

**SB 74**  
**BILL INFO**  
**&**  
**RESEARCH**  
**(FILE 1)**

<TARGET><BILL>SB 74</BILL><SUBJECT>SB 74 BILL  
INFORMATION and RESEARCH (FILE  
1)</SUBJECT><COMM>SHSS29</COMM></TARGET>

# Alaska State Legislature

SENATOR PETE KELLY

SESSION:  
Alaska State Capitol  
Juneau, AK 99801  
Phone: (907) 465-3709  
Fax: (907) 465-4714



INTERIM:  
1292 Sadler Way Suite 308  
Fairbanks, AK 99701  
Phone: (907) 451-4347  
Fax: (907) 451-4348

## Sponsor Statement – Senate Bill 74

“An Act relating to permanent fund dividends; relating to a medical assistance reform program; establishing a personal health savings account program for medical assistance recipients; relating to the duties of the Department of Health and Social Services; establishing medical assistance demonstration projects; and relating to a study by the Department of Health and Social Services.”

Senate Bill 74 starts the process of cost containment and reform needed to slow the growth of the Alaska Medicaid program. Medicaid has grown to \$1.8 Billion of the annual operating budget, and has accounted for 22% of the total UGF increases over the last ten years. The current and former administrations have testified the Medicaid program, as it stands, is not sustainable. Low oil prices and billions of dollars in revenue shortfalls have forced us to change how we do business. In July 2013, the Medicaid Budget Group of the Department of Health and Social Services reported the total spending on Medicaid services will reach \$6.3 billion in 2032, including \$2.8 billion in state matching funds. If we don't act now to bend the growth curve of Medicaid, many of our most venerable Alaskans will be without critical health care services they need.

SB 74 takes a measured approach by setting a framework for a medical assistance reform program into statute (Section 2). This program requires the Department of Health and Social Services to expand the use of telemedicine, enhance fraud prevention and enforcement, undertake pharmacy initiatives, reduce the cost of the state's home and community-based services with a new waiver program, and more. Reforms and costs containment to the Medicaid program will also be accomplished through two new demonstration projects through the Centers for Medicaid and Medicare Services (Sections 3 and 6).

SB 74 directs DHSS to initiate a managed care demonstration project for individuals enrolled in Denali KidCare and allow others to opt in (Section 5). According to the Kaiser Family Foundation, thirty-nine states now contract with comprehensive managed care organizations (MCOs) to serve at least some Medicaid beneficiaries, and nationally, over half of all Medicaid beneficiaries get their care through these plans. Alaska can no longer afford to be one of the twelve outliers.

Managed care is frequently maligned as dis-incentivizing proper or appropriate care. Rather, health plan management has shown that it actually improves care outcomes, grants better,

appropriate access and saves money. Most states employ some form of managed care in their Medicaid programs. It works much like traditional health insurance where a Medicaid member becomes a subscriber in the health plan and the plan is paid by the state Medicaid office via a capitated rate, a global rate or a pass through on fee for service billings. The state then invoices the federal government and is paid at the prevailing Medicaid rate. This is relatively simple to implement and there are many examples of successful implementations across the nation.

The new reform program will also look at payment redesign (Section 2). Alaska has some of the highest Medicaid rates in the nation and has not employed many of the rate innovations of other states or those of Medicare, the other and largest government payer. These innovations frequently streamline the payment process, eliminate billing and payment irregularities and eliminate payment errors. In addition to Medicare, many insurance carriers and 47 of 50 states employ the Diagnosis Related Group (DRG) Medicaid payment mechanism and two others are in stages of implementation by July 2015. There are several other payment blueprints in place in other states that can be employed.

The use of telemedicine for primary care and urgent care will also be expanded under SB 74 (Sections 2 and 5). A study by Alaska Native Tribal Health Consortium (ANTHC) found telemedicine averted the need for travel in 40% of cases reviewed using telemedicine. ANTHC is leading the state's charge on telemedicine, and should be built on for even greater access statewide.

SB 74 begins the process to explore privatizations (Section 8). The department is directed to conduct feasibility studies at Alaska Psychiatric Institute, Alaska Pioneer Homes, and select facilities of the division of juvenile justice (DJJ). There are various options for privatization the department can explore through the studies that would result in the best options for Alaskan consumers while ensuring state dollars are stretched as far as possible. Some options include turning over DJJ facilities to local tribes in order to create a residential psychiatric treatment center; turning an entirely GF program into a tribal run Medicaid reimbursable program providing culturally relevant services.

The call to reform Medicaid is not new. In the fall of 2010 the Medicaid Task force convened and developed a report for the Governor in May 2011. The Medicaid Reform Advisory Group was created in December 2013, and worked up until the transition to the new administration. While several of the reform measures of these groups were implemented and helped to contain costs, we must build on their efforts and go even further. SB 74 gives the legislature the ability to fundamentally review how the state is doing business in the Medicaid program. In these serious budget times, reform cannot wait.

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## Sectional Analysis – Senate Bill 74

“An Act relating to permanent fund dividends; relating to a medical assistance reform program; establishing a personal health savings account program for medical assistance recipients; relating to the duties of the Department of Health and Social Services; establishing medical assistance demonstration projects; and relating to a study by the Department of Health and Social Services.”

**Section 1:** Allows recipients of medical assistance to have 10 percent of their annual permanent fund dividends deposited into a personal health savings account.

**Section 2:** Requires the Department of Health and Social Services (the department) to design and implement a medical assistance (Medicaid) reform program.

**Section 3:** Requires the department to develop and implement a personal health savings account program for recipients of medical assistance.

**Section 4:** Sunsets personal health savings accounts in Sections 1 and 3 and the medical assistance reform program in Section 2 on October 1, 2022.

**Section 5:** Required the department to develop a managed care demonstration project. The managed care program would be mandatory for individuals eligible for Denali Kidcare, and optional for other Medicaid recipients.

**Section 6:** Required the department to design and implement a demonstration project to reduce nonurgent use of emergency departments by Medicaid recipients.

**Section 7:** Requires the department to apply for a provider choice waiver if the waiver is necessary to implement portions of the medical assistance reform program established under Section 2.

**Section 8:** Requires the department to conduct a study analyzing the feasibility of privatizing certain services.

**Section 9:** Requires the department to amend the state Medicaid plan and apply for any waivers necessary to implement the projects and programs described in the bill.

**Section 10:** Sunsets Section 11 on October 1, 2022.

**Section 11:** Provides that Section 1-3 of the bill take effect only if the department certifies to the revisor of statutes, on or before October 1, 2017, that all of the provisions enacted by Sections 2, 3, 5 -7, and 9 of the bill have been approved by the United States Department of Health and Human Services.

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## MEMORANDUM

To: Senator Bert Stedman, Chair  
Senate Health & Social Services Committee

FROM: Senator Pete Kelly 

Date: 3/18/2015

Re: Hearing Request for SB 74

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I am requesting SB 74 – Medicaid Reform to be scheduled at your earliest convenience to be heard in Senate Health & Social Services.

Heather Shadduck is the staff assigned to SB 74 and can be reached with any questions at 465-2138.

## Memorandum (April 8, 2015)

### Summary of Changes SB 74 to CS SB 74 version "I"

The committee substitute for SB 74 version I, makes the following substantive changes:

- Deletes sections 1 and 3 of SB 74 related to health savings accounts and funding the accounts with 10% of a recipients permanent fund dividend.
- As a conforming change, deletes language in section 4 of SB 74 that would have put a sunset date on the health savings account provisions.
- Adds a new section 1 related to false claims for medical assistance and providing for a civil penalty to be imposed by either a court or an administrative agency and providing for enhanced damages to be awarded to the state.
- Amends Section 2 of SB 74 to make a conforming change by deleting subparagraph (1) which related to health savings accounts and renumbering the remaining subparagraphs.
- Amends Section 2, subparagraph (2) of SB 74 by adding language requiring the DHSS reform program to include referrals for career and education services.
- Amends Section 2, subparagraph (4) of SB 74 by adding "behavioral health" to the list of services that telemedicine should be expanded to include.
- Amends Section 2, subparagraph (9) of SB 74 by adding language providing that the payment process should be reformed by implementing fee agreements based on performance measures that include premium payments for centers of excellence and penalties for certain hospital related outcomes, such as hospital acquired infections, readmissions, and failures of outcomes.

- Amends section 2, of SB 74 by adding a new section (b) that requires the identify areas where access to telemedicine would be most effective and to coordinate with Indian Health Services providers where appropriate to gain access to telemedicine equipment.
- Amends Section 2(b) of SB 74, the report section on reforms by changing the annual report due date from 10 days after session starts to October 15 of each year, and adds a number of subparagraphs in (4) – (13) that are designed to provide information to the legislature on the progress of reforms and other information relevant to management of the program.
- Amends Section 2 of SB 74 by adding a new section (d) that is a definition of telemedicine.
- Section 3 of version I relates to direction to the department on reducing use of emergency room services. This was section 6 in the original version of SB 74. There was no change between the two sections other than numbering.
- Section 4, the repeal section of SB 74 is deleted. It repealed the health savings account sections and the reform sections. While reform provisions are included in version I, they are not subject to sunset.
- It is replaced with a new section 4 relating to efforts at fighting fraud or waste of Medicaid funds and reporting the results to the Legislature.
- Section 5 of SB 75, the section on managed care and a demonstration project using persons enrolled in Denali KidCare has been amended to be broader in scope in terms of both the types of actions the Commissioner can take and the population groups in Medicaid that can be included. This provides flexibility to the department to obtain the greatest possible coverage and savings.
- The rest of the sections in the CS are not substantively different than SB 74 or are related to implementation of the bill, section 7 (Medicaid Choice Waiver); section 8 (Transition Regulations); Section 9 (Conditional Effect), and sections 6,7,8 have an immediate effective date.

29-LS0692\I  
Glover  
4/7/15

**CS FOR SENATE BILL NO. 74( )**  
**IN THE LEGISLATURE OF THE STATE OF ALASKA**  
**TWENTY-NINTH LEGISLATURE - FIRST SESSION**

**BY**

**Offered:**  
**Referred:**

**Sponsor(s): SENATORS KELLY, Giessel**

**A BILL**  
**FOR AN ACT ENTITLED**

1 **"An Act relating to a medical assistance reform program; relating to the duties of the**  
2 **Department of Health and Social Services; establishing medical assistance**  
3 **demonstration projects; relating to civil penalties for medical assistance fraud; relating**  
4 **to studies by the Department of Health and Social Services; relating to cost-containment**  
5 **measures for medical assistance; and providing for an effective date."**

6 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

7 **\* Section 1.** AS 47.05 is amended by adding new sections to read:

8 **Sec. 47.05.202. False claims for medical assistance; civil penalty.** (a) A  
9 person may not

10 (1) knowingly submit, authorize, or cause to be submitted to a medical  
11 assistance agency a false or fraudulent claim for payment or approval;

12 (2) knowingly make, use, or cause to be made or used, a false record or  
13 statement to get a false or fraudulent claim for payment paid or approved by the

1 medical assistance program under AS 47.07;

2 (3) conspire to defraud the medical assistance program by getting a  
3 false or fraudulent claim paid or approved;

4 (4) knowingly make, use, or cause to be made or used, a false record or  
5 statement to conceal, avoid, or decrease an obligation to pay or transmit money or  
6 property to the medical assistance program under AS 47.07.

7 (b) A violation under this section is punishable by a civil penalty of not less  
8 than \$100 and not more than \$25,000 in addition to the costs and fees associated with  
9 an enforcement action brought under AS 37.10.090 and 37.10.100.

10 (c) In addition to a civil penalty and costs and fees assessed under (b) of this  
11 section, and except as provided under (d) of this section, a court shall award damages  
12 in an amount that is three times the amount of actual damages sustained by the state  
13 for a violation of (a) of this section.

14 (d) A court may reduce the damages assessed for a violation of (a) of this  
15 section to the amount of actual damages sustained by the state and waive the civil  
16 penalty allowed under (b) of this section if the court finds, by a preponderance of the  
17 evidence, that the person who committed the violation furnished a state official who is  
18 investigating the violation with all information known to that person about the  
19 violation and fully cooperated with the investigation, and the information and  
20 cooperation led state officials to discover additional violations within 30 days after  
21 receiving the information.

22 (e) The damages and penalties available under this section are not exclusive,  
23 and the remedies provided are in addition to other remedies provided by applicable  
24 law.

25 (f) In this section, "knowingly" means that a person, with or without specific  
26 intent to defraud,

27 (1) has actual knowledge of the information;

28 (2) acts in deliberate ignorance of the truth or falsity of the  
29 information; or

30 (3) acts in reckless disregard of the truth or falsity of the information.

31 **Sec. 47.05.203. Department authority to impose civil penalties.** The

1 department may adopt regulations to assess the civil penalties provided under  
2 AS 47.05.202(b) against a medical assistance provider, and, if the penalties are not  
3 paid, the department may refer the case to the attorney general for prosecution under  
4 AS 47.05.202.

5 \* **Sec. 2.** AS 47.05 is amended by adding a new section to read:

6 **Sec. 47.05.260. Medical assistance reform program.** (a) The department  
7 shall adopt regulations to design and implement a program for reforming the state  
8 medical assistance program under AS 47.07. The reform program must include

9 (1) referrals to community and social support services, including career  
10 and education training services available through the Department of Labor and  
11 Workforce Development under AS 23.15, the University of Alaska, or other sources;

12 (2) distribution of an explanation of medical assistance benefits to  
13 recipients for health care services received under the program;

14 (3) expanding the use of telemedicine for primary care, behavioral  
15 health, and urgent care;

16 (4) enhancing fraud prevention, detection, and enforcement;

17 (5) reducing the cost of behavioral health, senior, and disabilities  
18 services provided to recipients of medical assistance under the state's home and  
19 community-based services waiver under AS 47.07.045;

20 (6) pharmacy initiatives;

21 (7) enhanced care management;

22 (8) redesigning the payment process by implementing fee agreements  
23 based on performance measures that include premium payments for centers of  
24 excellence according to nationally acceptable criteria and penalties for hospital  
25 acquired infections, readmissions, and failures of outcomes;

26 (9) stakeholder involvement in setting annual targets for quality and  
27 cost-effectiveness;

28 (10) to the extent consistent with federal law, reducing travel costs by  
29 requiring a recipient to obtain medical services in the recipient's home community, to  
30 the extent appropriate services are available in the recipient's home community.

31 (b) The department shall identify the areas of the state where improvements in

1 access to telemedicine would be most effective in reducing the costs of medical  
2 assistance and improving access to health care services for medical assistance  
3 recipients. The department shall make efforts to improve access to telemedicine for  
4 recipients in those locations. The department may enter into agreements with Indian  
5 Health Service providers, if necessary, to improve access by medical assistance  
6 recipients to telemedicine facilities and equipment.

7 (c) On or before October 15 of each year, the Department of Health and Social  
8 Services shall prepare a report and submit the report to the senate secretary and the  
9 chief clerk of the house of representatives and notify the legislature that the report is  
10 available. The report must include

- 11 (1) realized cost savings related to reform efforts under this section;
- 12 (2) realized cost savings related to medical assistance reform efforts  
13 undertaken by the department other than the reform efforts described in this Act;
- 14 (3) a statement of whether the Department of Health and Social  
15 Services has met annual targets for quality and cost-effectiveness;
- 16 (4) recommendations for legislative or budgetary changes related to  
17 medical assistance reforms during the next fiscal year;
- 18 (5) changes in federal laws that the department expects will result in a  
19 cost or savings to the state of more than \$1,000,000;
- 20 (6) a description of any medical assistance grants, options, or waivers  
21 the department applied for in the previous fiscal year;
- 22 (7) the results of demonstration projects the department has  
23 implemented;
- 24 (8) legal and technological barriers to the expanded use of  
25 telemedicine, improvements in the use of telemedicine in the state, and  
26 recommendations for changes or investments that would allow cost-effective  
27 expansion of telemedicine;
- 28 (9) the percentage decrease in costs of travel for medical assistance  
29 recipients compared to the previous fiscal year;
- 30 (10) the percentage decrease in the number of medical assistance  
31 recipients identified as frequent users of emergency departments compared to the

1 previous fiscal year;

2 (11) the percentage increase or decrease in the number of hospital  
3 readmissions within 30 days after a hospital stay for medical assistance recipients  
4 compared to the previous fiscal year;

5 (12) the percentage increase or decrease in average state general fund  
6 spending for each medical assistance recipient compared to the previous fiscal year;

7 (13) the percentage increase or decrease in uncompensated care costs  
8 incurred by medical assistance providers compared to the percentage change in private  
9 health insurance premiums for individual and small group health insurance.

10 (d) In this section, "telemedicine" means the practice of health care delivery,  
11 evaluation, diagnosis, consultation, or treatment, using the transfer of medical data  
12 through audio, visual, or data communications that are performed over two or more  
13 locations between providers who are physically separated from the recipient or from  
14 each other.

15 \* **Sec. 3.** AS 47.07 is amended by adding a new section to read:

16 **Sec. 47.07.038. Reduction of nonurgent use of emergency department**  
17 **services by medical assistance recipients; project.** (a) On or before September 1,  
18 2015, the department shall design and implement a project to reduce nonurgent use of  
19 emergency departments by recipients of medical assistance under this chapter and  
20 improve appropriate care in appropriate settings for recipients. The project under this  
21 section must include

22 (1) to the extent consistent with federal law, a system for electronic  
23 exchange of patient information among emergency departments;

24 (2) a process for defining and identifying frequent users of emergency  
25 departments;

26 (3) a procedure for educating patients about the use of emergency  
27 departments and appropriate alternative services and facilities for nonurgent care;

28 (4) to the extent consistent with federal law, a process to disseminate  
29 lists of frequent users to hospital personnel to ensure that frequent users can be  
30 identified through the electronic information exchange system described under (1) of  
31 this subsection;

1 (5) a process for assisting frequent users with plans of care and for  
2 assisting patients in making appointments with primary care providers within 96 hours  
3 after an emergency department visit;

4 (6) strict guidelines for the prescribing of narcotics;

5 (7) a prescription monitoring program;

6 (8) designation of medical personnel to review feedback reports  
7 regarding emergency department use.

8 (b) The department shall adopt regulations necessary to implement this section  
9 and request technical assistance from and apply to the United States Department of  
10 Health and Human Services for waivers or amendments to the state plan as necessary  
11 to implement the projects under this section.

12 \* **Sec. 4.** AS 47.07 is amended by adding a new section to read:

13 **Sec. 47.07.076. Report to legislature.** (a) The department and the attorney  
14 general shall annually prepare a report relating to the medical assistance program  
15 under AS 47.07. The report must identify

16 (1) the amount and source of funds used to prevent or prosecute fraud,  
17 abuse, payment errors, and errors in eligibility determinations for the previous fiscal  
18 year;

19 (2) actions taken to address fraud, abuse, payment errors, and errors in  
20 eligibility determinations during the previous fiscal year;

21 (3) specific examples of fraud or abuse that were prevented or  
22 prosecuted;

23 (4) identification of vulnerabilities in the medical assistance program,  
24 including any vulnerabilities identified by independent auditors with whom the  
25 department contracts under AS 47.05.200;

26 (5) initiatives the department has taken to prevent fraud or abuse;

27 (6) recommendations to increase effectiveness in preventing and  
28 prosecuting fraud and abuse;

29 (7) the return to the state for every dollar expended by the department  
30 and the attorney general to prevent and prosecute fraud and abuse;

31 (8) estimated payment error rate measurement for the medical

1 assistance program;

2 (9) results from the Medicaid Eligibility Quality Control program.

3 (b) On or before October 15 of each year, the department shall submit the  
4 report required under this section to the senate secretary and the chief clerk of the  
5 house of representatives and notify the legislature that the report is available.

6 \* **Sec. 5.** The uncodified law of the State of Alaska is amended by adding a new section to  
7 read:

8 **MEDICAID MANAGED CARE OR CASE MANAGEMENT DEMONSTRATION**  
9 **PROJECT.** (a) On or before January 31, 2016, the Department of Health and Social Services  
10 shall design and initiate one or more managed care or case management demonstration  
11 projects. The department shall contract with a third party to provide managed care or case  
12 management services for a group or groups of individuals who qualify for medical assistance  
13 under AS 47.07 and may separate a group or groups of individuals into different managed  
14 care or case management demonstration projects based on efficiency and cost savings. The  
15 purpose of a demonstration project is to ensure sustainability while reducing the cost of  
16 medical assistance payments and increasing access to and improving the quality of care  
17 available to all medical assistance recipients. A project or projects developed under this  
18 section may include

19 (1) comprehensive care management;

20 (2) care coordination, including the assignment of a primary care case  
21 manager located in the local geographic area of the recipient;

22 (3) health promotion;

23 (4) mental health parity as described in 42 U.S.C. 300gg-26.3;

24 (5) comprehensive transitional care from and follow-up to inpatient treatment;

25 (6) individual and family support;

26 (7) referral to community and social support services, including career and  
27 education training services available through the Department of Labor and Workforce  
28 Development under AS 23.15, the University of Alaska, or other sources.

29 (b) The department shall enter into contracts with one or more third-party primary  
30 care case managers, managed care organizations, prepaid ambulatory health plans, or prepaid  
31 inpatient health plans to implement the project established under this section. The contract

1 must provide for a fee based on a per capita expense that is fair and economical. The  
2 department or administrator shall develop a comprehensive system of prior authorizations for  
3 payment of services under the project. However, prior authorization may not be required for  
4 mental health or primary care services.

5 (c) The department or a third-party administrator shall designate health care providers  
6 or one or more teams of health care providers to provide services that are primary care and  
7 patient centered as described by the department for purposes of a project under this section.  
8 The department or a third-party administrator shall enter into necessary provider and fee  
9 agreements. For primary care case managers, the fee agreement must include an incentive-  
10 based management fee system. The fee agreements may not be based on a fee for service but  
11 must be based on performance measures, as determined by the department.

12 (d) A project under this section must include additional cost-saving measures that  
13 include innovations to

14 (1) reduce travel through the expanded use of telemedicine for primary care,  
15 urgent care, and behavioral health services; to the extent legal barriers prevent the expanded  
16 use of telemedicine, the department shall identify those barriers;

17 (2) simplify administrative procedures for providers, including streamlined  
18 audit, payment, and stakeholder engagement procedures.

19 (e) In this section, "department" means the Department of Health and Social Services.

20 \* **Sec. 6.** The uncodified law of the State of Alaska is amended by adding a new section to  
21 read:

22 DEPARTMENT OF HEALTH AND SOCIAL SERVICES FEASIBILITY STUDY.

23 (a) The department shall conduct a study analyzing the feasibility of privatizing services  
24 delivered at Alaska Pioneers' Homes, the Alaska Psychiatric Institute, and select facilities of  
25 the division of juvenile justice. The department shall deliver a report summarizing the  
26 department's conclusions to the senate secretary and the chief clerk of the house of  
27 representatives and notify the legislature that the report is available within 10 days after the  
28 convening of the Second Regular Session of the Twenty-Ninth Alaska State Legislature.

29 (b) In this section, "department" means the Department of Health and Social Services.

30 \* **Sec. 7.** The uncodified law of the State of Alaska is amended by adding a new section to  
31 read:

1 MEDICAID STATE PLAN; WAIVERS; INSTRUCTIONS; NOTICE TO REVISOR  
2 OF STATUTES. The Department of Health and Social Services shall amend and submit for  
3 federal approval a state plan for medical assistance coverage consistent with this Act. The  
4 Department of Health and Social Services shall apply to the United States Department of  
5 Health and Human Services for any waivers necessary to implement this Act. The  
6 commissioner of health and social services shall certify to the revisor of statutes if the  
7 provisions of AS 47.05.260(a)(5), (8), and (10), added by sec. 2 of this Act, the provisions of  
8 AS 47.07.038, added by sec. 3 of this Act, and the provision of sec. 5 of this Act are approved  
9 by the United States Department of Health and Human Services.

10 \* **Sec. 8.** The uncodified law of the State of Alaska is amended by adding a new section to  
11 read:

12 **TRANSITION: REGULATIONS.** The Department of Health and Social Services may  
13 adopt regulations necessary to implement the changes made by this Act. The regulations take  
14 effect under AS 44.62 (Administrative Procedure Act), but not before the effective date of the  
15 relevant provision of this Act implemented by the regulation.

16 \* **Sec. 9.** The uncodified law of the State of Alaska is amended by adding a new section to  
17 read:

18 **CONDITIONAL EFFECT.** (a) AS 47.05.260(a)(5), enacted by sec. 2 of this Act, takes  
19 effect only if the commissioner of health and social services certifies to the revisor of statutes  
20 under sec. 7 of this Act, on or before October 1, 2017, that all of the provisions added by that  
21 section have been approved by the United States Department of Health and Human Services.

22 (b) AS 47.05.260(a)(8), enacted by sec. 2 of this Act, takes effect only if the  
23 commissioner of health and social services certifies to the revisor of statutes under sec. 7 of  
24 this Act, on or before October 1, 2017, that all of the provisions added by that section have  
25 been approved by the United States Department of Health and Human Services.

26 (c) AS 47.05.260(a)(10), enacted by sec. 2 of this Act, takes effect only if the  
27 commissioner of health and social services certifies to the revisor of statutes under sec. 7 of  
28 this Act, on or before October 1, 2017, that all of the provisions added by that section have  
29 been approved by the United States Department of Health and Human Services.

30 (d) AS 47.07.038, enacted by sec. 3 of this Act, takes effect only if the commissioner  
31 of health and social services certifies to the revisor of statutes under sec. 7 of this Act, on or

1 before October 1, 2017, that all of the provisions added by that section have been approved by  
2 the United States Department of Health and Human Services.

3 (e) Section 5 of this Act takes effect only if the commissioner of health and social  
4 services certifies to the revisor of statutes under sec. 7 of this Act, on or before October 1,  
5 2017, that all of the provisions added by that section have been approved by the United States  
6 Department of Health and Human Services.

7 \* **Sec. 10.** If AS 47.05.260(a)(5), enacted by sec. 2 of this Act, takes effect, it takes effect on  
8 the day after the date the commissioner of health and social services makes a certification to  
9 the revisor of statutes under secs. 7 and 9(a) of this Act.

10 \* **Sec. 11.** If AS 47.05.260(a)(8), enacted by sec. 2 of this Act, takes effect, it takes effect on  
11 the day after the date commissioner of health and social services makes a certification to the  
12 revisor of statutes under secs. 7 and 9(b) of this Act.

13 \* **Sec. 12.** If AS 47.05.260(a)(10) takes effect, it takes effect on the day after the date the  
14 commissioner of health and social services makes a certification to the revisor of statutes  
15 under secs. 7 and 9(c) of this Act.

16 \* **Sec. 13.** If AS 47.07.038, enacted by sec. 3 of this Act, takes effect, it takes effect on the  
17 day after the date the commissioner of health and social services makes a certification to the  
18 revisor of statutes under secs. 7 and 9(d) of this Act.

19 \* **Sec. 14.** If sec. 5 of this Act takes effect, it takes effect on the day after the date the  
20 commissioner of health and social services makes a certification to the revisor of statutes  
21 under secs. 7 and 9(e) of this Act.

22 \* **Sec. 15.** Sections 6, 7, and 8 of this Act take effect immediately under AS 01.10.070(c).

**1. (a) Senator Stoltze: Specific to the Key Campaign recommendations, would changes to the Durable Medical Equipment Program in the state require regulatory or statutory changes?**

The revisions to the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) program would involve a comprehensive regulation change that includes changes to the coverage and payment rules for DMEPOS items. Key components of the revisions would include:

- Revising coverage and payment rules for durable medical equipment to adopt the “capped rental” model, currently used by Medicare, rather than purchasing items. This would generate savings by not purchasing items that are only needed for a short time period or if the recipient’s needs change during the rental period.
- Along with the transition to the capped rental model the DMEPOS rates need to be updated to the 2015 Medicare rates (and adjusted annually thereafter). This will have a mixed result by raising the reimbursement on some items and decreasing the reimbursement on others. The net result is expected to be a small increase in overall reimbursement (2-3%) that would be offset by other changes.
- Adding a discounted reimbursement rate for gently used durable medical equipment. Currently the fee schedule limits reimbursement to new equipment. The initial proposal is to reimburse 60% of the new equipment rate for gently used equipment.
- Reimbursement for “higher allowable” requests and “miscellaneous items” would be capped at the provider’s acquisition cost. This will encourage providers to use the most cost effective items and yield substantial savings.

**1. (b) Senator Stoltze: Specific to the Key Campaign recommendations, would expansion of telemedicine in the state require regulatory or statutory changes?**

Expansion of telemedicine services would require neither statutory nor regulatory changes. Telemedicine is identified on claims by modifiers appended to the code that defines the service provided. Services that require hands-on care, such as home health, personal care attendant services, and waiver services cannot be billed via telemedicine.

**2. Senator Kelly: Provide data and explain Medicaid growth this past year—both in dollars and numbers of recipients.**

Increased enrollment happens for various reasons. Below is a list of some of the reasons behind the larger jumps in Medicaid history.

FY2005 Indian Health System and Medicaid Reform.

FY2009/2010 Denali KidCare income restrictions reduced to allow more children and pregnant women onto Medicaid.

FY2014 Medicaid enrollment is also being impacted by the ACA in three ways:

- Beginning in January 2014, all states must use the Modified Adjusted Gross Income (MAGI) standard for Medicaid and CHIP eligibility, and the health insurance marketplace eligibility. The MAGI standard includes no asset test and a standard 5% disregard.
- Each state must use a “no wrong door” system where individuals and families can apply for health insurance through a single entity, regardless of the type of insurance (e.g. Medicaid, CHIP, health care exchange). Applicants must also be able to apply via telephone and on-line, as well as in-person.
- The insurance mandate leads to more people seeking health insurance and ultimately enrolling in Medicaid.

Please also see attached “Senate HSS 2-25-15 Question 2.”

**3. Senator Stedman: Break down slide 13 pie chart (“Employment Status of Alaska’s Medicaid Expansion Population”) by regions.**

See “Senate HSS 2-25-15 Question 3 and 4,” attached.

**4. Senator Stedman: Give us some sense of how accurate (“sensitive”) the enrollment and cost-per-individuals numbers are.**

See “Senate HSS 2-25-15 Question 3 and 4,” attached.

**5. Senator Stoltze: Please provide detail on why the Administration believes it has the authority to proceed with expansion—including the hiring and reforms—without legislation?**

- Under the Social Security Act, if a state participates in Medicaid, it must cover all persons who are considered mandatory eligible. Those include the aged, the blind and the disabled who meet certain income and asset standards. The state must also cover low income children, their parents or caretaker relatives, and pregnant women who meet certain income standards. The state may also provide coverage to certain optional categories of persons, such as the higher income children through the CHIP program, which Alaska did (Denali Kid Care). Currently Medicaid does not cover adults who do not have children but who would meet the same income guidelines. Under the Affordable Care Act, the federal government determined that individuals who are between the age of 19 to 64 and who do not have children and whose income does not exceed 138% of the Federal Poverty Guidelines are considered mandatory eligibles for purposes of the Medicaid program. AS 47.07.020, requires Alaska to cover all mandatory eligible persons identified in the Social Security Act. Since the expansion population is a mandatory category under the Social Security Act and is therefore required to get Medicaid coverage, they are already included in AS 47.07.2020(a) and there is no need to amend that statute.
- DHSS does need receipt and spending authority from the legislature for expansion, like all other components of the Medicaid program.

- Since most of the programmatic framework for the Medicaid program is in regulation, we believe that most, if not all, of the reform measures that will be taken in the coming months/years will be done via amendment to the regulations; AS 47.07.036 guides the Department's decisions in evaluating and prioritizing reforms.
- Statute is not needed for the Administration to request the creation of new positions. Requests for new positions may be submitted to the Office of Management and Budget by a department when there is a clearly defined and justified need for the positions and the requesting agency has sufficient authority and allocation to cover costs. In the event that existing allocations are not sufficient to meet the need, a supplemental request would be submitted to fund new positions deemed critical to the mission of the agency.

**6. Senator Stedman: Provide a breakdown that demonstrates the impact of Medicaid expansion in small towns, rural Alaska.**

Please find attached two documents:

- 1) A report conducted by Evergreen Economics on the breakdown by legislative district of the estimated number of individuals that would be eligible under Medicaid expansion. The spreadsheet also includes the federal match funding associated with the health care of the expansion population. The federal funding estimates are based on the annual health care costs as determined by Evergreen Economics. (Senate HSS 2-25-15 Question 6-1)
- 2) Two pages extracted from the Northern Economics report on the fiscal impact of Medicaid expansion. Unfortunately, the report didn't get into much detail on Alaska's smaller communities, but it does break down the economic impact by region. (Senate HSS 2-25-15 Question 6-2)

**7. Senator Stedman: How does the FY2015 Medicaid budget compare to FY2016? How much is included in FY2016 for Medicaid growth not including Medicaid expansion?**

Response was already sent separately to Senator Stedman as DHSS LegLog #2930, attached again here.

**8. Division of Public Assistance Director Ron Kreher would also like to offer the following clarification of his response to a question from Senator Stedman about staffing Medicaid expansion:**

The Office of Management and Budget has approved approximately 40 Long-term Non-Permanent positions that the division can support within our FY15 allocation to help address the current backlog of work and support anticipated growth in referrals from hospitals implementing Hospital Presumptive Eligibility for Medicaid. We will recruit and fill these positions, train and have them on line in mid-April. As soon as the division has the authority to do so, a short recruitment period will be used to fill the requested full-time positions. Incumbents in the LTNP positions will be a potential hiring pool for filling the new positions.

Senate HSS 2-25-15 Question 2

**Medicaid Expenditures by Fund Source  
(dollars in thousands)**

Fiscal Year	Recipients*	General Funds***	Designated General Funds***	Federal Funds***	Other Funds***	Total Funds
1991	48,667	\$80,094		\$91,990	\$1,796	\$173,880
1992	56,380	\$93,582		\$105,740	\$934	\$200,256
1993	63,663	\$103,447		\$119,602	\$708	\$223,757
1994	69,631	\$123,553		\$142,729	\$1,402	\$267,684
1995	69,739	\$127,125		\$149,589	\$1,792	\$278,506
1996	69,608	\$138,013		\$167,280	\$3,105	\$308,398
1997	71,449	\$141,517		\$183,355	\$6,568	\$331,440
1998	83,013	\$125,541		\$231,330	\$5,476	\$362,347
1999	79,821	\$131,328	\$195	\$261,316	\$2,851	\$395,690
2000	96,001	\$145,250	\$265	\$307,508	\$17,686	\$470,709
2001	104,717	\$152,427	\$364	\$387,432	\$43,671	\$583,894
2002	109,541	\$192,558	\$364	\$461,847	\$38,911	\$693,680
2003	115,987	\$211,075	\$1,427	\$558,581	\$57,034	\$828,117
2004	118,453	\$230,119	\$4,512	\$658,741	\$78,119	\$971,491
2005	125,309	\$276,089	\$1,533	\$685,474	\$61,822	\$1,024,918
2006	122,975	\$348,648	\$1,500	\$664,722	\$45,007	\$1,059,877
2007	121,865	\$374,492	\$52	\$651,908	\$26,924	\$1,053,376
2008	117,472	\$408,250	\$1,558	\$604,348	\$9,632	\$1,023,788
2009	123,791	\$389,170	\$74	\$682,270	\$6,774	\$1,078,288
2010	126,127	\$400,284	\$87	\$822,907	\$6,982	\$1,230,260
2011	134,768	\$466,585	\$192	\$888,944	\$4,527	\$1,360,248
2012	138,755	\$566,267	\$195	\$798,346	\$4,825	\$1,369,633
2013	146,613	\$613,951	\$455	\$827,695	\$6,692	\$1,448,793
2014****	146,460	\$676,509	\$1,798	\$758,061	\$8,043	\$1,652,671
2015****	150,681	\$693,278	\$1,797	\$966,322	\$8,043	\$1,669,439
2016****	152,941	\$673,032	\$1,797	\$1,111,707	\$8,042	\$1,794,578

Source: Medicaid Budget Group using Alaska Budget System data.

\* Medicaid Recipients up through FY2013 ( data sources: JUCE, COGNOS, Budget Over Book, and Annual Reports)

\*\*\* Funding for FY2014 FY2015 FY2016 Governor's Budget (11059)

\*\*\*\* 2014 / 2015 / 2016 Recipients derived from Enrollment multiplied by .93 (Average of recipients from 2000 - 2013)

Senate HSS 2-25-15 Question 2

**Participation in Medicaid**

Fiscal Year	Alaska Population	Medicaid Enrollment***	Medicaid Recipients	Percent of Population Enrolled in Medicaid	Percent of Enrollees Receiving Benefits
2000	626,931	110,219	96,033	18%	87%
2001	632,200	116,226	104,730	18%	90%
2002	640,643	121,582	109,571	19%	90%
2003	647,884	126,632	116,008	20%	92%
2004	657,483	129,528	118,466	20%	91%
2005	664,334	131,136	125,318	20%	96%
2006	671,202	131,996	122,978	20%	93%
2007	676,056	128,295	121,864	19%	95%
2008	681,977	125,138	117,472	18%	94%
2009	692,314	127,944	123,791	18%	97%
2010	710,231	135,086	126,127	19%	93%
2011	722,190	146,244	134,768	20%	92%
2012	732,183	150,998	138,755	21%	92%
2013	741,232	151,797	146,613	20%	97%
****2014	735,601	157,484	146,460	21%	89%
****2015	759,244	162,023	150,681	21%	93%
****2016	767,948	164,453	152,941	21%	93%

Annual Growth Percentage	Enrollment	Recipients
2001	5.5%	9.1%
2002	4.6%	4.6%
2003	4.2%	5.9%
2004	2.3%	2.1%
2005	1.2%	5.8%
2006	0.7%	-1.9%
2007	-2.8%	-0.9%
2008	-2.5%	-3.6%
2009	2.2%	5.4%
2010	5.6%	1.9%
2011	8.3%	6.9%
2012	3.3%	3.0%
2013	0.5%	5.7%
2014	3.7%	-0.1%
2015	2.9%	2.9%
2016	1.5%	1.5%

Source: Medicaid Budget Group (MMIS/JUCE/COGNOS) and AK Dept. of Labor and Workforce Development.

Enrollment and recipients are unduplicated counts of individuals in each fiscal year.

\* Medicaid Recipients up through FY2014 ( data sources: JUCE, COGNOS, Budget Over Book, and Annual Reports)

\*\*\* 2015 / 2016 Enrollment derived from MESA FORECAST (Ted Helvoight)

\*\*\*\* 2014 / 2015 / 2016 Recipients derived from Enrollment multiplied by .93 (Average of recipients from 2000 - 2013)

**Senate HSS 2-25-15 Follow up Questions 3 & 4**  
**Prepared by Dept. of Health & Social Services**  
**March 10, 2015**

Table 1 shows the employment status of the expansion population at the regional level for 2012 and 2013.

**Table 1: Employment Status of Expansion Population by Region, Years 2012-2013**

Region	Employed	Not Employed	Not in Workforce	Unable to Work
Anchorage / Mat-Su	40.4%	34.5%	22.7%	2.4%
Gulf Coast	50.9%	21.6%	20.7%	6.8%
Interior	44.9%	21.4%	32.2%	1.6%
Northern	27.0%	52.2%	13.4%	7.5%
Southeast	54.8%	26.3%	15.7%	3.3%
Southwest	56.2%	33.3%	8.0%	2.5%
Entire State*	44.7%	30.4%	21.7%	3.2%

Source: Analysis by Evergreen Economics of data from BRFSS survey

\* Statewide percentages are slightly different from those reported in the February 6, 2015 memo from Evergreen Economics. These percentages represent Evergreen's final estimates.

**Data Accuracy: Baseline as Compared to Upper and Lower Bounds**

Table 2 shows our projection of size of the newly eligible population and the number of the newly eligible persons we believe will enroll in Medicaid. In addition, Table 2 shows the lower and upper bounds of our population and enrollment projections.

**Table 2: Estimates of Newly Eligible Population and Enrollment in the Medicaid Program with Lower & Upper Bounds**

Expansion Characteristic	2016	2017	2018	2019	2020	2021
Newly Eligible Adults	41,910	41,980	42,050	42,120	42,190	42,260
<i>Lower Bound</i>	34,827	34,885	34,944	35,002	35,060	35,118
<i>Upper Bound</i>	48,993	49,075	49,156	49,238	49,320	49,402
Newly Eligible Persons that Enroll in Medicaid*	20,066	23,273	26,492	26,535	26,580	26,623
<i>Lower Bound</i>	16,675	19,340	22,015	22,051	22,088	22,124
<i>Upper Bound</i>	23,457	27,206	30,969	31,019	31,072	31,122

Source: Analysis by Evergreen Economics of data from various sources

Table 3 shows our projected baseline and lower and upper bound per-enrollee costs of providing Medicaid services to newly eligible enrollees. This cost projection assumes that the expansion population will have similar healthcare needs as adults currently enrolled in Medicaid with similar demographic characteristics. Based on our analysis of BRFSS data comparing health characteristics of the newly eligible population and those currently eligible for Medicaid, we found the two groups to be very similar.

**Table 3: Estimates of Newly Eligible Population and Enrollment in the Medicaid Program with Lower & Upper Bounds**

	2016	2017	2018	2019	2020	2021
Cost Per Newly Eligible Enrollee	\$7,248	\$7,495	\$7,752	\$8,018	\$8,293	\$8,433
<i>Lower Bound</i>	\$6,951	\$7,188	\$7,434	\$7,689	\$7,953	\$8,087
<i>Upper Bound</i>	\$7,545	\$7,803	\$8,070	\$8,346	\$8,633	\$8,779

Source: Analysis by Evergreen Economics of data from various sources

Table 4 shows our projected baseline and lower and upper bound total cost of providing Medicaid services to newly eligible enrollees.

**Table 4: Estimates of Newly Eligible Population and Enrollment in the Medicaid Program with Lower & Upper Bounds**

	2016	2017	2018	2019	2020	2021
Per Enrollee Cost	\$145,435	\$174,438	\$205,368	\$212,747	\$220,433	\$224,514
<i>Lower Bound</i>	\$115,901	\$139,014	\$163,664	\$169,544	\$175,670	\$178,922
<i>Upper Bound</i>	\$176,984	\$212,278	\$249,918	\$258,898	\$268,252	\$273,218

Source: Analysis by Evergreen Economics of data from various sources

Senate Health & Social Services Committee 2-25-15 follow up. Question 6-1.  
 Prepared by Dept. of Health and Social Services March 11, 2015

**Estimated Counts of Newly Eligible Population, Enrollees, and Federal Matching Funds By House District, Fiscal Year 2016**

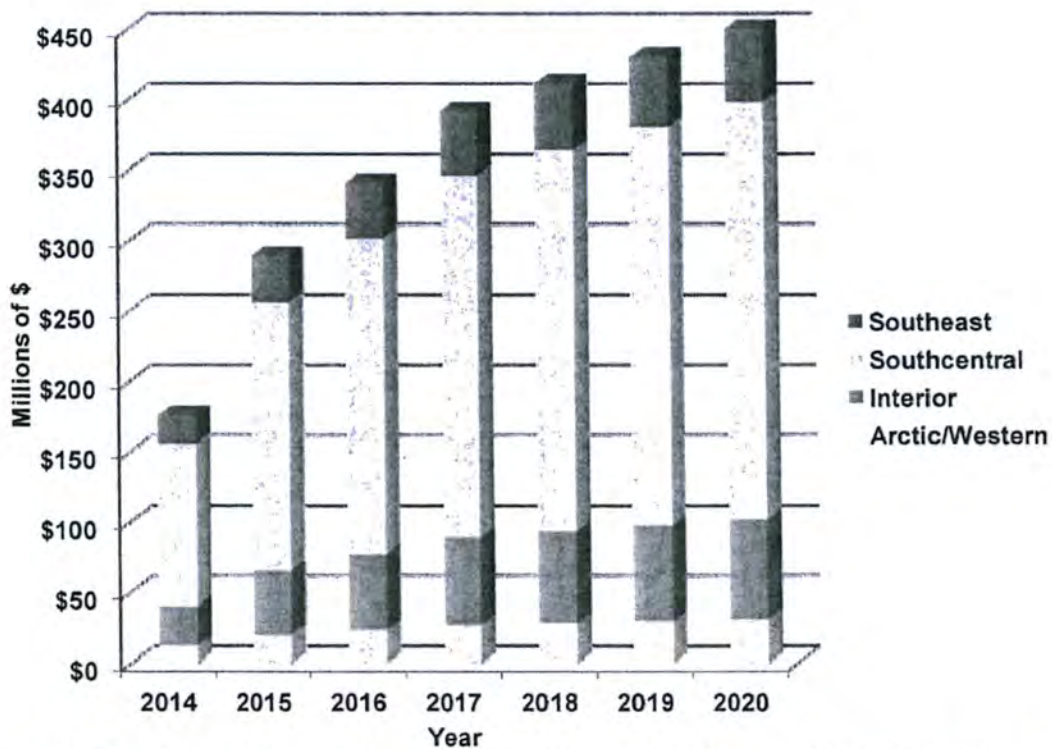
House/Senate District Rep/Sen	Expansion Population	Enrollees	Federal Matching Funds
HD 1/SD A Kawasaki/Kelly	945	452	\$3,279,391
HD 2/SD A Thompson/Kelly	956	458	\$3,317,563
HD 3/SD B Wilson/Coghill	919	440	\$3,189,164
HD 4/SD B Guttenberg/Coghill	1,008	483	\$3,498,017
HD 5/SD C Wool/Bishop	1,045	500	\$3,626,416
HD 6/SD C Talerico/Bishop	914	438	\$3,171,813
HD 7/SD D Gattis/Huggins	932	446	\$3,234,277
HD 8/SD D Neuman/Huggins	1,035	496	\$3,591,713
HD 9/SD E Colver/Dunleavy	981	470	\$3,404,320
HD 10/SD E Keller/Dunleavy	974	466	\$3,380,028
HD 11/SD F Hughes/Stoltze	923	442	\$3,203,045
HD 12/SD F Tilton/Stoltze	950	455	\$3,296,742
HD 13/SD G Saddler/MacKinnon	950	455	\$3,296,742
HD 14/SD G Reinbold/MacKinnon	974	466	\$3,380,028
HD 15/SD H LeDoux/Wielechowski	912	437	\$3,164,872
HD 16/SD H Gruenberg/Wielecho	968	463	\$3,359,206
HD 17/SD I Josephson/Gardner	1,021	489	\$3,543,130
HD 18/SD I Drummond/Gardner	1,041	498	\$3,612,535
HD 19/SD J Tarr/Ellis	889	426	\$3,085,056
HD 20/SD J Gara/Ellis	1,066	510	\$3,699,291

HD 21/SD K Claman/Costello	988	473	\$3,428,611
HD 22/SD K Vazquez/Costello	986	472	\$3,421,671
HD 23/SD L Tuck/McGuire	993	475	\$3,445,963
HD 24/SD L Johnson/McGuire	951	455	\$3,300,212
HD 25/SD M Millet/Meyer	999	478	\$3,466,784
HD 26/SD M Lynn/Meyer	989	474	\$3,432,082
HD 27/SD N Pruitt/Giessel	939	450	\$3,258,569
HD 28/SD N Hawker/Giessel	982	470	\$3,407,790
HD 29/SD O Chenault/Micciche	1,425	682	\$4,945,113
HD 30/SD O Olson/Miccheche	1,337	640	\$4,639,730
HD 31/SD P Seaton/Stevens	1,373	657	\$4,764,659
HD 32/SD P Stutes/Stevens	1,376	659	\$4,775,070
HD 33/SD Q Kito/Egan	1,377	659	\$4,778,541
HD 34/SD Q Munoz/Egan	1,300	622	\$4,511,331
HD 35/SD R Kreiss-Tomkins/Stedr	1,248	598	\$4,330,878
HD 36/SD R Ortiz/Stedman	1,259	603	\$4,369,050
HD 37/SD S Edgmon/Hoffman	1,451	695	\$5,035,339
HD 38/SD S Herron/Hoffman	1,187	568	\$4,119,192
HD 39/SD T Foster/Olson	633	303	\$2,196,671
HD 40/SD T Nageak/Olson	714	342	\$2,477,762
<b>Total Alaska</b>	<b>41,910</b>	<b>20,066</b>	<b>\$145,438,368</b>

Figure 8 shows the projected annual regional economic output effects of Medicaid expansion under the Mid Participation scenario and Figure 9 presents the cumulative economic output effects over the period 2014 to 2020.

