

**2/13/12**  
**DEPARTMENT OF**  
**HEALTH AND**  
**SOCIAL**  
**SERVICES:**  
**MEDICAID 101**  
**AND THE**  
**AFFORDABLE CARE**  
**ACT**

<TARGET><BILL></BILL><SUBJECT>2-13-12 DEPARTMENT OF  
HEALTH AND SOCIAL SERVICES MEDICAID 101 AND THE  
AFFORDABLE CARE ACT</SUBJECT><COMM>HFIN27</COMM></TARGET>

Department of Health & Social Services



*Partnerships*

**Medicaid Review 2012**

Kimberli Poppe-Smart, Deputy Commissioner





## Roadmap for Today's Discussion

- Medicaid 101
- Medicaid Task Force Initiatives
- Affordable Care Act Implications - *potential*



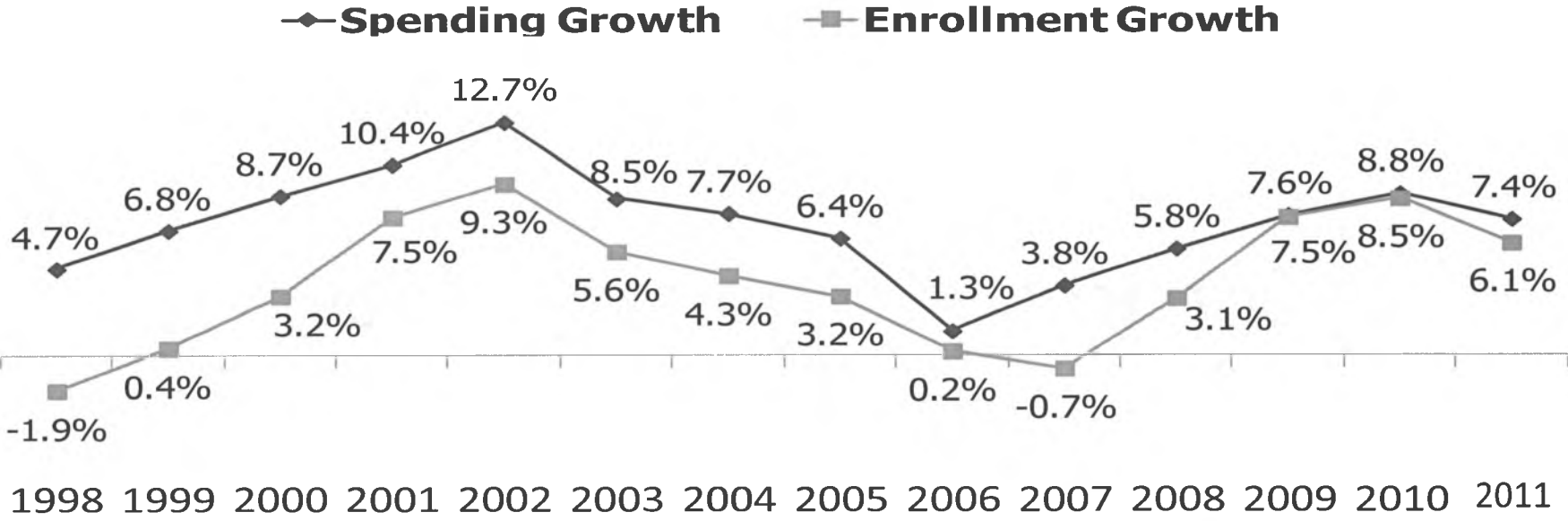


