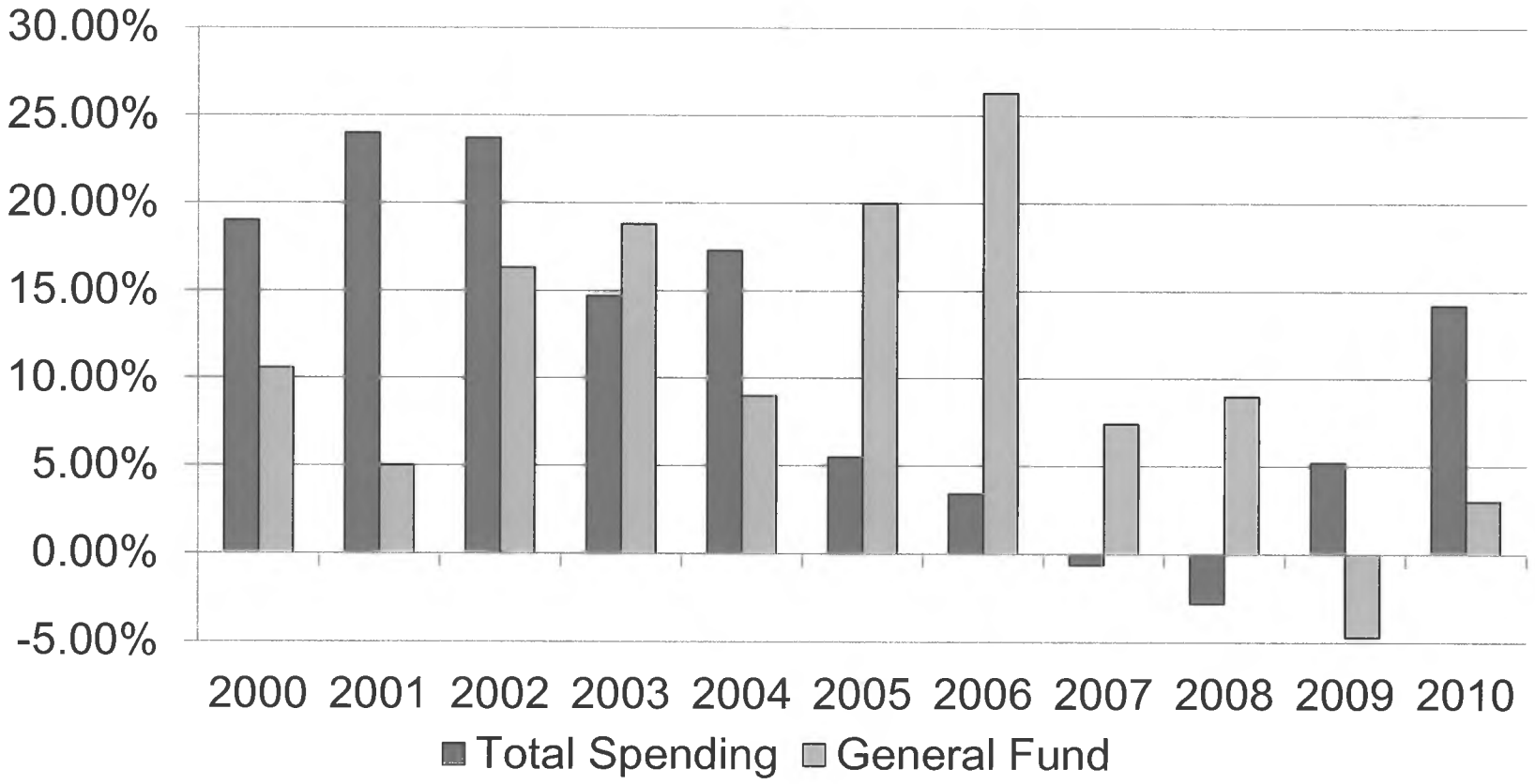
Total Medicaid Spending Growth, U.S. FY 2000 - FY 2010



SOURCE: FY 2011 estimated by HMA. 2009 and 2010 from: Vernon Smith, Kathy Gifford, Eileen Ellis, Robin Rudowitz. Caryn Marks and Molly O'Malley, "The Crunch Continues: Medicaid Spending, Coverage and Policy in the Midst of a Recession," The Kaiser Commission on Medicaid and the Uninsured, September 2009. http://www.kff.org/medicaid/7985.cfm