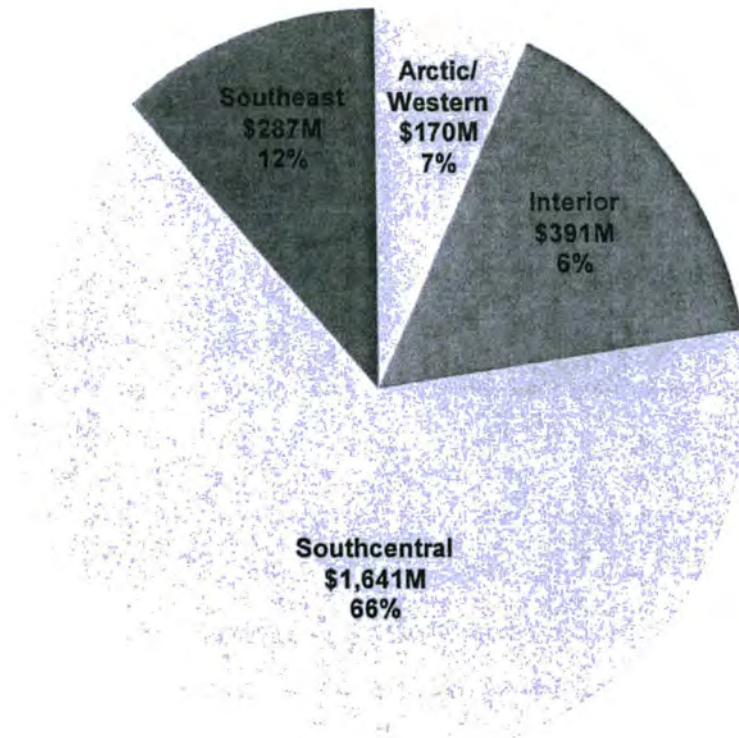
As expected, the majority (66 percent) of the additional economic activity associated with the increase in Medicaid spending is projected to occur in the Southcentral region where Anchorage, the Matanuska-Susitna Borough, Kenai Peninsula Borough, and the Valdez-Cordova Census Area are located. Cumulatively, this region is projected to realize a \$1.6 billion increase in economic output over the 2014 to 2020 time period.

**Figure 8. Annual Regional Economic Output Effects of Medicaid Expansion, Mid Participation Scenario, 2014 to 2020**



Source: Northern Economic, Inc. estimates using UI, 2013 data, and FY2010 data on Medicaid payments to medical facilities across the state.

Figure 9. Cumulative Regional Economic Output Effects of Medicaid Expansion, Mid Participation Scenario, 2014-2020



Source: Northern Economic, Inc. estimates using UI, 2013 data, and FY2010 data on Medicaid payments to medical facilities across the state (Perdue, 2012).



THE STATE  
of **ALASKA**  
GOVERNOR BILL WALKER

Department of  
Health and Social Services


FINANCE AND MANAGEMENT SERVICES  
Juneau Office

P.O. Box 110650  
Juneau, Alaska 99811-0650  
Phone: 907 465 3082  
Fax: 907 465 2499

**MEMORANDUM**

**DATE:** March 2, 2015

**TO:** The Honorable Senator Bert Stedman, Chair  
The Honorable Senator Cathy Giessel, Vice Chair  
Senate Health and Social Services Standing Committee

**FROM:** Sana Efird   
Assistant Commissioner

**SUBJECT:** Senate Health and Social Services Medicaid Expansion Hearing Follow-Up

On February 25, 2015, the Department of Health and Social Services received the following question from you regarding the Senate Health and Social Services Medicaid expansion hearing. The following is submitted in response:

- *How does the FY2015 Medicaid budget compare to FY2016? How much is included in FY2016 for Medicaid growth not including Medicaid expansion?*

In FY2015, the Medicaid Services budget is \$1,669,141.0 compared to the FY2016 Governor's budget of \$1,669,141.0 plus \$145,438.4 in federal funds for Medicaid expansion. There was no Medicaid increment for growth in the FY2016 Governor's budget. However, there is a decrement of \$20,000.0 in the FY2016 Governor's Amended budget for cost containment initiatives.

If you have any additional questions regarding this issue, please contact Sana Efird at 465-1630.

cc: Amanda Ryder, Fiscal Analyst, Legislative Finance  
Adam Bryan, Capital Budget Coordinator, Office of Management and Budget  
Valerie Davidson, Commissioner  
Jay Butler, Chief Medical Officer  
Jon Sherwood, Deputy Commissioner  
Ree Sailors, Deputy Commissioner  
Sarah Woods, Deputy Director  
Melissa Ordner, Budget Manager  
Anthony Newman, Legislative Liaison  
Wilda Laughlin, Deputy Legislative Liaison  
Vickie Wilson, Acting Director, Alaska Pioneer Homes

Albert Wall, Director, Division of Behavioral Health  
Christy Lawton, Director, Office of Children's Services  
Margaret Brodie, Director, Division of Health Care Services  
Karen Forrest, Director, Division of Juvenile Justice  
Ron Kreher, Acting Director of Public Assistance  
Duane Mayes, Director, Senior and Disabilities Services

Log 2930/2015

# FISCAL NOTES

# Fiscal Note

State of Alaska  
2015 Legislative Session

Bill Version: SB 74  
Fiscal Note Number: \_\_\_\_\_  
( ) Publish Date: \_\_\_\_\_

Identifier: SB074-DHSS-MAA-03-22-15  
Title: MEDICAID REFORM/PFD/HSAS/ER  
USE/STUDIES  
Sponsor: KELLY  
Requester: Senate Health & Social Services Committee

Department: Department of Health and Social Services  
Appropriation: Health Care Services  
Allocation: Medical Assistance Administration  
OMB Component Number: 242

## Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2016	Included in	Out-Year Cost Estimates				
	Appropriation Requested	Governor's FY2016 Request	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
<b>OPERATING EXPENDITURES</b>	<b>FY 2016</b>	<b>FY 2016</b>					
Personal Services	500.6		500.6	500.6	500.6	500.6	500.6
Travel	4.0		4.0	4.0	4.0	4.0	4.0
Services	47.0		47.0	47.0	47.0	47.0	47.0
Commodities	48.0		10.0	10.0	10.0	10.0	10.0
Capital Outlay							
Grants & Benefits							
Miscellaneous							
<b>Total Operating</b>	<b>599.6</b>	<b>0.0</b>	<b>561.6</b>	<b>561.6</b>	<b>561.6</b>	<b>561.6</b>	<b>561.6</b>

## Fund Source (Operating Only)

1002 Fed Rcpts	299.8		280.8	280.8	280.8	280.8	280.8
1003 G/F Match	299.8		280.8	280.8	280.8	280.8	280.8
<b>Total</b>	<b>599.6</b>	<b>0.0</b>	<b>561.6</b>	<b>561.6</b>	<b>561.6</b>	<b>561.6</b>	<b>561.6</b>

## Positions

Full-time	5.0		5.0	5.0	5.0	5.0	5.0
Part-time							
Temporary							

Change in Revenues							

**Estimated SUPPLEMENTAL (FY2015) cost:** 0.0 *(separate supplemental appropriation required)*  
*(discuss reasons and fund source(s) in analysis section)*

**Estimated CAPITAL (FY2016) cost:** 0.0 *(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? **10/01/15**

## Why this fiscal note differs from previous version:

Not applicable, initial version.

Prepared By:	Margaret Brodie, Director	Phone:	(907)334-2520
Division:	Health Care Services	Date:	03/21/2015 04:30 PM
Approved By:	Sarah Woods, Deputy Director Finance & Management Services	Date:	03/22/15
Agency:	Health & Social Services		

FISCAL NOTE ANALYSIS

STATE OF ALASKA  
2015 LEGISLATIVE SESSION

BILL NO. SB074

Analysis

**Section 2(a)(5)** of the bill directs the Department to enhance Medicaid fraud prevention, detection and enforcement.

Fraud prevention starts with the provider enrollment process. Enhancements to the provider enrollment process include requiring all ordering, rendering or referring providers to be enrolled with the Medicaid program, including all home and community-based waiver and behavioral health rehabilitation providers. In addition to the enrollment requirement, all categories of providers will be assigned a risk level that will be used to determine levels of pre-enrollment screening. Enhancements to the screening process includes pre- and post-enrollment site visits for medium and high risk categories of providers, and requiring background checks as a condition of enrollment.

1 Medical Asst Administrator III, range 20 - \$112.6

1 Medical Asst Administrator IV, range 21 - \$119.2

FY2016 Personal services total \$231.8

Travel total \$2.0

Lease costs, phone, etc - \$9.4 x 2 = \$18.8

Office supplies - \$2.0 x 2 = \$4.0

FY2016 Commodities, ongoing total \$4.0

Computer, software - \$2.6 x 2 = \$5.2

One-time office set-up - \$5.0 x 2 = \$10.0

FY2016 Commodities, one-time total \$15.2

FISCAL NOTE ANALYSIS

STATE OF ALASKA  
2015 LEGISLATIVE SESSION

BILL NO. SB074

Analysis Continued

**Section 3** of the bill directs the Department to create an optional Health Savings Account for Medicaid recipients. This bill also includes the requirement that the Health Savings Account program must include recipient cost-sharing. Cost sharing would have to comply with federally mandated limits, based on household income. Recipient may elect to have 10 percent of their annual permanent fund dividend put into the Health Savings Account. The program is also required to include consumer education.

Health Care Services anticipates an impact due to intensive account management requirements. The Department estimates that approximately 7,400 health savings accounts will need to be established, verified and accounted for on a weekly basis.

3 Accounting Technician IIIs, range 16 = \$89.6 x 3 = \$268.8

FY2016 Personal services total \$268.8

Travel \$2.0

Lease costs, phone, etc - \$9.4 x 3 = \$28.2

Office supplies - \$2.0 x 3 = \$6.0

Computer, software - \$2.6 x 3 = \$7.8

One-time office set-up - \$5.0 x 3 = \$15.0

One-time commodities total \$22.8

# Fiscal Note

State of Alaska  
2015 Legislative Session

Bill Version: SB 74  
Fiscal Note Number: \_\_\_\_\_  
( ) Publish Date: \_\_\_\_\_

Identifier: SB074-DHSS-PAA-03-20-15  
Title: MEDICAID REFORM/PFD/HSAS/ER  
USE/STUDIES  
Sponsor: KELLY  
Requester: Senate Health & Social Services Committee

Department: Department of Health and Social Services  
Appropriation: Public Assistance  
Allocation: Public Assistance Administration  
OMB Component Number: 233

### Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2016	Included in	Out-Year Cost Estimates				
	Appropriation Requested	Governor's FY2016 Request	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
<b>OPERATING EXPENDITURES</b>	<b>FY 2016</b>	<b>FY 2016</b>					
Personal Services	35.0						
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits							
Miscellaneous							
<b>Total Operating</b>	<b>35.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

### Fund Source (Operating Only)

1002 Fed Rcpts	17.5						
1003 G/F Match	17.5						
<b>Total</b>	<b>35.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

### Positions

Full-time							
Part-time							
Temporary							

<b>Change in Revenues</b>							
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**Estimated SUPPLEMENTAL (FY2015) cost:** 0.0 *(separate supplemental appropriation required)*  
*(discuss reasons and fund source(s) in analysis section)*

**Estimated CAPITAL (FY2016) cost:** 0.0 *(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? no  
If yes, by what date are the regulations to be adopted, amended or repealed? n/a

### Why this fiscal note differs from previous version:

Not applicable, initial version.

Prepared By: <u>Ron Kreher, Acting Director</u>	Phone: <u>(907)465-5847</u>
Division: <u>Public Assistance</u>	Date: <u>03/20/2015 03:50 PM</u>
Approved By: <u>Sarah Woods, Deputy Director Finance &amp; Management Services</u>	Date: <u>03/20/15</u>
Agency: <u>Health &amp; Social Services</u>	

## FISCAL NOTE ANALYSIS

STATE OF ALASKA  
2015 LEGISLATIVE SESSION

BILL NO. SB074

### Analysis

Section 3 of the bill requires the Department to develop and implement a personal health savings account program for Medicaid recipients that includes recipient cost-sharing and copayment structures.

Background: The Division of Public Assistance is currently using two systems to make Medicaid eligibility determinations and manage case actions -- the older Eligibility Information System (EIS) and the new system, Alaska's Resource for Integrated Eligibility Services (ARIES) - until ARIES implementation is fully complete. Both systems have an interface which passes information about Medicaid recipients to the Enterprise System, also known as the Medicaid Management Information System (MMIS).

The data needed to determine potential cost-sharing and copayments is not included in the Division's current interfaces with the Enterprise System. In order to support cost-sharing and copayment structures, both eligibility systems will require technical changes to enable the transmission of the necessary information to the Medicaid Management Information System.

For ARIES, this will be a change request to current, planned contracted work entailing changes to the interface design specifications and system testing. The cost of these ARIES system changes is eligible for funding through an existing capital appropriation and will not require additional funding authority.

EIS system changes will require additional funding authority to research, design, develop, test and implement changes necessary to modify the existing interface with the Enterprise System.

# Fiscal Note

State of Alaska  
2015 Legislative Session

Bill Version: SB 74  
Fiscal Note Number: \_\_\_\_\_  
( ) Publish Date: \_\_\_\_\_

Identifier: SB074-DHSS-CDDG-03-19-15  
Title: MEDICAID REFORM/PFD/HSAS/ER  
USE/STUDIES  
Sponsor: KELLY  
Requester: Senate Health & Social Services Committee

Department: Department of Health and Social Services  
Appropriation: Senior and Disabilities Services  
Allocation: Community Developmental Disabilities Grants  
OMB Component Number: 309

**Expenditures/Revenues**

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2016 Appropriation Requested	Included in Governor's FY2016 Request	Out-Year Cost Estimates				
	FY 2016	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
<b>OPERATING EXPENDITURES</b>							
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits				(11,635.8)	(11,635.8)	(11,635.8)	(11,635.8)
Miscellaneous							
<b>Total Operating</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>(11,635.8)</b>	<b>(11,635.8)</b>	<b>(11,635.8)</b>	<b>(11,635.8)</b>

**Fund Source (Operating Only)**

1004 Gen Fund				(5,000.0)	(5,000.0)	(5,000.0)	(5,000.0)
1037 GF/MH				(6,635.8)	(6,635.8)	(6,635.8)	(6,635.8)
<b>Total</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>(11,635.8)</b>	<b>(11,635.8)</b>	<b>(11,635.8)</b>	<b>(11,635.8)</b>

**Positions**

Full-time							
Part-time							
Temporary							

<b>Change in Revenues</b>							
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**Estimated SUPPLEMENTAL (FY2015) cost:** 0.0 *(separate supplemental appropriation required)*  
*(discuss reasons and fund source(s) in analysis section)*

**Estimated CAPITAL (FY2016) cost:** 0.0 *(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:**

Not applicable, initial version.

Prepared By: <u>Duane Mayes, Director</u>	Phone: (907)269-2083
Division: <u>Senior and Disabilities Services</u>	Date: 03/19/2015 06:00 PM
Approved By: <u>Sarah Woods, Deputy Director Finance &amp; Management Services</u>	Date: 03/19/15
Agency: <u>Health &amp; Social Services</u>	

## FISCAL NOTE ANALYSIS

STATE OF ALASKA  
2015 LEGISLATIVE SESSION

BILL NO. SB074

### Analysis

Section 2(a)(6) of the bill requires the State to reform the Medicaid program in a manner that reduces the cost of providing services to seniors and individuals with disabilities. To achieve savings, the department will apply to the Centers for Medicare and Medicaid Services (CMS) to develop the 1915(i) funding authority, and provide Medicaid-funded home and community-based services that are currently 100% GF-funded.

Individuals receiving home and community based services through the Community Developmental Disabilities Grant (CDDG) program must meet the eligibility requirements in AS 47.80.900. The CDDG program provides home and community-based services to support individuals' desire to live as independently as they are able.

The department will use the 1915(i) funding option to refinance the Community Developmental Disabilities Grant program using the following assumptions:

953 individuals accessed CDDG services in FY2014 with an average cost per recipient of \$12.2 per individual per year.

Current CDDG program and funding (general fund) = \$11,635.8.

Estimated general fund to be refinanced with Federal Funds = \$11,635.8

State Plan and regulation changes are required to implement the new option and would involve extensive public comment. The Department expects the 1915(i) option to be implemented by FY2018.

# Fiscal Note

State of Alaska  
2015 Legislative Session

Bill Version: SB 74  
Fiscal Note Number: \_\_\_\_\_  
( ) Publish Date: \_\_\_\_\_

Identifier: SB074-DHSS-CO-03-20-15  
Title: MEDICAID REFORM/PFD/HSAS/ER  
USE/STUDIES  
Sponsor: KELLY  
Requester: Senate Health & Social Services Committee

Department: Department of Health and Social Services  
Appropriation: Departmental Support Services  
Allocation: Commissioner's Office  
OMB Component Number: 317

**Expenditures/Revenues**

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2016	Included in	Out-Year Cost Estimates				
	Appropriation Requested	Governor's FY2016 Request	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
<b>OPERATING EXPENDITURES</b>	<b>FY 2016</b>	<b>FY 2016</b>					
Personal Services							
Travel	6.0						
Services	759.0						
Commodities							
Capital Outlay							
Grants & Benefits							
Miscellaneous							
<b>Total Operating</b>	<b>765.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

**Fund Source (Operating Only)**

1002 Fed Rcpts	20.0						
1003 G/F Match	20.0						
1004 Gen Fund	725.0						
<b>Total</b>	<b>765.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

**Positions**

Full-time							
Part-time							
Temporary							

<b>Change in Revenues</b>							
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**Estimated SUPPLEMENTAL (FY2015) cost:** 0.0 *(separate supplemental appropriation required)*  
*(discuss reasons and fund source(s) in analysis section)*

**Estimated CAPITAL (FY2016) cost:** 0.0 *(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? no  
If yes, by what date are the regulations to be adopted, amended or repealed? n/a

**Why this fiscal note differs from previous version:**

Not applicable, initial version.

Prepared By: <u>Sana Efird, Assistant Commissioner</u>	Phone: <u>(907)465-1630</u>
Division: <u>Finance and Management Services</u>	Date: <u>03/20/2015 01:37 PM</u>
Approved By: <u>Sarah Woods, Deputy Director Finance &amp; Management Services</u>	Date: <u>03/20/15</u>
Agency: <u>Health &amp; Social Services</u>	

## FISCAL NOTE ANALYSIS

STATE OF ALASKA  
2015 LEGISLATIVE SESSION

BILL NO. SB074

### Analysis

#### **Reform performance targets:**

Section 2(a)(10) of the bill requires the Department to seek stakeholder input in establishing annual targets or performance metrics for the quality and cost effectiveness of activities the Department undertakes in the name of Medicaid reform. Section 2(b) requires the Department to report to the legislature annually on cost savings resulting from reform, and whether or not the Department has met the defined targets.

Performance indicators to measure quality and cost-effectiveness in the Medicaid program were established in recent years through the department's Results-based Budgeting and Accountability initiative. These metrics will be refreshed and updated to include measures associated with the new reform efforts and incorporate the required targets. The Department will use existing boards and commissions to facilitate stakeholder involvement in this process, which will reduce the need for additional funds associated with convening stakeholder meetings. The enhanced process for tracking and reporting on the Medicaid targets will be incorporated into existing budget and annual report systems to meet the annual report requirement.

#### One-time costs:

##### 72000 Travel: \$6.0 (\$3.0 GF/ \$3.0 Fed)

Travel to Wasilla, Barrow, Ketchikan and Kodiak for 1 staff and 1 contracted court reporter

##### 73000 Contractual Services: \$34.0 (\$17.0 GF/\$17.0 Fed)

A professional services contract (\$30.0) is required for a consultant to compile existing measures, identify gaps related to measuring outcomes from new reform efforts, conduct literature reviews to identify grades of evidence for potential new measures, define specifications for each quality and cost measure, compile and analyze input from stakeholders and technical experts, and test the measures for validity and reliability. Line item also includes costs for renting public meeting space in Wasilla, Barrow, Ketchikan and Kodiak, and court reporter services for these four meetings.

#### **Residential services privatization feasibility:**

Section 8 of this bill directs the Department to conduct a study analyzing the feasibility of privatizing services delivered at the Department's 24/7 residential facilities - Alaska Pioneers' Homes, the Alaska Psychiatric Institute, and "select facilities" in the Division of Juvenile Justice. A summary of the findings is due to the legislature by late January 2016.

The Division of Alaska Pioneer Homes has six 24-hour facilities which provide assisted living care and memory care to residents, along with a central office and a pharmacy:

- (1) Central Office - 11 permanent employees,
- (2) Sitka Pioneer Home - 86 permanent employees, 65 licensed assisted living home beds
- (3) Fairbanks Pioneer Home - 103 permanent employees, 93 licensed assisted living home beds
- (4) Alaska Veterans and Pioneers Home - 103 permanent positions, 79 licensed assisted living home beds
- (5) Anchorage Pioneer Home - 177 permanent positions, 168 licensed assisted living home beds
- (6) Ketchikan Pioneer Home - 64 permanent positions, 48 licensed assisted living home beds
- (7) Juneau Pioneer Home - 50 permanent positions, 48 licensed assisted living home beds
- (8) Centralized Pharmacy - 6 permanent positions

The Alaska Psychiatric Institute is a 24-hour, 80 bed, nationally accredited inpatient psychiatric hospital employing 247 permanent staff and organizationally housed within the Division of Behavioral Health (DBH).

## FISCAL NOTE ANALYSIS

STATE OF ALASKA  
2015 LEGISLATIVE SESSION

BILL NO. SB074

### Analysis Continued

The Division of Juvenile Justice operates eight 24-hour Alaska youth facilities:

- (1) Bethel Youth Facility - 28 permanent employees, 6 beds
- (2) Fairbanks Youth Facility - 40 permanent employees, 36 beds
- (3) Johnson Youth Center (Juneau) - 36 permanent employees, 30 beds
- (4) Kenai Peninsula Youth Facility - 18 permanent positions, 10 beds
- (5) Ketchikan Regional Youth Facility - 18 permanent positions, 18beds
- (6) Mat-Su Youth Facility (Palmer) - 20 permanent positions, 15 beds
- (7) McLaughlin Youth Center (Anchorage) - 166 permanent positions, 132 beds
- (8) Nome Youth Facility - 19 permanent positions, 14 beds

The Department would contract out for this study, which will assess the most common types of privatization and rank them by applicability for DHSS residential services:

- (1) outsourcing
- (2) public-private partnership
- (3) asset sales or leasing
- (4) vouchers
- (5) government corporation
- (6) complete privatization

The contractor will need to provide:

- (1) a final written feasibility analysis report
- (2) a comprehensive assessment of the ranked privatization options
- (3) an analysis of the impact to DHSS residential services and clientele thereof that privatization will cause
- (4) resulting employer costs of any labor relations and/or union contract stipulations regarding privatizing state employee duties
- (5) recommendations for cost saving measures that would help the Department, should privatization be deemed not feasible.

The contractor must consider:

- the complex nature of the population served by each facility category
- the variety of Alaskan communities
- stakeholders' needs

The contractor must bring to bear considerable expertise in the services and systems, legal authorities, frameworks and funding mechanisms specific to each of the three residential service categories. Additionally, the contractor must have knowledge of the process and outcomes of privatization of similar services in other states, and specific application to services provided in Alaska.

# Fiscal Note

State of Alaska  
2015 Legislative Session

Bill Version: SB 74  
Fiscal Note Number: \_\_\_\_\_  
( ) Publish Date: \_\_\_\_\_

Identifier: SB074-DCCED-DOI-03-20-15  
Title: MEDICAID REFORM/PFD/HSAS/ER  
USE/STUDIES  
Sponsor: KELLY  
Requester: (S) HEALTH AND SOCIAL SERVICES

Department: Department of Commerce, Community and  
Economic Development  
Appropriation: Insurance Operations  
Allocation: Insurance Operations  
OMB Component Number: 354

**Expenditures/Revenues**

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2016	Included in	Out-Year Cost Estimates					
	Appropriation Requested	Governor's FY2016 Request	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
<b>OPERATING EXPENDITURES</b>	<b>FY 2016</b>	<b>FY 2016</b>						
Personal Services								
Travel								
Services								
Commodities								
Capital Outlay								
Grants & Benefits								
Miscellaneous								
<b>Total Operating</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

**Fund Source (Operating Only)**

None							
<b>Total</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

**Positions**

Full-time							
Part-time							
Temporary							

<b>Change in Revenues</b>							
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**Estimated SUPPLEMENTAL (FY2015) cost:** 0.0 *(separate supplemental appropriation required)*  
*(discuss reasons and fund source(s) in analysis section)*

**Estimated CAPITAL (FY2016) cost:** 0.0 *(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? No  
If yes, by what date are the regulations to be adopted, amended or repealed?

**Why this fiscal note differs from previous version:**

Not applicable, initial version.

Prepared By: Lori Wing-Heier, Director  
Division: Division of Insurance  
Approved By: Catherine Reardon, Director  
Agency: Division of Administrative Services, DCCED

Phone: (907)465-2515  
Date: 03/20/2015 11:04 AM  
Date: 03/20/15

FISCAL NOTE ANALYSIS

STATE OF ALASKA  
2015 LEGISLATIVE SESSION

BILL NO. SB74

**Analysis**

SB74 amends Title 43: Revenue and Taxation, and Title 47: Welfare, Social Services and Institutions, to implement Medicare reform. The Division of Insurance does not anticipate a fiscal impact from this legislation.

# Fiscal Note

State of Alaska  
2015 Legislative Session

Bill Version: SB 74  
Fiscal Note Number: \_\_\_\_\_  
( ) Publish Date: \_\_\_\_\_

Identifier: SB074-DHSS-HCMS-03-22-15  
Title: MEDICAID REFORM/PFD/HSAS/ER  
USE/STUDIES  
Sponsor: KELLY  
Requester: Senate Health & Social Services 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)

	FY2016 Appropriation Requested	Included in Governor's FY2016 Request	Out-Year Cost Estimates				
	FY 2016	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
<b>OPERATING EXPENDITURES</b>							
Personal Services							
Travel							
Services	6,540.4		4,390.4	4,390.4	4,390.4	4,390.4	4,390.4
Commodities							
Capital Outlay							
Grants & Benefits	(9,393.7)		(9,393.7)	(9,393.7)	(9,393.7)	(9,393.7)	(9,393.7)
Miscellaneous							
<b>Total Operating</b>	<b>(2,853.3)</b>	<b>0.0</b>	<b>(5,003.3)</b>	<b>(5,003.3)</b>	<b>(5,003.3)</b>	<b>(5,003.3)</b>	<b>(5,003.3)</b>

**Fund Source (Operating Only)**

1002 Fed Rcpts	(318.2)		(1,393.2)	(1,393.2)	(1,393.2)	(1,393.2)	(1,393.2)
1003 G/F Match	(2,535.1)		(3,610.1)	(3,610.1)	(3,610.1)	(3,610.1)	(3,610.1)
<b>Total</b>	<b>(2,853.3)</b>	<b>0.0</b>	<b>(5,003.3)</b>	<b>(5,003.3)</b>	<b>(5,003.3)</b>	<b>(5,003.3)</b>	<b>(5,003.3)</b>

**Positions**

Full-time							
Part-time							
Temporary							

<b>Change in Revenues</b>							
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**Estimated SUPPLEMENTAL (FY2015) cost:** 0.0 *(separate supplemental appropriation required)*  
*(discuss reasons and fund source(s) in analysis section)*

**Estimated CAPITAL (FY2016) cost:** 0.0 *(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:**

Not applicable, initial version.

Prepared By: <u>Margaret Brodie, Director</u>	Phone: (907)334-2520
Division: <u>Health Care Services</u>	Date: 03/21/2015 03:30 PM
Approved By: <u>Sarah Woods, Deputy Director Finance &amp; Management Services</u>	Date: 03/22/15
Agency: <u>Health &amp; Social Services</u>	

## FISCAL NOTE ANALYSIS

STATE OF ALASKA  
2015 LEGISLATIVE SESSION

BILL NO. SB074

### Analysis

**Section 2(a)(3)** of this bill requires that the Department provide an Explanation of Benefits to recipients who receive Medicaid services. There is currently no comprehensive mechanism to notify recipients when a claim is filed and paid on their behalf.

We conservatively estimate that about 50% of all Medicaid eligibles receive a service in any given month. It would require the distribution of an explanation of benefits (EOB) to approximately 70,000 recipients each month.

Providing an explanation of benefits would require a system modification to automatically produce a benefit statement attached to each claim per recipient. We estimate that it will cost \$375.0 to modify the Xerox payment processing system to accommodate this aspect of the bill. This will be a one-time cost to be incurred in FY2016.

Contractor to prepare and distribute 70,000 letters monthly - \$15.0/month  
Operations/overhead/staff costs to answer explanation of benefit questions - \$75.0/month  
Postage - \$34.0/month  
Total - \$124.0 x 12 = \$1,488.0

**Section 2(a)(4)** of the bill expands use of telemedicine for primary and urgent care. **Section 5(d)(1)** requires the department to identify legal barriers that prevent the expanded use of telemedicine as part of a managed care demonstration project for Denali KidCare. These provisions intend to decrease costs associated with travel to hub locations by increasing access to various levels of care via real time and store-and-forward delivery in recipients' home community. In Medicaid, telemedicine services are considered the same as a face-to-face visit as long as it falls within the scope of the practitioner's license. Telemedicine services are available to a wide array of providers that fall within the scope of Medicaid's coverage provisions. The department already has a number of telemedicine initiatives underway to coordinate and expand these efforts across tribal and non-tribal providers. The Department anticipates no additional cost or savings as result of this section.

**Section 2(a)(5)** of the bill directs the Department to enhance Medicaid fraud prevention, detection and enforcement. Additional systems changes will be needed to accommodate a projected 3,000 additional Medicaid providers for an estimated cost of \$200.0. Ongoing maintenance costs of \$20.0 per month plus \$275.0 of initial start-up contractor staff costs will be needed.

Xerox contractual costs: \$200.0 + \$240.0 + \$275.0 = \$715.0

**Section 2(a)(7)** of the bill would require the department to design and adopt regulations to address Medicaid reform for pharmacy initiatives, establish a prescription drug monitoring program and develop strict guidelines for the prescribing of narcotics.

The department has implemented numerous pharmacy initiatives during the last 5 years. Previously implemented initiatives include program coverage reforms, claims pricing and payment reforms, increased usage of generic medications, prior authorizations, quantity limits, therapeutic duplication edits, independent expert reviewers of atypical requests for high doses of pain medications, and independent expert reviewers of psychotropic medication regimens for foster children.

Research and development of new claims processing edits, payment rates, and program coverage rules occur continuously and are already incorporated into the department's workflow.

To meet the prescription monitoring database HCS will need \$85.0 for an RSA with the Department of Commerce,

FISCAL NOTE ANALYSIS

STATE OF ALASKA  
2015 LEGISLATIVE SESSION

BILL NO. SB074

Analysis Continued

**Section 2(a)(8)** of the bill requires the Department to implement enhanced care management. In **Section 5**, this legislation proposes to design and initiate a managed care demonstration project on or before October 1, 2015. Because of the potential overlap between enhanced care management and other provisions of the legislation, we are not able to determine savings at this time.

**Section 2(a)(9)** of the bill requires a redesign of the Medicaid payment process. This section converts the process from a fee-for-service model that incentivizes volume, to an outcome-based model that incentivizes efficient care. \$1,150.0 will be needed for one-time systems changes and consultation work to design and implement payment methodology changes, provider education, and policy documentation. The Department is not able to provide specific cost savings associated with this section at this time.

**Section 2(a)(11)** of the bill requires medical services to be provided in the home community of the recipient, potentially through use of telemedicine or other diagnosis and treatment in recipients' home communities unless unavailable. Currently, travel is only authorized when medically necessary and when the service required is not available in the recipient's home community. Travel is authorized to the closest, available, appropriate provider. We do not project any additional costs or savings as a result of this addition.

**Section 5** of the bill requires the Department to initiate a managed care demonstration. The demonstration project is to ensure sustainability while reducing the cost of medical assistance payments and increasing access to and improving the quality of care available to all medical assistance recipients. Based on prior experience it is uncertain we will get an offer with a reasonable expectation that it will reduce costs. We will not enter into a contract if anticipated savings do not offset the cost of the contract. Therefore, we have assumed administration fees are offset by reductions in service spending. Increased Medicaid cost as a result of the administrative case management fee:

2013 Denali KidCare Recipients:	47,987	
Estimated Administrative Fee	\$3.85 PMPM	
<u>Months in a year</u>		<u>12</u>
Yearly Medicaid Increase in Costs	\$2,217.0	

**Section 6** of the bill requires the Department to implement a demonstration project to reduce non-urgent use of emergency department services by Medicaid recipients by September 1, 2015.

- Development of an electronic exchange, \$150.0 one-time
- Alaska Prescription Drug Monitoring Program, \$85.0 annually
- Increase Alaska Medicaid Coordinated Care Initiative contract (current contract cost is \$3.85 per client per month) to manage this population:  $\$3.85 \times 7,800 \times 12 = \$360.4$ .

The estimated cost savings is based upon a Medicaid emergency room over-utilizer population of 7,800. The Department believes that it can reduce the number of emergency room visits by this over-utilizer group by 30% with case management.

Number of paid ER visits in FY2014 - 114,570  
Average price per ER visit FY2014 (only for physician services) - \$613.39  
Assumes over-utilizer made at least five trip to ER in FY2014 -  $7,800 \times \$613.39 \times 5 = \$23,922.2 \times 30\% = \$7,176.7$

# Fiscal Note

State of Alaska  
2015 Legislative Session

Bill Version: SB 74  
Fiscal Note Number: \_\_\_\_\_  
( ) Publish Date: \_\_\_\_\_

Identifier: SB074-DHSS-BHMS-03-20-15  
Title: MEDICAID REFORM/PFD/HSAS/ER  
USE/STUDIES  
Sponsor: KELLY  
Requester: Senate Health & Social Services Committee

Department: Department of Health and Social Services  
Appropriation: Medicaid Services  
Allocation: Behavioral Health Medicaid Services  
OMB Component Number: 2660

**Expenditures/Revenues**

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2016	Included in	Out-Year Cost Estimates				
	Appropriation Requested	Governor's FY2016 Request	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
<b>OPERATING EXPENDITURES</b>	<b>FY 2016</b>	<b>FY 2016</b>					
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits				7,856.0	7,918.8	8,789.9	8,860.2
Miscellaneous							
<b>Total Operating</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>7,856.0</b>	<b>7,918.8</b>	<b>8,789.9</b>	<b>8,860.2</b>

**Fund Source (Operating Only)**

1002 Fed Rcpts				4,399.4	4,434.5	4,922.3	4,961.7
1003 G/F Match				3,456.6	3,484.3	3,867.6	3,898.5
<b>Total</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>7,856.0</b>	<b>7,918.8</b>	<b>8,789.9</b>	<b>8,860.2</b>

**Positions**

Full-time							
Part-time							
Temporary							

<b>Change in Revenues</b>							
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**Estimated SUPPLEMENTAL (FY2015) cost:** 0.0 *(separate supplemental appropriation required)*  
*(discuss reasons and fund source(s) in analysis section)*

**Estimated CAPITAL (FY2016) cost:** 0.0 *(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:**

Not applicable, initial version.

Prepared By: Albert Wall, Director Phone: (907)465-4841  
Division: Behavioral Health Date: 03/20/2015 01:00 PM  
Approved By: Sarah Woods, Deputy Director Finance & Management Services Date: 03/20/15  
Agency: Health & Social Services

FISCAL NOTE ANALYSIS

STATE OF ALASKA  
2015 LEGISLATIVE SESSION

BILL NO. SB074

**Analysis**

Section 2(a)(6) of the bill requires the State to reform the Medicaid program in a manner that reduces the cost of providing behavioral health services. To achieve savings, the department will apply to the Centers for Medicare and Medicaid Services (CMS) to develop the 1915(i) funding authority, and provide Medicaid-funded behavioral health services that are currently GF-funded through the Behavioral Health Treatment and Recovery Grants program.

This option will serve Medicaid-eligible adults with behavioral health needs that result in multiple admissions to inpatient or residential care. The population includes homeless, those re-entering from incarceration, and others who intermittently use services.

The federal match rate for the 1915(i) option is the regular match rate, usually 50% but 65% for the Children's Health Insurance Program (CHIP) and 100% for tribal services provided to Indian Health Service beneficiaries. Behavioral Health Medicaid Services average 56% federal match.

Medicaid State Plan and regulation changes are required to implement these changes. The estimated effective date of regulation changes is July 2017.

# Fiscal Note

State of Alaska  
2015 Legislative Session

Bill Version: SB 74  
Fiscal Note Number: \_\_\_\_\_  
( ) Publish Date: \_\_\_\_\_

Identifier: SB074-DHSS-SDMS-03-19-15  
Title: MEDICAID REFORM/PFD/HSAS/ER  
USE/STUDIES  
Sponsor: KELLY  
Requester: Senate Health & Social Services Committee

Department: Department of Health and Social Services  
Appropriation: Medicaid Services  
Allocation: Senior and Disabilities Medicaid Services  
OMB Component Number: 2662

**Expenditures/Revenues**

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2016 Appropriation Requested	Included in Governor's FY2016 Request	Out-Year Cost Estimates					
			FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
<b>OPERATING EXPENDITURES</b>								
Personal Services								
Travel								
Services								
Commodities								
Capital Outlay								
Grants & Benefits					16,846.4	16,846.4	16,846.4	16,846.4
Miscellaneous								
<b>Total Operating</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>16,846.4</b>	<b>16,846.4</b>	<b>16,846.4</b>	<b>16,846.4</b>	<b>16,846.4</b>

**Fund Source (Operating Only)**

1002 Fed Rcpts				15,073.0	15,073.0	15,073.0	15,073.0
1003 G/F Match				1,773.4	1,773.4	1,773.4	1,773.4
<b>Total</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>16,846.4</b>	<b>16,846.4</b>	<b>16,846.4</b>	<b>16,846.4</b>

**Positions**

Full-time							
Part-time							
Temporary							

<b>Change in Revenues</b>							
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**Estimated SUPPLEMENTAL (FY2015) cost:** 0.0 *(separate supplemental appropriation required)*  
*(discuss reasons and fund source(s) in analysis section)*

**Estimated CAPITAL (FY2016) cost:** 0.0 *(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:**

Not applicable, initial version.

Prepared By: <u>Duane Mayes, Director</u>	Phone: (907)269-2083
Division: <u>Senior and Disabilities Services</u>	Date: 03/19/2015 05:45 PM
Approved By: <u>Sarah Woods, Deputy Director Finance &amp; Management Services</u>	Date: 03/19/15
Agency: <u>Health &amp; Social Services</u>	

## FISCAL NOTE ANALYSIS

STATE OF ALASKA  
2015 LEGISLATIVE SESSION

BILL NO. SB074

### Analysis

#### **1915(k) option**

Section 2(a)(6) of the bill requires the State to reform the Medicaid program in a manner that reduces the cost of providing services to seniors and individuals with disabilities. The department will apply to the Centers for Medicare and Medicaid Services (CMS) to develop a new Medicaid funding authority, the 1915(k) "Community First Choice Option" (CFC), which serves people who meet an institutional level of care (LOC). The state will realize savings because the 1915(k) authority includes a 56% federal match, an increase of 6% over the current 50% match, decreasing the State's general fund match to 44%.

The 1915(k) option will replace the current 1915(c) waivers, as all 1915(c) waiver service recipients do meet an institutional LOC.

The 1915(c) waivers are:

- Children with Complex Medical Conditions (CCMC)
- Adults with Physical and Developmental Disabilities (APDD)
- Alaskans Living Independently (ALI)
- People with Intellectual and Developmental Disabilities (IDD)

All four of the waivers would transition to the 1915(k) option authority.

Estimated 1915(c) recipients transitioning to the 1915(k) option = 5,200

Federal funding under current 1915(c) waiver at FMAP (50%) = \$ 110,827.7

Federal funding under proposed 1915(k) option at FMAP (56%) = \$ 117,477.4

The program transition results in an increase of \$6,649.7 in federal receipts, and a corresponding GF decrease.

Implementation of the new funding option will require substantial changes to the current Home and Community Based Services (HCBS) operational infrastructure. The estimated effective date for this refinancing proposal from (c) to (k) is FY2018.

#### **1915(i) State Plan option**

The department will apply to CMS for the 1915(i) option under Medicaid. The 1915(i) option includes a federal match of 50%, reducing to 50% what is currently a 100% general fund contribution for certain services.

The Department will use this option to refinance the following 100% GF-funded grant programs: General Relief/Temporary Assistance (GR), certain Senior Community Based Grant components, and Community Developmental Disabilities Grant (CDDG).

General Relief/Temporary Assistance (GR) provides temporary residential care for vulnerable adults who are ineligible for assistance from other programs.

Current funding for GR program: \$8,113.0

Total number served: 630

Average cost per individual: \$12,878.00

Estimated eligible for 1915(i): 349

General fund to be reduced: \$ 4,494.3

FISCAL NOTE ANALYSIS

STATE OF ALASKA  
2015 LEGISLATIVE SESSION

BILL NO. SB074

**Analysis Continued**

Adult Day Grant:

Total general fund expenditures: \$1,757.0

Total number served: 416

Average cost per individual: \$4,223.58.

Estimated eligible for 1915(i): 114

General fund to be reduced for the Adult Day Grant: \$481.5.

Senior In-Home Grant:

Total general fund expenditures: \$2,917.3

Total number served: 1,528

Average cost per individual: \$1,909.20.

Estimated eligible for 1915(i): 123

Estimated general fund to be reduced for the Senior In-Home Grant: \$234.8.

The combined estimated general fund to be reduced through the use of the 1915(i) option = \$716.3

Community Developmental Disabilities Grant (CDDG) program provides home and community-based services to support individuals to live as independently as they are able.

Total general fund expenditures: \$11,635.8

Total number served: 953

Average cost per recipient: \$12.2

Estimated eligible for 1915(i): 953

Estimated general fund to be reduced: \$11,635.8

State Plan and regulation changes are required to implement the new option and would involve extensive public comment. The Department expects the 1915(i) option to be implemented by FY2018.