# Medicaid as an Integral Health Care Component





## National Percent Change in Total Medicaid Spending and Enrollment, FY 1998 – FY 2011



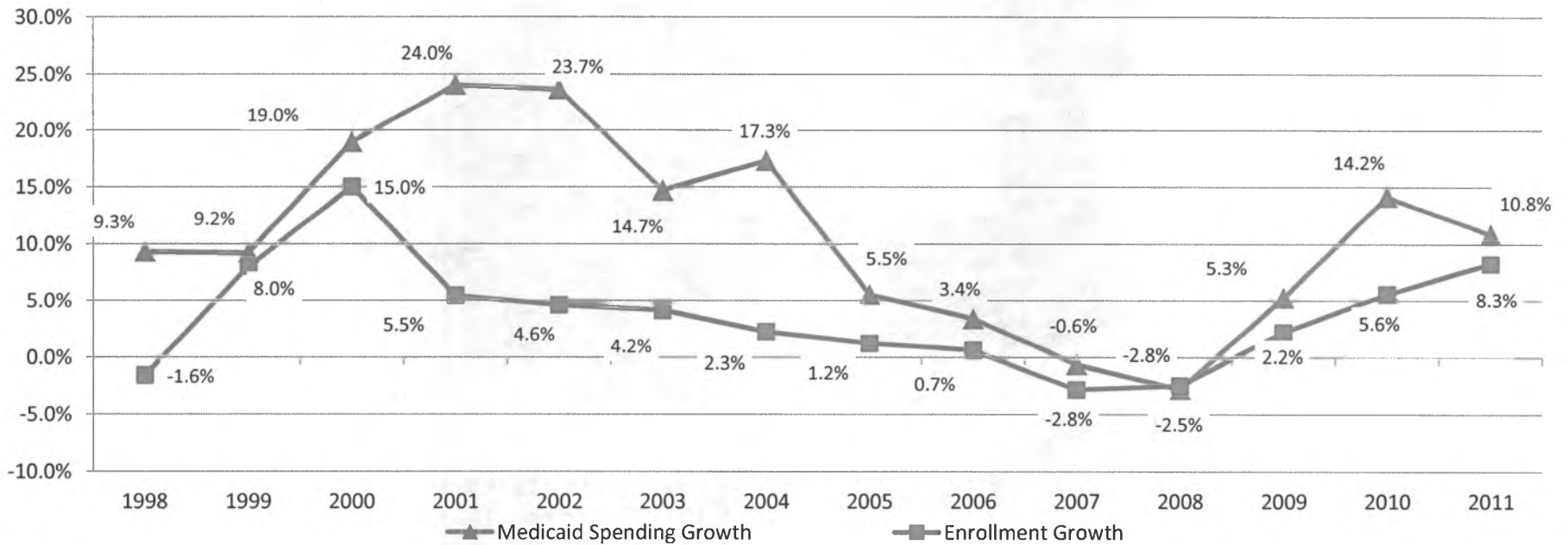
adopted

NOTE: Enrollment percentage changes from June to June of each year. Spending growth percentages in state fiscal year.  
 SOURCE: Enrollment Data for 1998-2009: *Medicaid Enrollment in 50 States*, KCMU. Spending Data from KCMU Analysis of CMS Form 64 Data for Historic Medicaid Growth Rates. FY 2010 and FY 2011 data based on KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2010.