Figure 5

Total Medicaid Spending Growth, State of Alaska FY 2000 - FY 2010



Source: FY11 DHSS Budget Overview Book, p. 25. Updated with FY10 Actuals with data from ALDER

Figure 6

End Of ARRA FMAP in July 2011

- On average, states will see an increase in the non-federal share by over 30% due to loss of FMAP inflation and enrollment growth
- California with a 50% FMAP could see 30% growth in their non-federal share
- Arkansas with a 71.37% FMAP could see 44%
- Florida with a 55.45% FMAP could see 36%
- **Alaska will see a 38% increase in the non-federal share due to loss of FMAP, inflation, and enrollment growth.**

Examples for other states assume just a 5% cost growth

Figure 7

Options

- Eligibility
- Provider Rates
- Benefits
- Utilization Controls
- Improved Purchasing
- Cost Sharing
- Anti-Fraud

Sort of like choosing your poison…

Figure 8

Eligibility

- Normally an option states use to control budget
- This option is prevented by Maintenance Of Effort requirements
  - ARRA
  - PPACA until 2014
- Cannot adopt more restrictive standards, methodologies or procedures

Figure 9

Provider Rates

- Most common reduction by states
- Many rate reduction options
- Considerations
  - Reducing rates in one area may cause cost increases in another
  - Potential litigation
  - CMS approval of State Plan Amendment (SPA)
  - Impact on access and quality of care
  - Provider taxes affect state's ability to reduce rates

Figure 10


Medicaid Physician Fees--25 Highest Paying States
WY
AK
NM
AZ
NV
ID
MT
ND
NE
DE
OK
CT
IA
NC
SD
VT
KS
SC
WA
LA
GA
OR
VA
AL
AR
0.50
1.00
1.50
Data show Medicaid-to-Medicare payment ratios, where Medicare fees are adjusted for geographic cost differences. Source: Zuckerman et al., Health Affairs, April 2009

Figure 11

Payment Comparisons

2009 Payment Levels for Level 5 Office Visit (99215)	Office Site	Hospital Site
Alaska Medicaid	$ 209.11	$ 209.11
Alaska Medicare	$ 164.32	$ 135.62
Washington Medicaid	$ 76.00	$ 59.62
Montana Medicaid	$ 129.21	$ 104.39

Figure 12

Benefits

- States that provide optional benefits can eliminate them for adults
  - EPSDT (Early Periodic Screening, Diagnosis, and Treatment) and nursing facility services are not optional
- States can establish limits on benefits for certain adults
  - Can be soft or hard limits

Figure 13

Benefits, cont.

- Considerations
  - Reducing benefits in one area may cause cost increases in another
  - Federal Litigation-Medicaid Rules and Olmstead
  - May need to address transition issues
  - CMS approval of SPA
  - Impact on access and quality of care

Figure 14

Mandatory vs. Optional benefits

- Inpatient hospital
- Outpatient hospital
- Physicians
- Nurse midwives
- Lab and X-ray
- Advanced Nurse Practitioners
- Early Periodic Screening, Diagnosis, and Treatment
- Family planning services
- Pregnancy-related services
- Nursing facility (NF) services
- Home Health (NF qualified)
- Medical/surgical dental services
- MH Rehab/Stabilization
- Diagnostic/Screening/Preventive
- Therapies (OP, PT, SLP)
- Inpatient psychiatry <21 years
- Drugs
- Intermediate Care Facility/Mental Retardation
- Personal care
- Dental
- Other home health
- Other licensed practitioners
- Transportation
- Targeted Case Management

Figure 15

Utilization Controls

- States may impose utilization controls to ensure appropriateness of treatment being funded
- Wide range of controls and screens
  - Prior Authorization
  - Post payment reviews
  - Hard or soft edits
  - Bundling, unbundling, and order of billing
  - New edits and audits for FFS (fee-for-service)

Figure 16

Improved Purchasing

- Medicaid has significant market share
- Can be used to reduce cost and increase quality
- Range of benefits including drugs, DME, medical supplies, etc.
- Provider and manufacturer contracting
- Centers of Excellence