# Fiscal Note

State of Alaska  
2015 Legislative Session

Bill Version: SB 74  
Fiscal Note Number: \_\_\_\_\_  
( ) Publish Date: \_\_\_\_\_

Identifier: SB074-DHSS-SDSA-03-19-15  
Title: MEDICAID REFORM/PFD/HSAS/ER  
USE/STUDIES  
Sponsor: KELLY  
Requester: Senate HSS Committee

Department: Department of Health and Social Services  
Appropriation: Senior and Disabilities Services  
Allocation: Senior and Disabilities Services Administration  
OMB Component Number: 2663

## Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2016 Appropriation Requested	Included in Governor's FY2016 Request	Out-Year Cost Estimates					
			FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
<b>OPERATING EXPENDITURES</b>								
Personal Services	108.0		324.0	324.0	324.0	324.0	324.0	324.0
Travel	2.3		6.8	6.8	6.8	6.8	6.8	6.8
Services	186.8		193.9	540.8	10.6	10.6	10.6	10.6
Commodities	2.5		7.6	7.6	7.6	7.6	7.6	7.6
Capital Outlay								
Grants & Benefits								
Miscellaneous								
<b>Total Operating</b>	<b>299.6</b>	<b>0.0</b>	<b>532.3</b>	<b>879.2</b>	<b>349.0</b>	<b>349.0</b>	<b>349.0</b>	<b>349.0</b>

## Fund Source (Operating Only)

1002 Fed Rcpts	189.9		306.2	479.7	174.5	174.5	174.5
1003 G/F Match	109.7		226.1	399.5	174.5	174.5	174.5
<b>Total</b>	<b>299.6</b>	<b>0.0</b>	<b>532.3</b>	<b>879.2</b>	<b>349.0</b>	<b>349.0</b>	<b>349.0</b>

## Positions

Full-time	1.0		3.0	3.0	3.0	3.0	3.0
Part-time							
Temporary							

<b>Change in Revenues</b>							
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**Estimated SUPPLEMENTAL (FY2015) cost:** 0.0 (separate supplemental appropriation required)  
*(discuss reasons and fund source(s) in analysis section)*

**Estimated CAPITAL (FY2016) cost:** 0.0 (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:

Not applicable, initial version.
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Prepared By: <u>Duane Mayes, Director</u>	Phone: (907)269-2083
Division: <u>Senior and Disabilities Services</u>	Date: 03/19/2015 04:45 PM
Approved By: <u>Sarah Woods, Deputy Director Finance &amp; Management Services</u>	Date: 03/19/15
Agency: <u>Health &amp; Social Services</u>	

FISCAL NOTE ANALYSIS

STATE OF ALASKA  
2015 LEGISLATIVE SESSION

BILL NO. SB074

**Analysis**

Section 2(a)(6) of this bill requires the State to reform the Medicaid program in a manner that reduces the cost of providing services to seniors and individuals with disabilities. The department will apply to the Centers for Medicare and Medicaid Services (CMS) to develop two new Medicaid funding authorities, the 1915(i) and 1915(k) State Plan options. Under these new authorities the state will realize savings in the provision of home and community-based services (HCBS).

Services under these new funding authorities will reduce general fund expenditures by replacing 100% general fund services (1915(i) option) or capturing a higher federal match rate (1915(k)).

In FY2018 the Department anticipates new costs associated with initial eligibility assessments of individuals previously served through the general fund grant programs or services. The estimated number of new assessments = 1,539. Cost per assessment = \$225.41 (not including travel). Estimated cost to manage the 1,539 initial eligibility assessments = \$346.9 in FY2018.

In FY2016, FY2017, and FY2018 the Department anticipates additional expenditures related to the "Automated Services Plan" management information system. State staff, providers, and consumers will have access to the system and a public web resource center. The Department will plan and configure substantial, necessary software changes to this system for new assessments, additional programmatic elements, and interfaces with other department data management systems. Additional user accounts and licenses, and training and support for all users, will need to be developed and supported.

Estimated costs for system changes and development = \$550.0, of which \$300.0 is eligible for enhanced federal funding at a 90% federal match, and the remaining \$250.0 is eligible for the standard 50% federal match. Much of these costs will be realized in the development years (one-third each in FY2016-FY2018), while the savings will continue and grow as overall expenditures grow.

To plan, develop, and manage the new program, beginning in FY2016 Senior and Disabilities Services will require 3 additional full-time staff: one staff person beginning in FY2016 and two more staff beginning in FY2017. These will be Health Program Manager II positions (step C) each = \$108.0; Travel = \$2.3; Services = \$3.5; Commodities = \$2.5. Regulation changes are required to implement the new options and would involve extensive public comment. The estimated effective date of regulation changes is July 2017.

# Fiscal Note

State of Alaska  
2015 Legislative Session

Bill Version: SB 74  
Fiscal Note Number: \_\_\_\_\_  
( ) Publish Date: \_\_\_\_\_

Identifier: SB074-DHSS-RR-03-21-15  
Title: MEDICAID REFORM/PFD/HSAS/ER  
USE/STUDIES  
Sponsor: KELLY  
Requester: Senate Health & Social Services Committee

Department: Department of Health and Social Services  
Appropriation: Health Care Services  
Allocation: Rate Review  
OMB Component Number: 2696

**Expenditures/Revenues**

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2016	Included in	Out-Year Cost Estimates					
	Appropriation Requested	Governor's FY2016 Request	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
<b>OPERATING EXPENDITURES</b>	<b>FY 2016</b>	<b>FY 2016</b>						
Personal Services	177.8		297.0	297.0	177.8	177.8	177.8	
Travel	2.0		2.0	2.0	2.0	2.0	2.0	
Services	9.4		18.8	18.8	9.4	9.4	9.4	
Commodities	9.6		11.6	4.0	2.0	2.0	2.0	
Capital Outlay								
Grants & Benefits								
Miscellaneous								
<b>Total Operating</b>	<b>198.8</b>	<b>0.0</b>	<b>329.4</b>	<b>321.8</b>	<b>191.2</b>	<b>191.2</b>	<b>191.2</b>	

**Fund Source (Operating Only)**

1002 Fed Rcpts	99.4		164.7	160.9	95.6	95.6	95.6
1003 G/F Match	99.4		164.7	160.9	95.6	95.6	95.6
<b>Total</b>	<b>198.8</b>	<b>0.0</b>	<b>329.4</b>	<b>321.8</b>	<b>191.2</b>	<b>191.2</b>	<b>191.2</b>

**Positions**

Full-time	1.0		2.0	2.0	1.0	1.0	1.0
Part-time							
Temporary							

<b>Change in Revenues</b>							
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**Estimated SUPPLEMENTAL (FY2015) cost:** 0.0 *(separate supplemental appropriation required)*  
*(discuss reasons and fund source(s) in analysis section)*

**Estimated CAPITAL (FY2016) cost:** 0.0 *(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:**

Not applicable, initial version.

Prepared By: Margaret Brodie, Director	Phone: (907)334-2520
Division: Health Care Services	Date: 03/21/2015 01:20 PM
Approved By: Sarah Woods, Deputy Director Finance & Management Services	Date: 03/21/15
Agency: Health & Social Services	

## FISCAL NOTE ANALYSIS

STATE OF ALASKA  
2015 LEGISLATIVE SESSION

BILL NO. SB074

### Analysis

**Section 2(a)(9)** of the bill requires a redesign of the Medicaid payment process. This section converts the process from a fee-for-service model that incentivizes volume, to an outcome-based model that incentivizes efficient care.

The Office of Rate Review (ORR) currently sets reimbursement rates for a range of Medicaid services. ORR would still be required to set a baseline rate for Medicaid services but would need to identify and establish metrics, track outcomes and ultimately tie reimbursement to those outcomes. One Medical Assistant Administrator IV would be needed for a period of two years to establish metrics and targets.

1 Medical Assistance Administrator IV, range 21 - \$119.2

Lease costs, phone, etc - \$9.4

Office supplies - \$2.0

Computer, software - \$2.6

One-time office set-up - \$5.0

FY2016 Commodities, one-time total \$7.6

**Section 5** of the bill requires the Department to initiate a managed care demonstration. The purpose of the demonstration project is to ensure sustainability while reducing the cost of medical assistance payments and increasing access to and improving the quality of care available to all medical assistance recipients. Based on prior experience it is uncertain we will get an offer with a reasonable expectation that it will reduce costs. We will not enter into a contract if anticipated savings do not offset the cost of the contract.

Therefore, we have assumed administration fees are offset by reductions in service spending.

1 exempt Actuary – est. competitive salary w/ benefits - \$177.8

Lease costs, phone, etc - \$9.4

Office supplies - \$2.0

Computer, software - \$2.6

One-time office set-up - \$5.0

FY2016 Commodities, one-time total \$7.6

# Fiscal Note

State of Alaska  
2015 Legislative Session

Bill Version: SB 74  
Fiscal Note Number: \_\_\_\_\_  
( ) Publish Date: \_\_\_\_\_

Identifier: SB074-DHSS-SCBG-03-19-15  
Title: MEDICAID REFORM/PFD/HSAS/ER  
USE/STUDIES  
Sponsor: KELLY  
Requester: Senate Health & Social Services Committee

Department: Department of Health and Social Services  
Appropriation: Senior and Disabilities Services  
Allocation: Senior Community Based Grants  
OMB Component Number: 2787

## Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2016 Appropriation Requested	Included in Governor's FY2016 Request	Out-Year Cost Estimates				
	FY 2016	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
<b>OPERATING EXPENDITURES</b>							
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits				(716.3)	(716.3)	(716.3)	(716.3)
Miscellaneous							
<b>Total Operating</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>(716.3)</b>	<b>(716.3)</b>	<b>(716.3)</b>	<b>(716.3)</b>

## Fund Source (Operating Only)

1004 Gen Fund				(716.3)	(716.3)	(716.3)	(716.3)
<b>Total</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>(716.3)</b>	<b>(716.3)</b>	<b>(716.3)</b>	<b>(716.3)</b>

## Positions

Full-time							
Part-time							
Temporary							

<b>Change in Revenues</b>							
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**Estimated SUPPLEMENTAL (FY2015) cost:** 0.0 *(separate supplemental appropriation required)*  
*(discuss reasons and fund source(s) in analysis section)*

**Estimated CAPITAL (FY2016) cost:** 0.0 *(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:

Not applicable, initial version.

Prepared By: <u>Duane Mayes, Director</u>	Phone: (907)269-2083
Division: <u>Senior and Disabilities Services</u>	Date: 03/19/2015 06:00 PM
Approved By: <u>Sarah Woods, Deputy Director Finance &amp; Management Services</u>	Date: 03/19/15
Agency: <u>Health &amp; Social Services</u>	

FISCAL NOTE ANALYSIS

STATE OF ALASKA  
2015 LEGISLATIVE SESSION

BILL NO. SB074

**Analysis**

Section 2(a)(6) of the bill requires the State to reform the Medicaid program in a manner that reduces the cost of providing services to seniors and individuals with disabilities. To achieve savings, the department will apply to the Centers for Medicare and Medicaid Services (CMS) to develop the 1915(i) funding authority, and provide Medicaid-funded home and community-based services that are currently 100% GF-funded.

The department will use this option to refinance the Senior Community Based Grant component's Adult Day and Senior In-Home Services for those who are receiving the service and are also Medicaid eligible.

Adult Day Grant: Total general fund expenditures = \$1,757.0 serving 416 recipients. SDS anticipates serving 114 under the 1915(i) option with an average cost per individual of \$4,223.58. Estimated general fund to be reduced for the Adult Day Grant = \$481.5.

Senior In-Home Grant: Total general fund expenditures = \$2,917.3, serving 1,528 individuals. SDS anticipates serving 123 under the 1915(i) option with an average cost per individual of \$1,909.20. Estimated general fund to be reduced for the Senior In-Home Grant = \$234.8.

The combined estimated general fund to be reduced through the use of the 1915(i) option = \$716.3

State Plan and regulation changes are required to implement the new option and would involve extensive public comment. The Department expects the 1915(i) option to be implemented by FY2018.

# Fiscal Note

State of Alaska  
2015 Legislative Session

Bill Version: SB 74  
Fiscal Note Number: \_\_\_\_\_  
( ) Publish Date: \_\_\_\_\_

Identifier: SB074-DHSS-QAA-03-21-15  
Title: MEDICAID REFORM/PFD/HSAS/ER  
USE/STUDIES  
Sponsor: KELLY  
Requester: Senate Health & Social Services Committee

Department: Department of Health and Social Services  
Appropriation: Departmental Support Services  
Allocation: Quality Assurance and Audit  
OMB Component Number: 2880

**Expenditures/Revenues**

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2016	Included in	Out-Year Cost Estimates				
	Appropriation Requested	Governor's FY2016 Request	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
<b>OPERATING EXPENDITURES</b>	<b>FY 2016</b>	<b>FY 2016</b>					
Personal Services	231.8		231.8	231.8	231.8	231.8	231.8
Travel	2.0		2.0	2.0	2.0	2.0	2.0
Services	64.3		64.3	64.3	64.3	64.3	64.3
Commodities	19.2		4.0	4.0	4.0	4.0	4.0
Capital Outlay							
Grants & Benefits							
Miscellaneous							
<b>Total Operating</b>	<b>317.3</b>	<b>0.0</b>	<b>302.1</b>	<b>302.1</b>	<b>302.1</b>	<b>302.1</b>	<b>302.1</b>

**Fund Source (Operating Only)**

1002 Fed Rcpts	158.7		151.1	151.1	151.1	151.1	151.1
1003 G/F Match	158.6		151.0	151.0	151.0	151.0	151.0
<b>Total</b>	<b>317.3</b>	<b>0.0</b>	<b>302.1</b>	<b>302.1</b>	<b>302.1</b>	<b>302.1</b>	<b>302.1</b>

**Positions**

Full-time	2.0		2.0	2.0	2.0	2.0	2.0
Part-time							
Temporary							

<b>Change in Revenues</b>							
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**Estimated SUPPLEMENTAL (FY2015) cost:** 0.0 *(separate supplemental appropriation required)*  
*(discuss reasons and fund source(s) in analysis section)*

**Estimated CAPITAL (FY2016) cost:** 0.0 *(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? 07/01/16

**Why this fiscal note differs from previous version:**

Not applicable, initial version.

Prepared By: <u>Sana Efird, Assistant Commissioner</u>	Phone: <u>(907)465-1630</u>
Division: <u>Finance and Management Services</u>	Date: <u>03/21/2015 04:30 PM</u>
Approved By: <u>Sarah Woods, Deputy Director Finance &amp; Management Services</u>	Date: <u>03/21/15</u>
Agency: <u>Health &amp; Social Services</u>	

FISCAL NOTE ANALYSIS

STATE OF ALASKA  
2015 LEGISLATIVE SESSION

BILL NO. SB074

**Analysis**

Section 2(a)(5) of the bill directs the Department to enhance Medicaid fraud prevention, detection and enforcement.

Enhanced fraud detection and enforcement will require the ability to track investigations and cases across all Medicaid divisions including Health Care Services, Behavioral Health and the Division of Senior and Disabilities Services. One Research Analyst IV and one Medical Assistance Administrator III is needed in Medicaid Program Integrity, also known as Quality Assurance and Audit. A case tracking system designed specifically for fraud cases will be required. Additional expertise in data analytics will be provided by the Research Analyst position, and the Medical Assistance Administrator will be required to conduct and coordinate investigations across all Medicaid Divisions.

In addition, enhanced fraud detection case tracking software and license fees are estimated at \$45.5 annually .

1 Medical Asst Administrator III - range 20, \$112.6

1 Research Analyst IV - range 21, \$119.2

**FY2016 Personal services total \$231.8**

**Travel total \$2.0**

Lease costs, phone, etc -  $\$9.4 \times 2 = \$18.8$

Software and licensing fees - \$45.5

**FY2016 Services total: \$64.3**

Office supplies -  $\$2.0 \times 2 = \$4.0$

**FY2016 Commodities, ongoing total \$4.0**

Computer, software -  $\$2.6 \times 2 = \$5.2$

One-time office set-up -  $\$5.0 \times 2 = \$10.0$

**FY2016 Commodities, one-time total \$15.2**

# Fiscal Note

State of Alaska  
2015 Legislative Session

Bill Version: SB 74  
Fiscal Note Number: \_\_\_\_\_  
( ) Publish Date: \_\_\_\_\_

Identifier: SB074-DHSS-TRG-03-21-15  
Title: MEDICAID REFORM/PFD/HSAS/ER  
USE/STUDIES  
Sponsor: KELLY  
Requester: Senate Health & Social Services Committee

Department: Department of Health and Social Services  
Appropriation: Behavioral Health  
Allocation: Behavioral Health Treatment and Recovery  
Grants  
OMB Component Number: 3099

### Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2016 Appropriation Requested	Included in Governor's FY2016 Request	Out-Year Cost Estimates				
			FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
<b>OPERATING EXPENDITURES</b>							
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits				(3,456.6)	(3,484.3)	(3,867.6)	(3,898.5)
Miscellaneous							
<b>Total Operating</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>(3,456.6)</b>	<b>(3,484.3)</b>	<b>(3,867.6)</b>	<b>(3,898.5)</b>

### Fund Source (Operating Only)

1003 G/F Match				(3,456.6)	(3,484.3)	(3,867.6)	(3,898.5)
<b>Total</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>(3,456.6)</b>	<b>(3,484.3)</b>	<b>(3,867.6)</b>	<b>(3,898.5)</b>

### Positions

Full-time							
Part-time							
Temporary							

<b>Change in Revenues</b>							
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**Estimated SUPPLEMENTAL (FY2015) cost:** 0.0 *(separate supplemental appropriation required)*  
*(discuss reasons and fund source(s) in analysis section)*

**Estimated CAPITAL (FY2016) cost:** 0.0 *(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:

Not applicable, initial version.

Prepared By: <u>Albert E. Wall, Director</u>	Phone: <u>(907)465-4841</u>
Division: <u>Behavioral Health</u>	Date: <u>03/21/2015 12:00 PM</u>
Approved By: <u>Sarah Woods, Deputy Director Finance &amp; Management Services</u>	Date: <u>03/21/15</u>
Agency: <u>Health &amp; Social Services</u>	

## FISCAL NOTE ANALYSIS

STATE OF ALASKA  
2015 LEGISLATIVE SESSION

BILL NO. SB074

### Analysis

Section 2(a)(6) of the bill directs the Department of Health and Social Services (DHSS) to reduce the cost of behavioral health services provided to recipients of medical assistance under the state's home and community based services waiver. Behavioral Health will accomplish this by working with the Centers for Medicare and Medicaid Services to elect the Section 1915(i) option. This option will provide funds to cover services provided to Medicaid-eligible adults with demonstrated behavioral health needs that result in multiple admissions to inpatient or residential care. The population includes homeless, those re-entering from incarceration, and others who intermittently use services. These services are currently provided through behavioral health grants with 100% general funds. The Department anticipates that behavioral health grants will be reduced through the 1915(i) option beginning in FY2018 by the following amounts: FY2018 -\$3,456.6, FY2019 -\$3,484.3, FY2020 -\$3,867.6, FY2021 -\$3,898.5.

Specific services that are currently funded through General Fund grant dollars, but are eligible for Medicaid reimbursement will be transitioned to Medicaid reimbursement as grant funds decrease. Grants will not be completely eliminated as some services provided through grants are not reimbursable through Medicaid.

# Fiscal Note

State of Alaska  
2015 Legislative Session

Bill Version: SB 74  
Fiscal Note Number: \_\_\_\_\_  
( ) Publish Date: \_\_\_\_\_

Identifier: SB074-DHSS-GRTAL-03-19-15  
Title: MEDICAID REFORM/PFD/HSAS/ER  
USE/STUDIES  
Sponsor: KELLY  
Requester: Senate Health & Social Services Committee

Department: Department of Health and Social Services  
Appropriation: Senior and Disabilities Services  
Allocation: General Relief/Temporary Assisted Living  
OMB Component Number: 2875

**Expenditures/Revenues**

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2016	Included in	Out-Year Cost Estimates				
	Appropriation Requested	Governor's FY2016 Request	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
<b>OPERATING EXPENDITURES</b>	<b>FY 2016</b>	<b>FY 2016</b>	<b>FY 2017</b>	<b>FY 2018</b>	<b>FY 2019</b>	<b>FY 2020</b>	<b>FY 2021</b>
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits				(4,494.3)	(4,494.3)	(4,494.3)	(4,494.3)
Miscellaneous							
<b>Total Operating</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>(4,494.3)</b>	<b>(4,494.3)</b>	<b>(4,494.3)</b>	<b>(4,494.3)</b>

**Fund Source (Operating Only)**

1004 Gen Fund				(4,494.3)	(4,494.3)	(4,494.3)	(4,494.3)
<b>Total</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>(4,494.3)</b>	<b>(4,494.3)</b>	<b>(4,494.3)</b>	<b>(4,494.3)</b>

**Positions**

Full-time							
Part-time							
Temporary							

<b>Change in Revenues</b>							
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**Estimated SUPPLEMENTAL (FY2015) cost:** 0.0 *(separate supplemental appropriation required)*  
*(discuss reasons and fund source(s) in analysis section)*

**Estimated CAPITAL (FY2016) cost:** 0.0 *(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:**

Not applicable, initial version.

Prepared By: Duane Mayes, Director	Phone: (907)269-2083
Division: Senior and Disabilities Services	Date: 03/19/2015 06:00 PM
Approved By: Sarah Woods, Deputy Director Finance & Management Services	Date: 03/19/15
Agency: Health & Social Services	

FISCAL NOTE ANALYSIS

STATE OF ALASKA  
2015 LEGISLATIVE SESSION

BILL NO. SB074

**Analysis**

Section 2(a)(6) of the bill requires the State to reform the Medicaid program in a manner that reduces the cost of providing services to seniors and individuals with disabilities. To achieve savings, the department will apply to the Centers for Medicare and Medicaid Services (CMS) to develop the 1915(i) funding authority, and provide Medicaid-funded home and community-based services that are currently 100% GF-funded.

General Relief/Temporary Assistance (GR) provides temporary residential care for vulnerable adults who are ineligible for assistance from other programs. The department will use the 1915(i) funding option to refinance this 100% General Fund-funded program for Medicaid-eligible individuals.

Current funding for GR program: \$8,113.0  
Total number served: 630  
Average cost per individual: \$12,878.00  
Estimated eligible for 1915(i): 349  
General fund to be refinanced w/Medicaid: \$ 4,494.3

State Plan and regulation changes are required to implement the new option and would involve extensive public comment. The Department expects the 1915(i) option to be implemented in FY2018.



# LEGISLATIVE RESEARCH SERVICES

Alaska State Legislature  
Division of Legal and Research Services  
State Capitol, Juneau, AK 99801

(907) 465-3991 phone  
(907) 465-3908 fax  
research@akleg.gov

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## Research Brief

TO: Senator Pete Kelly  
FROM: Chuck Burnham, Legislative Analyst  
DATE: March 2, 2015  
RE: Medicaid: Status of State Expansion under the Affordable Care Act and Selected Information on the Use of Managed Care Organizations  
*LRS Report 15.284*

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***You asked about the status of Medicaid expansion under the Affordable Care Act (ACA) among the states. You also wished to know about the use of managed care organizations (MCOs) in state Medicaid programs. Specifically, you wanted to know whether states that expanded Medicaid under the ACA implemented use of MCOs as part of the expansion, and if that administrative structure was delineated in legislation authorizing the expansion.***

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The federal Patient Protection and Affordable Care Act (P.L. 111-148), or ACA, includes a requirement that states expand Medicaid programs to cover individuals with incomes of up to 138 percent of the federal poverty level.<sup>1</sup> However, the June 2012 U.S. Supreme Court decision in *National Federation of Independent Business v. Sebelius*, made Medicaid expansion under the ACA optional for the states. According to the Kaiser Family Foundation (KFF), to date 28 states have expanded their Medicaid programs under the provisions of the ACA. Governors and/or legislative leadership in seven of the 22 states that have thus far rejected expansion, including Alaska, are currently considering expansion.<sup>2</sup>

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### Use of Private Managed Care Organizations in Medicaid<sup>3</sup>

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“Managed care organization” (MCO) is a term covering an array of health insurance delivery models. Typically MCOs contract with health care providers and medical facilities to provide services at reduced costs for members covered by the organization. According to the federal Centers for Medicare and Medicaid Services (CMS), managed care is intended to provide a

health care delivery system organized to manage cost, utilization, and quality. Medicaid managed care provides for the delivery of health benefits and additional services through contracted arrangements between state agencies and managed care organizations that accept a set per member per month (capitation) payment for these services.

By contracting with various types of MCOs to deliver Medicaid program health care services to their beneficiaries, states can reduce program costs and better manage utilization of health services.

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<sup>1</sup> Text of the ACA can be accessed at <http://www.gpo.gov/fdsys/granule/PLAW-111publ148/PLAW-111publ148/content-detail.html>. Portions of the federal healthcare overhaul are also contained in the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), <http://www.gpo.gov/fdsys/pkg/PLAW-111publ152/pdf/PLAW-111publ152.pdf>.

<sup>2</sup> The KFF tracks state actions on expansion of Medicaid under the ACA at <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicare-under-the-affordable-care-act/#>. The Foundation is a not-for-profit research organization with the goal of being “a trusted source of information in a health care world dominated by vested interests.” The KFF generally supports the ideal that all people have access to health insurance, but takes no position on the ACA or any other law.

<sup>3</sup> The efficacy of managed care as a means to reduce costs and improve quality is a question outside the scope of your request. It is important to note, however, that research on the topic has reached mixed conclusions. Nonetheless, recent studies have shown that well-designed and implemented managed care strategies can transfer risk away from government payers (see, for example, <http://www.columbia.edu/~jnv2106/jvanparys.jmp.pdf>).

Improvement in health plan performance, health care quality, and outcomes are key objectives of Medicaid managed care.<sup>4</sup>

According to the federal Centers for Medicaid and Medicare Services (CMS), pursuant to regulations at 42 CFR 438, four types of managed care entities are recognized for Medicaid programs as follows:

- Managed Care Organizations (MCOs)
  - Comprehensive benefit package
  - Payment is risk-based/capitation
- Primary Care Case Management (PCCM)
  - Primary care case managers contract with the state to furnish case management (location, coordination, and monitoring) services
  - Generally, paid fee for service for medical services rendered plus a monthly case management fee
- Prepaid Inpatient Health Plan (PIHP)
  - Limited benefit package that includes inpatient hospital or institutional services (example: mental health)
  - Payment may be risk or non-risk
- Prepaid Ambulatory Health Plan (PAHP)
  - Limited benefit package that does not include inpatient hospital or institutional services (examples: dental and transportation)
  - Payment may be risk or non-risk

States can implement managed care delivery systems for Medicaid recipients under three separate authorizations within the federal Social Security Act (P.L. 74-271): state plans (Section 1932[a]), plan waivers under Section 1915(a-b), and plan waivers under Section 1115.<sup>5</sup> The KFF provides a useful overview of states' use of waivers in expanding Medicaid under the ACA at <http://files.kff.org/attachment/issue-brief-the-aca-and-medicaid-expansion-waivers>.

### Recent Medicaid MCO Activity in the States

Research by the KFF and others has illustrated that Medicaid enrollment in MCOs has increased substantially in recent years. This growth has been driven, in part, by expansion of Medicaid under the ACA; however, the use of MCOs has also increased in non-expansion states as policymakers and others continue to seek ways to control the growth of costs. According to data compiled by the consultancy PricewaterhouseCoopers (PwC), enrollment in private MCOs by Medicaid recipients increased by roughly 9.3 million individuals in the year beginning third-quarter 2013. Over the same time period, total Medicaid enrollment increased by approximately 9 million enrollees. That is to say, net growth in the number of Medicaid enrollees covered by a private MCO has been somewhat greater than overall Medicaid expansion.

According to PwC, the share of Medicaid recipients nationwide receiving comprehensive medical coverage through a private MCO increased from about 59 percent to 66 percent over the year studied.<sup>6</sup> These recipients are spread among the 39 states with Medicaid MCOs in place, wherein enrollment ranges from 11 percent in Iowa to 100 percent in Tennessee—one of the states that has rejected expansion under the ACA. According to the KFF, 90 percent of all Medicaid recipients live within the 39 states with Medicaid MCOs.

<sup>4</sup> <http://medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-site.html>.

<sup>5</sup> Waivers exempt states from certain requirements of federal law in order to allow flexibility to design programs to most effectively deliver and fund services. Relevant sections of federal law and regulation, state managed care profiles, details on the parameters of waivers, and technical assistance for states regarding managed care are all available at <http://medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-site.html>.

<sup>6</sup> Ari Gottlieb, "The Expanded State of Medicaid in the United States: Private Medicaid Health Plans Crossing the Tipping Point," PricewaterhouseCooper, January 2015, [http://www.mhpa.org/\\_upload/201501StateofMedicaid2014.pdf](http://www.mhpa.org/_upload/201501StateofMedicaid2014.pdf).

As the increases in enrollment figures referenced above suggest, a great deal of activity has occurred with regard to Medicaid managed care in recent years.<sup>7</sup> Among the changes states have variously implemented over fiscal years 2014 and 2015 is the addition of geographic areas covered by MCOs (9 states), creation or expansion of eligibility groups (34 states), and enactment of policies making enrollment in managed care mandatory for some segment of Medicaid recipients (13 states).<sup>8</sup> The attached table shows for each state the status of Medicaid expansion under the ACA, level of enrollment in private MCOs for Medicaid recipients, and an account of the states where selected expansions to MCO coverage have been implemented.

### Implementation of Medicaid MCOs in Legislation Expanding Medicaid under the ACA

We located no instance in which legislation to expand Medicaid under the ACA created an associated MCO program, or directed state agencies to do so, where no such program previously existed. There are likely a number of reasons this approach has not widely been undertaken. First, of course, is the fact that Medicaid MCOs were already operating in many states when ACA expansion was undertaken. Further, where those programs do not exist at the time of expansion, an amendment to the state plan or approval of a waiver as mentioned above is required prior to the implementation of a Medicaid managed care program.

In a number of states where expansion under the ACA has taken place, it was not accomplished through stand-alone legislation. For example, Delaware, New Jersey, Rhode Island, and Washington expanded Medicaid through line items in budget bills—a legislative vehicle that is not necessarily well suited for detailed programmatic directives. In other states—prominently Kentucky and Ohio—expansion under the ACA was directed by their respective governor absent enabling legislation.

Although we located no legislation directing creation of Medicaid MCOs, a number of states' enabling measures provided some degree of direction regarding managed care. For example, California's voluminous ACA legislation includes a requirement that Medicaid recipients enroll in Medi-Cal managed care in counties where such plans are or become available [Cal. Welfare and Institutions Code § 14005.60(c)(1-2)].<sup>9</sup> Enabling legislation in Michigan is more broadly prescriptive regarding the use of MCOs, directing an aggressive move toward the use of waivers to mandate Medicaid managed care as follows:

By September 30, 2015, the department of community health shall develop and implement a plan to enroll all existing fee-for-service enrollees into contracted health plans if allowable by law, if the medical assistance program is the primary payer and if that enrollment is cost-effective. This includes all newly eligible enrollees [in Medicaid under the ACA]. The department of community health shall include contracted health plans as the mandatory delivery system in its waiver request. The department of community health also shall pursue any and all necessary waivers to enroll persons eligible for both Medicaid and Medicare into the 4 integrated care demonstration regions beginning July 1, 2014. By September 30, 2015, the department of community health shall identify all remaining populations eligible for managed care, develop plans for their integration into managed care, and provide recommendations for a performance bonus incentive plan mechanism for long-term care managed care providers that are consistent with other managed care performance bonus incentive plans.<sup>10</sup>

The legislation authorizing Medicaid expansion under the ACA in New Hampshire seeks to control costs, in part, by making premium assistance for certain adults newly eligible for Medicaid contingent upon those enrollees choosing either a qualified health plan from a federally-facilitated health exchange or one of the state-contracted MCOs.<sup>11</sup>

<sup>7</sup> Legislative Research calculations based on data provided by Gottlieb, PwC, pp. 13-14.

<sup>8</sup> The KFF publishes a great deal of data and analysis through its Medicaid Managed Care Market Tracker at <http://kff.org/state-category/medicaid-chip/medicaid-managed-care-market-tracker/>.

<sup>9</sup> See § 9 of the enabling legislation in California is available at [http://www.leginfo.ca.gov/pub/13-14/bill/asm/ab\\_0001-0050/abx1\\_1\\_bill\\_20130614\\_amended\\_sen\\_v97.htm](http://www.leginfo.ca.gov/pub/13-14/bill/asm/ab_0001-0050/abx1_1_bill_20130614_amended_sen_v97.htm).

<sup>10</sup> Act No. 107, 2013, Section 105d(i)(4), <http://www.legislature.mi.gov/documents/2013-2014/publicact/pdf/2013-PA-0107.pdf>.

<sup>11</sup> New Hampshire SB 413-FN-A, § XXIV(a), <http://www.gencourt.state.nh.us/legislation/2014/SB0413.html>.

These examples are by no means exhaustive of legislative directives regarding MCOs and ACA expansion, and as we indicated above, policymakers across the country are aggressively seeking changes to and increased use of managed care for Medicaid enrollees. Ultimately, should Alaska pursue such policies, their specific design and implementation would necessarily be driven by the state's unique geography, demographics, medical markets, and the needs of Medicaid recipients.

We hope this is helpful. If you have questions or need additional information, please let us know.

**Medicaid: Status of State Expansion under the Affordable Care Act (ACA) and Selected Information on the use of Private Managed Care Organizations (MCO)**

Location	Status of Medicaid Expansion Under the Affordable Care Act <sup>1</sup>	Private MCO Enrollment <sup>2</sup> (Thousands)	Private MCO as a Percent of Total Enrollment	Fiscal Years 2014-2015 <sup>3</sup>		
				New Geographic Areas Added	New Eligibility Groups Added	New Mandatory Enrollment
<b>United States</b>	Adopted: 28 states Reconsidering: 7 states Rejected: 15 states	43,331	65%	9 States	34 States	13 States
Alabama	Rejected	0	0%			
Alaska	Reconsidering	0	0%			
Arizona	Adopted	1,316	83%		X	
Arkansas	Adopted	166	19%			
California	Adopted	7,931	77%	X	X	X
Colorado	Adopted	780	72%	X	X	
Connecticut	Adopted	0	0%			
Delaware	Adopted	181	78%		X	
Florida	Rejected	2,685	74%	X	X	X
Georgia	Rejected	1,177	68%		X	
Hawaii	Adopted	326	100%		X	
Idaho	Rejected	0	0%			
Illinois	Adopted	378	12%	X	X	X
Indiana	Adopted	760	68%		X	X
Iowa	Adopted	59	11%	X	X	
Kansas	Rejected	399	93%			
Kentucky	Adopted	1,050	90%		X	
Louisiana	Rejected	907	71%		X	X
Maine	Rejected	0	0%			
Maryland	Adopted	1,077	84%			
Massachusetts	Adopted	773	42%		X	X
Michigan	Adopted	1,459	76%		X	
Minnesota	Adopted	801	75%		X	
Mississippi	Rejected	160	21%		X	
Missouri	Reconsidering	389	47%			
Montana	Reconsidering	0	0%			
Nebraska	Rejected	188	81%		X	
Nevada	Adopted	403	67%		X	
New Hampshire	Adopted	127	86%	X	X	X
New Jersey	Adopted	1,476	92%		X	
New Mexico	Adopted	578	89%		X	X
New York	Adopted	4,389	76%	X	X	X

**Medicaid: Status of State Expansion under the Affordable Care Act (ACA) and Selected Information on the use of Private Managed Care Organizations (MCO) (continued)**

Location	Status of Medicaid Expansion Under the Affordable Care Act <sup>1</sup>	Private MCO Enrollment <sup>2</sup> (Thousands)	Private MCO as a Percent of Total Enrollment	Fiscal Years 2014-2015 <sup>3</sup>		
				New Geographic Areas Added	New Eligibility Groups Added	New Mandatory Enrollment
North Carolina	Rejected	0	0%			
North Dakota	Adopted	13	Unavailable	X	X	X
Ohio	Adopted	2,133	84%		X	
Oklahoma	Rejected	0	0%			
Oregon	Adopted	850	86%		X	
Pennsylvania	Adopted	1,668	74%		X	
Rhode Island	Adopted	223	86%		X	
South Carolina	Rejected	737	64%		X	X
South Dakota	Rejected	0	0%			
Tennessee	Reconsidering	1,241	100%			
Texas	Rejected	3,539	89%		X	
Utah	Reconsidering	195	78%		X	X
Vermont	Adopted	0	0%			
Virginia	Reconsidering	707	78%		X	
Washington	Adopted	1,186	73%		X	X
West Virginia	Adopted	202	40%		X	
Wisconsin	Rejected	702	62%	X	X	
Wyoming	Reconsidering	0	0%			

Notes: 1) Expansion status as of January 27, 2015. "Reconsidering" indicates that following the state's initial rejection of expansion, the governor and/or legislature in the states listed have indicated that serious consideration is being given to pursuing Medicaid expansion under the ACA.

2) This column shows the number of Medicaid enrollees covered by a comprehensive Managed Care Organization plan for medical services offered by private-sector insurance providers or public organizations that are not state agencies. Figures include only medical coverage; behavioral, dental, and pharmaceutical managed care plans are not considered.

3) These three columns indicate whether states have expanded the geographical scope and eligibility of Medicaid MCO plans, and if mandatory enrollment in an MCO has been implemented, during fiscal years 2014 and 2015.

Sources: Status of Medicaid expansion and MCO geographic / eligibility expansion and mandatory enrollment: Kaiser Family Foundation, State Health Facts, Medicaid and CHIP, <http://kff.org/state-category/medicaid-chip/>. Private MCO enrollment by state data: Ari Gottlieb, "The Expanded State of Medicaid in the United States: Private Medicaid Health Plans Crossing the Tipping Point," PricewaterhouseCooper, January 2015, [http://www.mhpa.org/\\_upload/201501StateofMedicaid2014.pdf](http://www.mhpa.org/_upload/201501StateofMedicaid2014.pdf).



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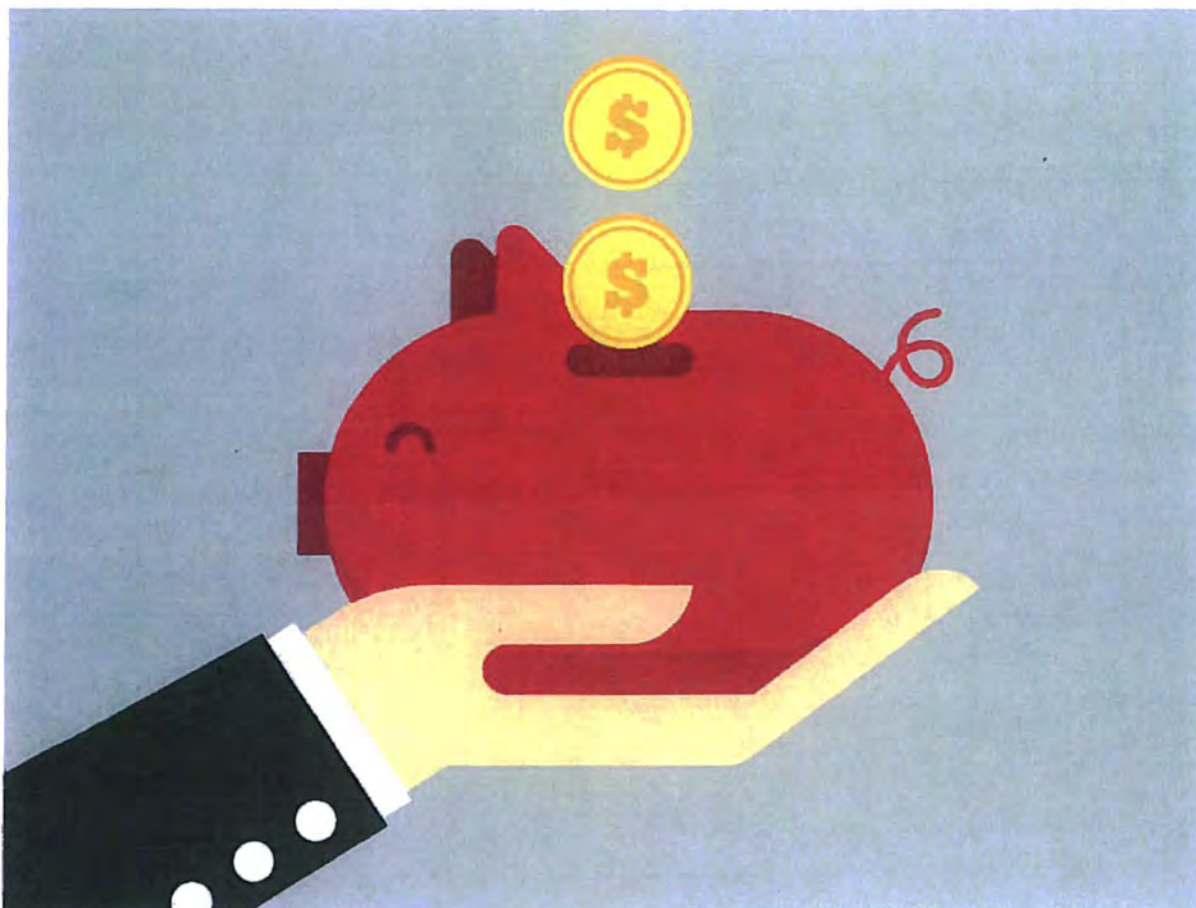
policy-ish

## States Experiment With Health Savings Accounts For Medicaid

JULY 22, 2014 9:43 AM ET

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If all goes according to plan, next year many Arkansas Medicaid beneficiaries will be required to make monthly contributions to so-called Health Independence Accounts. Those who don't may have to pay more of the cost of their medical services, and in some cases may be refused services.

Supporters say it will help nudge Medicaid beneficiaries toward becoming more cost-conscious health care consumers. Patient advocates are skeptical, pointing to studies showing that such financial "skin-in-the-game" requirements discourage low-income people from getting care that they need.

The states of Michigan and Indiana have already implemented health savings accounts for their Medicaid programs, modeled after the accounts that are increasingly popular in the private market.

In Michigan and Indiana, people can use the funds, which may be supplemented by the state, to pay for services subject to the plan deductible, for example, or to cover the cost of other medical services.



SHOTS - HEALTH NEWS  
Arkansas Medicaid Expansion  
Attracts Other States' Interest

The program particulars in each state differ. But both states – and the Arkansas proposal – require beneficiaries to make monthly

contributions into the accounts in order to reap certain benefits, such as avoiding cost sharing for medical services. Funds in the accounts may roll over from one year to the next, and participants may be able to use them to cover their medical costs if they leave the Medicaid program.

"We believe in consumerism," says John Selig, director of the Arkansas Department of Human Services. By requiring Medicaid beneficiaries to make a monthly contribution to a Health Independence Account, "we think they'll use care more appropriately and get a sense of how insurance works."

Under the health law, states can expand Medicaid coverage to adults with incomes up to 138 percent of the federal poverty level.

Arkansas is one of several states, including Iowa and Pennsylvania, that is experimenting with using Medicaid funds to enroll new Medicaid-eligible beneficiaries in private health insurance through the Affordable Care act marketplace.

For 2015, Arkansas wants to expand its experiment by introducing the Health Independence Accounts. Nearly all beneficiaries earning between 50 and 138 percent of the poverty level (\$5,835 to \$16,105 for an individual) would have to participate through monthly contributions of between \$5 and \$25, depending on their income, or face cost-sharing requirements capped at 5 percent of income by Medicaid rules.



SHOTS - HEALTH NEWS  
In Michigan, Businessmen And  
Politicians Agree On Medicaid

In addition, Medicaid enrollees with incomes over the poverty level could be refused services if they don't make their monthly contribution and don't make a

copayment. (This year, those with incomes between 100 and 138 percent of poverty already have copays.)

Each month that a beneficiary would make a payment to his or her account, the state would contribute \$15. Unused amounts would roll over from one year to the next up to a maximum of \$200, which could be used by the beneficiary for health care costs if he or she leaves Medicaid for private coverage.

At least 40 states charge premiums or cost sharing for at least some beneficiaries. These beneficiaries already have skin in the game, advocates say, and they question the value of these special accounts that add a whole new layer of complexity for people

who may not ever have had insurance before.

"We're creating these incredibly complicated administrative structures, and I don't think people will understand them," says Judith Solomon, vice president for health policy at the Center on Budget and Policy Priorities.

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[http://www.wsha.org/wshaNews\\_detail.cfm?EID=2015-01-28%2000%3A00%3A00%2E0](http://www.wsha.org/wshaNews_detail.cfm?EID=2015-01-28%2000%3A00%3A00%2E0)

### **Description**

ER Is for Emergencies is a campaign in Washington State to help reduce preventable emergency room visits and redirect care to the most appropriate setting. The campaign Web site includes the following materials:

- One-page document outlining the Seven Best Practices
- Patient brochure to help redirect care to the most appropriate setting (also available in Spanish, Russian, and Vietnamese)
- Educational videos and archived webinars

### **Links to the QualityTool:**

- This tool is available at  
<http://www.wsha.org/ERemergencies.cfm>(link is external)

### **Developer:**

Washington State Medical Association; Washington State Hospital Association; Washington Chapter of the American College of Emergency Physicians

### **Funding Sources:**

Washington State Medical Association; Washington State Hospital Association; Washington Chapter of the American College of Emergency Physicians

State of New Mexico:

[http://www.santafenewmexican.com/news/business/obamacare-helps-drive-state-s-job-growth/article\\_e843b3d8-5c9b-54e3-b828-dafecf049fa2.html](http://www.santafenewmexican.com/news/business/obamacare-helps-drive-state-s-job-growth/article_e843b3d8-5c9b-54e3-b828-dafecf049fa2.html)

- The decision to expand Medicaid in NM has led to a “meteoric” rise in health care hiring accounting for nearly half of all new private-sector jobs.
- Health care hiring accounted for 43 percent of the total job gains in NM in 2014.

State of Kentucky:

- Recent Deloitte Consulting Medicaid expansion report for Kentucky showed:
  - Medicaid expansion created 12,000 health care jobs in KY in 2014 (more than the 7600 predicted in 2013 study.
  - Expected 40,000 jobs created by 2021.
  - \$30 billion to KY economy through 2021.
  - Net budget gain of \$820 million for state and local governments through 2021.
- In Kentucky, after expansion, uncompensated care visits at hospitals fell 55 percent from the prior year. Also primary care revenues increased 52 percent and hospitals showed an average 27 percent growth in revenues.