## Percent Change in Alaska's Total Medicaid Spending and Enrollment, FY 1998 – FY 2011

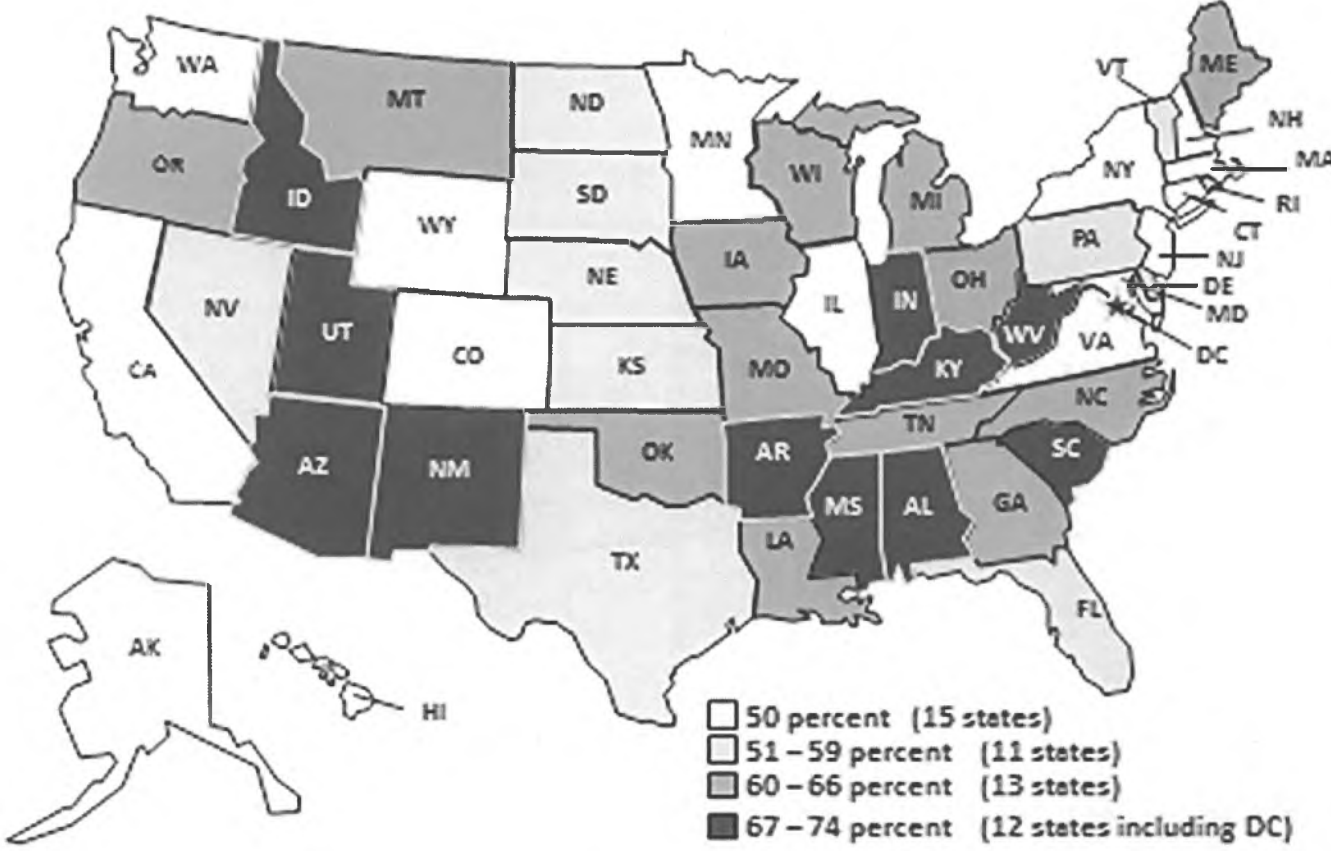


Source: ABS for spending; MMIS / JUCE for enrollment. See also pages 40-41 of FY2013 DHSS Budget Overview.