Figure 17

Cost Sharing

- Recipient pays a portion of the cost of services
- Personal responsibility-reduction in inappropriate utilization
- Recipient assumes a portion of responsibility for services
- Considerations
  - May cause care to be delayed resulting in higher cost care later
  - Medicaid Rules complex and prescriptive
  - May result in a reduction in provider revenues

Figure 18

Existing Cost Sharing in Alaska

- $50 per day, up to a maximum $200 per discharge, for inpatient hospital services
- 5% of charges for outpatient hospital services
- $3 per day for physician services
- $2 for each prescription filled/refilled

Figure 19

BUT....Services exempt from cost sharing requirements:

- services provided to a recipient under age 18
- services provided to a recipient in a long term care facility
- services provided to a pregnant woman, including postpartum services
- family planning services and supplies
- emergency services

Figure 20

Services exempt from cost sharing, continued

- hospice care services
- tribal health services provided to an American Indian or an Alaska Native
- services provided to an individual who is eligible for both Medicare and Medicaid when Medicare is the primary payer of the service

Figure 21

AND…
Inability to Pay Cost Share

42 CFR 447.15

The provider may **not** deny services to any eligible individual on account of the individual's inability to pay the cost sharing amount

Figure 22

Anti-Fraud

- In some states may be an untapped area for savings
- Fraud in Medicaid is a reality
- Numerous methods and vendors
- Fraud undermines the entire program
- Politically popular reduction

Figure 23

Anti-fraud efforts, audits, and other activities in Alaska

- Surveillance Utilization Review (SUR)
- Audits required by AS 47.05.200
- Credit Balance Audits
- Focused reviews
- CMS Medicaid Integrity Program
- Payment Error Rate Measurement
- "Cluster Audits"
- Medicaid Recovery Audit Contractors
- Medicaid Fraud Control Unit (MFCU)

Figure 24

Provider Taxes

- Provides a means to generate revenue specific to fund Medicaid
- Use is growing as budgets decrease
- Can provide needed provider rate increases/avoid decreases
- Can provide money for the state
- Some provider types work better than others
- Federal rules complex but taxes can work

Figure 25

Provider Tax Considerations

- Alaska has never pursued provider taxes
- Unlikely in a state with an aversion to any kind of taxes
- Taxes are levied against all providers of a certain type or group, regardless of whether each provider has Medicaid patients. For this reason, hospitals and nursing homes are provider types that are more often taxed as they all have Medicaid patients. On the other hand, not all physicians have Medicaid patients.

Figure 26

Provider Tax Considerations, cont.

- Taxation will affect current payment methodologies. Tax payments could be accounted for in cost-based payment methodologies for hospitals and nursing homes
- Where used, the industry is more than not in support
- If Alaska Medicaid cuts funding, industry support may develop.
- If implemented in Alaska, there will be a high degree of CMS oversight

Figure 27

Revenue Maximization

- While most states have focused on this, still may be opportunities.
- Allowable federal funding can replace state funding
- States should make sure their reviews are current
- Opportunities with state and local programs and certain inmate care

Figure 28

Alaska Revenue Maximization

- When Medicaid-eligible IHS beneficiaries receive services at IHS facilities, the State receives 100 percent FMAP (Federal Medical Assistance Percentage).
- In SFY 2010, if **all** Alaska Native Medicaid recipients had received services **exclusively** from IHS facilities, it would have saved Alaska Medicaid about $108 million GF.

Figure 29

Third Party Liability

- Provides an opportunity to shift costs or collect money from other liable 3rd party entities
- Wide range of programs and activities
- Electronic matches can improve effectiveness
- Contingent fee contracts are matchable

Figure 30

Alaska Medicaid TPL Activity

- Recovery
  - Post-payment (Net recovery $9.1 M)
  - Accident, Estate Recovery, and Trust ($2.5 M recovered)
- Cost Avoidance
  - HIPP (Health Insurance Premium Payment)
  - Data Matches with Insurance Carriers
  - Medicare Buy-in (pay Medicare Part and A and B premiums; net savings $35.4 M)

Figure 31

Next Meeting
What other States are doing

- Positive policy benefits
- Cost containment
- Benefits
- Deficit Reduction Act
- Pharmacy cost containment
- Care management
- Quality measures
- EMR/EHR and E-Prescribing
- Provider taxes