[http://www.nytimes.com/2015/02/13/us/study-backs-kentucky-medicare-expansion.html?\\_r=0](http://www.nytimes.com/2015/02/13/us/study-backs-kentucky-medicare-expansion.html?_r=0)

## Medicaid Expansion Issue Brief

### No Net Additional State Funding Needed to Implement Medicaid Expansion – Several States Project Net Savings to State’s General Fund over First Three Years –

#### Summary Findings

The option available to each State to implement an expansion of Medicaid to all persons under 138 percent of the federal poverty level (Medicaid Expansion) has resulted in projections of immediate savings in several States. Under the Medicaid Expansion, health care costs are fully financed by the Federal government through the end of 2016, with the State required to cover only a portion of related administrative costs. Reductions in costs for other existing State-funded programs—primarily resulting from reduced numbers of uninsured residents and their associated uncompensated care costs—are sufficient to more than offset the additional administrative costs from implementation of the Medicaid Expansion. The State of Alaska is likewise projected to experience net reductions in State-funded expenditures during implementation of the Medicaid Expansion.

#### Modest Additional Administrative Costs Offset by Reductions in State Funding for Existing Programs

Republican- and Democratic-led states project net reductions in State-funded expenditures as a result of Medicaid Expansion implementation. The offsetting savings to a State’s General Fund are achieved, in part, from: 1) Reductions in State-only spending on programs aimed at uninsured residents; 2) reductions in State-only spending on health care services to prisoners; 3) the transition of some State employees to Medicaid; and 4) increases in revenues to the State resulting from the inflow of millions of dollars in new Federal funding.

#### Estimated Effect of Medicaid Expansion on State Spending in Selected States

Shown below are projections of the impact of Medicaid Expansion implementation in several States. Some States have already implemented the Medicaid Expansion (New Mexico, Colorado, and Oregon), and other states are considering implementing the Medicaid Expansion or have begun the implementation process (Montana, Idaho, New Hampshire, and Wyoming).

<b>New Mexico: Estimated Effect of Medicaid Expansion on State Spending, FY 2014 to FY 2017 (in millions)</b>					
	<b>FY 2014</b>	<b>FY 2015</b>	<b>FY 2016</b>	<b>FY 2017</b>	<b>Cumulative: 2014 - 2017</b>
Health Service costs	\$0.0	\$0.0	\$0.0	\$27.4	\$27.4
Administrative costs	\$2.6	\$2.8	\$2.9	\$3.0	\$11.3
Expansion savings*	(\$18.8)	(\$35.2)	(\$32.0)	(\$28.9)	(\$114.9)
<b>Net change</b>	<b>(\$16.2)</b>	<b>(\$32.4)</b>	<b>(\$29.1)</b>	<b>\$1.5</b>	<b>(\$76.2)</b>

\*Figures include savings for individuals currently covered by the State Coverage Insurance Program who would enroll in Medicaid under the expansion. Source: New Mexico Human Services Department  
[http://www.hsd.state.nm.us/uploads/Filelinks/f13cd6ab72d244089c5bf80111f07524/Medicaid\\_Expansion\\_update\\_2014.docx](http://www.hsd.state.nm.us/uploads/Filelinks/f13cd6ab72d244089c5bf80111f07524/Medicaid_Expansion_update_2014.docx)

<b>New Hampshire: Estimated Effect of Medicaid Expansion on State Spending, 2014 to 2017 (in thousands)*</b>					
	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>Cumulative: 2014 - 2017</b>
<b>Net costs</b>	<b>(\$3,053)</b>	<b>(\$3,958)</b>	<b>(\$18,643)</b>	<b>(\$854)</b>	<b>(\$26,508)</b>

\* Figures assume implementing the Medicaid expansion in 2014 under a fee for service system, for all adults in the state with an income not exceeding 138 percent FPL.  
Source: New Hampshire Department of Health and Human Services (prepared by Lewin Group)  
<http://www.dhhs.nh.gov/ombp/documents/nhimpactofmedicaidexpansionv8550719.pdf>  
<http://www.dhhs.state.nh.us/ombp/documents/nhmedicaidexpansion-phaseiiireport-v6-551398.pdf>

## Medicaid Expansion Issue Brief

### Colorado: Estimated Effect of Medicaid Expansion on Annual State-Supported Spending, FY 2013-14 to FY 2016-17 (in millions)

	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	Cumulative: 2014 - 2017
General fund	(\$25.2)	(\$42.2)	(\$42.2)	(\$20.1)	(\$129.7)

Source: Colorado Health Foundation (prepared by Charles Brown Consulting)

[https://www.statereforum.org/sites/default/files/medicaid\\_expansion\\_examining\\_the\\_impact\\_on\\_colorado\\_s\\_economy\\_2.11.2013.pdf](https://www.statereforum.org/sites/default/files/medicaid_expansion_examining_the_impact_on_colorado_s_economy_2.11.2013.pdf)

### Montana: Estimated Effect of Medicaid Expansion on State Spending, FY 2014 to FY 2017, Under Two Scenarios (in millions)\*

	FY 2014	FY 2015	FY 2016	FY 2017	Cumulative: 2014 - 2017
Low-cost	(\$55.2)	(\$30.0)	(\$32.5)	(\$12.8)	(\$130.5)
High-cost	(\$56.3)	(\$32.7)	(\$35.4)	(\$13.6)	(\$138.0)

\*Figures includes state Medicaid spending, reduction in uncompensated care (including reduced DSH payments), and additional state and local tax revenue generated from implementation of Medicaid Expansion.

Source: Montana Office of the Commissioner of Securities and Insurance (prepared by Bureau of Business and Economic Research, University of Montana). [http://csi.mt.gov/health/media/BBER\\_MedicaidExpansion.pdf](http://csi.mt.gov/health/media/BBER_MedicaidExpansion.pdf)

### Idaho: Estimated Effect of Medicaid Expansion on State Spending in Idaho, 2014 to FY 2017 (in millions)\*

	2014	2015	2016	2017	Cumulative: 2014 - 2017
General Fund*	(\$49.9)	(\$100.6)	(\$104.4)	(\$88.7)	(\$343.6)

\* Figures include additional state tax revenue, Catastrophic Health Care Cost Program (CAT Fund) savings, additional behavioral and public health savings, and County Indigent Fund savings.

Source: Idaho Workgroup on Medicaid Expansion (analysis by Idaho Hospital Association)

<http://gov.idaho.gov/priorities/pdf/Medicaid%20Expansion%20Workgroup%20Final%20Report%20to%20Governor%20Otter.pdf>

### Oregon: Estimated Effect of Medicaid Expansion on State Spending, 2013 to 2017 (in millions)\*

	2013 - 2014	2014 - 2015	2015-2016	2016-2017	Cumulative: 2013 - 2017
	Biennium		Biennium		
General fund	(\$89.0)		(\$112.0)		(\$201.0)

\*Figure includes \$591 million in state spending on new coverage, \$321 million in savings due to enhanced federal matching funds from transitioning some adults into the newly eligible group and reduced costs to serve the uninsured and cover public employees and educators, and \$349 million in tax revenue due to increased economic activity generated by the new federal investment.

Source: Oregon Health Authority (prepared by Manatt Health Solutions)

[http://www.manatt.com/uploadedFiles/Content/5\\_Insights/White\\_Papers/OR\\_Effect%20of%20ACA%20Medicaid%20Expansion\\_Feb2013\\_Final.pdf](http://www.manatt.com/uploadedFiles/Content/5_Insights/White_Papers/OR_Effect%20of%20ACA%20Medicaid%20Expansion_Feb2013_Final.pdf)

In Wyoming, the Department of Health-issued report does not separate mandatory Medicaid provisions from the Medicaid Expansion option, and the report does not identify non-Department savings (such as prison health care and State employee costs). Nonetheless, just \$0.6 million in Year 1 and \$6.3 million in Year 2 were identified as additional State funding needed prior to accounting for the these additional offsets. (<http://www.health.wyo.gov/Media.aspx?mediald=13196>)

Estimates in Alaska Likewise Show a Net Reduction in State Funding Required During Implementation  
For the State of Alaska, preliminary projections anticipate net annual savings to the State's General Fund during implementation of the Medicaid Expansion, with cumulative savings carrying well past 2016.

medicaid  
and the uninsured

September 2012

**Medicaid Financing: An Overview of the Federal Medicaid Matching Rate (FMAP)****Key Findings in Brief**

**The Federal Medical Assistance Percentage (FMAP) determines the federal share of the cost of Medicaid services in each state.**

- The FMAP is based on a formula in the federal Medicaid statute that is based on state per capita income. The lower a state's per capita income, the higher the state's FMAP, or federal Medicaid matching rate. FMAPs vary from a floor of 50 percent to a high of 74 percent.
- There are exceptions to the FMAP formula for certain services and certain populations. The Affordable Care Act (ACA) provides an FMAP of 100 percent for the period 2014-2016 and at least 90 percent thereafter for the cost of covering newly eligible low-income adults.
- The costs of administration are generally matched at 50 percent, although some administrative activities receive a higher federal matching rate.
- The federal matching rates for the costs of the Children's Health Insurance Program (CHIP) are enhanced relative to the Medicaid FMAP.

**The FMAP has a multiplier effect in state economies.**

- Typically states are required to spend some of their own funds to draw down federal Medicaid dollars. For every \$1 in state funds spent on Medicaid, states can draw down at least \$1 additional from the federal government.
- States with higher FMAPs can leverage as much as \$2.85 in federal matching funds for each \$1 they spend.
- States that extend Medicaid coverage under the ACA will receive a favorable FMAP for the expansion population. The federal government will pick up the entire cost of coverage for the first three years, which will be scaled down to a matching rate of 9:1 in 2020 and beyond. So, for every \$1 a state spends on this population, it will leverage \$9 in federal matching funds. This will not vary by per capita income like the basic FMAP.

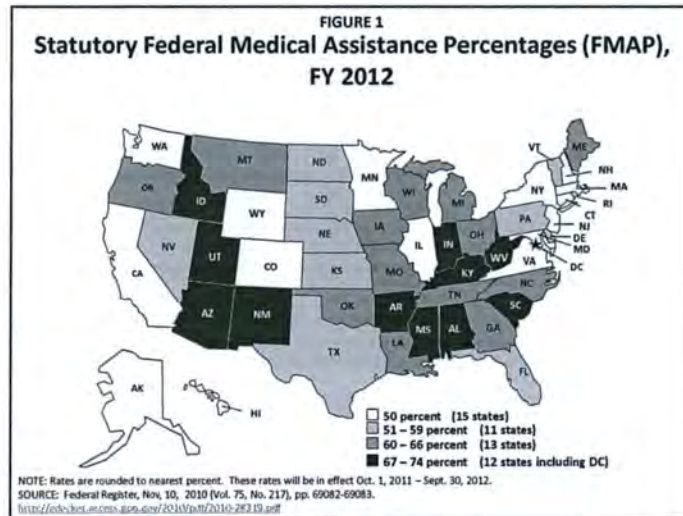
**The FMAP formula has remained basically unchanged throughout the history of the Medicaid program, and temporary adjustments to the formula have resulted in FMAP increases, not decreases.**

- On two separate occasions during the last decade, FMAPs were temporarily increased to provide fiscal relief to states during economic downturns.
- Specific-state FMAP adjustments have been made (i.e. for Louisiana following Hurricane Katrina).

Medicaid is the federal-state program for health and long-term care coverage for low-income Americans. Since its enactment in 1965, the Medicaid program has used the Federal Medical Assistance Percentage (FMAP) to determine the share of the cost of covered services that the federal government will pay in each state. On average, the federal share has been 57 percent. Beginning in 2014, the Affordable Care Act (ACA) establishes enhanced FMAPs for the cost of services to low-income adults with incomes up to 138%<sup>1</sup> of the Federal Poverty Level (FPL) who are not currently covered. The expansion FMAPs are 100 percent in 2014 through 2016, and then phase down to 90 percent in 2020 and beyond.<sup>2</sup> To place these new FMAPs in context, this policy brief provides an overview of the FMAP and temporary changes to the formula over the history of the program.

## Overview of the FMAP Formula

The Medicaid program is jointly funded by states and the federal government. In states that choose to participate—and all states have done so since 1982—the federal government pays at least half the cost of providing needed services to program beneficiaries. The federal share of those costs is determined by the Federal Medical Assistance Percentage (FMAP). The FMAP is calculated annually using a formula set forth in federal statute.<sup>3</sup> The FMAP is inversely proportional to a state's average personal income relative to the national average. States with lower average personal incomes have higher FMAPs. Personal income data is lagged, so data used for FY 2012 is from the three years of 2008 to 2010. For FY 2012, the FMAPs range from a floor of 50 to 74 percent (Figure 1). On average, the federal government pays 57 percent of the cost of Medicaid. The state share of the costs of most Medicaid services and populations is equal to 100 minus the FMAP. (The state-by-state FMAPs for FY 2012 and FY 2013 can be seen in Table 1, on page 6, and a longer discussion of the FMAP formula is described in the Appendix.)



There are several exceptions to the regular FMAPs for specific populations and services, which are summarized in Table 2 (on page 8). Some of these were enacted in the Affordable Care Act (ACA). Others are of long standing. For example, since 1973 the federal government has matched the cost of family planning services and supplies at a 90 percent rate.<sup>4</sup> Similarly, since 1976, the federal government has matched the cost of services furnished to Medicaid-eligible Native Americans and Alaska Natives through Indian Health Service (IHS) and tribal facilities at an FMAP of 100 percent.<sup>5</sup>

FMAPs do not apply to administrative costs, which are generally matched by the federal government at 50 percent match, with some exceptions described in the Appendix and Table 3 (on page 9).

## Temporary Modifications to the FMAP Formula

Despite criticism from the Government Accountability Office (GAO) and others, the FMAP formula has been basically unchanged since the enactment of Medicaid in 1965. GAO has long argued the variable in the formula, per capita income, has two major shortcomings. First, it does not adequately measure a state's total resources available to finance health and long-term care for low-income populations. Second, it does not adequately measure the size of a state's population in poverty and the cost of serving that population.<sup>6</sup> In addition, the formula does not adjust quickly for economic downturns, when unemployment increases, caseloads rise, and state revenues fall.<sup>7</sup>

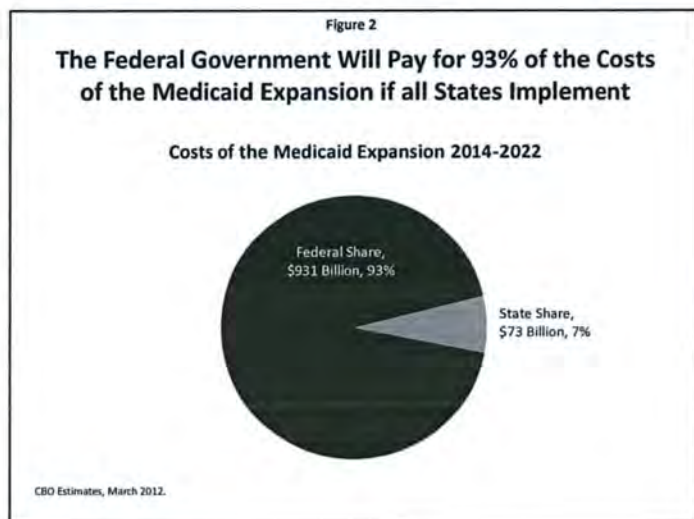
There have, however, been two occasions on which Congress has temporarily increased FMAPs to provide fiscal relief to state Medicaid programs during recessions. The first occurred in response to the 2001 recession. During the 5-quarter period beginning April 2003 through June 2004, every state's FMAP was increased by 2.95 percentage points, and every state was held harmless against any decline in its FMAP that would otherwise have occurred under the normal operation of the formula. The resulting additional federal assistance totaled \$10 billion.<sup>8</sup>

The second increase occurred in response to the Great Recession of 2007-2009. As in the case of the 2001 recession, states were held harmless against any decline in their FMAP that would otherwise have occurred, and there was an across-the-board increase in FMAPs, although, in this case, the increase was 6.2 percentage points. In addition, there was an increase in FMAP ranging from 1.88 to 5.39 percentage points, based on the increase in a state's unemployment rate. This three-part fiscal relief, including a 6-month phase-down, ran from October 2008 through June 3, 2011, and resulted in additional payments to states totaling \$103 billion.<sup>9</sup>

Congress has also temporarily adjusted FMAPs for individual states that confront unusual circumstances. This happened in the cases of Alaska,<sup>10</sup> Michigan,<sup>11</sup> and, most recently, Louisiana, due to extreme fluctuations in state per capita income in the aftermath of Hurricane Katrina.<sup>12</sup> In all of these cases, Congress enacted legislation to increase, not decrease, the FMAP. On one occasion in the early 1980s, legislation was passed to temporarily reduce federal Medicaid matching payments to states over a 3-year period, but this legislation did not alter the FMAP formula.<sup>13</sup>

#### Enhanced FMAPs in the ACA

Under the ACA, effective January 1, 2014, the federal government will pay 100 percent of the costs incurred by most states to cover newly eligible non-disabled adults under 65 with incomes at or below 138 percent of the FPL (\$15,415 per year for an individual in 2012) through 2016. This federal matching rate will phase down to 90 percent by 2020.<sup>14</sup> States that extend Medicaid coverage to low-income, non-disabled adults will not pay toward the cost of services for this newly eligible population during 2014, 2015, and 2016. This is the same 100 percent FMAP that now applies to the cost of services furnished to Native American Medicaid beneficiaries by the IHS and tribal providers. By 2020, states will have to pay 10 percent of the cost for those newly eligible. The Congressional Budget Office estimates that the federal government will pay for 93 percent of the costs of the Medicaid expansion over the 2014 to 2022 period if all states were to participate (Figure 2).<sup>15</sup>



In addition, federal regulations provide for a temporary increase in the federal administrative matching rate to 90 percent for the costs of upgrading eligibility and enrollment systems to prepare for implementation of coverage expansions under health reform.<sup>16</sup>

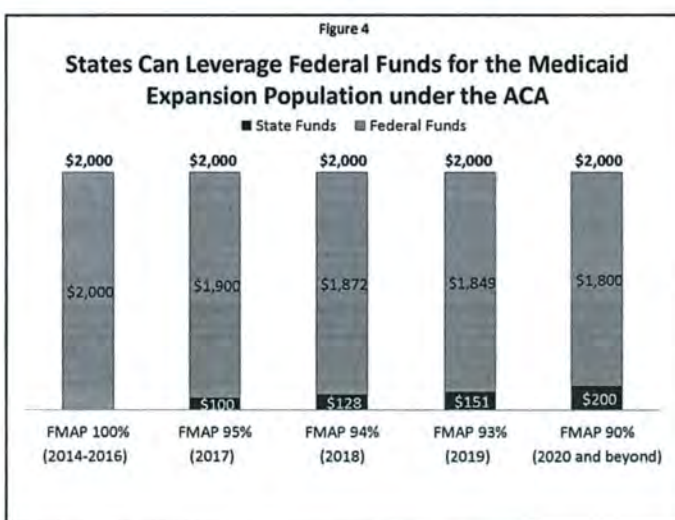
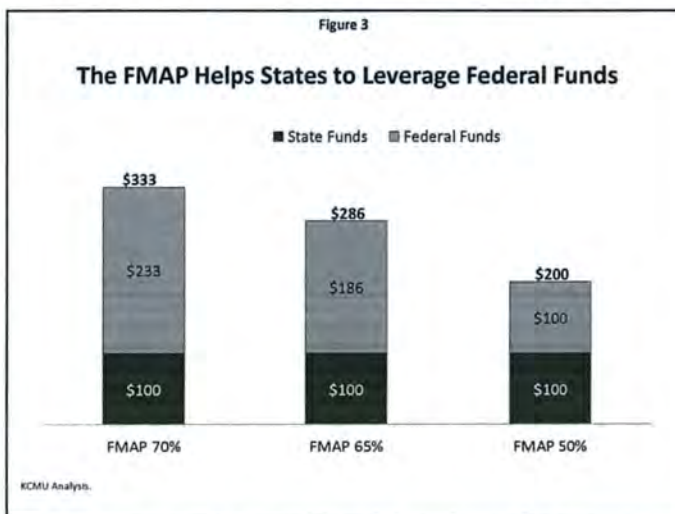
### FMAP Multiplier

FMAPs determine the federal government’s share of financing for Medicaid, which provides health and long-term care services to low-income citizens.<sup>17</sup> Viewed through a financing lens, however, FMAPs are also a measure of the leverage of a state dollar. For example, in a state with a 50 percent FMAP, \$100 in state spending can leverage \$100 in federal funds, adding \$200 in spending to the state’s economy – a multiplier of 1:1. In a state with a 70 percent FMAP, \$100 of state spending brings in \$233 in federal funds, adding \$333 in spending to the state’s economy – a multiplier of 1:2.33 (Figure 3).

A high FMAP is intended to assist a low per capita income state in purchasing covered services for its Medicaid beneficiaries. It can pay providers and plans the same amount as a low FMAP state, but with less fiscal effort. To spend \$1000 on a child, a state with a 50

percent FMAP must spend \$500 in state funds, while a state with a 70 percent FMAP must pay \$300 in state funds. However, when the high FMAP state wants to reduce its state general fund spending, it requires deeper cuts in payments to providers and plans than the low FMAP state. Using the above example, a \$100 cut in state spending would reduce total spending on the child from \$1000 to \$800 in a state with a 50 percent match rate and from \$1000 to \$667 in a state with a 70 percent match rate.

The multipliers associated with the Medicaid expansion are highly favorable to the states. Assume that a state pays \$2,000 for a covered service for an adult eligible under the expansion. During the first three years, there is no state contribution. In 2017, when the FMAP phases down to 95 percent, the state contribution to pay for a \$2000 service would be \$100 and the state share would only increase to \$200 in 2020 and beyond. The \$200 state share in 2020 still leverages \$1800 in federal funds (Figure 4).



## **Conclusion**

The FMAP formula governs the relative share of the cost of Medicaid services that the federal government pays. This formula has been basically unchanged since the enactment of the program in 1965. There are some exceptions to the formula for particular services and populations—i.e., 100% for services furnished through IHS and tribal facilities and 90% for family planning services and supplies. Those exceptions are higher than any state’s regular FMAP, apply uniformly to all states, and have been unchanged since their enactment in the 1970s. In recent years, Congress has twice increased FMAPs across the board to provide temporary fiscal relief to states during recessions. The historical record, which shows stability in availability of federal funds over time, can help inform states as they consider whether to move forward with the Medicaid expansion.

**Table 1: Current FMAPs for Medicaid and CHIP**

State	Medicaid				CHIP			
	FY 2012		FY 2013		FY 2012		FY 2013	
	FMAP	Multiplier	FMAP	Multiplier	FMAP	Multiplier	FMAP	Multiplier
United States	50.00%	1.00	50.00%	1.00	65.00%	1.86	65.00%	1.86
Alabama	68.62%	2.19	68.53%	2.18	78.03%	3.55	77.97%	3.54
Alaska	50.00%	1.00	50.00%	1.00	65.00%	1.86	65.00%	1.86
Arizona	67.30%	2.06	65.68%	1.91	77.11%	3.37	75.98%	3.16
Arkansas	70.71%	2.41	70.17%	2.35	79.50%	3.88	79.12%	3.79
California	50.00%	1.00	50.00%	1.00	65.00%	1.86	65.00%	1.86
Colorado	50.00%	1.00	50.00%	1.00	65.00%	1.86	65.00%	1.86
Connecticut	50.00%	1.00	50.00%	1.00	65.00%	1.86	65.00%	1.86
Delaware	54.17%	1.18	55.67%	1.26	67.92%	2.12	68.97%	2.22
District of Columbia	70.00%	2.33	70.00%	2.33	79.00%	3.76	79.00%	3.76
Florida	56.04%	1.27	58.08%	1.39	69.23%	2.25	70.66%	2.41
Georgia	66.16%	1.96	65.56%	1.90	76.31%	3.22	75.89%	3.15
Hawaii	50.48%	1.02	51.86%	1.08	65.34%	1.89	66.30%	1.97
Idaho	70.23%	2.36	71.00%	2.45	79.16%	3.80	79.70%	3.93
Illinois	50.00%	1.00	50.00%	1.00	65.00%	1.86	65.00%	1.86
Indiana	66.96%	2.03	67.16%	2.05	76.87%	3.32	77.01%	3.35
Iowa	60.71%	1.55	59.59%	1.47	72.50%	2.64	71.71%	2.53
Kansas	56.91%	1.32	56.51%	1.30	69.84%	2.32	69.56%	2.29
Kentucky	71.18%	2.47	70.55%	2.40	79.83%	3.96	79.39%	3.85
Louisiana	61.09%	1.57	61.24%	1.58	72.76%	2.67	72.87%	2.69
Maine	63.27%	1.72	62.57%	1.67	74.29%	2.89	73.80%	2.82
Maryland	50.00%	1.00	50.00%	1.00	65.00%	1.86	65.00%	1.86
Massachusetts	50.00%	1.00	50.00%	1.00	65.00%	1.86	65.00%	1.86
Michigan	66.14%	1.95	66.39%	1.98	76.30%	3.22	76.47%	3.25
Minnesota	50.00%	1.00	50.00%	1.00	65.00%	1.86	65.00%	1.86
Mississippi	74.18%	2.87	73.43%	2.76	81.93%	4.53	81.40%	4.38
Missouri	63.45%	1.74	61.37%	1.59	74.42%	2.91	72.96%	2.70
Montana	66.11%	1.95	66.00%	1.94	76.28%	3.22	76.20%	3.20
Nebraska	56.64%	1.31	55.76%	1.26	69.65%	2.29	69.03%	2.23
Nevada	56.20%	1.28	59.74%	1.48	69.34%	2.26	71.82%	2.55
New Hampshire	50.00%	1.00	50.00%	1.00	65.00%	1.86	65.00%	1.86
New Jersey	50.00%	1.00	50.00%	1.00	65.00%	1.86	65.00%	1.86
New Mexico	69.36%	2.26	69.07%	2.23	78.55%	3.66	78.35%	3.62
New York	50.00%	1.00	50.00%	1.00	65.00%	1.86	65.00%	1.86
North Carolina	65.28%	1.88	65.51%	1.90	75.70%	3.12	75.86%	3.14
North Dakota	55.40%	1.24	52.27%	1.10	68.78%	2.20	66.59%	1.99
Ohio	64.15%	1.79	63.58%	1.75	74.91%	2.99	74.51%	2.92
Oklahoma	63.88%	1.77	64.00%	1.78	74.72%	2.96	74.80%	2.97
Oregon	62.91%	1.70	62.44%	1.66	74.04%	2.85	73.71%	2.80
Pennsylvania	55.07%	1.23	54.28%	1.19	68.55%	2.18	68.00%	2.13
Rhode Island	52.12%	1.09	51.26%	1.05	66.48%	1.98	65.88%	1.93
South Carolina	70.24%	2.36	70.43%	2.38	79.17%	3.80	79.30%	3.83
South Dakota	59.13%	1.45	56.19%	1.28	71.39%	2.50	69.33%	2.26
Tennessee	66.36%	1.97	66.13%	1.95	76.45%	3.25	76.29%	3.22
Texas	58.22%	1.39	59.30%	1.46	70.75%	2.42	71.51%	2.51
Utah	70.99%	2.45	69.61%	2.29	79.69%	3.92	78.73%	3.70
Vermont	57.58%	1.36	56.04%	1.27	70.31%	2.37	69.23%	2.25
Virginia	50.00%	1.00	50.00%	1.00	65.00%	1.86	65.00%	1.86
Washington	50.00%	1.00	50.00%	1.00	65.00%	1.86	65.00%	1.86
West Virginia	72.62%	2.65	72.04%	2.58	80.83%	4.22	80.43%	4.11
Wisconsin	60.53%	1.53	59.74%	1.48	72.37%	2.62	71.82%	2.55
Wyoming	50.00%	1.00	50.00%	1.00	65.00%	1.86	65.00%	1.86
Puerto Rico and US Territories	50.00%	1.00	55.00%	1.22	65.00%	1.86	68.50%	2.17

## APPENDIX

**The FMAP Formula.** The FMAP formula is:

$$1 - \left[ \left( \frac{(\text{State Per Capita Income})^2}{(\text{National Per Capita Income})^2} \right) * 0.45 \right]$$

Under this formula, a state's FMAP is based on the ratio of its per capita income, squared, to the U.S. per capita income, squared. States with per capita incomes above the national level receive a lower federal matching rate; states with per capita incomes below the national level receive a higher matching rate. A state with average per capita income will have an FMAP of 55 percent. The effect of the square is to increase the range of the matching percentages.

The operation of the formula is bound by statute. No state can have an FMAP lower than 50 percent or higher than 83 percent. As shown in Table 1 (prior page), FMAPs in FY 2012 ranged from 50 percent to a high of 74.18 percent, well below the 83 percent upper bound. In FY 2013, the highest FMAP will be 73.43 percent. This reflects a historical trend in which FMAPs at the upper end are slowly declining.<sup>18</sup>

FMAPs are recalculated for each federal fiscal year and published in October or November of the prior calendar year, so that states have notice of any changes. The recalculation is based on state and national income data from the most recently available three-year period. For example, the FMAPs for FY 2013, which begins October 1, 2012, were published on November 30, 2011 and are based on per capita income data for 2008, 2009, and 2010.<sup>19</sup>

It is not unusual for any given state's FMAP to change by a percentage point or two from year-to-year due to changes in personal income. For example, Florida's FMAP will increase from 56.04 percent in FY 2012 to 58.08 percent in FY 2013. North Dakota's FMAP, on the other hand, will fall from 55.40 percent in FY 2012 to 52.27 percent in FY 2013. Because of the amount and size of most state Medicaid programs, even these small percentage point changes can have significant year-to-year fiscal consequences for state budgets.

Table 1 shows each state's FMAP for FY 2012 and FY 2013. Fourteen states have federal matching rates of 50 percent in both years: Alaska, California, Colorado, Connecticut, Illinois, Maryland, Massachusetts, Minnesota, New Hampshire, New Jersey, New York, Virginia, Washington, and Wyoming. At the other end of the spectrum, six states and the District of Columbia have matching rates of 70 percent or higher in both years: Arkansas, Idaho, Kentucky, Mississippi, South Carolina, and West Virginia.

**Enhanced FMAP for CHIP.** The enhanced FMAP, or eFMAP, is used to determine the federal share of the cost of the Children's Health Insurance Program (CHIP). It is also set by statute<sup>20</sup> and is equal to a state's FMAP, increased by 30 percent of 100 minus the state's FMAP (expressed in percentage points). For example, the eFMAP for a state with an FMAP of 50 percent is 65 percent (50 percent plus 15 percentage points (0.3 times 100 percent minus 50 percent)). By statute, the eFMAP cannot exceed 85 percent. Federal matching rates for the CHIP program are shown in Table 1. Each state's CHIP matching rate is scheduled to increase by 23 percentage points beginning October 1, 2015.<sup>21</sup>

**Exceptions to FMAP.** A state's FMAP determines the federal government's share of the state's cost for most Medicaid services and most groups of Medicaid beneficiaries. There are some exceptions, uniform across all states (see Table 2, next page). Some of these exceptions apply to mandatory populations or services. The federal government pays 100 percent of the cost of Medicaid services furnished to Native Americans and Alaska Natives who are Medicaid beneficiaries by the IHS or by tribes or tribal organizations contracting with the IHS. The federal government pays 90 percent of the costs of family planning services and supplies.

Other exceptions apply to optional populations or services. In states that elect to cover uninsured women who need treatment for breast or cervical cancer, the costs of treatment services are matched at the state's CHIP eFMAP rate. The federal government will match at a 90 percent rate, for eight calendar quarters, the cost of

providing health home services to beneficiaries with chronic conditions.<sup>22</sup> Beginning on January 1, 2013, the costs of approved clinical preventive services for adults covered without cost-sharing requirements will be matched at the state’s regular FMAP plus one percentage point.<sup>23</sup>

A number of the special FMAPs relate to long-term care services and supports. Under the Community First Choice option, the costs of home and community-based attendant services and supports a state elects to provide to individuals with disabilities are matched at the state’s regular FMAP plus 6 percentage points.<sup>24</sup> Under the “Money Follows the Person” (MFP) Rebalancing Demonstration Program, the costs of transitioning individuals out of institutions into the community are matched at an “MFP-enhanced” FMAP—the state’s regular FMAP plus half of the percentage point difference between the FMAP and 100 percent.<sup>25</sup> And, under the State Balancing Incentive Payments Program, the costs of furnishing non-institutionally based long-term care services and supports are matched at a participating state’s FMAP plus 5 percentage points or plus 2 percentage points, depending upon the percentage of long-term care spending that a state applies to home- and community-based services.<sup>26</sup>

Finally, under ACA, effective January 1, 2014, the federal government will pay 100 percent of the costs incurred by most states that cover non-disabled adults under 65 with incomes at or below 138 percent of the federal poverty level (\$15,415 per year for an individual in 2012) through 2016. This federal matching rate will phase down to 90 percent by 2020.<sup>27</sup>

**Table 2: Special Federal Matching Percentages (FMAPs)**

Service/Population	FMAP
Breast and Cervical Cancer Treatment	State's CHIP eFMAP rate
Clinical Preventive Services for Adults (effective January 1, 2013)	State's FMAP + 1 percentage point
Family Planning Services	90%
Health Home Services for Beneficiaries with Chronic Conditions	90%*
Home and Community-Based Attendant Services and Supports for People with Disabilities	State's FMAP + 6 percentage points
Money Follows the Person (MFP) Rebalancing Demonstration	MFP-enhanced FMAP**
State Balancing Incentive Payments Program	State’s FMAP + 5 or 2 percentage points***
Services provided through Indian Health Service and Tribal Facilities	100%
Newly eligible, non-disabled adults under age 65 up to 138% FPL (effective January 1, 2014)	100%****
* These services are matched at the enhanced rate for eight calendar quarters. ** Authorized through 2016. *** Authorized through 2015. **** In most states the FMAP is 100% from 2014-2016, 95% for 2017, 94% for 2018, 93% for 2019, and 90% for 2020 and beyond.	

**Administrative Matching Rates.** In general, costs incurred by states in administering the Medicaid program are matched by the federal government at a 50 percent rate. There are, however, several types of administrative functions which are matched at higher rates, ranging from 75 to 100 percent. These rates, each of which is specified in statute,<sup>28</sup> are shown in Table 3. In addition, federal regulations provide for a temporary increase in the federal matching rate to 90 percent for the costs of upgrading eligibility and enrollment systems to prepare for the implementation of coverage expansions under health reform.<sup>29</sup> Because administrative costs, on average, account for only about 4 percent of total federal program spending, these matching rates are of less fiscal consequence to a state than its FMAP.

<b>Administrative Activity or Function</b>	<b>Matching Rate</b>
Adoption and use of electronic health record (EHR) technology	100%
Citizenship verification	90%
Design, development, and installation of information systems for citizenship verification	90%
Management and operation of information systems for citizenship verification	75%
Design, development, and installation of MMIS	90%
Management and operation of MMIS	75%
Identification and education of individuals with sickle cell gene	50%
Immigration status verification	100%
Independent external reviews of managed care plans	75%
Medical and utilization review	75%
Preadmission screening and resident review	75%
Skilled professional medical personnel	75%
State fraud and abuse control unit activities	75%
State survey and certification	75%
Translation and interpretation services for children	75%
Other program administration activities	50%**
* By regulation, the matching rate for the costs of upgrading eligibility and enrollment systems incurred before December 31, 2015 is 90%.	
** Includes identification and education of individuals with Sickle Cell Disease.	

<sup>1</sup> The income standard for the newly eligible low-income adult group is at or below 133% of FPL (\$14,856 for an individual, \$30,656 for a family of four in 2012). However, in calculating income, the Medicaid statute requires that states disregard an amount of income equal to 5 percent of the FPL, which takes into account family size. As a result, the effective income eligibility level is at or below 138% of FPL (\$15,415 for an individual, \$31,809 for a family of four in 2012).

<sup>2</sup> Kaiser Commission on Medicaid and the Uninsured, *How will the Medicaid Expansion for Adults Impact Eligibility and Coverage?*, July 2012, available at <http://www.kff.org/medicaid/8338.cfm>.

<sup>3</sup> Sections 1905(b) and 1101(a)(8)(B) of the Social Security Act. The formula does not determine the FMAPs for the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands; for these jurisdictions, the FMAPs are fixed in statute. The FMAP for the District of Columbia is set at 70 percent per section 4725(b) of the Balanced Budget Act of 1997, P.L. 105-33. The FMAPs for Puerto Rico and the territories are set at 55% per section 2005(c) of the Patient Protection and Affordable Care Act, P.L. 111-148.

<sup>4</sup> Section 299E(a) of the Social Security Amendments of 1972. P.L. 92-603.

<sup>5</sup> Section 402(e) of the Indian Health Care Improvement Act of 1976, P.L. 94-437.

<sup>6</sup> The Government Accountability Office (GAO) has proposed revising the formula by substituting total taxable resources and people in poverty for per capita income as the factors driving the formula. Government Accountability Office, *Medicaid: Matching Formula's Performance and Potential Modifications* (GAO/T-HEHS-95-226), July 27, 1995. Differences in Funding Ability Among States Often are Widened, (GAO-03-620), July 10, 2003.

<sup>7</sup> Government Accountability Office, *Medicaid: Improving Responsiveness of Federal Assistance to States During Economic Downturns* (GAO 11-395), March 31, 2011; *Medicaid: Prototype Formula would Provide Automatic, Targeted Assistance to States During Economic Downturns* (GAO 12-38), November 2011.

<sup>8</sup> V. Wachino, M. O'Malley, R. Rudowitz, *Financing Health Coverage: the Fiscal Relief Experience*, Kaiser Commission on Medicaid and the Uninsured, November 2005, available at <http://www.kff.org/medicaid/7434.cfm>.

<sup>9</sup> Kaiser Commission on Medicaid and Uninsured, *Impact of the Medicaid Fiscal Relief Provisions in the American Recovery and Reinvestment Act (ARRA)*, October 2011, available at <http://www.kff.org/medicaid/8252.cfm>.

<sup>10</sup> Section 4725(a) of the Balanced Budget Act of 1997, P.L. 105-33, set the FMAP for Alaska at 59.8 percent for fiscal years 1998, 1999, and 2000.

<sup>11</sup> Section 614 of the Children's Health Insurance Program Reauthorization Act of 2009, P.L. 111-3, requires that, in calculating per capita income for a state, the Secretary disregard employer pension and insurance fund contributions made beginning in calendar year 2003 if they exceed 25 percent of the total increase in personal income in the state for the year. The purpose was to adjust for the impact of the one-time auto manufacturer pension distribution on Michigan's FMAP beginning in FY 2006.

<sup>12</sup> Section 2006 of the Patient Protection and Affordable Care Act, P.L. 111-148. This provision was subsequently modified to adjust for an unintentional overpayment by section 3204(b) of the Middle Class Tax Relief and Job Creation Act of 2012, P.L. 112-96, and by section 100123 of the Moving Ahead for Progress in the 21st Century Act (MAP-21), P.L. 112-141.

<sup>13</sup> Section 2161(a) of the Omnibus Budget Reconciliation Act of 1981, P. L. 97-35, temporarily reduced federal Medicaid matching payments to states over a 3-year period but it did so without altering the FMAP formula. Instead, it reduced the amount of federal Medicaid matching funds a state would otherwise receive after applying its regular FMAP to its spending on services. The amount of the reduction was determined by a percentage: 3 percent in FY 1982, 4 percent in FY 1983, and 4.5 percent in FY 1984. This percentage was adjusted downward in the case of states with high unemployment, states that adopted specified policies to control hospital costs, states that had high fraud and abuse recoveries, and states that met low spending growth targets.

<sup>14</sup> For states that were covering childless adults at their existing federal matching rates prior to March 23, 2010, the ACA phases in an increase in the federal matching rate so that by 2019, federal matching rates for this population will equal the rate for the newly eligible Medicaid expansion population at 93% in 2019 and 90% in 2020 and prospectively. Kaiser Commission on Medicaid and the Uninsured, *Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL*, May 2010, available at <http://www.kff.org/healthreform/8076.cfm>.

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<sup>15</sup> The CBO revised its estimates for federal and state Medicaid spending in light of the Supreme Court decision in the National Federation of Independent Business (NFIB) case. The revised estimate projects federal Medicaid spending of \$642 billion and state Medicaid spending of \$41 billion over the 2014 through 2022 period. Table 4 available at <http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf>.

<sup>16</sup> 76 *Fed. Reg.* 21949 (April 19, 2012). Enhanced funding at the 90% rate is available for costs of goods and services incurred by December 31, 2015 for design, development and implementation (DDI) that comply with certain defined standards and conditions. Enhanced funding at the 75% rate is available for maintenance and operations (M&O) of systems that were built using enhanced funding during the DDI phase. Available at <https://www.federalregister.gov/articles/2011/04/19/2011-9340/medicaid-program-federal-funding-for-medicaid-eligibility-determination-and-enrollment-activities>.

<sup>17</sup> At least nominally. The effective federal matching rate is also a function of the nature of the state share. D. Rousseau and A. Schneider, *Current Issues in Medicaid Financing—An Overview of IGTs, UPLs, and DSH*, Kaiser Commission on Medicaid and the Uninsured, April 2004, available at <http://www.kff.org/medicaid/7071.cfm>.

<sup>18</sup> Kaiser Commission on Medicaid and the Uninsured, *An Overview of Changes in the Federal Medical Assistance Percentages (FMAPs) for Medicaid*, July 2011, available at <http://www.kff.org/medicaid/8210.cfm>.

<sup>19</sup> 76 *Fed. Reg.* 74061 (November 30, 2011), available at <http://www.gpo.gov/fdsys/pkg/FR-2011-11-30/pdf/2011-30860.pdf>.

<sup>20</sup> Section 2105(b) of the Social Security Act.

<sup>21</sup> Section 2101(a) of the Patient Protection and Affordable Care Act, P.L. 111-148. This enhanced eFMAP cannot exceed 100 percent and expires on September 30, 2019. Federal allotments for CHIP are fully authorized through FY 2015 only, section 10203 of P.L. 111-148.

<sup>22</sup> Section 1945(c)(1) of the Social Security Act, as added by section 2703 of the Patient Protection and Affordable Care Act, P.L. 111-148.

<sup>23</sup> Section 1905(b)(5) of the Social Security Act, as added by section 4106 of the Patient Protection and Affordable Care Act, P.L. 111-148.

<sup>24</sup> Section 1915(k)(2) of the Social Security Act, as added by Section 2401 of the Patient Protection and Affordable Care Act, P.L. 111-148.

<sup>25</sup> The MFP Rebalancing Demonstration program was authorized through 2011 by section 6071 of the Deficit Reduction Act of 2005, P.L. 109-171, and reauthorized through 2016 by section 2403 of the Patient Protection and Accountable Care Act, P.L. 111-148. The “MFP-enhanced” FMAP cannot exceed 90 percent. The total amount of federal matching funds for this demonstration is capped at \$450 million per year.

<sup>26</sup> The State Balancing Incentive Payments Program is authorized through 2015 by section 10202 of the Patient Protection and Affordable Care Act, P.L. 111-148. The enhanced FMAP is applied to the cost of non-institutional long-term care services and supports, not across-the-board, in states that elect to participate. States in which less than 25 percent of Medicaid long-term care spending was used to pay for home and community-based services (HCBS) in 2009 qualify for a 5 percentage point increase in their FMAP. States in which less than 50 percent of Medicaid long-term care spending was used to pay for HCBS services receive a 2 percentage point increase. Total federal matching funds available through 2015 are capped at \$3 billion.

<sup>27</sup> Kaiser Family Foundation, *A Guide to the Supreme Court’s Affordable Care Act Decision*, July 2012, available at <http://www.kff.org/healthreform/8332.cfm>. For states that were covering childless adults prior to March 23, 2010, the ACA phases in an increase in the federal matching rate so that by 2019, federal matching rates for this population will equal the rate for the newly eligible Medicaid expansion population at 93% in 2019 and 90% in 2020 and beyond. Kaiser Commission on Medicaid and the Uninsured, *Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL*, May 2010, available at <http://www.kff.org/healthreform/8076.cfm>.

<sup>28</sup> Section 1903(a)(2)–(7) of the Social Security Act.

<sup>29</sup> See footnote 16.

1330 G STREET NW, WASHINGTON, DC 20005  
PHONE: (202) 347-5270, FAX: (202) 347-5274  
WEBSITE: WWW.KFF.ORG/KCMU

This report (#8352) is available on the Kaiser Family Foundation's website at [www.kff.org](http://www.kff.org).



The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.

### Few, if Any, Additional State Funds Needed in 2015 and 2016

– Nearly Sufficient Savings to the State of Alaska from One Offset Alone:  
Partial Shift of Prisoner Health Care Costs to Medicaid –

#### Summary Findings

Implementation of the Medicaid Expansion option in Alaska will result in significant savings in other components of the State of Alaska budget. One initiative alone is projected to offset largely the additional State-funded Medicaid administrative costs required to implement the Medicaid Expansion over the initial two years. (No State funding is needed to finance *health care services* to the newly-eligible individuals in 2015 and 2016, as the Federal government will cover 100 percent of these expenditures through 2016.) Immediate attention is warranted to refine the administrative cost estimates and to solidify the calculations of likely General Fund offsets.

Rough estimates are that State-funded Medicaid administrative costs might increase by \$5 million-\$6 million per year to implement the Medicaid Expansion. Extending Medicaid eligibility to State prisoners is projected to reduce State-funded expenditures by roughly \$5 million per year when fully implemented. After accounting for this one offset, the State of Alaska will require few—if any—net additional State funds in 2015 or 2016 to implement the Medicaid Expansion option. In fact, other identified offsets will likely result in a net reduction in required State General Fund dollars the first two years.<sup>1</sup>

#### Expansion of Medicaid to Prisoners

Federal law prior to the Affordable Care Act (ACA) excluded from Medicaid eligibility adults who did not have disabilities, were not pregnant, or did not have dependent children, unless states obtained waivers to expand coverage to these populations. This resulted in few prisoners being eligible for Medicaid. Currently, the State of Alaska does not extend Medicaid eligibility to prisoners and solely relies on State tax dollars to provide health services to State prisoners, a population with mental illness, substance use disorder, infectious disease, and chronic condition rates that are as much as 7 times higher than those in the general population.<sup>2</sup> Under the Medicaid Expansion option, the State of Alaska will have the opportunity to reduce *State-funded* health care costs for prison inmates, as Medicaid eligibility could be made available to nearly all prisoners and a portion of their costs would be borne by the Federal government.