# Statutory Federal Medical Assistance Percentages (FMAP). FY 2012

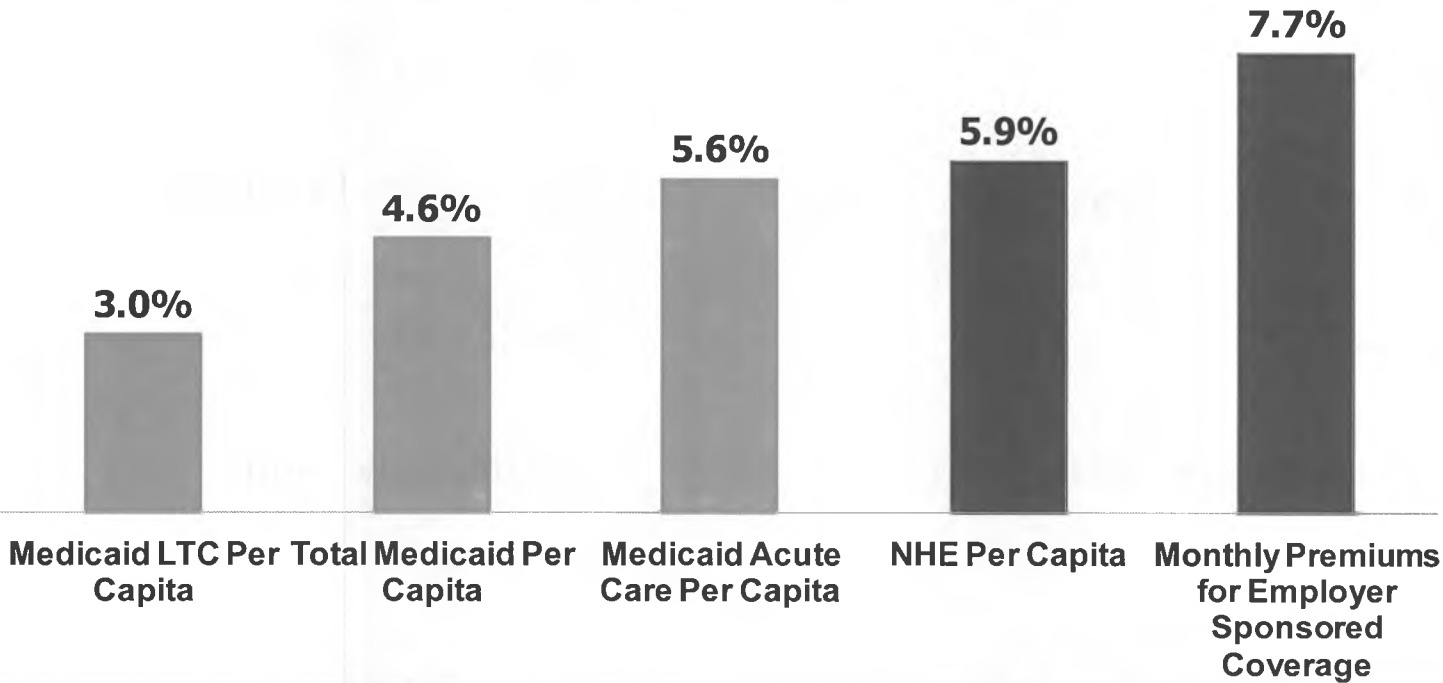


NOTE: Rates are rounded to nearest percent. These rates will be in effect Oct. 1, 2011.  
SOURCE: Federal Register, Nov., 10 2010 (Vol. 75, No. 217), pp. 69082-69083  
<http://edocket.access.goo.gov/2010/pdf/2010-28319.pdf>



# Medicaid spending growth per enrollee has been slower than growth in private health spending

## Spending Growth 2000-2009



SOURCE: Urban Institute, 2010. Estimates based on data from Medicaid Financial Management Reports (HCFA/CMS Form 64), Medicaid Statistical Information System (MSIS), and KCMU/HMA enrollment data. Expenditures exclude prescription drug spending for dual eligibles to remove the effect of their transition to Medicare Part D in 2006.