#### Experiences in Other States (Pre-Medicaid Expansion)

For Medicaid-enrolled prisoners, States can obtain federal Medicaid matching funds *for health care services provided when they are admitted as inpatients in a community hospital, nursing facility, juvenile psychiatric facility, or intermediate care facility for at least 24 hours.*<sup>3</sup> As of December 2013 (pre-Medicaid Expansion authorization), at least 14 states billed Medicaid for at least some allowable services provided to inmates.<sup>4</sup> For example, North Carolina reported saving

Department of Corrections (DOC): In 2012, the State of Alaska DOC budgeted \$32.4 million for prisoners' health care. Of this amount, \$17.5 million was used to purchase health care from private providers. The State spent an average of \$6.7 million on a subgroup considered "high-cost" cases, with a most of the care provided as inpatient services requiring an overnight stay.

Currently in Alaska, Medicaid does not pay for any health care for prisoners. Extending Medicaid eligibility to prisoners is estimated to save the State \$5 million per year in General Fund dollars when fully implemented.

## Medicaid Expansion Briefing Paper

\$2.5 million in the first year (2011) of billing Medicaid for allowable services and has increased federal revenues in subsequent years, despite having only about 2 percent of inmates in the state's prisons eligible for Medicaid at any given time (pre-Medicaid Expansion). Pennsylvania reported \$7.1 million in annual savings pre-Medicaid Expansion. California reported saving about \$31 million in 2013.<sup>5</sup>

### Savings to States to Grow

Each of the states that sought Federal Medicaid matching funds for certain services to inmates pre-Medicaid Expansion implementation anticipate substantially greater budget offsets as a result of Medicaid Expansion implementation. This will be achieved due to Medicaid eligibility extending to 70 percent-90 percent of prisoners (versus 2 percent-4 percent pre-Medicaid Expansion). California, New York, and Colorado—all of which have moved forward with the Medicaid Expansion—estimate, respectively, that 72 percent, 80 percent, and 90 percent of inmates would qualify for the program in 2014.<sup>6</sup> And the federal Medicaid matching rates for most of the enrollees will be 90 percent-100 percent versus the current nationwide average of 57 percent, and a 50 percent Federal matching rate in Alaska.<sup>7</sup>

### Additional Benefits

In addition to the savings on State-funded health care expenditures for prison inmates, Medicaid Expansion enables states to facilitate continued access to care for individuals recently released from incarceration, thereby preventing disruptions that can lead to higher future costs. Many recently released inmates who lack access to care rely on emergency department services, shifting much of the cost burden to hospitals and state, county, and city agencies.<sup>8</sup> Recently released inmates account for a significant share of total uncompensated care.<sup>9</sup> In addition, lack of access to care for recently released inmates with mental illnesses or substance use disorders is linked with a higher recidivism rate, which increases the cost burden for state and local corrections agencies.<sup>10</sup>

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<sup>1</sup> See the State-commissioned Lewin Report and the ANTHC-commissioned Urban Institute report for listings of offsets <http://www.anthctoday.org/news/medicaid.html>.

<sup>2</sup> 76 *Federal Register* 39438-43. See <http://www.gpo.gov/fdsys/pkg/FR-2011-07-06/pdf/2011-16844.pdf>.

<sup>3</sup> 42 U.S.C. § 1396d(a)(29)(A).

<sup>4</sup> Council of State Governments Justice Center, *Policy Brief: Opportunities for Criminal Justice Systems to Increase Medicaid Enrollment, Improve Outcomes, and Maximize State and Local Budget Savings* (New York: Dec. 2013), 4. <http://csgjusticecenter.org/wp-content/uploads/2013/12/ACA-Medicaid-Expansion-Policy-Brief.pdf>.

<sup>5</sup> Christine Vestal, "States Missing Out on Millions in Medicaid for Prisoners," *Stateline: The Daily News Service of the Pew Charitable Trusts* (Washington, D.C.), June 25, 2013. <http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2013/06/25/states-missing-out-on-millions-in-medicaid-for-prisoners>

<sup>6</sup> Government Accountability Office (GAO), *Medicaid: Information on Inmate Eligibility and Federal Costs for Allowable Services* (Washington, D.C.: Sept. 5, 2014), 4. <http://www.gao.gov/assets/670/665552.pdf>.

<sup>7</sup> Kaiser Commission on Medicaid and the Uninsured, *Medicaid Financing: An Overview of the Federal Medicaid Matching Rate (FMAP)* (Washington, D.C.: Sept. 2012), 1. <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8352.pdf>.

<sup>8</sup> Council of State Governments Justice Center, 1.

<sup>9</sup> Allison Hamblin, et al., *Medicaid and Criminal Justice: The Need for Cross-System Collaboration Post Health Care Reform* (Oakland: Community Oriented Correctional Health Services, Jan. 2011), 1. [http://www.cochs.org/files/CHCS\\_Final.pdf](http://www.cochs.org/files/CHCS_Final.pdf).

<sup>10</sup> *Ibid.*

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## The ACA and Medicaid Expansion Waivers

Robin Rudowitz, Samantha Artiga and MaryBeth Musumeci

### Executive Summary

Under the Affordable Care Act (ACA), Medicaid plays a key role in efforts to reduce the number of uninsured by expanding eligibility to nearly all low income adults with incomes at or below 138% FPL (\$16,242 per year for an individual in 2015); however, the Supreme Court ruling on the ACA's constitutionality effectively made the expansion a state option. As of February 2015, 29 states including DC are implementing the expansion. Nearly all states (24 of 29) are implementing the expansion as set forth by law, but a limited number of states have obtained or are seeking approval through Section 1115 waivers to implement the expansion in ways that extend beyond the flexibility provided by the law. More states are discussing alternative models through waivers as a politically viable way to implement expansion in order to extend coverage and capture federal dollars.

This brief provides an overview of the role of Section 1115 waivers in expanding coverage since the enactment of the ACA. The brief also highlights key themes in these waivers including implementing the Medicaid expansion through a premium assistance model, charging premiums, eliminating certain required benefits (most notably non-emergency medical transportation), and using healthy behavior incentives as well as provisions that CMS has not approved.

**To date, five states have received approval of a Section 1115 waiver to implement the Medicaid expansion (Arkansas, Iowa, Michigan, Pennsylvania and most recently Indiana).** These waivers allow the states to implement the Medicaid expansion in ways that do not meet federal rules and still access enhanced federal matching funds for newly eligible adults. Under the ACA, the federal government will pay 100% of the costs of those newly eligible for 2014-2016 and then the federal share phases down to 90% in 2020 and beyond. While the waivers are each unique, they include some common provisions such as implementing the Medicaid expansion through a premium assistance model, charging premiums, eliminating certain required benefits (most notably non-emergency medical transportation), and using healthy behavior incentives. The Pennsylvania waiver was approved under Governor Corbett, but the current Governor Wolf announced that Pennsylvania will transition to a traditional Medicaid expansion plan and he will not implement the benefit and work changes that the previous Governor had initiated.

**The most recent waiver approval in Indiana includes provisions that had not been approved in other states.** These new provisions include allowing the state not to provide retroactive eligibility; to make coverage effective beginning on the date of the first premium payment, rather than on the date of application; and to bar certain expansion adults from re-enrolling in coverage for six months if they are dis-enrolled for unpaid premiums. In addition, under separate waiver authority (§1916(f)), Indiana received approval to charge

higher cost sharing for non-emergency use of the emergency room than otherwise allowed under federal rules (Table 1).

**Several states have waiver proposals pending or in development.** There is no deadline for states to participate in the Medicaid expansion and moving into the legislative sessions for 2015, other states continue to explore opportunities to implement the Medicaid expansion. Governors in both [Tennessee](#) and [Utah](#) have been negotiating plans with CMS, but these plans also need to be approved by the state legislature. In a special session in early February, the legislature in Tennessee rejected the Governor’s expansion plan. In Utah, a legislative taskforce did not endorse the Governor’s plan but legislative debate continues. The Wyoming Department of Health published its recommendation for an alternative Medicaid Expansion plan, called the SHARE plan, in November 2014; however, the state Senate voted against the plan in early February 2015. [New Hampshire](#), a state that had implemented the expansion, also has a waiver pending with CMS to continue the expansion through a premium assistance model.

**Table 1: Key Themes in ACA Expansion Waivers and Proposals**

	Premium Assistance	Premiums / Monthly Contributions	Healthy Behavior Incentives	Benefits	Work Referral	Co-Payments <sup>7</sup>	Waivers of Retroactive Eligibility / Reasonable Promptness
<b>Approved Waivers</b>							
Arkansas <sup>1</sup>	Mandatory for QHPs	X					
Iowa	Optional for QHPs	X	X	X			
Indiana <sup>2</sup>	Optional for ESI	X	X	X		X	X
Michigan		X	X				
Pennsylvania <sup>3</sup>		X	X	X			
<b>Waiver Proposals</b>							
New Hampshire <sup>4</sup>	Mandatory for QHPs				X		X
Tennessee <sup>5</sup>	Optional for ESI	X	X	X		X	X
Utah <sup>5</sup>	Mandatory for QHPs and ESI	X	X	X		X	

<sup>6</sup>Cost-sharing waivers were approved in Indiana and are proposed in Tennessee and Utah through §1916(f) not §1115 waiver authority.

<sup>1</sup>The monthly contributions in AR are in lieu of cost-sharing requirements.

<sup>2</sup>Indiana may administer a voluntary state-run work search and job training program, which is separate from the Medicaid waiver.

<sup>3</sup>The Pennsylvania expansion waiver was approved under Governor Corbett who also had intended to restrict benefits through a SPA and to implement a state-only work-referral program. Governor Wolf (the new governor) announced that PA will transition to a traditional Medicaid expansion plan and will not implement the benefit and work changes.

<sup>4</sup>New Hampshire implemented the Medicaid expansion through a SPA, but has a waiver pending to move to a mandatory Marketplace premium assistance model by 1/2016.

<sup>5</sup>The Governors in Utah and Tennessee have waiver proposals that have not been officially submitted to CMS and are under debate in the state legislatures.

**CMS has denied a number of provisions included in Section 1115 Waiver proposals.** Provisions that CMS had denied waiver authority for include:

- Premiums for individuals with incomes < 100% FPL as a condition of eligibility;
- Requirements to provide wrap-around benefits for EPSDT and free choice of family planning provider to the extent that Marketplace plans do not offer coverage for these services; and
- Work requirements as a condition of Medicaid eligibility.

**To ensure Section 1115 waivers fulfill their purpose as research and demonstrations projects, it will be important to evaluate their effects.** Waivers are intended to be research and demonstration projects, and federal law requires that they be formally evaluated to measure how well they achieve objectives including the effects on access to care and outcomes for beneficiaries. Particularly as waiver designs become increasingly more complex, the evaluations will help inform policy makers if such policies can be effectively administered and if beneficiaries understand the policies. Ensuring that evaluations are timely and that findings are publicly available will be important for enabling researchers, policymakers, and other stakeholders to identify and examine lessons learned from these waiver experiences.

What happens with waivers between 2014 and 2016 also will be important to inform the use of the new state innovation waiver authority (Section 1332) available in 2017, which will allow states to waive Marketplace coverage provisions and combine those waivers with Medicaid and CHIP waivers. As more states seek waivers to implement the expansion, what we learn from their experiences will help inform the future direction of coverage for low-income adults and families. In addition, in states where Medicaid expansion without a waiver is not politically viable, large numbers of people are likely to remain without coverage. CMS, states, and other stakeholders will continue to navigate the balance between state waiver requests in an effort to reduce the number of uninsured adults while preserving key beneficiary protections and requirements in the Medicaid program.

## Introduction

To date, the majority of states (24 of 29) that have adopted the Medicaid expansion have done so under the existing rules and options provided by the Medicaid program. However, five states have obtained Section 1115 waiver approvals to implement the expansion in ways that extend beyond the flexibility provided by the law, and additional states are considering waiver approaches to adopt the expansion. This brief provides an overview of the role of Section 1115 waivers in expanding coverage since the enactment of the ACA and key themes in recently approved and proposed coverage expansion waivers. Detailed summaries of approved and proposed waivers are available at [www.kff.org](http://www.kff.org).

## Context for Understanding Expansion Waivers

**Section 1115 Medicaid waivers provide states with an avenue to test new approaches in Medicaid that differ from federal program rules.** These waivers are intended to allow for “experimental, pilot, or demonstration projects” that, in the view of the HHS Secretary, “promote the objectives” of the Medicaid program. Waivers can provide states with additional flexibility in how they operate their programs, beyond the flexibility already available to states under federal law, and can have a considerable impact on program financing. Under long-standing federal policy (not statute), federal spending under a state’s waiver must not exceed projected federal spending without the waiver. Budget neutrality is established using a cap on federal matching funds over the life of the waiver. Federal law requires that waivers be formally evaluated.

**Prior to the enactment of the ACA, a number of states used Section 1115 waivers to expand coverage to childless adults, who could not otherwise be covered under federal rules.** Before the ACA, Medicaid coverage was limited to individuals who met income and other eligibility requirements and fell into one of several specified groups, including children, pregnant women, parents, seniors and people with disabilities. Adults without dependent children, often referred to as childless adults, who did not qualify for Medicaid based on age or disability were ineligible for coverage, and federal law did not authorize federal Medicaid matching funds to cover these adults, regardless of how low their incomes were. The only way a state could extend Medicaid coverage to these adults was through a Section 1115 waiver. Because these waivers must be budget neutral for federal spending, states could not receive additional federal funds to expand coverage to these adults and, as such, needed to redirect existing federal funds or find offsetting program savings to finance such coverage.

**The ACA expands Medicaid to adults with significant federal funding.** The expansion eliminates the historic exclusion of adults without dependent children from the program and provides federal statutory authority to make millions of adults newly eligible for the program. The federal government is funding 100% of the cost of covering newly eligible adults for the first three years of the expansion, gradually phasing down to 90% by 2020 and beyond. The 90% match is significantly higher than the traditional Medicaid matching rate that ranges from a floor of 50% to a high of 73% based on a state’s relative per capita income. Under the ACA, the Medicaid expansion was intended to occur nationwide. However, the Supreme Court’s ruling on the ACA’s constitutionality effectively made the expansion a state option. As of February 2015, a total of 29 states (including the District of Columbia) have implemented the Medicaid expansion, and adoption of the expansion is under discussion in a number of other states.<sup>1</sup> There is no deadline for states to adopt the Medicaid

expansion. In states expanding Medicaid, most individuals with incomes above 138% up to 400% FPL (above Medicaid levels) are eligible for tax credits to purchase coverage in the Marketplaces. In states that do not implement the Medicaid expansion, Medicaid eligibility for adults is quite limited. Because the ACA envisioned low-income people receiving coverage through Medicaid, it does not provide financial assistance to people below poverty for other coverage options. As a result, in states that do not expand Medicaid, many adults will fall into a “coverage gap” of having incomes above Medicaid eligibility limits but below the lower limit for Marketplace premium tax credits.

**The ACA’s Medicaid expansion eliminates the need for a state to obtain a Section 1115 waiver to cover childless adults, but a small number of states have still used Section 1115 waivers to implement the Medicaid expansion in ways that differ from options provided to states under federal law.** CMS has issued guidance that establishes some parameters for such waivers. Through this guidance, CMS has indicated that states cannot receive the enhanced federal funding available for newly eligible adults unless they implement the full expansion to cover all newly eligible adults through 138% FPL; it also will not approve enrollment caps for the adult expansion group. CMS indicated it will approve a limited number of premium assistance waivers to test the use of Medicaid funds to purchase Marketplace coverage for the Medicaid expansion population, subject to certain requirements.

**Medicaid expansion waivers are subject to new rules about transparency, public input and evaluation.** As a result of longstanding concerns about the lack of public input and transparency in the waiver approval process, the ACA required the Department of Health and Human Services (HHS) to issue regulations designed to ensure that the public has meaningful opportunities to provide input into the Section 1115 waiver approval process. The rules, issued in February 2012, require public notice and comment periods at the state and federal levels before new waivers and extensions of existing waivers are approved by CMS.<sup>2</sup> The transparency regulations also require states to have an approved evaluation strategy in place that is publicly available. States must also submit an annual report to HHS that includes, among other things, a description of the changes occurring and their impact on outcomes, quality, and access; beneficiary satisfaction surveys; grievance and appeals data; financial data; audits; and other relevant developments. A federal contract has been awarded to conduct an evaluation of a number of Section 1115 waivers (related to the ACA Medicaid expansion as well as other demonstration waivers).

## A Look at Medicaid Expansion Waivers Post 2014

To date, a few states have sought Section 1115 waivers to implement the Medicaid expansion, in part because they could not otherwise secure political support to expand coverage. As of February 2015, CMS has approved waivers to implement the Medicaid expansion in five states ([Arkansas](#), [Iowa](#), [Michigan](#), [Pennsylvania](#) and most recently [Indiana](#)). Governors in [Utah](#) and [Tennessee](#) have been negotiating waivers with CMS, but formal waiver applications have not yet been submitted. These plans also need state legislative approval, and Tennessee's legislature recently did not vote a bill authorizing Medicaid expansion out of committee during a special session. [New Hampshire](#) has implemented the Medicaid expansion pursuant to a SPA, but has a pending waiver application to continue its Medicaid expansion through mandatory Marketplace premium assistance beginning in January 2016, as required by state law.<sup>3</sup> The Pennsylvania waiver was approved under Governor Corbett, but the current Governor Wolf announced that Pennsylvania will transition to a traditional Medicaid expansion plan and he will not implement the benefit and work changes that the previous Governor had initiated.

Each of the approved and proposed expansion waivers is unique, in many cases reflecting variations in the states' underlying Medicaid programs, but there are some common themes across the waivers. The following sections examine waiver provisions that have been approved and denied by CMS to date.

Table 1: Key Themes in ACA Expansion Waivers and Proposals

	Premium Assistance	Premiums / Monthly Contributions	Healthy Behavior Incentives	Benefit Changes	Work Referral	Co-Payments <sup>*</sup>	Waivers of Retroactive Eligibility / Reasonable Promptness
<b>Approved Waivers</b>							
Arkansas <sup>1</sup>	Mandatory for QHPs	X					
Iowa	Optional for QHPs	X	X	X			
Indiana <sup>2</sup>	Optional for ESI	X	X	X		X	X
Michigan		X	X				
Pennsylvania <sup>3</sup>		X	X	X			
<b>Waiver Proposals</b>							
New Hampshire <sup>4</sup>	Mandatory for QHPs				X		X
Tennessee <sup>5</sup>	Optional for ESI	X	X	X		X	X
Utah <sup>5</sup>	Mandatory for QHPs and ESI	X	X	X		X	

<sup>\*</sup>Cost-sharing waivers were approved in Indiana and are proposed in Tennessee and Utah through §1916(f) not §1115 waiver authority.

<sup>1</sup>The monthly contributions in AR are in lieu of cost-sharing requirements.

<sup>2</sup>Indiana may administer a voluntary state-run work search and job training program, which is separate from the Medicaid waiver.

<sup>3</sup>The Pennsylvania expansion waiver was approved under Governor Corbett who also had intended to restrict benefits through a SPA and to implement a state-only work-referral program. Governor Wolf (the new governor) announced that PA will transition to a traditional Medicaid expansion plan and will not implement the benefit and work changes.

<sup>4</sup>New Hampshire implemented the Medicaid expansion through a SPA, but has a waiver pending to move to a mandatory Marketplace premium assistance model by 1/2016.

<sup>5</sup>The Governors in Utah and Tennessee have waiver proposals that have not been officially submitted to CMS and are under debate in the state legislatures.

## WAIVER PROVISIONS APPROVED BY CMS

### PREMIUM ASSISTANCE

**Two states have received approval to implement the Medicaid expansion through a premium assistance model using mandatory enrollment in private coverage through Marketplace plans (Arkansas and Iowa).** According to guidance released by CMS, it will approve a limited number of waivers to allow state to use Medicaid funds to purchase coverage for some or all newly eligible beneficiaries in Marketplace Qualified Health Plans (QHPs) as a “private approach” to expansion. States can implement premium assistance programs without a waiver, subject to certain rules. Arkansas and Iowa received waivers to allow them to mandatorily enroll beneficiaries in premium assistance. In Arkansas all newly eligible adults, including childless adults between 0-138% FPL and parents between 17-138% FPL, are enrolled in premium assistance. In Iowa, only newly eligible adults with incomes above 100% up to 138% FPL were enrolled in premium assistance.<sup>4</sup> With the loss of one of the two Marketplace QHPs serving Medicaid beneficiaries in Iowa, beneficiaries instead are enrolled in Medicaid managed care as of December 2014, with the option to choose Marketplace premium assistance as an alternative (instead of imposing mandatory premium assistance) .

These states indicate that they are using premium assistance to test how private coverage works for Medicaid beneficiaries and whether enrolling beneficiaries in Marketplace coverage will increase provider access and reduce churn between Medicaid and Marketplace coverage due to income fluctuations. How premium assistance affects continuity of care, the impact on access to benefits, how well wrap-around coverage will work, how states will exempt people who are medically frail from their demonstrations, what the impact of premiums and cost sharing will be, and whether the demonstrations will be cost effective are key issues to monitor and are included in the evaluation requirements of these waivers.<sup>5</sup> Consistent with CMS guidance, the premium assistance waivers in Arkansas and Iowa were approved through 2016.<sup>6</sup>

**The waiver proposals in New Hampshire and Utah would also provide premium assistance for Marketplace coverage to some Medicaid expansion enrollees.** The New Hampshire proposal includes mandatory enrollment in Marketplace QHPs for Medicaid expansion adults beginning January 1, 2016. Utah’s proposal similarly would require most newly eligible adults to enroll in Marketplace QHPs. Expansion adults who have access to employer-sponsored insurance (ESI) in Utah would receive premium assistance for enrollment in their ESI.

**Indiana and Tennessee include optional premium assistance programs for beneficiaries with access to ESI.** The Tennessee proposal would offer newly eligible adults with access to ESI the option of receiving premium assistance to enroll in their ESI plan in the form of a defined contribution from the state. Under this Volunteer Plan, costs and benefits not covered by the defined contribution would be the responsibility of the beneficiary.<sup>7</sup>

## MONTHLY CONTRIBUTIONS AND PREMIUMS

**CMS has approved waivers that allow states to charge premiums or monthly contributions primarily for expansion adults between 100 and 138% FPL.** Under federal law, Medicaid beneficiaries with incomes below 150% FPL (\$17,655 per year for an individual in 2015) cannot be charged premiums. Premiums in the Medicaid program are limited because a large body of research shows that premiums and enrollment fees act as barriers to obtaining and maintaining coverage for people with low-incomes.<sup>8</sup> Each of the five approved expansion waivers allows the states to impose premiums or monthly contributions for newly eligible beneficiaries with incomes between 101-138% FPL. These premiums (equal to about 2% of income) are about the same level as those allowed for individuals at these incomes who are eligible for tax credits to purchase coverage through the Marketplace in states not expanding Medicaid.

**The consequences of non-payment of premiums for adults with incomes above poverty vary across states, but only Indiana includes a six month lock-out for beneficiaries dis-enrolled due to unpaid premiums.** In Michigan, payment of premiums is not a condition of eligibility. In Iowa, beneficiaries have a 90 day grace period to pay past-due premiums in full before they are dis-enrolled from Medicaid, and the state must waive premiums for beneficiaries who self-attest to financial hardship. Individuals can re-enroll at any time. Similarly, in the approved Pennsylvania waiver, there is a 90-day grace period before disenrollment for unpaid premiums, and beneficiaries may re-enroll without a lock-out period. Indiana's waiver is different than others approved to date in that it allows the state to impose a six month lock-out period for non-medically frail individuals above poverty who are dis-enrolled due to unpaid premiums after a 60 day grace period. Individuals who never make their initial premium payment are not subject to the 6 month lock-out.

**In Arkansas, Iowa and Indiana, the waivers allow the states to charge monthly contributions for individuals below poverty; however, failure to pay these charges cannot result in the termination of Medicaid coverage.** Arkansas received approval through a waiver amendment to require monthly income-based contributions to health savings accounts, ranging from \$5 to \$25 per month, for beneficiaries with incomes between 50-138% FPL to be used for co-payments and co-insurance. In Arkansas, those with incomes below poverty cannot be denied services for failure to pay. In Iowa, the waiver allows the state to impose monthly contributions of \$5 per month for beneficiaries with incomes between 50-100% FPL beginning in year two; however, premiums can be waived by completing healthy behavior activities and Medicaid eligibility cannot be terminated for non-payment of premiums for beneficiaries at or below 100% FPL.

The waiver in Indiana imposes monthly contributions to a Personal Wellness and Responsibility (POWER) health savings account for most newly eligible adults with incomes between 0-138% FPL. Those with incomes between 0-5% FPL (up to \$589 per year for an individual in 2015) must pay \$1.00 per month. If individuals with incomes at or below poverty do not pay the monthly POWER account contributions, they receive a less generous benefit package.

**In Indiana, the waiver allows the state not to begin coverage until the first premium is paid.** Under the Indiana waiver, beneficiaries who pay premiums will be eligible for an HIP Plus benefit package, which includes expanded benefits and co-payments only for non-emergency use of the ER. Coverage in HIP

Plus begins the first day of the month in which a beneficiary pays a premium, instead of the date of Medicaid application. To allow coverage to begin on the first day of the month in which a beneficiary pays a premium, instead of the date of Medicaid application, the state needed waivers of reasonable promptness and retroactive eligibility. Under federal law, Medicaid benefits must be provided with “reasonable promptness” to eligible beneficiaries, and coverage extends to bills incurred retroactively for three months prior to the month of application, if the individual would have been eligible during the retroactive period.<sup>9</sup> Indiana’s waiver also includes FQHCs, RHCs, CMHCs, and health department sites in an expanded presumptive eligibility program. Presumptive eligibility enables applicants to receive Medicaid-covered services as of the date that a qualified provider entity preliminarily determines that the applicant eligible for Medicaid, while the final determination is pending. To maintain the reasonable promptness waiver, the state must make final eligibility determinations for a certain percentage of presumptively eligible applicants (out of eligibility determinations made on all types of applications).

## HEALTHY BEHAVIOR INCENTIVES

**CMS has approved the use of healthy behavior incentives to reduce or eliminate beneficiaries’ out-of-pocket expenses.** The approved waivers in Iowa, Michigan, Pennsylvania and Indiana all include healthy behavior programs. Under these four waivers, individuals who complete specified healthy behaviors will have their premiums and cost sharing waived or reduced. Separate protocols must be approved by CMS to implement these health behavior programs. The protocols are required to: (1) specify the types of healthy behaviors (such as health risk assessments); (2) include a diverse set of behaviors as well as a strategy to measure access to providers to ensure that all beneficiaries have an opportunity to receive healthy behavior incentives; (3) engage stakeholders and the public in developing the healthy behavior standards; (4) show how healthy behaviors will be tracked and monitored at the enrollee and provider level; (5) include a beneficiary and provider education strategy; and (6) include the methodology describing how healthy behavior incentives will be applied to reduce premiums or copayments.

In Iowa, beneficiary premiums were waived for the first year of enrollment. In subsequent years, premiums are waived if beneficiaries complete specified healthy behavior activities. In the first year of the healthy behavior program, these include completing an online health risk assessment and obtaining a wellness examination. Iowa has retroactively broadened the definition of a qualifying wellness exam to allow providers to choose a routine medical exam in lieu of a more comprehensive annual physical, depending on the beneficiary’s individual needs.

In Michigan, demonstration beneficiaries have cost-sharing obligations based on their prior six months of copays. Cost-sharing will be paid into health accounts and can be reduced through compliance with healthy behaviors. The cost-sharing amounts are based on the state plan amounts and not changed from what would have been collected without the waiver. Beneficiaries cannot lose or be denied Medicaid eligibility, be denied health plan enrollment, or be denied access to services, and providers may not deny services for failure to pay copays or premiums. Similarly, under the approved waiver in Pennsylvania, beginning in demonstration year 2, beneficiaries can reduce their premiums or copayments by completing healthy behaviors including an annual wellness exam.

## WAIVERS OF REQUIRED BENEFITS

**CMS has approved limited waivers of required Medicaid benefits that allow states not to cover non-emergency medical transportation (NEMT).** In implementing the ACA, states have considerable flexibility in determining benefits packages for those newly eligible for coverage by the ACA's Medicaid expansion. States must cover the ten ACA-required Essential Health Benefits (EHBs) along with certain other mandatory Medicaid services. States also must meet mental health parity requirements. Beyond these requirements, states have flexibility to choose a benchmark plan for coverage that may include one of several specified private insurance options or "Secretary-Approved Coverage" which can include a state's current Medicaid benefits package for adults. However, some states have sought waiver approval for greater flexibility in the provision of benefits.

Iowa was the first state to receive approval to waive NEMT for newly eligible adults. The original NEMT waiver applied through December 31, 2014, and extension is conditioned on an evaluation of the waiver's impact on beneficiary access to care. In December 2014, CMS approved a waiver amendment extending the NEMT waiver through July 1, 2015, while noting that Iowa had submitted preliminary data that "raised concerns about beneficiary access[,] particularly for those with incomes below 100 percent of the FPL." CMS will consider additional data collected by the state as of May 31, 2015 in determining whether to further extend the NEMT waiver. Iowa provides NEMT to beneficiaries who are medically frail and those under age 21.

Following the original approval in Iowa, Pennsylvania was authorized to waive NEMT for newly eligible adults in 2015, with this benefit to be provided beginning in 2016. Most recently, Indiana was also allowed to waive NEMT for most newly eligible adults for one year, to be extended based on the results of an evaluation assessing the impact on access to care. Arkansas also sought waiver authority to limit NEMT to 8 trip legs per year for non-medically frail beneficiaries. Instead, the state will establish a prior authorization process for NEMT for newly eligible adults (a change that does not require waiver authority).

**The Indiana plan allows for different benefit packages for individuals below poverty who do not pay premiums.** Under the Indiana waiver, newly eligible adults 0-138% FPL who pay monthly POWER account contributions receive HIP Plus, which includes the ACA's essential health benefits and covers more services than the HIP Basic benefit package. Newly eligible adults at or below 100% FPL who do not pay premiums receive HIP Basic, an ABP that includes the ACA's essential health benefits but with fewer covered services (no vision or dental coverage) compared to HIP Plus. HIP Basic includes all EPSDT services for 19 and 20 year olds, consistent with federal law.

## COST SHARING WAIVERS

**Indiana has received approval to impose cost sharing in amounts greater than those allowed under federal law under separate Section 1916(f) authority.** Section 1115 waiver authority does not extend to Medicaid cost-sharing requirements. In order to impose higher cost sharing than otherwise allowed under federal law, a state needs to meet separate cost sharing waiver requirements under Section 1916(f). Section 1916(f) permits a state to seek a demonstration waiver to charge cost sharing above otherwise allowable amounts if the state meets specific requirements and criteria, including testing a unique and previously untested use of copayments and limiting the demonstration to no longer than two years.

In July 2013, final regulations were released that streamlined and simplified existing rules around premiums and cost-sharing in Medicaid, increased the nominal rate for cost-sharing, and increased allowable cost-sharing amounts for non-preferred drugs and non-emergency use of the emergency room. Indiana received Section 1916(f) waiver authority to charge cost sharing that exceeds the \$8 maximum allowed for non-emergency use of the emergency room under these federal rules. This waiver allows the state to implement a two-year demonstration (until Jan. 31, 2017) to test whether graduated co-payments (\$8 for first visit and \$25 for subsequent visits in the same year) discourage non-emergency use of the emergency room. This authority applies to both newly eligible adults and previously eligible parents. By May 1, 2015, the state must establish a control group with a minimum of 5,000 beneficiaries who will not be subject to the increased co-payments; selection of the control group will be detailed in the state's protocol submitted to CMS.

A few of the other recent ACA expansion waivers include cost sharing provisions. However, they do not increase beneficiary cost sharing amounts beyond what is allowed under current law. In Arkansas, beneficiaries between 50-138% FPL have cost-sharing consistent with existing Medicaid state plan and Marketplace QHP rules (as discussed above, monthly contributions are paid into an account used to pay for co-payments and co-insurance). In Michigan, after six months, all beneficiaries will have cost-sharing obligations based on their prior six months of copays, billed at the end of each quarter. Cost-sharing will be paid into health savings accounts and can be reduced through compliance with certain healthy behaviors. However, the cost-sharing amounts are the same as what the state would have been able to collect without a waiver. The Michigan waiver terms and conditions specify that beneficiaries cannot lose or be denied Medicaid eligibility, be denied health plan enrollment, or be denied access to services, and providers may not deny services for failure to pay copays or premiums.

## WAIVER PROVISIONS DENIED BY CMS

**CMS has not approved waiver requests proposing premiums for individuals with incomes below 100% FPL where payment is a condition of eligibility.** As noted above, Arkansas, Iowa and Indiana do impose monthly contributions for individuals with incomes below poverty; however, for Medicaid eligibility cannot be terminated for non-payment.

**CMS has denied requests to waive certain Medicaid benefits.** In their waiver proposals, some states requested additional changes in benefits that were not approved. Specifically, CMS denied Iowa and Indiana's requests to waive the provision of EPSDT services for newly eligible 19 and 20 year olds and requests from Iowa and Pennsylvania to waive the provision of free choice of family planning providers for newly eligible adults. Pennsylvania's original waiver proposal also sought benefits package changes for current and newly eligible beneficiaries, seeking to replace current state plan benefits with a "high risk" package for people who are medically frail and a "low risk" package for other beneficiaries. These changes are not included in the waiver approval and the state instead submitted a SPA to implement these changes. The state's new governor subsequently withdrew the pending SPA seeking a reduced benefit package.

**CMS has denied waivers for states seeking to impose cost sharing in amounts greater than those allowed under federal law.** While Indiana recently received waiver authority to impose higher than statutory cost-sharing under Section 1916(f), CMS did not approve a § 1916(f) waiver request to allow Arizona to impose a \$200 co-pay for non-emergency use of the emergency room.<sup>10</sup> Pennsylvania was also denied a

waiver request to impose higher than statutorily allowed cost sharing amounts for non-emergency use of the ER.

**CMS has not approved a waiver to include a work requirement or referral as a condition of Medicaid eligibility.** Pennsylvania initially sought a work requirement as a condition of Medicaid eligibility (later amended to a voluntary work search program) for current and newly eligible beneficiaries as part of its waiver application, but none of these elements were included as part of the demonstration approved by CMS. Indiana sought waiver authority to require a work referral as a condition of eligibility, which was not approved by CMS. Instead, Indiana may administer a voluntary state-run work search and job training program, which is separate from the Medicaid expansion demonstration. Utah's proposal includes a provision to automatically enroll able-bodied adults in a concurrent work program when newly eligible beneficiaries apply for Medicaid. The work program would include an online assessment and access to training opportunities and job postings. Utah is exploring possible sanctions related to benefits available under other state programs for non-compliance with the work program but is not proposing that work program participation be a condition of Medicaid eligibility and is not seeking federal waiver authority for the work program. New Hampshire's waiver proposal includes a referral to state job counseling services for unemployed applicants.

## Key Issues Looking Forward

To date, 29 states (including DC) are implementing the ACA's Medicaid expansion including five states that are implementing the expansion under waiver authority. Examining what provisions CMS has approved and denied in recent waiver approvals can shed light on what may be approved for other states considering waivers moving forward. A number of states currently debating moving forward with the expansion are considering implementing the expansion through a waiver.

To ensure Section 1115 waivers fulfill their purpose as research and demonstrations projects, it will be important to evaluate their effects. Waivers are intended to be research and demonstration projects, and federal law requires that they be formally evaluated to measure how well they achieve objectives and the effects on access to care and outcomes for beneficiaries. Particularly as waiver designs become increasingly more complex, the evaluations will help inform policy makers if such policies can be effectively administered and if beneficiaries understand the policies. Ensuring that evaluations are timely and that findings are publicly available will be important for enabling researchers, policymakers, and other stakeholders to identify and examine lessons learned from these waiver experiences.

What happens with waivers between 2014 and 2016 also will be important to inform the use of the new state innovation waiver authority (Section 1332) available in 2017, which will allow states to waive Marketplace coverage provisions and combine those waivers with Medicaid and CHIP waivers. As more states seek waivers to implement the expansion, what we learn from their experiences will help inform the future direction of coverage for low-income adults and families. In addition, in states where Medicaid expansion without a waiver is not politically viable, large numbers of people are likely to remain without coverage. CMS, states, and other stakeholders will continue to navigate the balance between state waiver requests in an effort to reduce the number of uninsured adults while preserving key beneficiary protections and requirements in the Medicaid program.

# Endnotes

<sup>1</sup> Status of State Action on the Medicaid Expansion Decision, Jan. 27, 2015. (Kaiser Family Foundation). <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>

<sup>2</sup> *The New Review and Approval Process Rule for Section 1115 Medicaid and CHIP Demonstration Waivers*. (Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, March 2012) <http://kff.org/health-reform/fact-sheet/the-new-review-and-approval-process-rule/>

<sup>3</sup> See N.H. Sen. Bill 413, available at <http://www.gencourt.state.nh.us/legislation/2014/SB0413.pdf>.

<sup>4</sup> As of December 1, 2015, Iowa beneficiaries from 101-138% FPL are no longer required to enroll in Marketplace premium assistance as a condition of eligibility because one of the two QHPs covering Medicaid beneficiaries is no longer participating. Instead, these beneficiaries can choose to receive coverage through the state's Medicaid managed care delivery system or enroll in the remaining QHP with premium assistance. As of January 1, 2015, beneficiaries from 101-138% FPL are enrolled in Medicaid managed care unless they opt to enroll in the remaining QHP. The state is submitting a waiver amendment about this program change to CMS after the required public notice and comment periods.

<sup>5</sup> MaryBeth Musumeci. *Medicaid Expansion Through Marketplace Premium Assistance* (Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, September 2013), <http://www.kff.org/medicaid/fact-sheet/medicaid-expansion-through-marketplace-premium-assistance/>.

<sup>6</sup> The shorter approval periods were designed to allow CMS use states' experience in these models to inform the new §1332 Marketplace innovation waiver authority available to states beginning in 2017.

<sup>7</sup> Instead of utilizing premium assistance models, approved waivers in Michigan, Pennsylvania, Indiana and Iowa for beneficiaries below 100% FPL, rely on Medicaid managed care organizations (MCOs) to delivery care to those newly eligible for coverage. Some of these states had considered premium assistance, but instead relied on existing delivery systems and MCOs to delivery care to the new population.

<sup>8</sup> Laura Snyder and Robin Rudowitz, *Premiums and Cost-Sharing in Medicaid: A Review of Research Findings*. (Kaiser Commission on Medicaid and the Uninsured, February 2013). <http://kff.org/medicaid/issue-brief/premiums-and-cost-sharing-in-medicaid-a-review-of-research-findings/>

<sup>9</sup> 42 U.S.C. §§ 1396a(a)(8), 1396a(a)(34); 42 C.F.R. § 435.914.

<sup>10</sup> Letter from Cindy Mann to Thomas Betlach, December 15, 2014. <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/az-hccc-ca.pdf>

# MEDICAID FRAUD

# State of Alaska Department of Law Press Release

## 1.2 Million Dollars in Restitution Ordered in Medicaid Case against Good Faith Services

December 1, 2014

The State of Alaska, Department of Law, Medicaid Fraud Control Unit (MFCU) announced today that Good Faith Services, LLC (Good Faith) entered a plea of guilty to a single count of Medical Assistance Fraud on Friday, November 28, 2014.

Good Faith was a personal care agency that provided Medicaid personal care, transportation and care coordination services to eligible Medicaid recipients. In July 2013, the MFCU announced the filing of criminal charges against twenty-five Anchorage based personal care attendants (PCA) and Medicaid recipients as part of an ongoing state and federal investigation into Medicaid fraud by the employees, PCAs and recipients associated with Good Faith. Since July 2013, the state filed criminal charges for medical assistance fraud on 53 individuals associated with Good Faith, including thirteen of the sixteen office staff. The MFCU investigation revealed that ten full time office employees billed Medicaid \$394,257 for services they claimed to be providing while simultaneously working in the office. The information filed further alleges that Good Faith billed Medicaid a total of \$1,033,673.83 for Medicaid services provided by PCAs prior to the PCA receiving a valid background check in violation of Alaska Administrative Regulations.

The plea agreement calls for Good Faith to be sentenced to a single count of medical assistance fraud, a class B felony offense, and to pay a fine of \$300,000 and restitution in the amount of \$1.2 million dollars. The corporation must be permanently dissolved and provide a declaration to the federal Department of Health and Human Services, Office of Inspector General, that the corporation will no longer be providing Medicaid services.

Agnes Francisco, 55, of Anchorage, Alaska and one of the owners of Good Faith also entered a plea of guilty to a single count of attempted medical assistance fraud, a class C felony. The plea agreement provides that the court will determine Francisco's sentence, but the court must find the aggravator that Francisco's conduct was designed to obtain a substantial pecuniary gain with a low risk of prosecution and punishment. This aggravator will allow the court to impose a period of incarceration up to five years, which is above the presumptive range of 0-2 years. The court may also impose a fine of up to \$50,000. Francisco's sentencing is scheduled for March 31, 2015.

Anchorage Adult Day Services also entered a plea of guilty at the same time to a single count of medical assistance fraud, a class B misdemeanor. The entity was charged with medical assistance fraud for allowing Francisco's son, Philip Francisco, to work for the business without a valid background check. The entity will pay a fine of \$20,000 and will be permanently suspended from providing Medicaid services.

The case against Good Faith was initiated by a citizen complaint and jointly investigated by the Alaska Department of Law, Medicaid Fraud Control Unit, the Department of Health and Social Services, the federal Department of Health and Human Services, Office of Inspector General, the FBI and Immigration and Customs Enforcement.

The Alaska MFCU is part of the Attorney General's Office. The MFCU is responsible for investigating and prosecuting Medicaid fraud and abuse, neglect or financial exploitations of patients in any facility that accepts Medicaid funds. The information filed by the Department of Law can be found on the MFCU website.

**CONTACT:** Assistant Attorney General Andrew Peterson at 907-269-6292. For more information about these cases or other cases handled by the Alaska MFCU, go to the MFCU website.

# # #

Department of Law [attorney.general@alaska.gov](mailto:attorney.general@alaska.gov) P.O. Box 110300, Juneau, AK 99811-0300  
Phone: 907-465-3600 Fax: 907-465-2075 TTY: 907-258-9161  
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# Alaska Dispatch News

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[Home](#) > Four months in jail for Mat-Su center owner charged with Medicaid fraud

Zaz Hollander <sup>(1)</sup>

April 8, 2015

WASILLA -- The owner of a Wasilla center for the disabled was sentenced Thursday to four months in jail and more than \$1.6 million in restitution for criminal Medicaid fraud charges linked to altered medical records.

The hefty sentence comes as the Alaska Legislature grapples with Gov. Bill Walker's proposal to expand Medicaid in the state.

Laura Sasseen, 58, was sentenced as part of a plea deal approved Thursday afternoon in Anchorage District Court.

Sasseen owns Mat-Su Activity and Respite Center LLC, a now-shuttered facility known as "MARC" along the Palmer-Wasilla Highway. The center served 29 developmentally disabled clients with jobs, day activities and caregiver support.

It employed more than 100 people before it closed in June 2014 amid the state investigation.

In September, the state's Medicaid Fraud Control Unit charged Sasseen and the center with felony charges of falsifying business records and misdemeanor charges of medical assistance fraud.

Sasseen is scheduled to start her jail time in May. Her sentence was actually for 360 days, but with 240 suspended.

The agreement calls for Sasseen to pay more than \$1.628 million in restitution to the state Medicaid program, according to assistant attorney general Andrew Peterson, who directs the state's Medicaid Fraud Control Unit. The figure represents a state estimate of MARC's improper billing to Medicaid for services without proper documentation to back it up.

The plea agreement also requires Sasseen pay a \$5,000 fine and do 160 hours of community service. She'll be banned from billing Medicaid for 10 years, and the commissioner of health and social services could extend that period for another 10 years.

The restitution is "one of the larger" amounts a judge has ordered for Medicaid fraud, Peterson said, adding the sentence for the misdemeanor plea deal matched that of a felony conviction.

Records were primarily altered to show an increase in the services the agency claimed to have provided, the state says.

"Instead of taking responsibility, she chose to alter medical records to financially better herself," he said Thursday by phone. "She hurt a lot of people. The business shut down. All the recipients went to other locations. There were significant consequences based on her financial actions."

Sasseen's attorney, Richard Payne in Wasilla, couldn't immediately be reached for comment.

Interviewed briefly the day she closed the center last summer, Sasseen said the state owed her \$300,000 in Medicaid payments and blamed her financial woes on the glitch-plagued Medicaid payment system.

The problems at the Mat-Su center came to light after the state notified Sasseen in 2012 that her business had been selected for a Medicaid audit. Peterson said the state audits about 75 providers a year.

Auditors noted modified documents; one former employee told investigators about "white-out changes" to case notes and timesheets.

The audit ultimately turned up \$37,000 in alterations to selected medical records from 2009 and 2010, Peterson said. That amounted to \$280,000 in overpayment when extrapolated to all the cases the center handled in that two-year period.

Sasseen also agreed to give up her right to administratively challenge the audit findings in the plea deal.

The case was investigated jointly by the Alaska Department of Law, Alaska State Troopers and the Department of Health and Social Services.

**Source URL:** <http://www.adn.com/article/20150408/four-months-jail-mat-su-center-owner-charged-medicaid-fraud>

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# **LEGISLATIVE FINANCE MEDICAID NUMBERS**

# Medicaid Comparisons between SB78 and SB74 Fiscal Notes, Medicaid Budget History and Projections

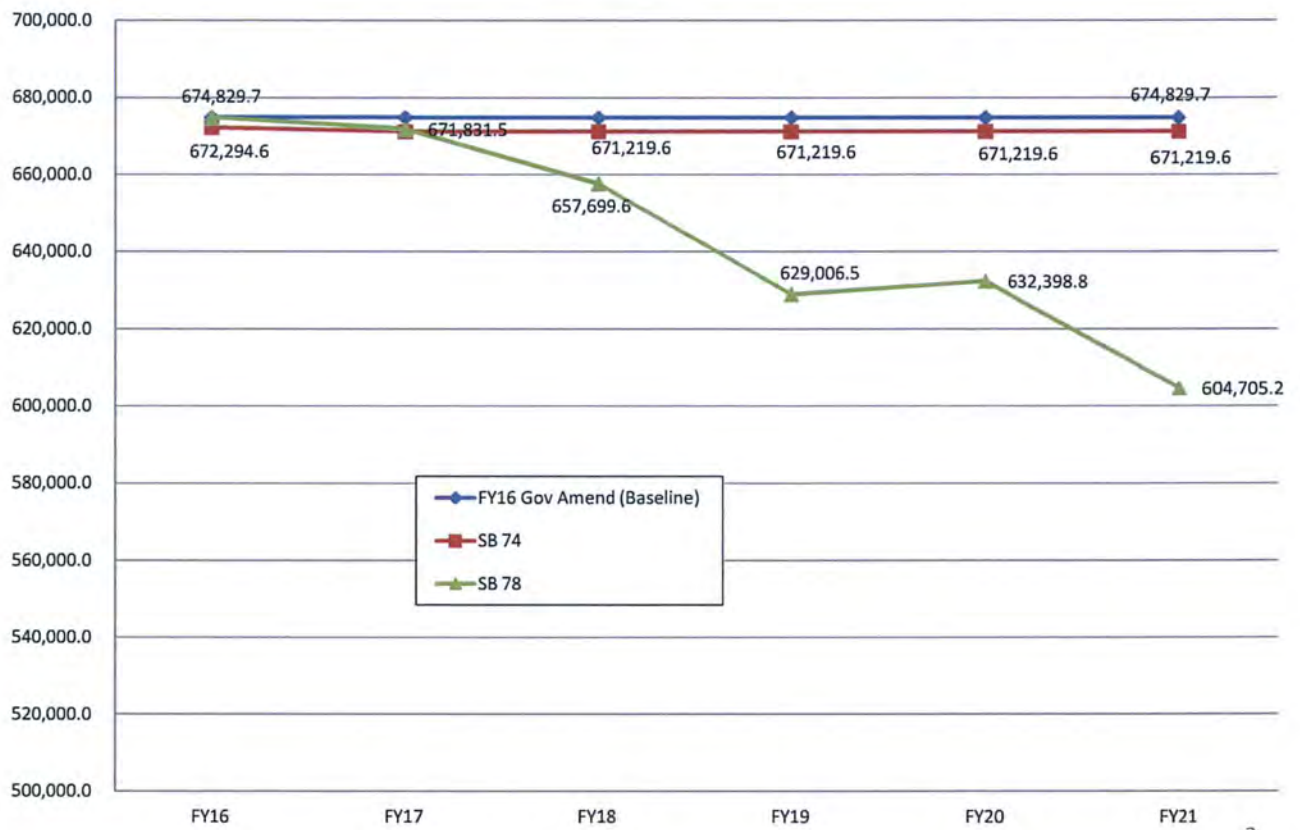
Senate Health and Social Services  
Committee

Monday, March 30, 2015

Amanda Ryder, Senior Fiscal Analyst  
Legislative Finance Division

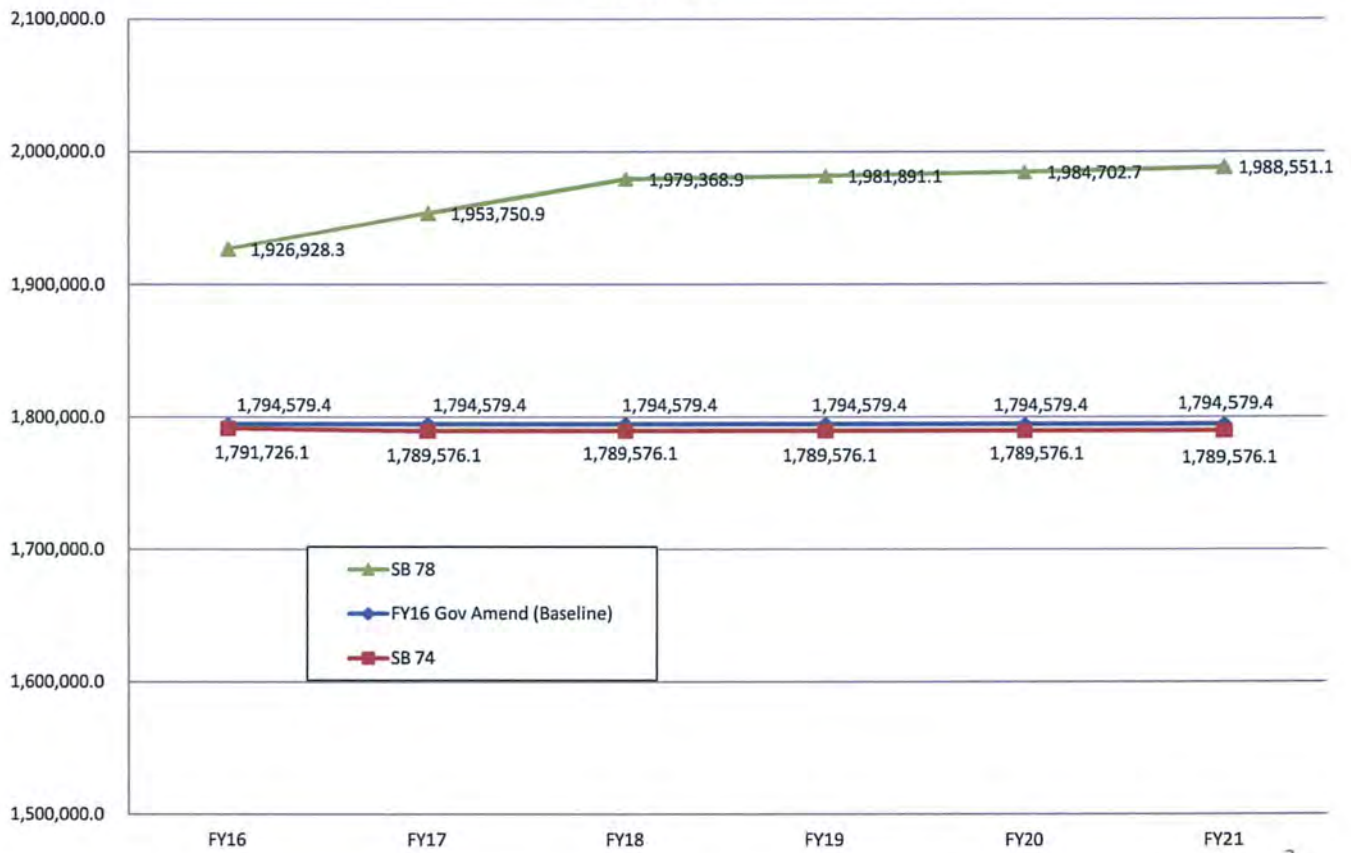
## Medicaid Fiscal Note Comparison: SB 74 & SB 78

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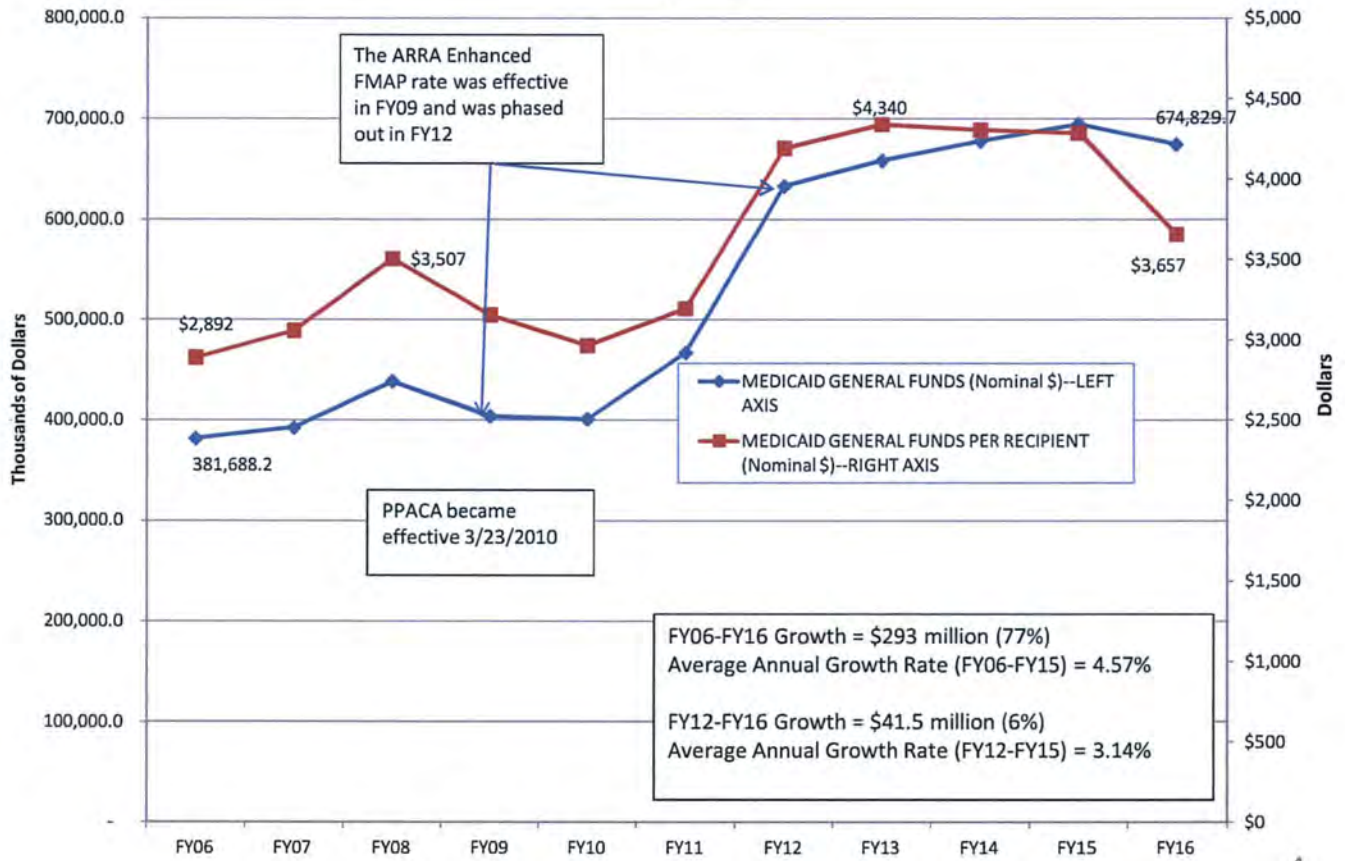
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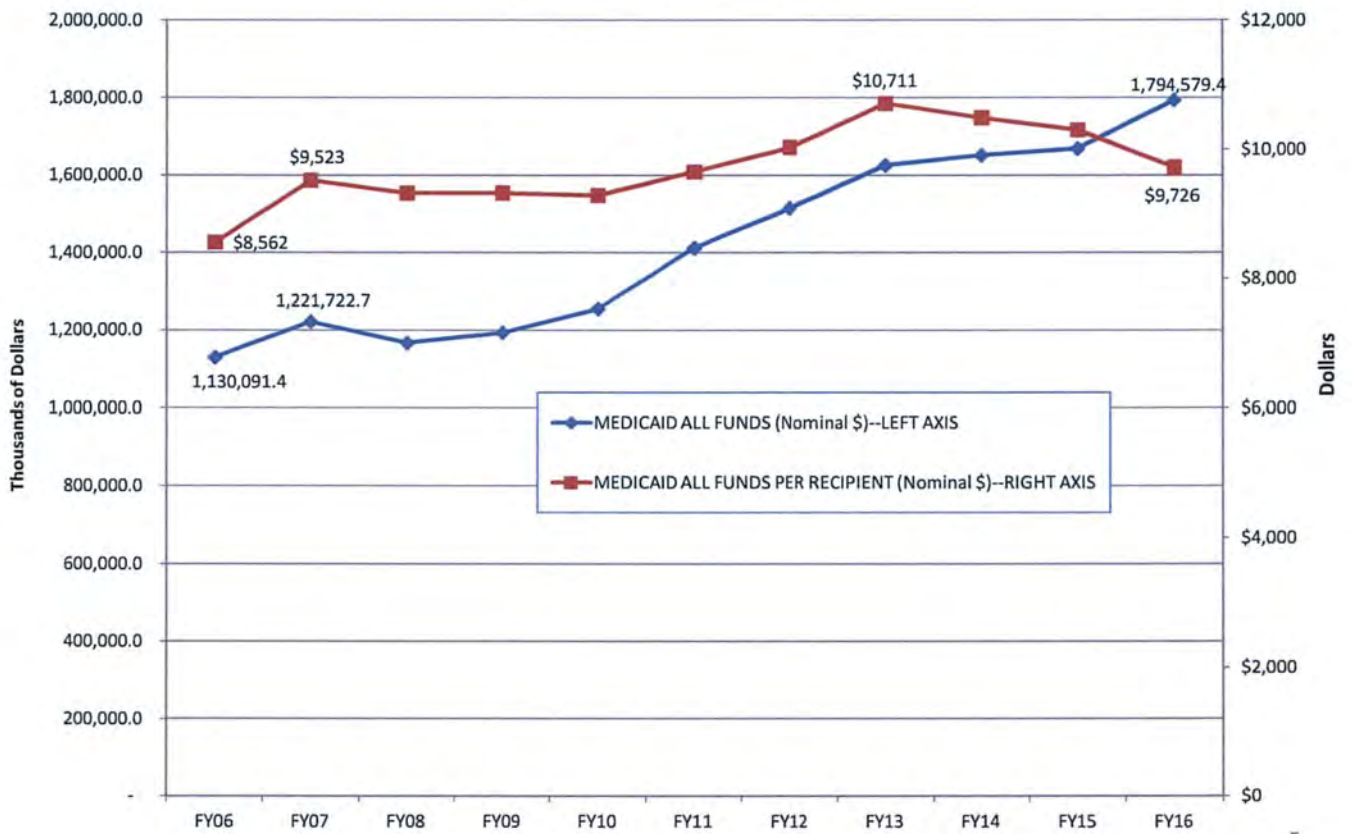
### Historical Medicaid Growth

FY14 \$  
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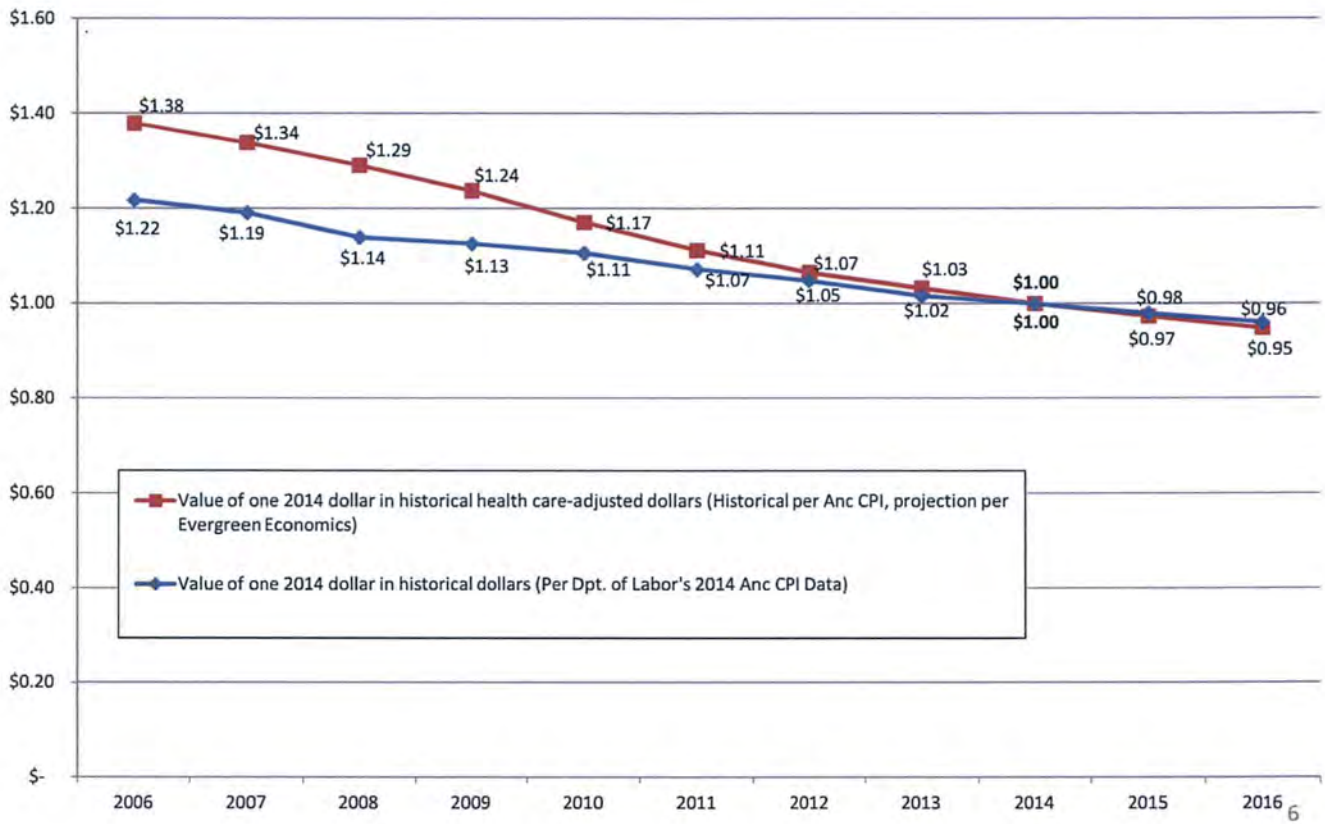


## Historical Medicaid Growth

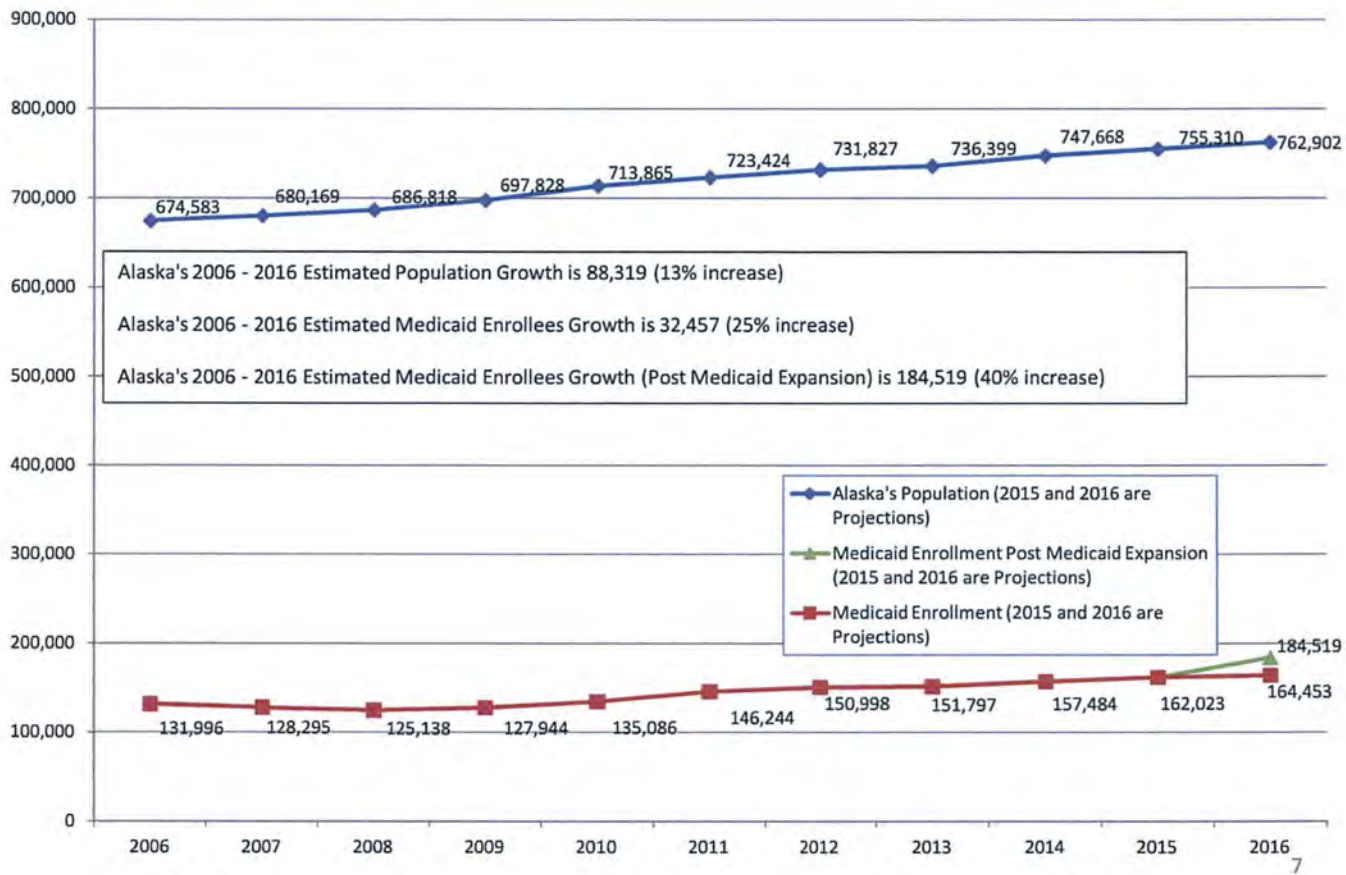
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### Anchorage CPI vs. Anchorage Health Care CPI

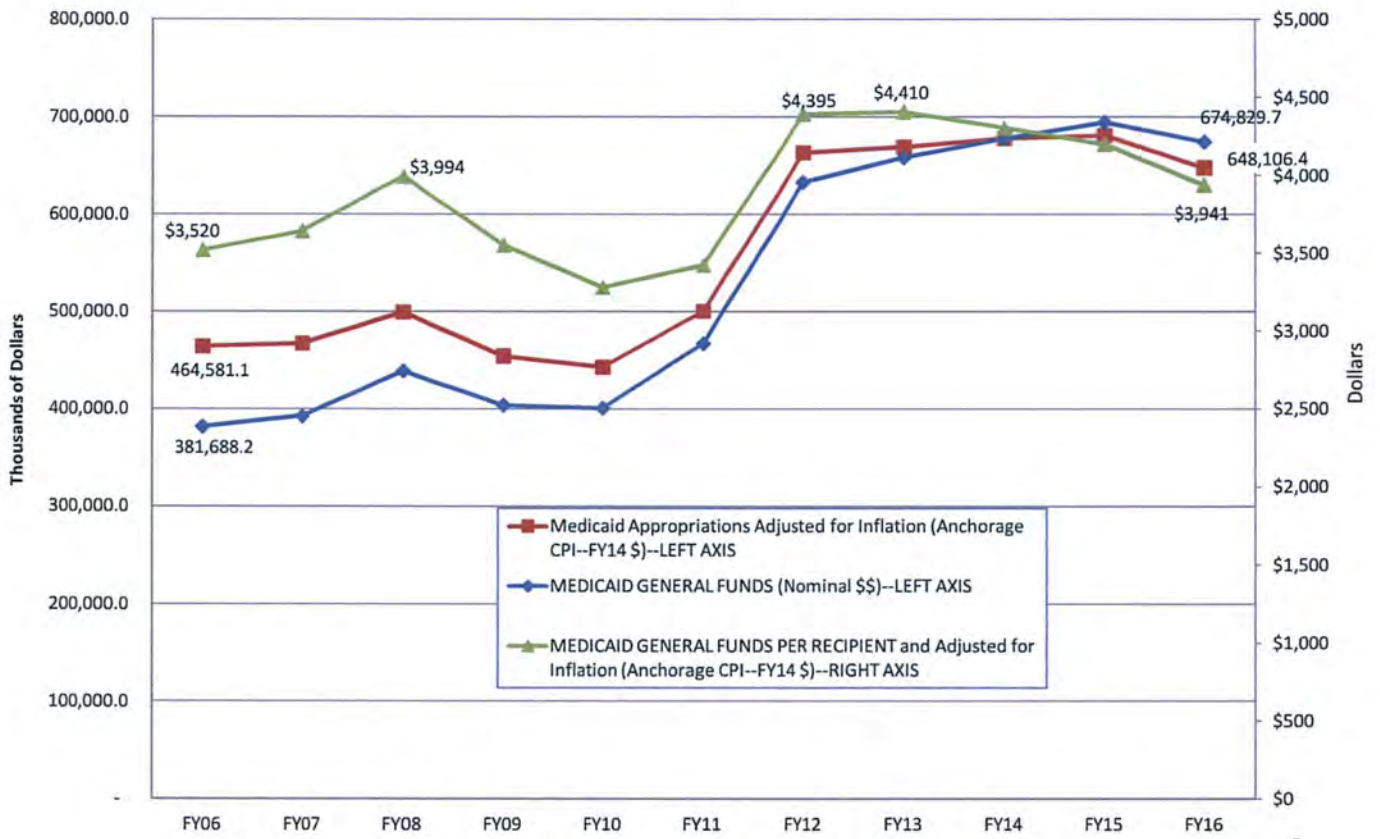


### Alaska's Population Growth and Medicaid Enrollee Growth



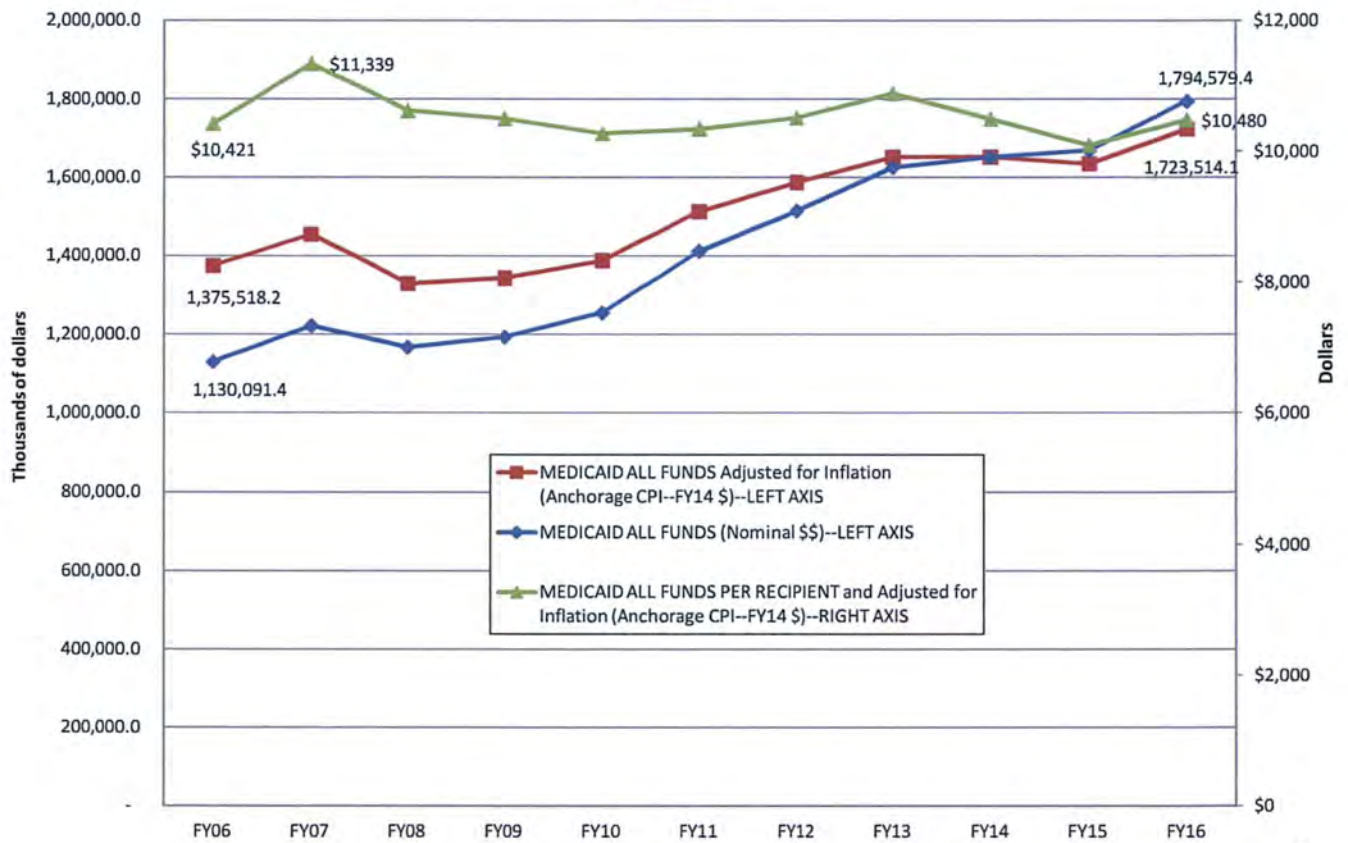
## Historical Medicaid Growth

Anchorage CPI Inflation Adjusted FY14 \$  
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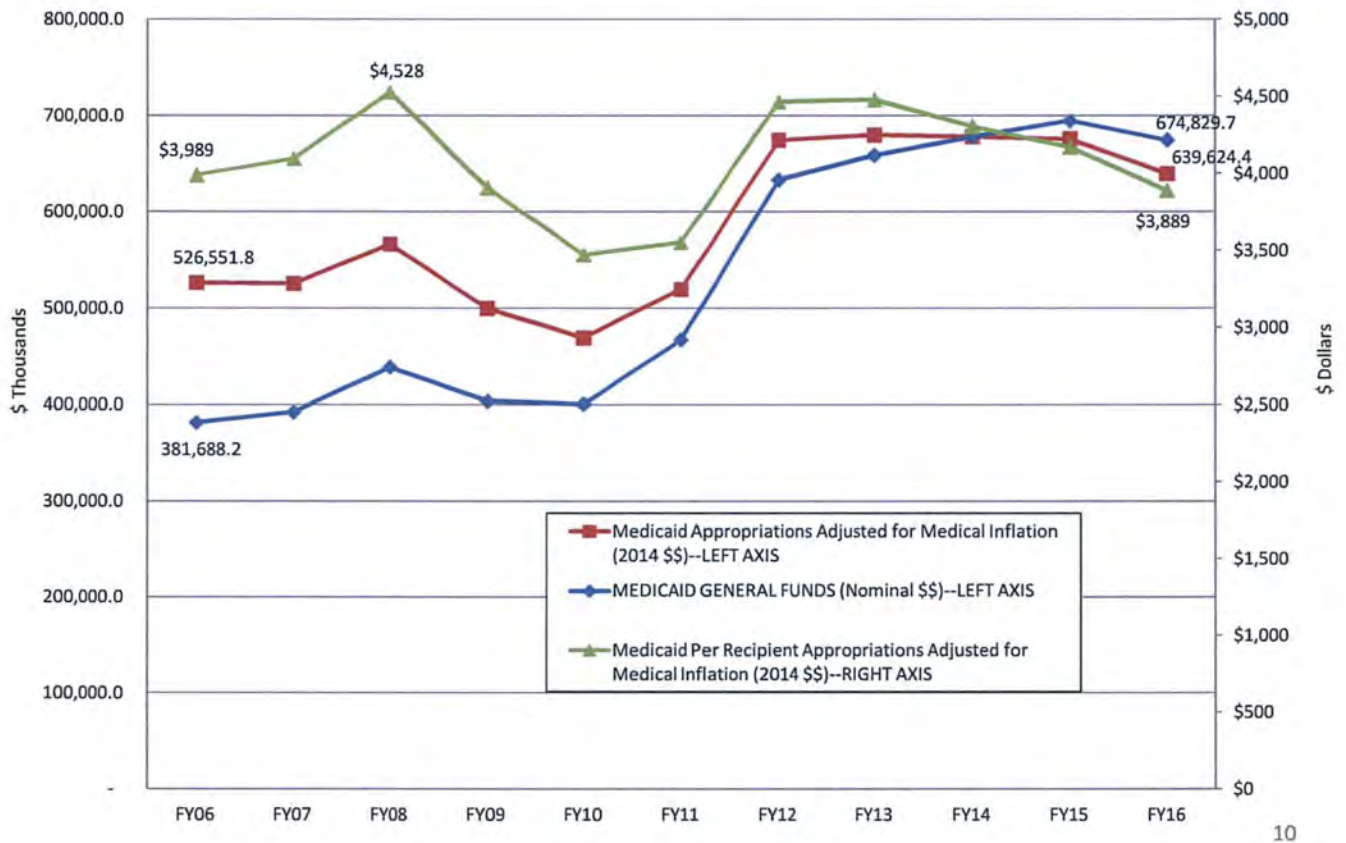
## Historical Medicaid Growth

Anchorage CPI Inflation Adjusted FY14 \$  
(All Funds)



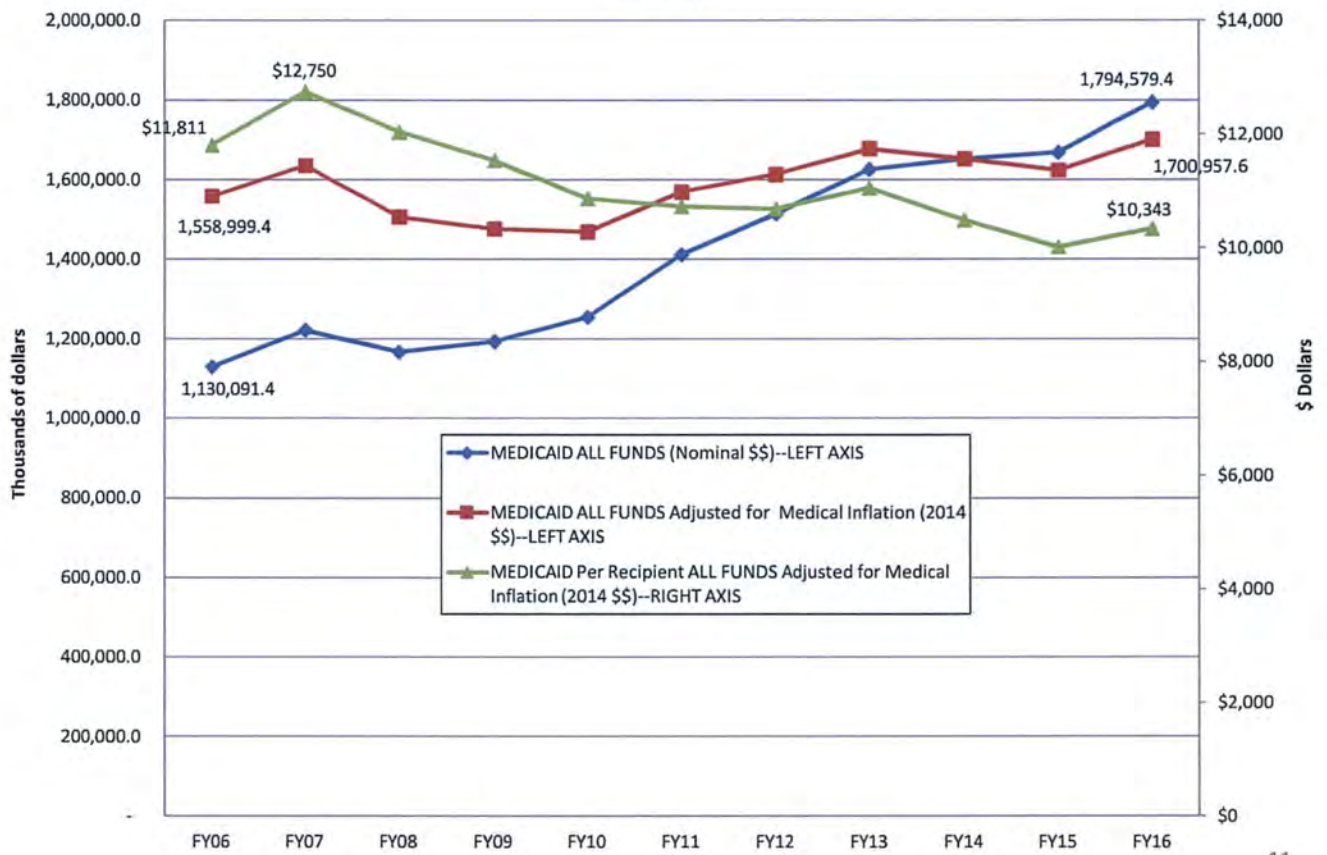
## Historical and Projected Medicaid Growth

Anchorage Health Care CPI Inflation Adjusted 2014 \$  
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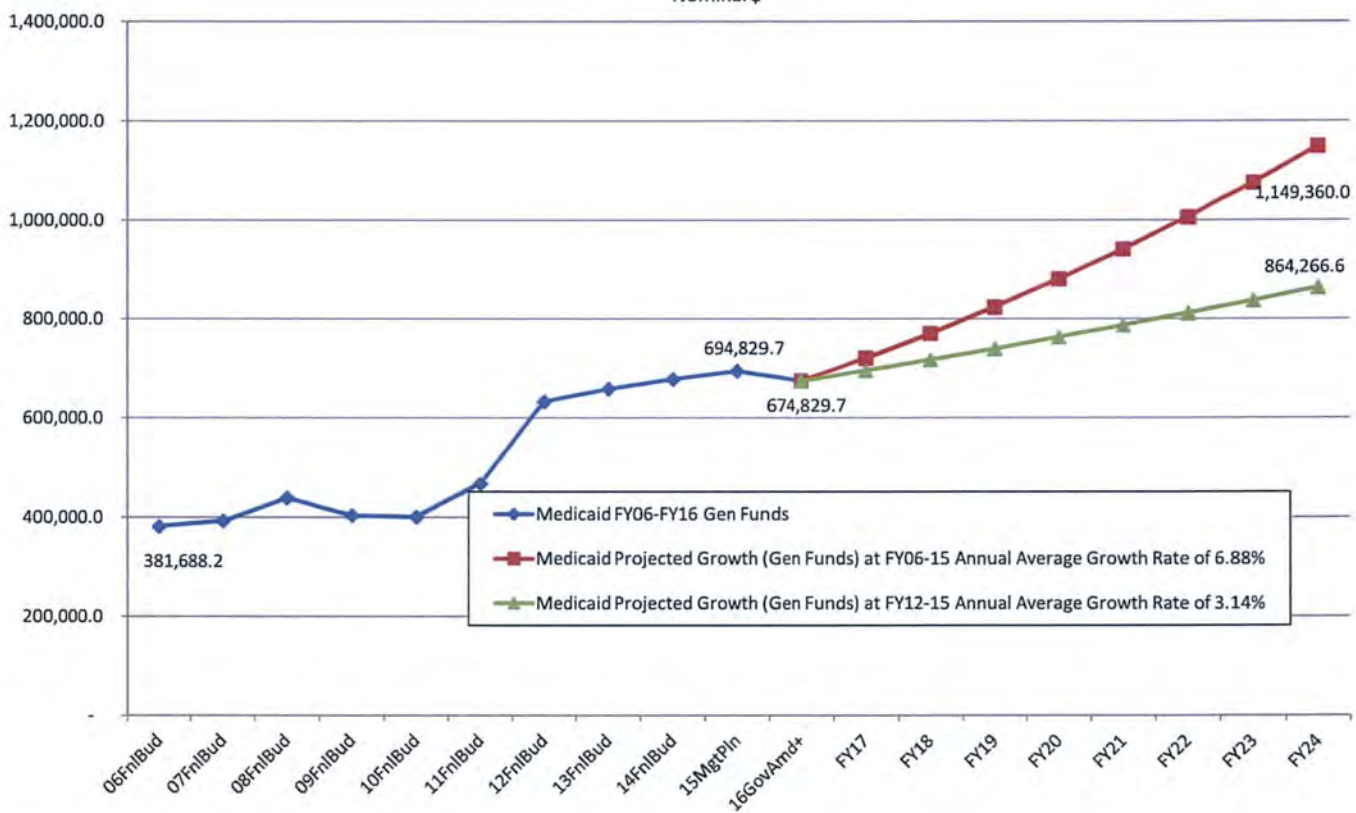
## Historical and Projected Medicaid Growth

Anchorage Health Care CPI Inflation Adjusted (2014 \$)  
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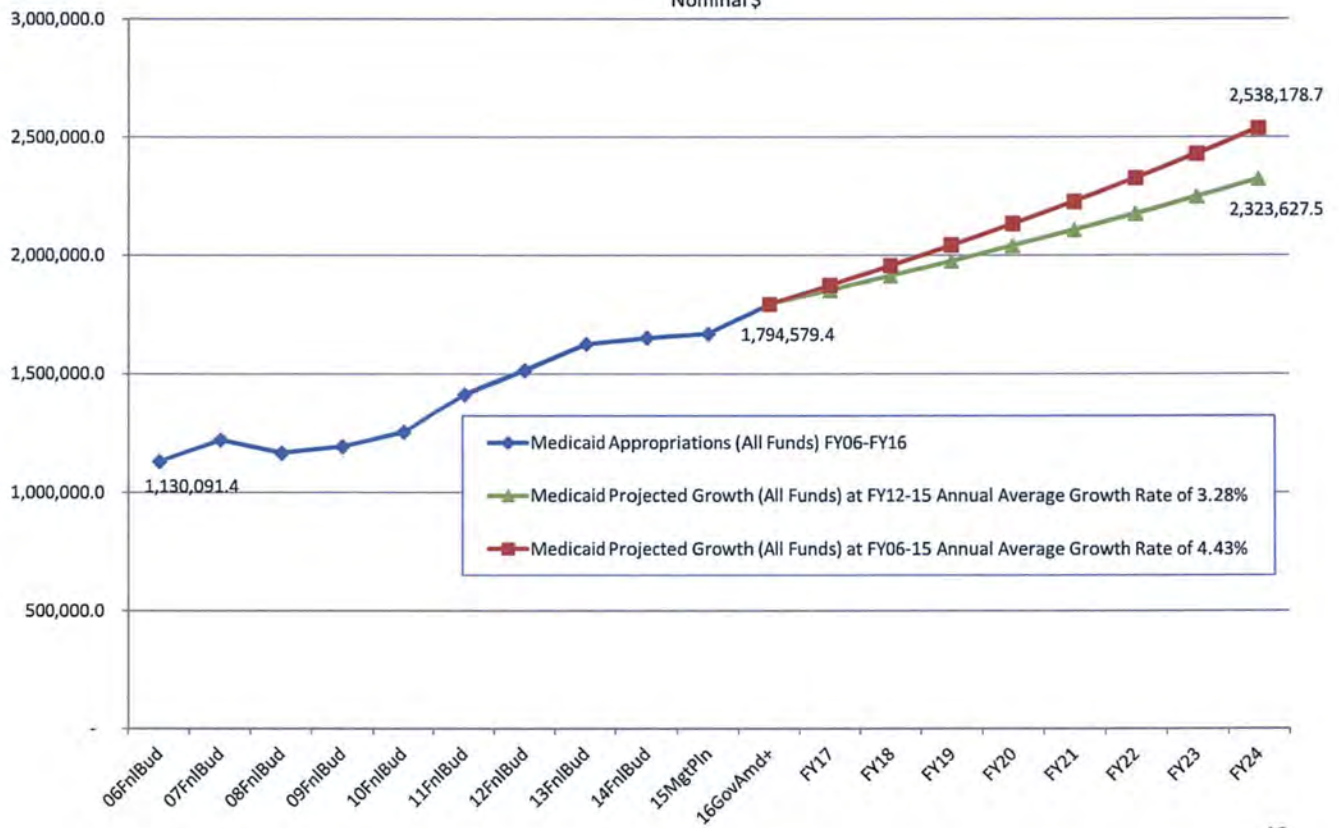
### Historical and Projected Medicaid Growth

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## Historical and Projected Medicaid Growth Rates