# Controlling Growth In Medicaid

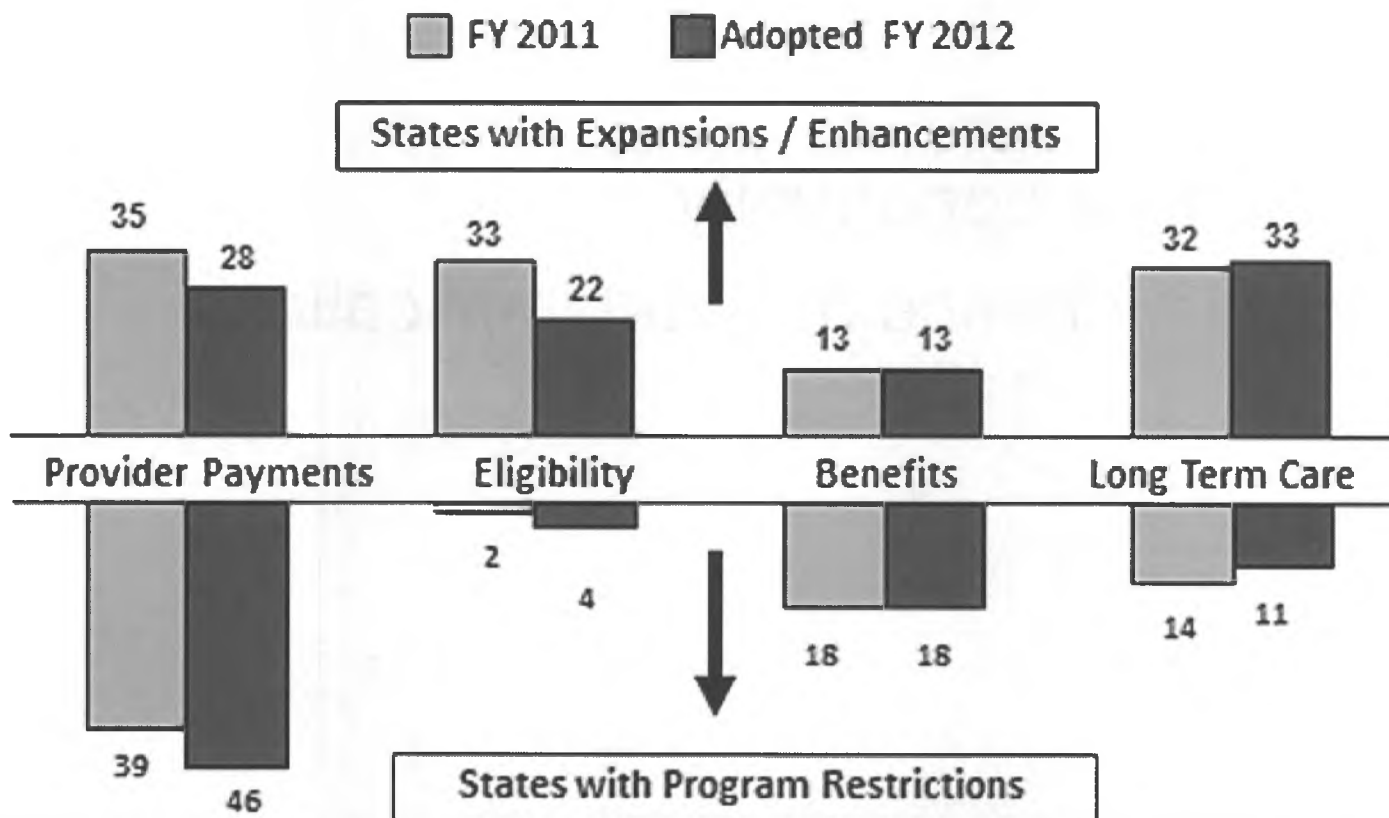
## *The Options are Limited*

•Eligibility	•Compliance/Anti-Fraud
•Covered Services	•Innovations in Service Delivery
•Rates	•Technology
•Utilization Controls	•Maximize Revenue





## State Policy Actions Implemented in FY 2011 and Adopted for FY 2012



NOTE: Past survey results indicate not all adopted actions are implemented. Provider payment restrictions include rate cuts for any provider or freezes for nursing facilities or hospitals.

SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2011.



## Eligibility

- Limited opportunity
- Maintenance of Effort implications





## Covered Services

- Optional Benefits, *but not really*
- Limits on benefits?
- Considerations
  - Shifting bulge
  - Medicaid rules, Olmstead and other implications
  - CMS approval process
  - Access and quality impacts





## Mandatory

- 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

## Optional

- 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





## Rates

- Most common reduction by states
- 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





## Payment Comparisons

	Payment Levels	
	Office Visit (99215)	Obstetrical Care (59400)
Alaska Medicaid	\$221.58	\$2821.81
Alaska Medicare	\$177.40	\$2354.90
Alaska Commercial Mean	\$290.64	\$4704.80
Washington Medicaid	\$76.86	\$2034.50
Washington Commercial Mean	\$183.24	\$2601.20
North Dakota Medicaid	\$186.19	\$2339.40
Idaho Medicaid	\$117.01	\$1539.21

Milliman Client Report: Physician Payment Rates in Alaska and Comparison States prepared for Alaska Health Care Commission 2011





## 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)





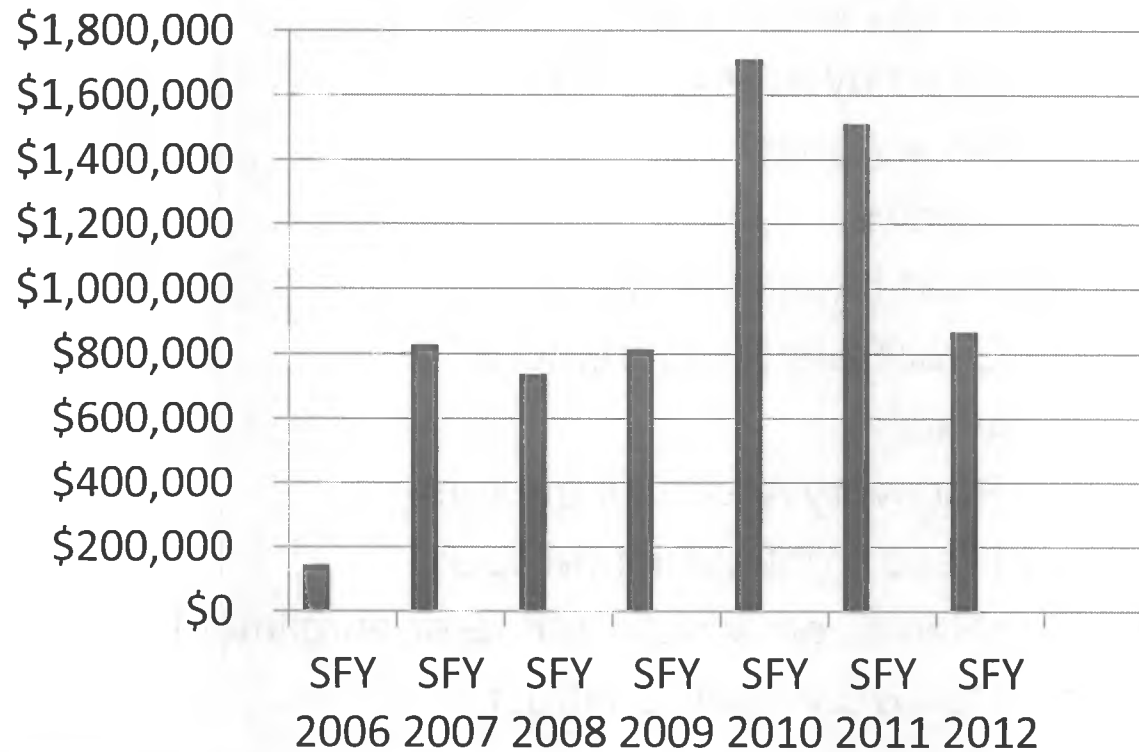
## Compliance / Anti-Fraud

- 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





## Program Integrity Collections



SFY 2006: \$ 144,205  
(Only last two quarters available)





## Existing Compliance Efforts 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)
- Provider, referrer, prescriber, renderer enrollment
- Medicaid Recovery Audit Contractor





## Innovations in Service Delivery/Payment

- Medical Home
- Tribal Health – *exemplar of alternative provider types*
- Bundled services
- Integrated BH/Primary care services
- *more*