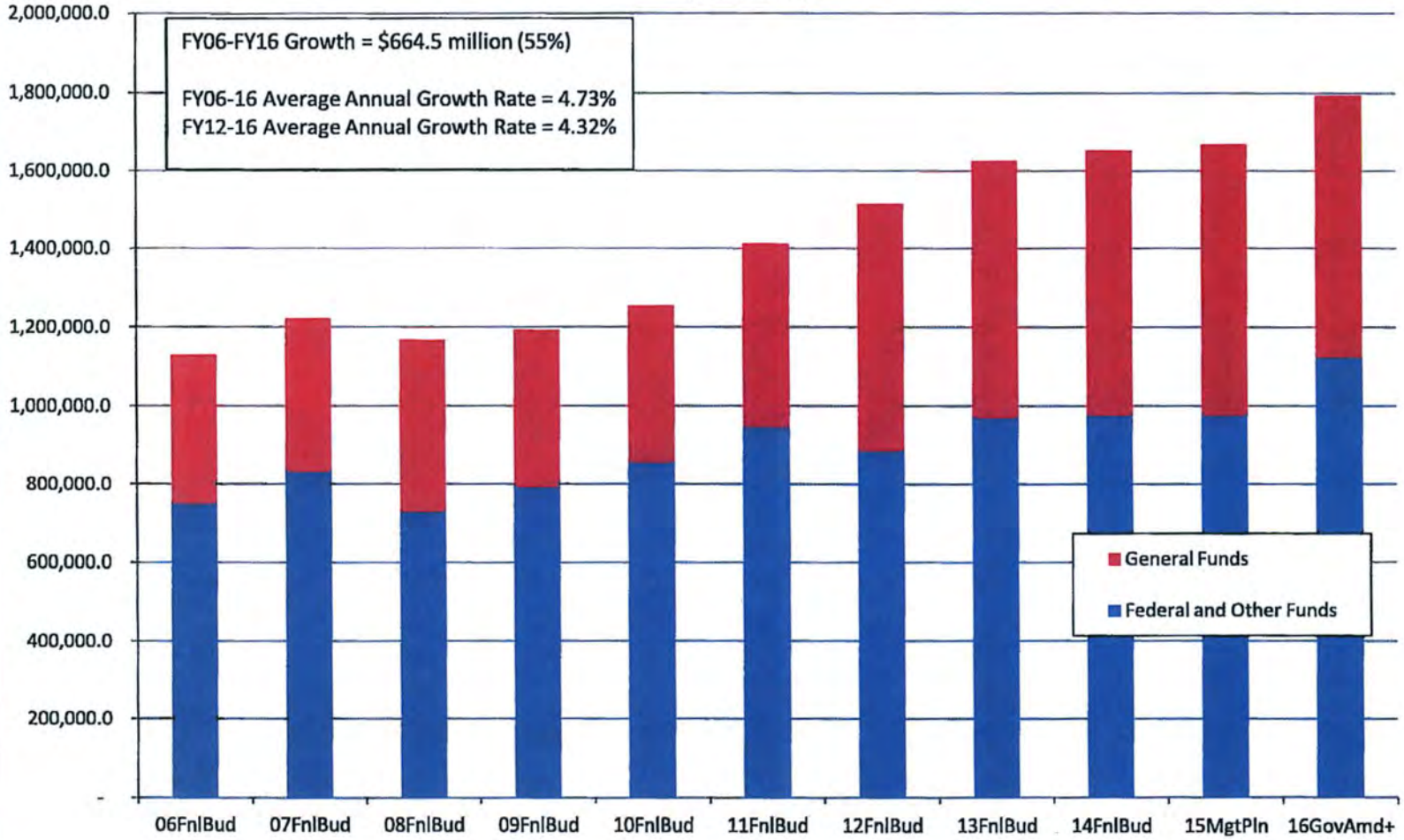
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# MEDICAID APPROPRIATIONS

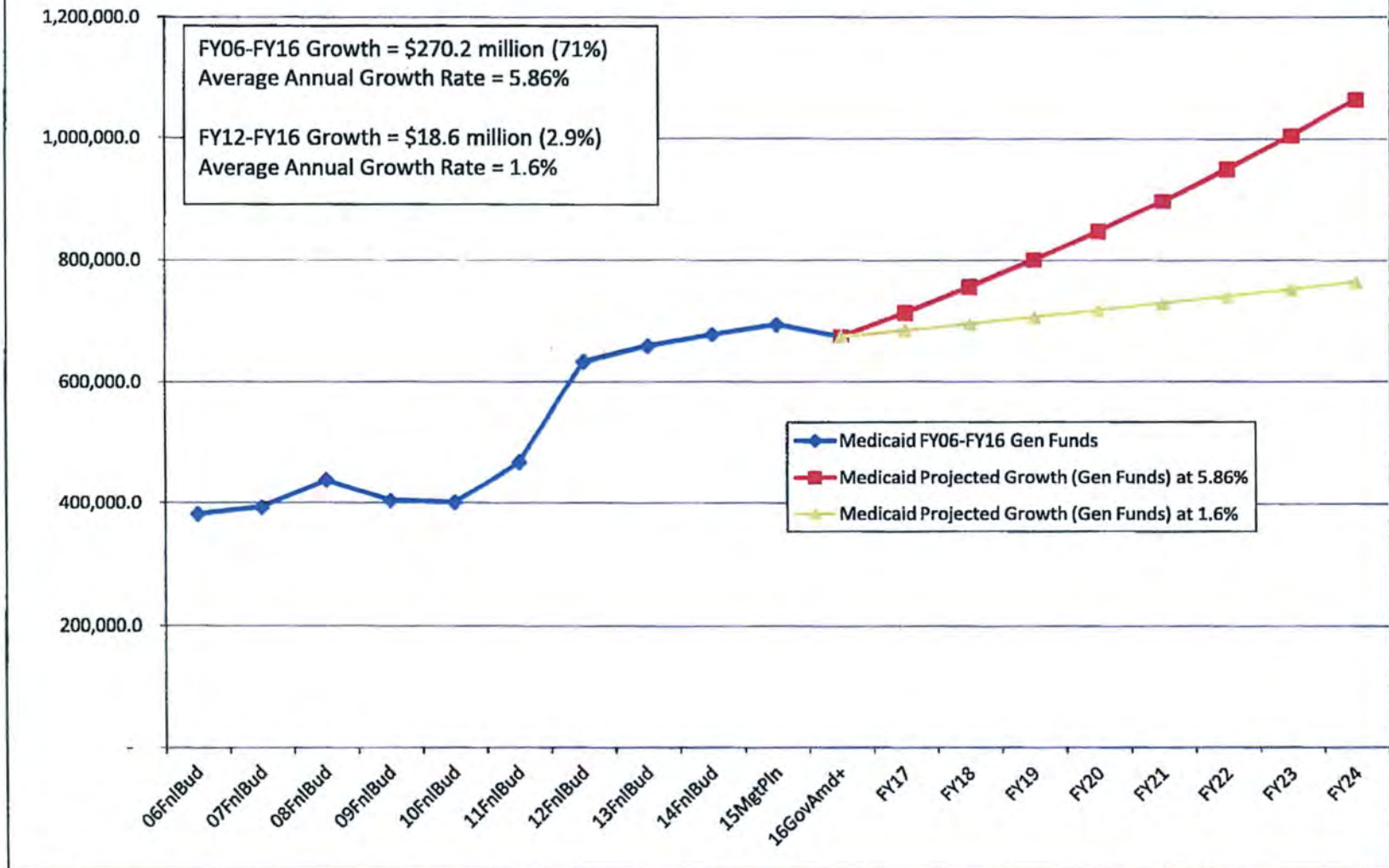
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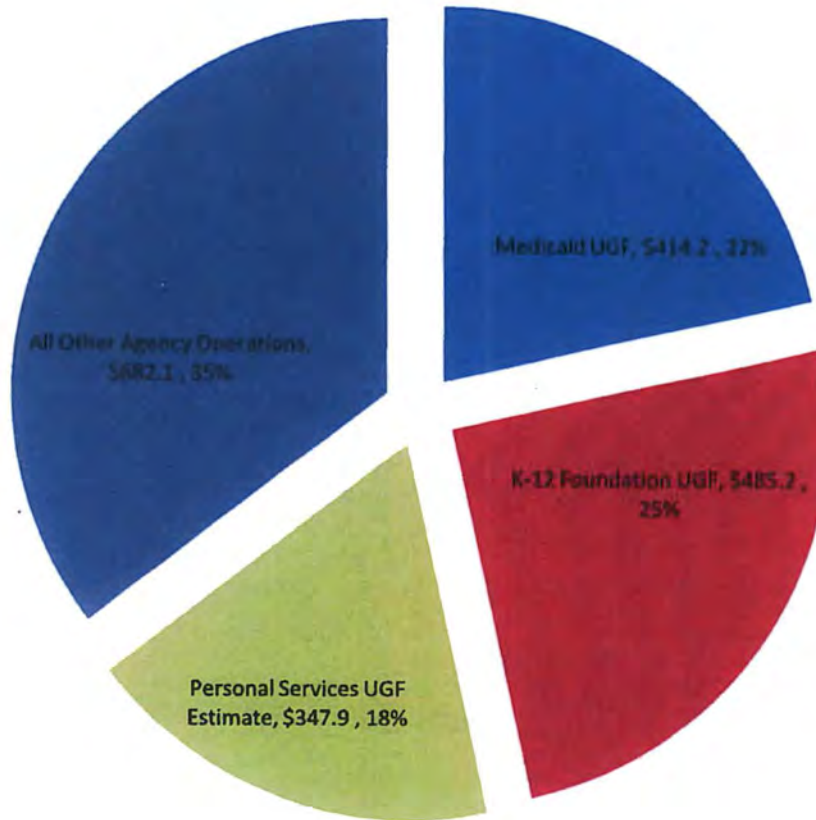


## Historical and Projected Medicaid Growth

(GF Only)  
(\$Thousands)



**Cost Drivers--Agency Operations  
Contribution to Budget Increases FY06-FY15 (\$ millions)  
\$1.9 Billion Total UGF Increase**



# **MANAGED CARE COST SAVINGS**



# **Medicaid Managed Care Cost Savings - A Synthesis of 24 Studies**

*Prepared for:*

**America's Health Insurance Plans**

*July 2004*

*Updated March 2009*

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## EXECUTIVE SUMMARY

In 2004, America's Health Insurance Plans engaged The Lewin Group to synthesize existing research on the savings achieved when states have implemented Medicaid managed care programs. This report is an update of the 2004 report, and includes both studies from the previous report and studies that have been released since 2004. In all, The Lewin Group reviewed 24 studies.<sup>1</sup> The studies reviewed were identified and selected by America's Health Insurance Plans and Lewin and include federally required independent assessments, studies commissioned by the federal and state governments, private foundations, and researchers, and one health plan-funded study. Studies are grouped into three categories:

1. State studies, which examine states' cost savings in their overall Medicaid managed care programs
2. Targeted Medicaid managed care studies, which assess savings in Medicaid managed care programs targeted to specific populations
3. Specific service studies, which analyze Medicaid managed care program savings for specific services.

Appendix A lists the studies reviewed.

It is worth noting that, although not a focal point of this engagement, many of the studies reviewed addressed the impact of managed care on access and continuity of care as well as on costs. In the overwhelming majority of cases, the state Medicaid managed care programs were found to have improved Medicaid beneficiaries' access to services, and both the programs and individual managed care organizations (MCOs) have earned high satisfaction ratings from enrollees.

The studies present compelling evidence that Medicaid managed care programs can yield savings. The studies also suggest that certain populations or services are especially likely to generate savings in a managed care delivery system. We summarize these findings below.

- **First, the studies strongly suggest that the Medicaid managed care model typically yields cost savings.** While percentage savings varied widely (from half of 1 percent to 20 percent), nearly all the studies demonstrated a savings from the managed care setting
- **Second, the studies provide some evidence that Medicaid managed care savings are significant for the Supplemental Security Income (SSI) and SSI-related population.** In Arizona, 60 percent of the \$102.8 million savings achieved from 1983 to 1991 is from the SSI population. In the Kentucky Region 3 Partnership, the SSI population made up 25 to 34 percent of total enrollment and accounted for 53 to 61 percent of the savings achieved from 1999 to 2003. An analysis of a subset of the entire Oklahoma aged, blind, and disabled (ABD) population who were enrolled in a particular Medicaid health plan

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<sup>1</sup> This total includes two reports on Michigan Medicaid, two reports on Maryland's HealthChoice's program, two on Ohio's program, and two reports on the Texas STAR+PLUS program.

and who were among the highest 10 percent of service users found that overall costs per member per month (PMPM) were four percent lower in managed care than in fee-for-service (FFS). The Texas STAR+PLUS program, which focuses on SSI enrollees, achieved PMPM savings of \$4 in the first waiver period and \$92 in the second waiver period. In addition, Pennsylvania HealthChoices, which relies heavily on capitation for its disabled population, experienced average annual per capita costs that were \$6,800 lower for its beneficiaries with disabilities than the average of surrounding states. These savings are notable even if they can not be solely attributed to managed care.

- **Third, various studies demonstrated that states' Medicaid managed care cost savings are largely attributable to decreases in inpatient utilization.** A study of preventable hospitalizations in California found that the rates of preventable hospitalization were 38 and 25 percent lower in managed care than in FFS for the Temporary Assistance for Needy Families (TANF) and SSI populations, respectively. In Ohio's PremierCare program, inpatient costs decreased 27 percent under capitated Medicaid managed care, from \$76 PMPM to \$55 PMPM. Furthermore, a study of inpatient utilization for alcohol-related treatment in Pennsylvania found that costs per person decreased by approximately 26 percent at the managed care site in Philadelphia County, while costs per person increased by approximately 32 percent at the FFS site in Allegheny County
- **Finally, pharmacy was also an area where Medicaid managed care programs yielded noteworthy savings.** A comparison of drug costs under FFS vs. Medicaid managed care, using FFS and MCO drug cost and utilization data for the TANF population from multiple states, found that the PMPM cost of drugs in the managed care setting was 10 to 15 percent lower than in the FFS setting. Arizona's PMPM for prescription drugs for the ABD Medicaid population, which are delivered and paid for within Arizona's Medicaid managed care model, were found to be far lower than the PMPM drug costs for the ABD population under any state Medicaid FFS. Pennsylvania's annual PMPM prescription cost increase of 14.4 percent under its FFS system fell to 9.1 percent during the 3 years following implementation of the HealthChoices program, the Commonwealth's Medicaid managed care program

The reports summarize the cost savings experience of just some of the states that have implemented managed care for their Medicaid populations. Since the early 1990s, state Medicaid programs have turned increasingly to managed care to improve access to care and contain costs. Many states have enrolled sizable portions of their Medicaid beneficiary populations in some form of managed care—most often in managed care plans that provide comprehensive services to their members on a coordinated, prepaid basis.<sup>2</sup> However, there is still substantial opportunity for states to expand Medicaid enrollment in managed care plans.

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<sup>2</sup> This report deals exclusively with savings from the comprehensive, prepaid managed care plan model in which health plans are paid a capitation rate and are responsible for providing and/or arranging for the provision of all or a majority of Medicaid covered services for their enrollees. The primary care case management (PCCM) model is also used by a large number of states, often in conjunction with the prepaid, comprehensive managed care plan model. Under the PCCM model, each Medicaid recipient is linked with a primary care physician who receives a per capita management fee to coordinate a patient's care. However, all medical services provided to the recipient are paid on a fee-for-service basis. References in this report to "Medicaid managed care," "managed care model," and "Medicaid managed care model" are references to the comprehensive prepaid managed care model only and are not inclusive of the PCCM model. The PCCM model is not the subject of this report.

According to the Centers for Medicare and Medicaid Services (CMS), 45.6 percent of the Medicaid population was enrolled in comprehensive prepaid managed care as of June 2007. A number of states, though, have “carved out” some of the highest-cost services from their managed care programs, and most states have excluded entire eligibility categories—generally the high-cost disabled populations—from their managed care initiatives. As a result, while more than half of all Medicaid beneficiaries are enrolled in some form of managed care, more than 80 percent of national Medicaid spending remains in the FFS setting.<sup>3</sup>

Given the adverse budget pressures currently confronting states, policymakers are understandably interested in assessing whether such Medicaid managed care expansion might ease these fiscal pressures. Within the Medicaid budget, the alternative paths to fiscal savings seem much more troublesome – cutting eligibility, eliminating benefits, or reducing already-low provider payment levels.

The findings from this study demonstrate that the managed care model achieves access and quality improvements while at the same time yielding Medicaid program savings. Further, it is clear that—through carefully crafted managed care program design that is tailored to the state’s Medicaid populations and geographic landscape—real opportunities exist for states to benefit from expanding the Medicaid managed care model to eligibility categories and services heretofore largely excluded from managed care.

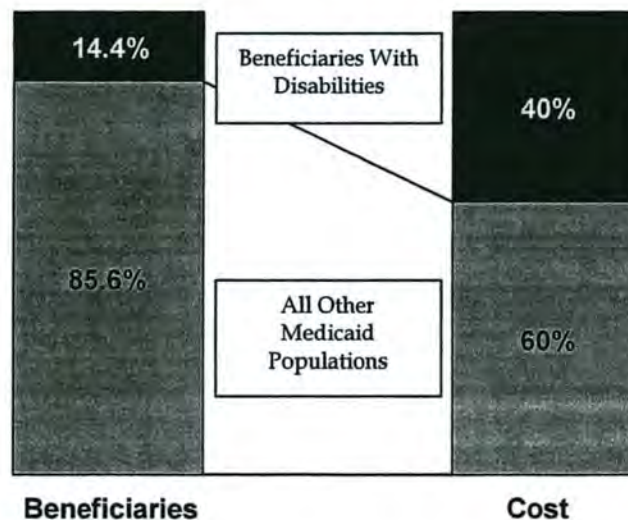
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<sup>3</sup> 2005 Medicaid Quarterly Statement, Centers for Medicare and Medicaid Services, <http://msis.cms.hhs.gov/>.

## I. INTRODUCTION AND CONCEPTUAL OVERVIEW

Since the early 1990s, state Medicaid programs have turned increasingly to the managed care model<sup>4</sup> because of its potential to contain rapidly rising Medicaid program costs, while improving access to care and bringing more mainstream providers into play. However, although a substantial proportion of Medicaid beneficiaries nationwide are enrolled in managed care, a large proportion of Medicaid expenditures – indeed 80 percent<sup>5</sup> – remain in the FFS system. This is largely because most states have not yet embraced the managed care model for people with disabilities enrolled in Medicaid. These subgroups, though comprising a relatively small percentage of Medicaid beneficiaries overall, represent the highest-need, highest-cost categories of eligibility, and thus a disproportionate share of total Medicaid expenditures.<sup>6</sup>

**Exhibit 1. Distribution of Population and Costs, FY2004**



In addition, a number of states “carve out” certain services, such as prescription drugs and mental health, from their existing managed care programs and pay for these services on a FFS basis.

<sup>4</sup> This report deals exclusively with savings from the comprehensive, prepaid managed care plan model in which health plans are paid a capitation rate and are responsible for providing and/or arranging for the provision of all or a majority of Medicaid covered services for their enrollees. The Primary Care Case Management (PCCM) model is also used by a large number of states, often in conjunction with the prepaid, comprehensive managed care plan model. Under the PCCM model, each Medicaid recipient is linked with a primary care physician who receives a per capita management fee to coordinate a patient’s care. However, all medical services provided to the recipient are paid on a fee-for-service basis. References in this report to “Medicaid managed care,” “managed care model,” “Medicaid managed care model,” and “capitated managed care” are references to prepaid managed care model only and are not inclusive of the PCCM model.

<sup>5</sup> 2005 Medicaid Quarterly Statement, Centers for Medicare and Medicaid Services, <http://msis.cms.hhs.gov/>.

<sup>6</sup> Kaiser Family Foundation State Health Facts, Distribution of Medicaid Enrollees by Enrollment Group and Distribution of Medicaid Payments by Enrollment Group, FY2004, <http://www.statehealthfacts.org>.

Thus, for state policymakers dealing with Medicaid budget woes, Medicaid managed care expansion emerges as a particularly attractive alternative to the other primary options available, including reductions in eligibility, benefits, or still deeper cuts in already low provider payment rates that further undermine Medicaid's ability to avoid being perceived as a "second class" system of coverage.

As states consider expansion of Medicaid managed care, it is useful to understand both the reasons the comprehensive, prepaid managed care model would be expected to save money and the challenges to such programs in yielding savings. This knowledge can help guide states not only in their broad decisions regarding implementation or expansion of Medicaid managed care, but perhaps more importantly in designing the specifics of managed care initiatives – including eligible populations to target, geographic areas to include, and whether enrollment is voluntary versus mandatory. Below we briefly outline some of the theoretical cost-savings opportunities and challenges associated with the managed care model in Medicaid, and then set the stage for the body of our report, which summarizes the research on Medicaid managed care.

### **A. Savings Potential of the Managed Care Model**

Savings opportunities in Medicaid managed care are largely created by the inherent structural challenges of coordinating care and containing costs in the FFS setting. The FFS model is an unstructured system of care that creates incentives to provide as many services as possible, while doing little to encourage providers to manage the mix and volume of services effectively. Managed care organizations (MCOs), on the other hand, combine within one entity the responsibility for both the financing and delivery of health care and thus have strong incentives – and means – to coordinate care and, in turn, reduce the costs of inpatient and other expensive categories of health care services, where Medicaid spending is concentrated.

Initiatives to generate savings in the Medicaid FFS setting have predominantly focused on price controls, whereby states cut their payments to providers. While this approach may result in savings, it is not without risks. Low payments drive mainstream physicians out of the Medicaid program, impeding Medicaid beneficiaries' access to primary, preventive and specialty care services and funneling Medicaid care toward more expensive institutional-based services.

Medicaid managed care plans have opportunities to achieve savings through a number of mechanisms, including but not limited to the following:

- Improving access to preventive and primary health care by requiring participating doctors and hospitals to meet standards for hours of operation, availability of services, and acceptance of new patients
- Investing in enrollee outreach and education initiatives designed to promote utilization of preventive services and healthy behaviors
- Providing a "medical home" to an individual and utilizing a physician's expertise to refer patients to the appropriate place in the system (as opposed to relying on the patient's ability to self-refer appropriately)
- Providing individualized case management services and disease management services

- Channeling care to providers who practice in a cost-effective manner
- Using lower cost services and products where such services and products are available and clinically appropriate (in lieu of higher-cost alternatives)
- Conducting provider profiling and enhancing provider accountability for quality and cost-effectiveness

## **B. Challenges Faced by the Medicaid Managed Care Model**

Collectively, the above mechanisms create strong savings opportunities for the Medicaid managed care model. At the same time, there are also some factors working against the model's ability to achieve savings in Medicaid. These challenges are outlined below.

**Transitory Enrollment.** A unique challenge in the Medicaid managed care arena is the volatile eligibility in the Transitional Assistance to Needy Families (TANF) population. Most Medicaid MCO enrollees are TANF beneficiaries, and by definition these persons have short-term enrollment duration. This poses a substantial administrative burden in continually processing a large volume of enrollments and disenrollments, including new member orientation activities and materials. The volatile nature of TANF enrollment also obviously inhibits the MCOs' ability to influence these persons' longer-term health status and cost trajectory.

**Poverty-Related Enrollee Characteristics.** Medicaid beneficiaries often face a number of barriers to health care that are related to their impoverished status. These include low educational attainment, language and literacy barriers, homelessness, lack of reliable transportation, and inadequate child care options, to name a few. Such barriers may challenge MCOs' efforts to manage and coordinate enrollee care and often require them to make additional investments to accomplish those goals.

**Prescription Drug Rebates.** The Omnibus Budget Reconciliation Act of 1990 established the Medicaid Drug Rebate Program, designed to ensure that Medicaid did not pay "list" prices for prescription drugs, but was able to take advantage of discounts that were available to manufacturers' most favored purchasers (the "best price"). Drug manufacturers participating in the drug rebate program provide quarterly rebates to states for drugs dispensed to state Medicaid beneficiaries. These rebates result in "best price" to Medicaid, i.e., Medicaid pays the lowest price paid for a prescription product by any purchaser, other than federal discount programs and state pharmaceutical assistance programs. However, the law excludes drugs paid for by Medicaid MCOs (on behalf of their Medicaid enrollees) from being counted toward manufacturers' rebate requirement. As private purchasers, Medicaid managed care plans are not entitled to the rebates mandated by the Medicaid Drug Rebate Program. Medicaid MCOs must enter into separate negotiations with drug manufacturers, either directly or through their contracting pharmacy benefits managers. Because MCOs do not have the same most favored status as Medicaid, they are not able to negotiate discounts as large as those realized by the state Medicaid agencies through the rebate program.

**Rural Barriers.** Rural settings pose daunting challenges to the managed care model in Medicaid (as well as for other payers). The limited number of providers can make development

of a network problematic, and the market may be unable to provide the economies of scale that are achievable in more metropolitan areas.

**Limited Price Discount Strategies.** One avenue for savings that exists for MCOs outside of Medicaid, price discounts, generally is not available in the Medicaid managed care arena. Outside the Medicaid arena, MCOs are often able to negotiate “discount for volume” arrangements with participating providers, whereby patients are channeled to providers who are willing to accept an MCO’s payment terms. Given the low level of Medicaid unit prices versus other payers, and the corresponding low levels of Medicaid participation among physicians, it is not realistic or appropriate from a network development perspective – to drive down Medicaid prices. Savings instead must occur predominantly through truly “managing care” as opposed to managing price.

**Capitation Rate-Setting.** An overarching issue that determines the level of Medicaid savings that will be achieved through the capitated model is the capitation rates themselves. It is by no means an automatic process for states to pay a capitation rate that builds in savings and is also sufficient to cover MCOs’ medical costs, administrative costs, and profit/operating margin needs. A delicate balance often exists. Capitation rates set unnecessarily high can obviously result in states having greater expenditures under their managed care program than in their FFS programs. Rates set too low will make it difficult to attract or retain health plans and could violate the federal requirement that rates must be actuarially sound.

### C. Objectives of This Report

Given both the potential of and challenges for managed care to yield savings to state Medicaid programs, as well as federal requirements that states report on the savings their Medicaid managed care programs have achieved, state and federal governments, private foundations, and health plans have commissioned numerous studies on the fiscal impacts of capitated Medicaid managed care initiatives. To better understand the findings of the research to date, America’s Health Insurance Plans has asked The Lewin Group (Lewin) to objectively summarize a sample of the body of research.

In total, Lewin reviewed 24 studies<sup>7</sup>, including federally-required independent assessments of state Section 1915(b) waiver programs targeting specific types of services or populations, and general reports on the impact of Medicaid managed care. Some of the studies were conducted by states, while others such as the independent assessments were conducted by entities such as academic research institutions or consulting or actuarial firms. Other studies were conducted under contract with the federal government or private foundations. One study was health plan funded. Studies were identified and selected by America’s Health Insurance Plans and Lewin with the goal of providing a balanced overview of cost savings that have been achieved under Medicaid managed care.

Section II of this report presents findings from the research, including an overview of each of the 24 studies that were reviewed followed by a summary of findings by topic area. The

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<sup>7</sup> This total includes two reports on Michigan Medicaid, two reports on Maryland’s HealthChoice’s program, and two reports on the Texas STAR+PLUS program.

assessment summarizes the basic structure of programs (e.g., eligibility, benefits, and enrollment), as well as cost savings. Cost savings generally are presented as a percent of estimated FFS costs or difference in per member per month (PMPM) costs between the FFS and prepaid Medicaid managed care settings. The second portion of Section II groups the study findings into selected areas (TANF/Supplemental Security Income [SSI], medical service category, etc.) and discusses the specific areas where savings appear to have been most substantial.

Section III summarizes the key findings from our syntheses and describes some potential policy implications.

## II. FINDINGS FROM THE RESEARCH

This section summarizes each of the 24 studies reviewed. Studies are grouped into those that examined states' overall capitated Medicaid managed care programs, those that looked at state capitated Medicaid managed care programs targeted to specific populations, and those that analyzed specific aspects of Medicaid managed care, such as the model's impact on pharmacy services. A summary of savings achieved under Medicaid managed care as reported in the studies is provided in Appendix B and detailed summaries of the studies are included in Appendix C. The section below also provides brief summaries of quality and access to health care outcomes of the capitated managed care programs, if the information was provided in the studies.

In considering the savings associated with Medicaid managed care reported in the studies reviewed, a few caveats are necessary. The savings data from the studies cannot be compared directly to one another because of differences in state programs and study methodologies for which no adjustments were made. The assessment of savings from Medicaid managed care programs is predicated on what Medicaid program costs would have been under FFS. As states expand their Medicaid managed care programs and gain more experience with managed care, they also erode the FFS baseline data used to determine cost-effectiveness.

It is also important to point out that assessments of savings from Medicaid managed care generally are comparing what *claims* costs would have been under FFS to the state's payments to MCOs within the managed care program for the health care and administrative services they are required to provide. That is, cost effectiveness is measured by *net* savings, after taking into account:

- Claims savings under managed care
- The administrative expenses MCOs incur as a result of their efforts to coordinate care and achieve savings
- Allowance for an operating surplus

MCO administrative activities typically include health care-related services such as case management, quality management, disease management, and utilization management. Payments to MCOs also incorporate a profit/operating margin. Health plans must have a realistic opportunity to achieve a favorable operating margin, particularly considering the downside financial risk that these organizations bear.

## A. Summary of Key Studies

### 1. *Cost Effectiveness Studies of Specific State Programs*

This section describes general studies of states' overall Medicaid managed care programs. This analysis included a review of 11 studies conducted in 9 states along with 2 independent assessments. Of these, Arizona, Kentucky, Michigan, New Mexico, Ohio, Washington, Pennsylvania, and Wisconsin all enroll both TANF and SSI beneficiaries into their capitated managed care initiatives. Only Kentucky, New Mexico, and Pennsylvania include children in foster care in their Medicaid managed care programs. Common state carve-outs include long-term care, pharmacy, mental health and substance abuse services, and school-based health services. MCO enrollment is mandatory in Arizona, Kentucky, Michigan, New Mexico, and Wisconsin, while Ohio, Pennsylvania, and Washington operate mixed mandatory/voluntary programs. Exhibit 2 summarizes selected components of states' Medicaid managed care programs.

**Exhibit 2. Summary of Select Medicaid Managed Care Programs**

State	TANF children	TANF adults	Foster Care	Pregnant Women	SSI, SSI-Related	Mandatory/Voluntary	Carve-Outs (As Of Year Evaluation Was Conducted)
AZ	✓	✓		✓	✓	M	Arizona capitates all services. Mental health services and long-term care services are provided through specialized capitated MCO programs, separate from the "acute" capitated program. Select drug classes or specific drugs.
KY	✓	✓	✓	✓	✓	M	Long-term care, mental health, and school-based services
MD	✓	✓	✓	✓	✓	M	Specialty mental health services, nursing facility services after the first 30 continuous days of care, LTC HCBS, physical therapy, speech therapy, occupational therapy, audiology services, and select drug classes or specific drugs
MI	✓	✓		✓	✓	M/V	Long-term care, dental, behavioral, school-based health services, select classes or specific drugs
NM	✓	✓	✓	✓	✓	M	Behavioral Health, select classes or specific drugs, long-term care
OH	✓	✓		✓	✓	M	Long-term care, mental health, substance abuse services, non-emergency transportation
PA	✓	✓	✓	✓	✓	M/V	Behavioral health, long-term care
WA	✓	✓		✓	✓	M/V	Vision (glasses only), long-term care
WI	✓	✓		✓	✓	M	Long-term care, transportation, family planning, prenatal care coordination, targeted case management, dental, chiropractic, school-based services, TB-related services, employer sponsored coverage wrap-around services, pharmacy

Notes: In Michigan's Medicaid program, managed care enrollment is mandatory for AFDC, SSI, and Aged, Blind and Disabled (ABD) populations in all but 19 counties where it is voluntary. In Wisconsin, most Medicaid beneficiaries are served in a mandatory enrollment model, which has been implemented in 47 counties; voluntary enrollment is used in 21 more rural counties. In Pennsylvania, HealthChoices is mandatory in the Southeast, Southwest, and Lehigh/Capital Zones, while the remainder of the Commonwealth is FFS or voluntary capitated managed care. Washington State's Medicaid program is mandatory for its' TANF beneficiaries. The State currently operates a voluntary program, the Washington Cost Offset Pilot Project, for its' SSI/SSI-related beneficiaries.

*a. Arizona*

The level of cost savings achieved by states' Medicaid managed care programs is presented primarily on a percentage or PMPM basis, given that the states all have different enrollment

levels. The Arizona study yielded the largest percentage costs savings among the states evaluated. In FY1991, total savings in the Arizona Health Care Cost Containment System (AHCCCS) were \$52 million, representing a 19 percent savings versus what FFS costs were estimated to have been absent Medicaid managed care. To calculate the FFS equivalent, researchers used cost data from states with similar programs.

Throughout the period of 1983 to 1993, AHCCCS achieved cost savings of 11 percent for medical services and seven percent in total cost savings once the MCOs' allocations for administrative costs and operating margins were factored in. AHCCCS slowed the growth rate in Medicaid expenditures between 1983 and 1991 to 6.8 percent under Medicaid managed care from an estimated 9.9 percent under FFS.<sup>8</sup> In March 1997, more than 450,000 AHCCCS beneficiaries were mandatorily enrolled in capitated MCOs. Enrollment as of February 2004 is above 750,000, resulting from coverage expansions. It can be inferred that the cost-effectiveness of the Medicaid managed care program has been at least partially responsible for enabling Arizona to finance such-large scale enrollment growth in the AHCCCS program.

*b. Wisconsin*

In Wisconsin, AFDC children and adults, pregnant women, children, and families are enrolled in the capitated managed care program on a mandatory basis in all regions where a sufficient MCO presence exists. In 2001 and 2002, it was estimated that Wisconsin's managed care programs achieved cost savings of 7.9 and 10.7 percent of what costs would have been under FFS.<sup>9</sup> These savings were driven in part by reductions in emergency room visits through use of a 24-hour nurse line that is available to all MCO members; decreased annual hospital admissions and days through utilization management techniques such as concurrent review, coordination of long-term care services, chronic disease management, prior authorization for certain services, discharge planning, and prescription drug management. During the study period, 283,207 individuals were enrolled in MCOs. Per member per month savings are shown in Exhibit 3.

**Exhibit 3. Wisconsin MCO Per Member Per Month Savings**

Coverage Category	2001 PMPM Savings	2002 PMPM Savings
BadgerCare	\$3.87	\$23.57
AFDC-Related/Healthy Start Children	\$11.37	\$11.26
Pregnant Women	\$111.83	\$152.39

The study also reports that Wisconsin Medicaid MCOs outperform FFS Medicaid on quality measures. MCO enrollees were more likely to have at least one primary care visit and were more likely to receive mental health/substance abuse evaluations. Inpatient admission rates were lower among MCO enrollees than those in FFS.

<sup>8</sup> U.S. General Accounting Office, *Arizona Medicaid - Competition Among Managed Care Plans Lowers Program Costs*, October 1995.

<sup>9</sup> Milliman USA, *Wisconsin HMOs' Success in Medicaid and BadgerCare: Government Cost Savings and Better Health Care Quality*, February 2002.

c. *Kentucky*

The prepaid Medicaid managed care program in Kentucky operates in the Commonwealth's largest urban area, which includes Jefferson County (Louisville) and 15 neighboring counties. About 20 percent of the Commonwealth's Medicaid population lives in this area, known as Region 3. Enrollment in an MCO is mandatory in the Region 3 Partnership and one MCO, Passport Health Plan, a provider-run Medicaid health plan, currently operates in the region. In FY2000, total Region 3 enrollment in Passport Health Plan was 97,255 individuals, and in CY2003, enrollment was about 126,524.<sup>10</sup>

From 1999 to 2003, the largest program cost savings have occurred in the SSI population. From year to year the SSI population accounted for 25 to 34 percent of Region 3 Medicaid managed care enrollment, but 53 to 61 percent of program savings were attributable to this subgroup.<sup>11</sup> The savings calculations account for start-up costs and costs related to Health Insurance Portability and Accountability Act (HIPAA) compliance requirements. Since 1999, program savings have grown as shown in Exhibits 3 and 4.

**Exhibit 4. Savings in the Kentucky Partnership Program**

Fiscal Year	Total Dollar Savings (millions)	Savings as a Percent of Estimated FFS Costs
1999	\$7.9	2.8%
2000	\$16.1	5.4%
2001	\$32.6	9.5%
2002	\$35.8	9.5%
2003*	\$17.7	4.1%

\* Calendar Year

**Exhibit 5. Per Member Per Month Savings by Population in the Kentucky Partnership**

Population	FY2000	FY2001	FY2002	CY2003*
TANF	\$8.25	\$15.08	\$15.09	\$6.69
Foster Care	\$7.72	\$14.27	\$14.39	\$15.17
Pregnant Women	\$11.58	\$18.47	\$15.59	\$4.60
SSI/Medicare	\$11.09	\$28.25	\$38.00	\$19.41
SSI/No Medicare	\$27.92	\$54.79	\$59.79	\$31.91
Composite	\$13.75	\$25.74	\$26.53	\$11.67

\*Calendar Year

The Kentucky Partnership has demonstrated favorable performance with respect to quality of care and access to services. Since 1997, Passport Health Plan has made improvements in several key performance indicators, including adolescent immunizations, well child visits in the first 15

<sup>10</sup> Milliman USA, Kentucky Region 3 Partnership Program, December 2003.

<sup>11</sup> Lewin analysis of data contained in Milliman 2003, Kentucky Region 3 Partnership Program, December 2003.

months of life, prenatal care in the first trimester or within 42 days of enrollment, well-child (i.e., EPSDT), and enrollee satisfaction. Additionally, the Passport Health Plan scored above the National Commission of Quality Assurance Quality (NCQA) Compass mean.<sup>12,13</sup>

d. Ohio

Multiple cost-effectiveness studies have been performed on Ohio's Medicaid managed care program. These evaluations have been conducted by Mercer Government Human Services Consulting, with whom the State of Ohio has contracted to perform Independent Assessments of the capitated model's financial performance relative to the State's fee-for-service (FFS) coverage setting.

The most recent Mercer study, completed in 2006 and evaluating FY2004 outcomes, found that Ohio's capitated programs created \$72.4 million in FY2004 savings, a percentage savings of 4.2% relative to expected FFS costs in the absence of the capitation initiative.<sup>14</sup> As shown in Table 6, savings were found to occur relative to FFS in the medical services arena as well as for administrative costs.

**Exhibit 6. Savings From Ohio's Capitated Medicaid Program, July 2003 - June 2004**

<b>Expenditures</b>	<b>Upper Payment Limit (estimated FFS costs in absence of capitated program)</b>	<b>Costs Under the Capitated Managed Care Program</b>	<b>Savings</b>
Medical Services	\$1,551,922,277	\$1,497,108,886	\$54,813,391
Administrative	\$54,456,231	\$36,902,780	\$17,553,451
<b>Total Program</b>	<b>\$1,606,378,508</b>	<b>\$1,534,011,666</b>	<b>\$72,366,842</b>

In an earlier assessment completed in August 2004, Mercer estimated that Ohio's capitation programs achieved Medicaid savings of \$26.4 million (4.2%) in FY2002 and \$55.1 million (7.0%) in FY2003. Ohio's FY2002 savings were derived by medical service category and are primarily attributed to a 27 percent decrease in PMPM costs for inpatient hospital services.<sup>15</sup>

Ohio's capitation programs at the time of these assessments predominantly included TANF populations. In several counties (primarily the State's largest urban areas), the TANF population was mandatorily enrolled into MCOs; whereas in several other counties enrollment into MCOs occurred on a voluntary basis. More recently, Ohio has begun mandatorily

<sup>12</sup> Passport Health Plan presentation, transmitted to Lewin on February 27, 2004 from AmeriHealth Mercy staff.

<sup>13</sup> Quality Compass is a database of health plan quality performance and enrollee satisfaction, as measured using HEDIS and CAHPS.

<sup>14</sup> Independent Assessment of Cost-Effectiveness for the Ohio Medicaid Managed Care Program, Mercer Government Human Services Consulting, March 2006.

<sup>15</sup> Independent Assessment for the Ohio Medicaid Managed Care Program, Mercer Government Human Services Consulting, August 2004.

enrolling its ABD population (with the exception of certain sub-populations)<sup>16</sup> into the 8-region system.

*e. Michigan*

Michigan's Medicaid managed care program is implemented statewide and is a mix of mandatory and voluntary enrollment. The State has implemented the State plan option to require Medicaid enrollees in rural areas to enroll in a single MCO. As of 2007, there were 937,815 individuals enrolled in a Michigan Medicaid MCO.<sup>17</sup>

A Michigan Department of Community Health presentation included data demonstrating historic savings in the Medicaid managed care program in terms of PMPM costs. From FY2001 to FY2004, the Medicaid PMPM costs have been lower in the managed care program than in FFS. Each year the savings surpassed the savings achieved in the preceding year.<sup>18</sup> Exhibit 7 below summarizes the savings achieved in the Medicaid managed care program.

**Exhibit 7. Michigan Medicaid Per Member Per Month Costs - FFS versus MCO**

Fiscal Year	FFS	Medicaid MCO	Percent Difference*
2001	\$177	\$161	-9%
2002	\$188	\$162	-14%
2003	\$199	\$167	-16%
2004	\$210	\$170	-19%

\* Lewin calculation

The presentation provided little detail about the source of savings, however it is reasonable to assume that some of the savings comes from the enrollment of the SSI and SSI-related population. While the presentation did not provide total program savings data, it demonstrates that the Medicaid managed care program is experiencing growing annual savings by virtue of the annual MCO payment rate increases being lower than what FFS PMPM cost increases were estimated to be.

A 2005 Center for Health Program Development and Management (University of Maryland, Baltimore County [UMBC]) report found that although total spending increased in the Michigan Medicaid program by almost \$550 million for FY2004 (primarily due to caseload growth), the state would continue to save between \$28 million and \$129 million in state funds in FY2006 if the state used a capitated managed care model (the model currently in place under Michigan's Medicaid program) over a FFS model.<sup>19</sup>

<sup>16</sup> Individuals are first classified as ABD by the SSA, then must meet certain criteria (e.g. income level) to be classified by the state.

<sup>17</sup> Michigan Department of Consumer and Industry Services, Michigan HMO Enrollment Information, [http://www.michigan.gov/documents/hmo\\_enrl\\_25290\\_7.html](http://www.michigan.gov/documents/hmo_enrl_25290_7.html).

<sup>18</sup> Michigan Department of Community Health, Presentation - Michigan Medicaid: New Direction, July 23, 2003.

<sup>19</sup> University of Maryland, Baltimore County, Center for Health Program Development and Management, Michigan Medicaid: Relative Cost Effectiveness of Alternative Service Delivery Systems, April 2005.

Michigan operates the Quality Assurance Assessment Program (QAAP), a unique program that assesses a fee of 6 percent on all non-Medicare premiums. All contracted MCOs pay the assessed fee to the State, which then becomes additional revenue to the State. Note that QAAP is not assessed on the State's FFS program; and therefore, results in higher costs to MCOs.

Exhibit 8 compares estimated State costs for MCOs and FFS. UMBC modeled 4 scenarios to find the impacts that different delivery systems would have on State funds. The baseline model included:

- A 6 percent premium assessment fee under QAAP
- A 12.4 percent MCO rate increase for FY2006 (to achieve actuarial soundness)<sup>20</sup>

The modeling included assessments with and without the 12.4 percent MCO rate increase for FY2006 because, at the time of the report, funding for the FY2006 rate increase was uncertain. If the rate increase did not occur, the State's program would encounter two problems:

- Operating the program below actuarial sound rates, thereby the State would have to seek a federal waiver
- The quality of care the MCOs provide, in addition to the MCOs financial solvency could suffer

**Exhibit 8. Comparison of Estimated State Costs - MCO vs. FFS  
Cumulative Data (FY2004-2006)<sup>21</sup>**

	MCO	FFS	Difference*
Without FY2006 MCO Rate Increase/QAAP	\$1,952	\$2,281	-16%
Without FY2006 MCO Rate Increase/Without QAAP	\$2,129	\$2,281	-7%
With FY2006 MCO Rate Increase/With QAAP	\$2,035	\$2,281	-12%
With FY2006 Rate Increase/Without QAAP	\$2,219	\$2,281	-2%

\*Lewin calculation

As noted above, a Medicaid managed care model without the QAAP produces lower savings for managed care. For example, although the State will still see a savings of \$152 million over a 3-year period without a 12.4 percent increase in capitation rates and without the use of QAAP, this savings is still half of what would be realized if QAAP were in place. Additionally, savings will still be met when the State implements an increase of capitation rates by 12.4 percent for FY2006 (for the State to meet actuarial soundness).

<sup>20</sup> This 12.4% rate increase was not implemented by the State.

<sup>21</sup> The State of Michigan operates a premium assessment fee, otherwise known as the Quality Assurance Assessment Program (QAAP). At the time of the evaluation, all operating MCOs were required to pay an assessed fee of six percent on all non-Medicare premiums. The fee is paid to the state and therefore becomes incoming revenue. QAAP is not applied to FFS and therefore results in higher costs to managed care.

*f. Maryland*

Maryland's Medicaid managed care program, HealthChoice, was implemented in 1997 under an 1115 demonstration waiver, which requires state demonstrations to be budget neutral over the five year waiver period.<sup>22</sup> Maryland has used savings from its prepaid Medicaid managed care initiative to finance an expansion in Medicaid eligibility and coverage. The Maryland Department of Health and Mental Hygiene projects individual Medicaid eligibility group costs on a PMPM basis; therefore, the State is at-risk if costs exceed the approved amount. The primary expenditures for the program include capitation payments made to participating MCOs in addition to FFS payments for carved-out services.<sup>23</sup>

The Maryland Department of Health and Mental Hygiene published an evaluation of HealthChoice in January 2002, which found the program to be budget neutral over the course of the evaluation period.<sup>24,25</sup> The report states that during the first two years of the waiver, the State exceeded its budget neutrality cap.<sup>26</sup> Budget neutrality means that any expansion programs or services funded through the HealthChoice waiver are financed through savings achieved as a direct result of the HealthChoice program. However, in the third year, waiver spending fell to about two percent under the cap and fourth year spending also was on target to stay under the cap. HealthChoice is a mandatory program. Enrollment has grown from 381,000 in CY2000 to almost 491,800 in CY2006.<sup>27</sup>

According to the evaluation, the HealthChoice program has improved access to health care services. The evaluation reports that the percentages of children who had a well-child visit, individuals who had accessed an ambulatory service, and children's access to dental services increased from 1997 to 2002.<sup>28</sup>

Beginning in FY2005, HealthChoice implemented expansion programs (e.g., family planning, primary adult care, and therapeutic rehabilitation services) to the existing program. Expenditures for these expansion programs have increased annually, and expenditures have also increased annually as a percent of total expenditures for each fiscal year beginning in 2005.

A December 2007 report on the budget neutrality of the HealthChoice program found that budget neutrality was met for FY2000 through FY2007. By the end of FY2000, HealthChoice was finally operating on a positive cumulative margin between the program's actual and maximum allowable expenditures, at approximately 1.2 percent under the budget cap. On a

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<sup>22</sup> To be budget neutral, the state must demonstrate over a five-year period that it did not spend more than it would have in the absence of the waiver.