## Technology

- Operational efficiencies
- Care delivery implications





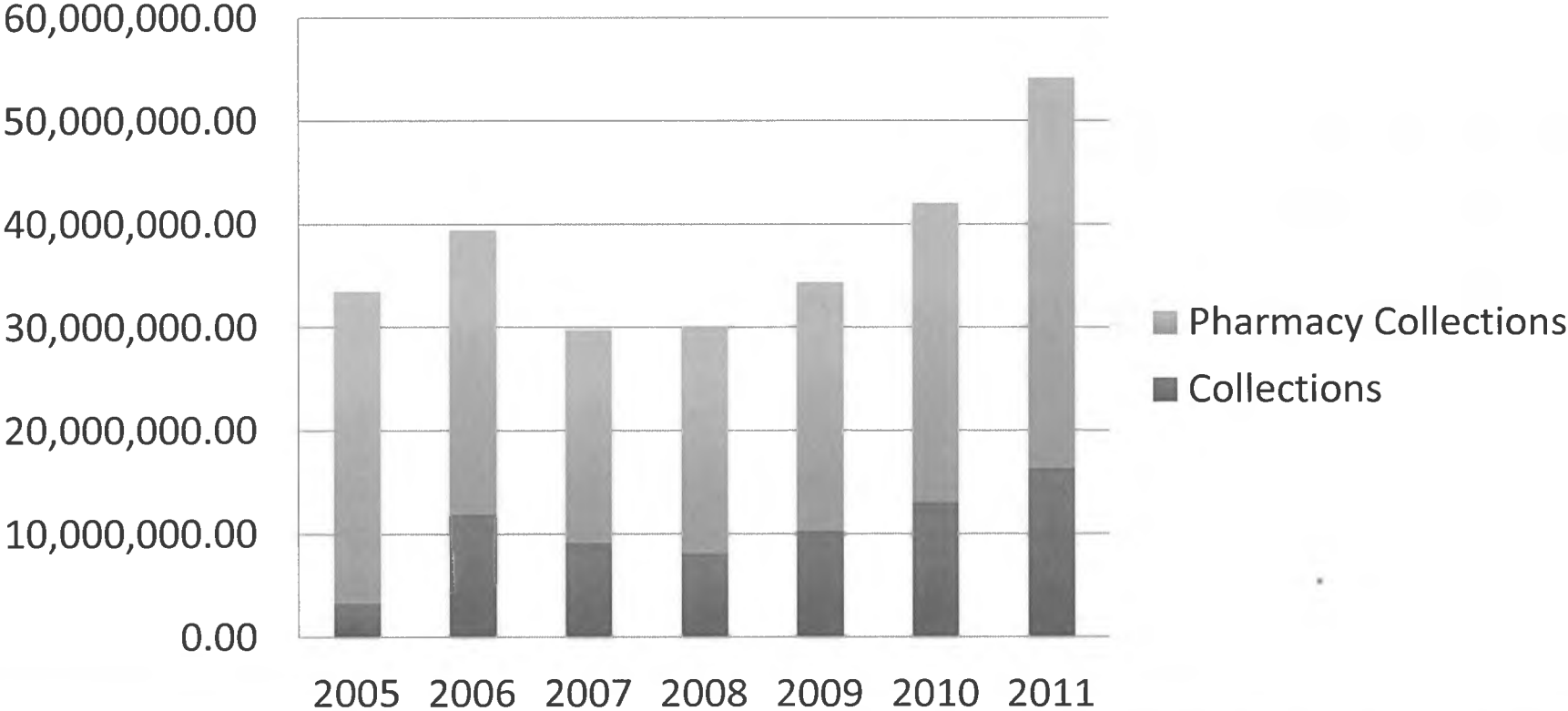
## Maximize Match/Collections/Refinancing Opportunities

- Replace state funding with federal funding where allowable
- Tribal Partner opportunities





# Accounting & Recovery Collections





## Medicaid Task Force

- Medical Home – primary, integrated care
  - Consultant
  - Pilots
  - Technical assistance
  - Data

*Estimate of cost avoidance: \$78,00 - \$165,000/1,000 participants. Mature programs are showing 10% savings.*





- Care Management Program – expanded element of medical home with focus on recipients at highest risk who offer the greatest potential for improvements in both health outcomes and enhanced funding/cost avoidance.

*Estimate of cost avoidance: Enhanced FMAP for 8 quarters for each participant. Conservative savings estimate of \$1,040,000 for 7,500 participants.*





- Pharmacy Initiatives

- Increased substitution to generic medications

- *Phase I: Q2 \$1,250,000 cost avoidance annualized at \$5,000,000*

- Increased Generic Medication through edits/PA

- *Phase 1: 6 months \$1,405,938 cost avoidance annualized at \$2,810,000*

- *State Maximum Allowable Cost*

- *Fully implemented: \$500,000 cost avoidance annualized at \$5.5-\$6 million*





- Pharmacy *continued*
  - Enhanced preferred Drug List – not implemented  
*Estimate of cost avoidance analysis underway.*
  - Psychiatric Medication Policy – not implemented  
*Estimate of cost avoidance \$182,000 – right care.*
- Pharmacy initiative cost avoidance through Q2: **\$4,655,938**  
annualized to **\$13,310,000 - \$13,810,000**





- Community First Choice – home and community based personal care services. Consultant engaged, design discussions and viability analysis underway.
  - *Estimate of cost avoidance: Enhanced FMAP of 6%.*





# Affordable Care Act