<sup>23</sup> University of Maryland, Baltimore County, Center for Health Program Development and Management, Status Report on the Budget Neutrality Calculation for the Maryland HealthChoice Program, December 2007.

<sup>24</sup> Maryland Department of Health and Mental Hygiene, HealthChoice Evaluation Final Report & Recommendations, January 2002.

<sup>25</sup> The HealthChoice evaluation began in January 2001, during its fourth waiver year.

<sup>26</sup> Initially, Maryland experienced a problem in setting appropriate capitation payment rates, effectively overpaying MCOs for SSI recipients and driving up total program costs.

<sup>27</sup> Maryland HealthChoice Program Factsheet, January 2007, <http://www.dhnh.state.md.us/mma/pdf/FINALHealthChoiceFactSheet.pdf>.

<sup>28</sup> Maryland Department of Health and Mental Hygiene, HealthChoice Evaluation Final Report & Recommendations, January 2002 and HealthChoice Evaluation Update, January 2004.

cumulative basis, HealthChoice was 10 percentage points under the budget cap as of FY2007, or about \$2 billion under the cap. Even with the existence of the aforementioned expansion programs, HealthChoice's budget neutrality has remained between 12.2 and 15.1 percentage points under the budget cap for each Fiscal Year (2005-2007).<sup>29</sup>

*g. Mathematica Study of Savings Experience In Five States*

A 2001 Mathematica Policy Research, Inc. study examined the research on the early experiences of Medicaid managed care programs implemented through 1115 waivers in Hawaii, Maryland, Oklahoma, Rhode Island, and Tennessee.<sup>30</sup> Researchers targeted these states because they were among the first states to turn to statewide Medicaid managed care programs to curtail growing program costs, among other program goals. Prior to implementing the demonstration programs, the states had varying levels of experience with managed care in their Medicaid programs; some had implemented capitated programs, Primary Care Case Management (PCCM) programs, or had no Medicaid managed care. All states covered the poverty-related eligibility groups (AFDC and AFDC-related) in their capitated Medicaid managed care programs, but differed in their coverage of the SSI and SSI-related population. The 1115 waiver programs in Hawaii, Oklahoma, and Rhode Island did not include the SSI populations or the medically needy aged and disabled populations. Maryland, Oklahoma, and Rhode Island excluded the medically needy children and adult populations.

To measure the impact of Medicaid managed care on total program costs, the States' annual growth rate of Medicaid medical costs were compared to the national average. The researchers hypothesized that the rate of growth of program costs would be reduced under managed care. The study authors concluded that the waiver programs had little impact on State expenditures. Maryland's Medicaid managed care program experienced a slight decrease in growth of Medicaid medical costs. Oklahoma, Rhode Island, and Hawaii had growth rates that were slightly higher than the national average. State expenditure growth rates generally were close to the national average (Exhibit 9).

**Exhibit 9. Growth Rate in Medicaid Medical Costs per Enrollee  
(includes all Medicaid beneficiaries)**

State	Average Annual Growth Rate (%)	National Average Growth Rate (%)	Years
HI	3.0	2.9	1993 – 1998
MD	- 0.2	2.6	1996 – 1998
OK	2.8	2.4	1995 – 1998
RI	3.4	2.9	1993 – 1998
TN	2.8	2.9	1993 – 1998

This study included a health outcomes analysis of shifting from FFS to managed care for the

<sup>29</sup> University of Maryland, Baltimore County, Center for Health Program Development and Management, Status Report on the Budget Neutrality Calculation for the Maryland HealthChoice Program, December 2007.

<sup>30</sup> Mathematica Policy Research, Inc., Reforming Medicaid: The Experiences of Five Pioneering States with Mandatory Managed Care and Eligibility Expansion, April 2001.

TennCare program. The analysis was not conducted for the other State programs because of data quality issues. The study reports that perinatal outcomes and the number of physician visits per beneficiary remained steady in the shift from FFS to managed care. The study analyzed the experience of SSI beneficiaries who were enrolled in TennCare and found that they had relatively high levels of access to care and satisfaction. The report states that most of these individuals had a usual source of care and received preventive care services.

*h. Pennsylvania*

In 1997, Pennsylvania implemented HealthChoices, a capitated Medicaid managed care program. At the time, enrollment into the program was mandatory in the more urban counties of the Commonwealth, while the remaining counties remained FFS or participated in a voluntary enrollment capitated managed care program. In 2003, the Commonwealth terminated planned expansion of the mandatory managed care program in the FFS counties in favor of an enhanced primary care case management (EPCCM) program. In response to this policy change, a coalition of the seven MCOs administering HealthChoices commissioned The Lewin Group to conduct a comparative evaluation of HealthChoices and FFS. One area of assessment was cost-effectiveness.<sup>31</sup>

HealthChoices has performed exceedingly well financially, serving as a national model. The HealthChoices MCOs have consistently controlled rates of medical cost escalation, collectively holding average annual medical cost escalation to 7.4 percent, compared to an average annual cost escalation of 10.4 percent under FFS. Based on data analysis, it appears that HealthChoices has saved Pennsylvania more than \$2.7 billion from 1999-2004.

**Exhibit 11. Pennsylvania's Comparisons of Annual Rates of Cost Escalation**

Medicaid Population Group	Years Assessed	Dept. Annual PMPM Cost Escalation*	MCO Annual PMPM Medical Cost
Pennsylvania FFS Medicaid**	1999 – 2002	10.4%	n/a
MCO Average***	2001 - 2004	7.4%	7.9%

\* Reflects Department of Public Welfare's increase in cost of health plan premiums.

\*\* 2002 was the most recent available for FFS data

\*\*\* Averages are first calculated for each health plan by assessing PMPM cost escalation in each rate cell across a fixed set of enrollment numbers (to ensure that the cost trend is not being driven by changes in enrollment mix). The average rates of increase for each health plan are then averaged together weighted by each plan's 2003 enrollment level.

Year after year, the financial status of HealthChoices has remained in balance.

A number of states have seen health plans exit the Medicaid market due to inadequate rates. In Pennsylvania, the collective medical loss ratio of the HealthChoices health plans is approaching 90 percent, and while there is some variability in operating margins across plans, in the aggregate the MCOs are holding administrative costs to approximately 8 percent of revenue and achieving an operating margin of about 3 percent.

<sup>31</sup> The Lewin Group, Comparative Evaluation of Pennsylvania's HealthChoices Program and Fee-for-Service Program, May 2005.

Furthermore, the cost-effectiveness that is occurring under HealthChoices is predominantly attributable to coordination of care. The HealthChoices program has served as a vehicle for propping up – rather than ratcheting down or discounting – unit prices paid to safety net providers vis-à-vis FFS rates.

*i. New Mexico*

The New Mexico Medical Review Association retained Lewin to conduct an independent assessment of the quality, access, and cost-effectiveness of health care services delivered under New Mexico's Managed Care program, Salud!<sup>32</sup> The Salud! Program was implemented on July 1, 1997. Prior to that, the State used a FFS program coupled with a PCCM called Primary Care Network (PCN). Though PCN managed to improve access and contain costs, the need for a more rigorous risk-based managed care model was evident.

To determine the cost-effectiveness of Salud!, Lewin estimated the FY2006 savings achieved relative to FFS costs. The savings fell between three and five percent. This percentage range was based on the following information:

- The initial 5 percent savings built into the program's capitation rates
- An earlier Lewin study estimating savings to be between 1 and 2 percent during FY2000 and FY2001, but growing between these two years
- The fact that Salud! capitation rates have increased, on average, 8.6 percent per year between 2003-2006, a trend line that closely parallels national Medicaid per capita cost norms
- The CY2005 program-wide medical loss ratio of 85.3 percent, which is well-matched with industry-wide Medicaid managed care norms, but is 2 to 3 percentage points below the average medical loss ratio typically occurring in other states with mandatory enrollment for both TANF and SSI subgroups

This savings range is translated into a total dollar savings estimate in Exhibit 12. In situations where a single savings estimate is needed, it is recommended that the midpoint range is used, or a four percent savings. During FY2006 Lewin estimated that Salud! created savings of \$33 million to \$56 million with the midpoint estimate being a savings of \$44 million. These figures include both the State and federal share of Medicaid expenditures.

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<sup>32</sup> The Lewin Group, Independent Assessment of New Mexico's Medicaid Managed Care Program – Salud!, February, 2007.

**Exhibit 12. Estimated Salud! Savings**

Salud PMPM Weighted Average Capitation Rate, FY2006	\$359.51
<b>Approximate Average Enrollment</b>	245,000
<b>Approximate member months, FY2006</b>	2,940,000
<b>Estimated Salud! Costs, Total Dollars, FY2006</b>	\$1,056,959,400
<b>Savings Percentage Versus FFS</b>	
Low Estimate	3%
Midpoint Estimate	4%
High Estimate	5%
<b>Estimated FFS Costs in Absence of Salud!</b>	
Low Estimate	\$1,089,648,866
Midpoint Estimate	\$1,100,999,375
High Estimate	\$1,112,588,842
<b>Estimated Salud! Savings, FY2006</b>	
Low Estimate	\$32,689,466
Midpoint Estimate	\$44,039,975
High Estimate	\$55,629,442

Note: Figures assume percent savings accrue to both physical and behavioral health cost components. All figures represent both State and federal share of Medicaid expenditures.

*j. Washington*

The State of Washington retained The Lewin Group to provide an analysis of possible new cost containment and revenue enhancement strategies for the State.<sup>33</sup> Washington's Medicaid program has already been successful in reducing and containing costs by working "smarter" and more efficiently than virtually all other states. As one of its efforts to contain costs, Washington established the Medicaid Utilization and Cost Containment Initiative (UCCI), which is designed to find efficiencies and lower expenditures in the State's Medicaid program, without reducing benefits or eligibility. In addition to UCCI, the State is also exploring other avenues for potential savings in its Medicaid program. It has also been estimated that between \$25.4 million and \$30.2 million in cost avoidance and recovery is attributable to UCCI (exclusive of additional administrative expenses associated with UCCI). The UCCI program savings were generated as a result of increasing coordination of benefits as well as provider audits and quality reviews.

<sup>33</sup> The Lewin Group, Medicaid Cost Containment: Report No. 3, January 2003.

## 2. Studies of Medicaid Managed Care Programs Involving Population Subgroups

The studies previously mentioned describe state experiences with Medicaid managed care programs that cover broad populations typically the TANF and TANF-related<sup>34</sup> children and adults, and in some cases the SSI and SSI-related children and adults, and pregnant women; and provide comprehensive Medicaid services, with noted carve-outs. Several states have also implemented targeted Medicaid managed care programs available only to specific Medicaid populations. This review of research included studies of the Texas STAR+PLUS program, a study of the impact of Medicaid managed care on the urban ABD population in Oklahoma, a prospective analysis of estimated savings achievable under Medicaid managed care for Hennepin County in Minnesota, and an evaluation of New Mexico's behavioral health program.

### a. An Independent Assessment of the STAR+PLUS Program

The State of Texas also conducted independent assessments of its 1915(b) waiver program, known as STAR+PLUS. STAR+PLUS provides integrated primary, acute, and long-term care services to the SSI and SSI-related<sup>35</sup> population residing in Harris County (Houston), including those who are dually eligible for Medicaid and Medicare.<sup>36</sup> Medicaid managed care enrollment is mandatory for the large majority of the SSI and SSI-related population; most STAR+PLUS eligible individuals choose between enrolling in one of two MCOs, while a smaller number (SSI clients under age 21) may choose between the HMOs and the PCCM program. Prescription drugs are carved-out of the capitated program. As of February 2004, there were 62,782 individuals enrolled in STAR+PLUS. During the period of the first independent assessment (February 1998 to January 2000), 55,000 were enrolled. During the second independent assessment period (September 1999 to August 2002), 57,000 were enrolled.<sup>37</sup> (This represents the large majority of the SSI and SSI-related population in Harris County, as enrollment is mandatory for all except approximately 5,000 who are allowed to participate voluntarily.)

Savings achieved in each year of the STAR+PLUS program have grown annually, suggesting that a ramp-up phenomenon exists as the health plans, enrollees, and provider community become increasingly accustomed to the managed care setting over time. During the first waiver period, Texas experienced additional costs of \$1.97 million or \$2.68 PMPM in Year 1 due to

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<sup>34</sup> TANF-related beneficiaries may include those individuals who do not qualify for cash payments under TANF but who are medically needy, pregnant women and children for whom the state's financial criteria for Medicaid eligibility may not be as strict, etc.

<sup>35</sup> Many Medicaid programs do not require receipt of cash assistance for eligibility under the Aged, Blind, and Disabled (ABD) program. A person may qualify even if his or her income and resources are too high for SSI. Thus, the SSI-related category includes those aged, blind, and disabled individuals who are medically needy but do not qualify for cash payments under SSI.

<sup>36</sup> Not all SSI and SSI-related beneficiaries are eligible for Medicare. SSI-related Medicaid beneficiaries are not eligible for Medicare because their income and resources are too high to qualify for SSI and, in turn, for Medicare. In addition, SSI beneficiaries are not eligible for Medicare until after 24 months of continuous disability benefits.

<sup>37</sup> Texas A&M Public Policy Research Institute, STAR+PLUS Medicaid Managed Care Waiver Study: An Independent Assessment of Access, Quality, and Cost-Effectiveness, October 1999. Of the 57,000 Medicaid beneficiaries participating in STAR+PLUS in the second independent assessment period, 44 percent received Medicaid benefits only and 56 percent were dually eligible. Dually eligible enrollees continued to receive acute care services from the Medicare provider of their choice and received only Medicaid long-term care services from their STAR+PLUS HMO.

implementation costs, and savings of \$7.57 million or \$10.22 PMPM in Year 2. Combined savings in Years 1 and 2 were \$6.05 million or \$4.11 PMPM.<sup>38</sup>

Waiver period one savings were less than one percent of the program cost for the entire waiver period. In the second waiver period, total savings were \$66 million or \$100.95 PMPM in Year 1 (February 2000 to January 2001), and \$56 million or \$82.71 PMPM in Year 2 (February 2001 to January 2002).

Combined savings in waiver period two were \$123 million or \$91.67 PMPM.<sup>39</sup> Waiver period two savings represent an almost 17 percent reduction in State Medicaid costs as compared to projected FFS costs for this population. In addition, it is worth noting that in the first waiver period, three MCOs participated in STAR+PLUS, while in the second waiver period, two participated.

The first assessment evaluated enrollee satisfaction and found that STAR+PLUS enrollees had satisfaction levels that were about the same as FFS enrollees. The STAR+PLUS evaluation indicated that the program had an inpatient discharge rate and average length of stay that was similar to the FFS baseline and decreased the number of emergency room visits. STAR+PLUS MCOs also assigned care coordinators to enrollees in an appropriate manner. The second assessment found that STAR+PLUS continued to reduce the number of inpatient discharges and average length of stay.

The State has sought to expand STAR+PLUS to several new market areas. A State slide presentation<sup>40</sup> explaining the State's approach contained some additional performance-related information. Member satisfaction ratings are consistently high across a series of specific access issues, inpatient stays have been lowered by 28 percent, the number of members accessing community-based adult day care services has increased 38 percent and the number of members accessing personal assistant services has increased 32 percent.

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<sup>38</sup> Ibid.

<sup>39</sup> Texas A&M Public Policy Research Institute, Medicaid Managed Care Waiver Study: An Independent Assessment of Access, Quality, and Cost-Effectiveness of the STAR+PLUS Program, June 2002.

<sup>40</sup> "Medicaid Managed Care Expansion" slide presentation, which state staff are currently using to describe the state's intended broadening of STAR+PLUS.

*b. Serving the Aged, Blind, and Disabled in Oklahoma Medicaid Managed Care*

Until the end of 2003, the aged, blind, and disabled (ABD) population in Oklahoma was mandatorily enrolled in the State's Medicaid managed care program known as SoonerCare.<sup>41</sup> In more urban areas of the State, Medicaid beneficiaries, including the ABD population, were enrolled in fully prepaid MCOs, while in more rural parts Medicaid beneficiaries received health care services through a partially prepaid PCCM delivery system. The Center for Health Care Strategies commissioned a study of Oklahoma's experience in providing prepaid health care services to the ABD population in the State's urban managed care service areas, i.e., Oklahoma City, Tulsa, and Lawton. The study focused on the 583 beneficiaries enrolled in the Heartland Health Plan of Oklahoma (HHPO) who also were among the top 10 percent of service users from among this urban ABD population.<sup>42</sup> The study analyzed enrollment and medical claims data from the 12 months before and following each member's enrollment into managed care, during the time period from February 1998 to December 2000.

The study found that average managed care claims PMPM were 15 percent lower than the cost of caring for those individuals in FFS in the 12 months prior to their enrollment in the MCO, even though the MCO benefit package was more comprehensive. When the study assessed the full managed care payment cost in relation to the FFS claims costs, overall PMPM costs were 4 percent lower under managed care.<sup>43</sup> In considering these savings estimates, it is important to remember that this study only looked at the subgroup of the Oklahoma Medicaid ABD population living in the State's urban Medicaid managed care region and that enrolled in a single MCO.

The study also summarized findings from a focus group and surveys related to access to care, continuity of care, and satisfaction. The focus group was conducted in October 2001 and surveys were fielded from September to December 2001. Focus group participants noted that HHPO provided access to a fuller range of services than were previously provided and that care coordination had improved in comparison to FFS Medicaid. They also felt that the overall quality of services for individuals with disabilities enrolled in HHPO had improved. Satisfaction survey results indicated that enrollees had a high level of satisfaction with managed care - 80 percent of respondents described their satisfaction as "very good" or "good," the two highest ratings.

*c. Medicaid Managed Care in Hennepin County, Minnesota*

A third study attempted to prospectively estimate the level of savings that could be achieved under Medicaid managed care for a study population of adult women in Hennepin County,

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<sup>41</sup> This report provides information regarding Oklahoma's experience enrolling the aged, blind, and disabled individuals into capitated Medicaid managed care, although effective January 2004, Oklahoma discontinued its capitated Medicaid managed care program. Following the November 2003 decision of one of the state's three MCOs to not renew its contract, the state decided to end its capitated program. Individuals who were enrolled in a Medicaid MCO are being transitioned into the PCCM program. Oklahoma Health Care Authority Press Releases on November 6 and 12, 2003, <http://www.ohca.state.ok.us/general/media/newpress/>.

<sup>42</sup> Center for Health Care Strategies, *Serving the Special Program/ Aged, Blind, and Disabled Population*, April 2002.

<sup>43</sup> *Ibid.*

Minnesota.<sup>44</sup> Hennepin County includes Minneapolis and is the State's largest county. Researchers used 1987 ambulatory care cost data from Maryland's AFDC Medicaid program to approximate cost of care because when the Minnesota data was originally collected as part of a related study, cost data were not collected. Researchers also assessed Minnesota's inpatient hospital payment rates (using data for 1985). The study estimated savings associated with moving to Medicaid managed care from FFS to be about 10 percent, taking into account the initial effects of switching to managed care.

*d. Assessment of HUSKY, Connecticut's Medicaid Managed Care Program*

Connecticut's mandatory capitated Medicaid managed care program began in 1995 as a 1915(b) waiver, and became known as Healthcare for UninsUred Kids and Youth (HUSKY) in 1997. HUSKY is mandatory for the TANF population (HUSKY A) and SCHIP (HUSKY B) throughout the entire State. As of December 2006, over 309,000 beneficiaries were enrolled in either HUSKY A or B through one of four MCOs. The Lewin Group studied the HUSKY program to assess the program's cost performance.<sup>45</sup> Lewin looked at the following Medicaid managed care models:

- Managed Care Organizations (MCOs)
- Primary Care Case Management (PCCM)
- Disease Management (DM)
- Complex Case Management (CCM)

Lewin found that the HUSKY population's per capita cost escalation has been below both the national rate of TANF cost escalation as well as the rate of inflation in selected non-HUSKY Medicaid subgroups (i.e., disabled eligibles, adults). Under the capitated HMO/MCO model that HUSKY operates, MCOs have held their medical loss ratios (between 90 and 91 percent) and administrative cost ratios (below 10 percent) at favorable levels when compared to their respective national averages.

Expenditures under HUSKY are at least 5 percent below what any newly implemented non-capitated Medicaid managed care model would be able to deliver, translating to an annual Medicaid spending differential of at least \$37 million (5 percent of the 4 MCOs' collective CY2005 Medicaid premium revenues of \$740 million).

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<sup>44</sup> Freund, D., Kniesner, T., LoSasso, A., How Managed Care Affects Medicaid Utilization A Synthetic Difference-in-Difference Zero-Inflated Model, April 1996.

<sup>45</sup> The Lewin Group, Assessment of HUSKY, Connecticut's Medicaid Managed Care Program, January 2007.

### Exhibit 15. Estimated Overall Percentage Savings by Model, TANF Population

Medicaid Managed Care Model	Overall Savings (Loss) Percentage Versus FFS
HMO/MCO	6.7%
PCCM/DM	2.0%
CCM	4.0%
PCCM/DM/CCM	4.2%

Source: Percentage savings estimates of each model prepared as part of Lewin Group report, "Assessment of Medicaid Managed Care Expansion Options in Illinois," May 2005. Savings percentages shown depict the region that is deemed most comparable to Connecticut, and represent percentage savings during the first implementation year.

Note also that the figures shown in Exhibit 15 depicted savings during the initial implementation year. The capitated HMO/MCO model is expected to yield growing savings over time, and as shown above, yields rough one and a half times more savings than the next closest model (PCCM/DM/CCC).

#### *e. New Mexico's Behavioral Health Program*

The Lewin Group conducted an independent assessment of the access, quality, and cost effectiveness of health care services delivered under New Mexico's Behavioral Health Collaborative (the Collaborative).<sup>46</sup> The Collaborative chose a capitated behavioral health plan to implement a new behavioral health system after a 2002 report found the previous behavioral health system to be fragmented, and saw costs for psychiatric inpatient services double from \$17 to \$38 million between FY1997-2001.

The cost-effectiveness of New Mexico's behavioral health initiative is extremely difficult to assess for several reasons. First, by many accounts there was an under-utilization of services under Salud! which prompted the switch to a behavioral health carve-out model. Against this baseline, Medicaid behavioral health care costs were presumed to need to increase. Second, additional services were added in the behavioral health plan's contract that were not covered under Salud!, which creates commensurate cost increases. Third, the program is in its first year of implementation. It is far too early to obtain sound data on the impacts of the newly redesigned system, and the carve-out approach requires years to evolve (rather than months) before its true impacts can be discerned.

Exhibit 16 presents the State's estimated Medicaid behavioral health costs during State FY2005 (under Salud!) and during State FY2006 under the carve-out initiative implemented by the capitated behavioral health plan. These figures estimate that behavioral health costs increased by 26 percent in total dollars, and by 33.6 percent on a PMPM basis from FY2005 - FY2006. This is clearly a large-scale, intentional increase designed to strengthen the behavioral health services delivery system and improve patient outcomes, yet it is not possible to make a determination as to whether these investments will prove to be cost-effective.

<sup>46</sup> The Lewin Group, Independent Assessment of New Mexico's Behavioral Health Program. March 2007

**Exhibit 16. Behavioral Health Cost Comparisons, FY2005 versus FY2006**

	Member months	MCO Behavioral Health Expenditures	Costs Including 15% Administration Allocation
<b>State FY2005</b>			
Total Dollars, MCOs, FY2005	3,139,978	\$131,693,246	\$151,447,233
PMPM, MCOs, FY2006		\$41.94	\$48.23
<b>State FY2006</b>			
Total Dollars, Value Options, FY2006	2,967,182	\$166,312,611	\$191,259,502
PMPM, Value Options, FY2006		\$56.05	\$64.46

### 3. Studies of Medicaid Managed Care Program Impacts On Specific Services

Several studies examine the impact of state Medicaid managed care programs on certain types of services. The following section describes the findings of studies of prescription drug use, preventable hospitalizations in California, and alcohol treatment and cost in Medicaid FFS versus Medicaid managed care.

#### a. Comparison of Medicaid FFS and Capitated Pharmacy Costs and Usage

The Center for Health Care Strategies funded 2 studies related to the impact of Medicaid managed care on prescription drug cost and utilization. Both of these studies were conducted by The Lewin Group. The first study examined FFS drug spending and usage data from 5 states compared to similar data from 13 Medicaid health plans in ten states,<sup>47</sup> specifically for the TANF population.<sup>48</sup> The study examined the key factors influencing prescription drug costs: prices, mix of drugs prescribed, and utilization. The study concluded that for the TANF population, PMPM prescription drug costs were 10 to 15 percent lower in capitated Medicaid managed than in the FFS setting, although MCOs initially started at a 15 percent price disadvantage largely due to Medicaid drug rebates rules. Once factors such as MCOs' lower dispensing fees, their ability to influence the mix of lower cost drugs used (including generics), and the lower number of prescriptions due to greater management of the pharmacy benefit are considered, drug expenditures in Medicaid MCOs become lower than in FFS.<sup>49</sup> According to Lewin's calculations, post-rebate average drug costs were \$20.46 PMPM in the FFS programs and \$17.36 PMPM in Medicaid managed care.

The second CHCS/Lewin study analyzed the option of carving-out prescription drugs from the prepaid managed care setting of Arizona's AHCCCS program, using a simulation based on

<sup>47</sup> States were requested to provide data from CY2001.

<sup>48</sup> Center for Health Care Strategies, Comparison of Medicaid Pharmacy Costs and Usage between the Fee-for-Service and Capitated Settings, prepared by The Lewin Group, January 2003.

<sup>49</sup> Lewin has documented in a series of studies, including the CHCS-funded studies referenced herein and additional studies that can be downloaded at no charge from Lewin's website ([www.lewin.com](http://www.lewin.com)) that the generic fill rate in the capitated setting is roughly ten percentage points higher than in the Medicaid FFS environment. Prescriptions filled per member per month are also considerably lower in the capitated setting.

Federal FY2002 cost data. Currently, prescription drugs are included in the AHCCCS MCO payment rate. Lewin assessed the effectiveness of the AHCCCS pharmacy benefit by comparing prescription drug cost and utilization data from AHCCCS to the data from other Medicaid programs, and prepared cost estimates of carving-out prescription drugs from AHCCCS.<sup>50</sup>

The study found the AHCCCS program to be exceptionally cost-effective in providing prescription drugs. The PMPM cost of providing pharmaceuticals to the ABD population in the AHCCCS program in Federal FY2002 was \$112.21, the lowest figure in the nation and 38 percent below the national average PMPM cost of \$181.01. The next nearest State was Michigan, whose PMPM costs were 11 percent higher than Arizona's. The difference in PMPM cost is particularly compelling because Arizona fully capitates prescription drugs costs, while nearly all other states pay for ABD persons' pharmacy claims under FFS.

Another important study finding is that carving out prescription drugs from the Medicaid managed care setting and paying for drugs on a FFS basis would result in a net cost to the state, not generate savings. The estimated net additional cost to the state of providing prescription drugs under FFS would be \$3.7 million. While Arizona would gain \$40 million in rebate savings, the administrative costs associated with carving out prescription drugs, such as developing and maintaining a preferred drug list and claims processing and changes in the drug mix and volume, would negate any savings and ultimately result in added costs.

#### *b. Preventing Unnecessary Hospitalization in Medi-Cal*

A study conducted by the Primary Care Research Center at the University of California and funded by the California HealthCare Foundation, compared Medi-Cal (California's Medicaid program) preventable hospitalization rates between 1994 and 1999 under managed care to FFS.<sup>51</sup> The study found that TANF and TANF-related enrollees in Medi-Cal managed care had 38 percent lower rates of preventable hospital admissions (7.1 per thousand) than in FFS (11.4 per thousand). Between 1994 and 1999, the Medi-Cal program experienced an average decrease in preventable admissions of 7,000 per year, resulting in a \$66 million reduction in inpatient hospital costs as compared to what would have been incurred in FFS.

The SSI-population enrolled in Medi-Cal managed care experienced a decrease of 25 percent in the rate of preventable hospitalizations. SSI-eligible Medi-Cal enrollees were required to enroll in managed care plans in 8 counties. The preventable hospitalization rates were 57.5 per thousand in managed care and 76.4 per thousand in FFS. While the actual rates of hospitalization were understandably higher among the SSI population, the difference in admission rates between managed care and FFS were similar between the TANF and SSI groups. This finding would seem to support the argument that the higher need SSI population would benefit, both in terms of care management and cost savings, from broader enrollment in managed care.

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<sup>50</sup> Center for Health Care Strategies, Analysis of Pharmacy Carve-Out Options for the Arizona Health Care Cost Containment System, prepared by The Lewin Group, November 2003.

<sup>51</sup> California HealthCare Foundation, Preventing Unnecessary Hospitalizations in Medi-Cal: Comparing Fee-for-Service with Managed Care, prepared by Primary Care Research Center, University of California, San Francisco, February 2004.

c. *Comparison of Alcohol Treatment and Costs between FFS and Medicaid Managed Care*

The National Institute on Alcohol Abuse and Alcoholism<sup>52</sup> funded a study on the two most populated counties in Pennsylvania, Allegheny and Philadelphia, to examine the differences between utilizing managed care with a behavioral health carve-out (Philadelphia) and serving persons entirely in the FFS setting (Allegheny) on the utilization and cost of alcohol-related treatments for high-risk beneficiaries being treated for alcohol abuse or other dependency problems. The study looked at the two populations between 1995 (before managed care-implementation) and 1998 (after managed care-implementation).

Over the study period, per person costs for those treated decreased from \$7,662 to \$5,664 at the managed care site in Philadelphia. Included in this decline was a \$1,200 reduction for alcohol abuse treatment, and a decrease of \$900 for drug abuse treatment per person. Length of stay and daily bed costs were also reduced at the managed care site in Philadelphia County. In contrast, the costs at the Allegheny County FFS site increased from \$4,871 to \$6,449 throughout the study period. The FFS site did, however, show a decline of \$400 in alcohol costs and \$250 for drug costs per person, although there was a significant increase of \$2,000 per person in psychiatric inpatient costs due to longer lengths of stay and more psychiatric co-morbidities.

A regression analysis of both sites showed that managed care did not significantly lower treatment costs, but the difference in costs were impacted by other variables. The FFS site in Allegheny County had increased costs due to psychiatric hospital inpatient stays in addition to increased psychiatric co-morbidities. The managed care site in Philadelphia County also showed a marked increase in co-morbid psychiatric problems, but managed care programs like the one in Philadelphia County are able to keep costs to a minimum by contracting with inpatient facilities and negotiating lower per diem rates. The managed care site was also able to lower costs by treating alcohol and drug dependencies at non-hospital facilities.

## B. Findings by Topic Area

Earlier, this report described some assumptions that could be made about savings under a prepaid Medicaid managed care program. It was expected that savings under managed care for the Medicaid population would be greater in urban settings, among the SSI and SSI-related populations, and that certain services would be more amenable to savings. Based on the studies reviewed, it is generally difficult to isolate the specific sources of Medicaid managed care savings because the studies do not provide sufficient detail or did not include such an analysis. However, some observations about source of savings can be made.

### 1. *The SSI and SSI-Related Population*

The studies provided some evidence that Medicaid managed care savings could be significant for the SSI and SSI-related population because they typically are high users of services and are the most costly group to cover. In some states, most of overall Medicaid managed care savings

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<sup>52</sup> Comparison of Alcohol Treatment and Costs After Implementation of Medicaid Managed Care, Rothbard, A. and Kuno, E., *The American Journal of Managed Care*, May 2006.

achieved is attributable to this population. In Arizona, 60 percent of the \$102.8 million achieved from 1983 to 1991 was from the SSI population. In the Kentucky Region 3 Partnership, the SSI population made up 25 to 34 percent of total enrollment and accounted for 53 to 61 percent of the savings achieved from 1999 to 2003. Oklahoma also provided Medicaid services to the ABD population through MCOs. An analysis of a subset of the entire ABD population who were enrolled in a particular health plan and who were among the highest 10 percent of service users found that average claims PMPM were lower in managed care than in FFS based on data from February 1998 to December 2000.

The STAR+PLUS program in Texas is targeted to the urban SSI population of Harris County. The independent assessments reviewed indicate that the enrollment of this Medicaid population into managed care has yielded savings and that the level of savings has grown over time. Savings during the first waiver period (February 1998 to January 2000) was \$6.05 million or \$4.11 PMPM, and \$123 million or \$91.67 PMPM in the second waiver period (September 1999 to August 2002). In addition, Pennsylvania HealthChoices, which relies heavily on capitation for its population with disabilities, experienced average per capita costs that were \$6,800 lower for its beneficiaries with disabilities than the average of surrounding states. These savings are notable even if they can not be solely attributed to managed care.

## ***2. Inpatient Services***

The studies demonstrated that cost savings are largely attributable to decreases in inpatient utilization. The study of preventable hospitalizations in California found that the TANF and TANF-related populations had 38 percent lower rates of preventable hospitalizations, saving the state an estimated \$66 million between 1994 and 1999. The SSI and SSI-related population had 25 percent lower rates of preventable hospitalizations.

Hospital care was also a key factor in the savings attained by Ohio's PremierCare. Inpatient costs decreased 27 percent under Ohio's Medicaid managed care program, from \$76 PMPM before implementation of the program (in CY2000) to \$55 PMPM once the program was implemented (in State FY2002). Furthermore, a study of inpatient utilization for alcohol-related treatment in Pennsylvania found that costs per person decreased by approximately 26 percent at the managed care site in Philadelphia County, while costs per person increased by approximately 32 percent at the FFS site in Allegheny County.

## ***3. Prescription Drugs***

Pharmacy was also an area where Medicaid managed care programs yielded noteworthy savings. The Center for Health Care Strategies' comparison of FFS and Medicaid managed care drug costs (CY2001), using FFS and MCO drug cost and utilization data for the TANF population from multiple states, found that the PMPM cost of drugs in a capitated setting was 10 to 15 percent lower than in the FFS setting (even after taking into consideration the larger rebates state agencies receive under FFS).

In a related study of prescription drug costs in Arizona's AHCCCS program, which currently carves in prescription drugs, it was determined (based on Federal FY2002 data) that retaining the benefit in the prepaid MCO model was more cost-effective when compared to carving it out.

This study also found that Arizona's PMPM pharmacy costs are well below those of any other state's Medicaid program – an important finding given that Arizona is the only State that fully capitates the Medicaid pharmacy benefit. For example, Arizona's PMPM pharmacy costs for the aged/blind/disabled population were found to be 38 percent below the national average. Additionally, Pennsylvania Medicaid's annual PMPM prescription annual cost increase of 14.4 percent under its FFS system dropped to 9.1 percent during the 3 years following the implementation of HealthChoices.

#### 4. Quality Impacts

Access to care and quality under Medicaid managed care were not the main focal points of this review of the research but the reviews of the studies yielded information on some access and quality data. Some studies<sup>53</sup> reported on analysis of utilization data and findings from consumer surveys. In most cases, state Medicaid managed care programs have improved Medicaid beneficiaries' access to services, and both the programs and individual MCOs have earned high satisfaction ratings from enrollees. We provide examples below.

In Wisconsin, HMOs members are more likely to have at least one primary care physician (PCP) visit than those in FFS. In 1997, 56.6 percent of HMO members had a PCP visit compared to 44.7 percent of those in FFS; in 1998, 57.3 percent of HMO members had a PCP visit compared to 42.3 percent of those in FFS.<sup>54</sup>

Connecticut's HUSKY population has been found to obtain a large volume of office visit services. Aggregating each MCO's utilization reports for CY2005 shows that more than 1.7 million visits occurred, split 54 percent between primary care and 46 percent specialist care. On average, HUSKY enrollees obtained 2.9 primary care visits during 2005 and 2.5 specialist visits.<sup>55</sup>

In the Pennsylvania HealthChoices program, the MCOs have significant experience monitoring and improving quality for their members. The Commonwealth plays a strong role in requiring a broad array of quality assurance and quality improvement components of all the HealthChoices MCOs. In addition to the required monitoring, the MCOs and their staff have a strong commitment to quality care, quality service, to monitoring themselves, and planning improvement initiatives, across every aspect of their business.

New Mexico's Salud! program has been successful providing and improving quality care to Medicaid members across the State. Although quality improvement is a continuous process, New Mexico and the MCOs are actively striving to provide quality services to members. In areas that score below national benchmarks, each MCO has internal procedures in place to ensure that these areas are addressed. Each MCO also performed well on HEDIS® and CAHPS® measures.

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<sup>53</sup> Wisconsin, Kentucky, Maryland, Tennessee, Texas, New Mexico, Connecticut, Pennsylvania, and Oklahoma.

<sup>54</sup> Milliman USA, Inc. Wisconsin HMOs' Success in Medicaid and BadgerCare: Government Cost Savings and Better Health Care Quality, February 2002.

<sup>55</sup> As a comparison, low risk children in Colorado's Medicaid program utilized primary care services at a rate of 1.2 visits per year and high risk children in Colorado's Medicaid program utilized services at a rate of 3.7 visits per year in 2002.

These types of findings are important because they demonstrate that Medicaid managed care can maintain or increase enrollees' ability to obtain necessary health care services while generating program savings.

### III. CONCLUSION

Studies indicate that Medicaid managed care has been successful in achieving cost savings in a variety of states for a variety of populations, although the level of savings varies. Savings in the states included in the studies reviewed ranged from half of 1 percent to 20 percent of what costs would have been under FFS and the research indicates that the level of savings grows over time as states gain more experience with their programs. According to the studies reviewed, Medicaid managed care enrollees have provided high ratings of the programs and their MCOs.

Based on the review of cost effectiveness studies of Medicaid managed care programs, there are several policy implications to be considered. First, states may want to consider including the SSI and SSI-related population in a Medicaid managed care program. While many Medicaid managed care initiatives have generated savings when focused on the TANF population, the savings that can be achieved in the SSI subgroup appear to exceed those available through serving TANF. The population of Medicaid beneficiaries with disabilities makes up 14.4 percent of total Medicaid enrollment, but accounts for 40 percent of total Medicaid expenditures.<sup>56</sup> The studies reviewed demonstrated very strong savings can be achieved by capitated health plans in SSI beneficiaries' inpatient and pharmacy costs.

Second, some states with Medicaid managed care programs are revisiting their carve-in/carve-out decisions. Pharmacy carve-outs enable states to obtain higher rebates through the federal rebate program, whereas capitating (or "carving in") the pharmacy benefit offers superior benefits management with regard to the mix and volume of medications.

In summary, while it is difficult to accurately predict the level of cost savings that will be achieved in any given Medicaid managed care program, our synthesis of findings from a large body of research on the topic clearly illustrates that Medicaid managed care typically saves money and represents a highly attractive alternative to reductions in eligibility and benefits and/or provider payment cuts. There have been instances where states have not achieved savings from their Medicaid managed care program in a given year, and other instances where health plans have exited the program. There is obviously always going to be a point below which the state's managed care payment rates are no longer viable for MCOs. However, the preponderance of the research evidence is that prepaid managed care partnerships between state Medicaid agencies and MCOs can produce substantial program cost savings without forcing the health plans to operate at a financial loss. The federal requirement for actuarially sound rates is a critical building block for successful program. As states consider expanding their Medicaid managed care programs and as other states implement new Medicaid managed care programs, they may wish to include certain populations (e.g., SSI) and services (e.g., pharmacy and mental health services) that have often been excluded from Medicaid managed care due to quality and access to care concerns. Some of the studies included in this report addressed quality and access to care and their findings demonstrated positive results from Medicaid managed care.

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<sup>56</sup> Kaiser Family Foundation State Health Facts, Distribution of Medicaid Enrollees by Enrollment Group and Distribution of Medicaid Payments by Enrollment Group, FY2004, <http://www.statehealthfacts.org>.

## Appendix A. Bibliography of Studies Reviewed

### Cost Effectiveness Studies of Specific State Programs

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- Wisconsin HMOs' Success in Medicaid and BadgerCare: Government Cost Savings and Better Health Care Quality, Milliman USA, Feb. 2002
- Kentucky Region 3 Partnership Program, Milliman USA, December 2003
- Independent Assessment for the Ohio Medicaid Managed Care Program, Mercer Government Human Services Consulting, March 2003
- Independent Assessment for the Ohio Medicaid Managed Care Program, Mercer Government Human Services Consulting, April 2004
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- Michigan Medicaid: New Directions Presentation by the Michigan Department of Community Health, July 23, 2003; and Michigan Medicaid: Relative Cost Effectiveness of Alternative Service Delivery Systems, April 2005
- HealthChoice Evaluation, Maryland Department of Health and Mental Hygiene, January 2002; and Status Report on the Budget Neutrality Calculation for the Maryland HealthChoice Program, December 1, 2007
- Reforming Medicaid: The Experiences of Five Pioneering States with Mandatory Managed Care and Eligibility Expansions, Mathematica Policy Research, for the Centers for Medicare and Medicaid Services, April 2001
- Comparative Evaluation of Pennsylvania's Health Choices Program and Fee-for-Service Program, The Lewin Group, May 2005, <http://www.lewin.com/NR/rdonlyres/49FBE34A-23DC-479E-A227-D464EECBBD6/0/3178.pdf>
- Independent Assessment of New Mexico's Medicaid Managed Care Program – Salud!, The Lewin Group, February 2007, <http://www.lewin.com/NR/rdonlyres/14A9B20B-FEC1-432E-A0D45BE461C305EA/0/NMPhysicalHealthMedicaidMCOAssessment421863.pdf>
- Medicaid Cost Containment: Report No. 3 (Washington State), The Lewin Group, January 2003.

### Studies of Medicaid Managed Care Programs Involving High-Need Population Subgroups

- STAR+PLUS Medicaid Managed Care Waiver Study: An Independent Assessment of Access, Quality, and Cost-Effectiveness, Texas A&M University, Public Policy Research Institute, October 1999 and June 2002
- Serving the Special Program/Aged, Blind and Disabled Population (in Oklahoma's Medicaid managed care) by Schaller Anderson, April 2002

- How Managed Care Affects Medicaid Utilization A Synthetic Differences Zero-Inflated Count Model, Freund, D., Kniesner, T., LoSasso, A., April 1996
- Assessment of HUSKY, Connecticut's Medicaid Managed Care Program, The Lewin Group, January 22, 2007, <http://www.lewin.com/NR/rdonlyres/BA89A732-061C-4396-BB7D-A2CD49021A25/0/CTMedicaidMCFinalRpt.pdf>
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#### Studies of Medicaid Managed Care Program Impacts On Specific Services

- Comparisons of Medicaid Pharmacy Costs of Usage between the Fee-for-Service and Capitated Setting, prepared for CHCS by The Lewin Group, January 2003. [http://www.chcs.org/publications3960/publications\\_show.htm?doc\\_id=213037](http://www.chcs.org/publications3960/publications_show.htm?doc_id=213037)
- Analysis of Pharmacy Carve-Out Options for the Arizona Health Care Cost Containment System, prepared for CHCS by The Lewin Group, November 2003. <http://www.lewin.com/NR/rdonlyres/B37D9B2E-D750-4CFD-AE09-ACC061E57033/0/PharmacyCarveOutAHCCCS.pdf>
- Preventing Unnecessary Hospitalization in Medi-Cal: Comparing Fee-for-Service with Managed Care, CHCF, February 2004
- Comparison of Alcohol Treatment and Costs After Implementation of Medicaid Managed Care, Rothbard, A. and Kuno, E., The American Journal of Managed Care, May 2006

## Appendix B. Summary of Reported Savings

State/Study	Estimated Savings Under Capitated Managed Care	Year
<b>State Programs</b>		
Arizona	19% of FFS costs	1991
	7% of FFS costs	1983 - 1993
Kentucky	2.8% of FFS costs	FY1999
	5.4% of FFS costs	FY2000
	9.5% of FFS costs	FY2001
	9.5% of FFS costs	FY2002
	4.1% of FFS costs	FY2003
Ohio	2.2% of FFS costs	State FY2002
	7.0% of FFS costs	State FY2003
	4.5% of FFS costs	State FY2004
Wisconsin	7.9% of FFS costs	2001
	10.2% of FFS costs	2002
Michigan	9% of FFS costs	FY2001
	14% of FFS costs	FY2002
	16% of FFS costs	FY2003
	19% of FFS costs	FY2004
	16% of FFS costs (without FY2006 MCO rate increase/with QAAP)	FY2006
	7% of FFS costs (without FY2006 MCO rate increase/without QAAP)	FY2006
	12% of FFS costs (with FY2006 MCO rate increase/with QAAP)	FY2006
	2% of FFS costs (with FY2006 MCO rate increase/without QAAP)	FY2006
Maryland	Over budget neutrality cap	7/97 - 6/99
	2% under its budget neutrality cap	7/97 - 6/00
	10% under its budget neutrality cap	FY1998 - FY2007
Pennsylvania	10 - 20% of FFS costs	2000 - 2004
New Mexico	3 - 5% of FFS costs	FY2006
Washington	--	--

State/Study	Estimated Savings Under Capitated Managed Care	Year
<b>Targeted Medicaid Managed Care Programs</b>		
Texas STAR+PLUS	\$4.11 PMPM	4/98 - 3/00
	\$91.67 PMPM, 17% of FFS costs	4/00 - 3/02
Oklahoma - Special Populations/ABD	4%	1998 - 2000
Minnesota Hennepin County	10% of FFS costs	--
Connecticut HUSKY	6.7% of FFS costs	CY2005
New Mexico Behavioral Health	Intentional increase w/ implementation	2005
<b>Service Specific Studies</b>		
CHCS - Prescription Drugs	Drug costs were 18% higher in FFS	--
Arizona - Prescription Drug Carve-Out Option	\$3.7M cost to carve-out Rx from capitation	--
California - Preventable Hospitalization	\$66M reduction in preventable hospital costs	1994 - 1999
Pennsylvania - Alcohol Treatment	Cost of treatment for alcohol-related conditions decreased by almost \$2K per member at the managed care site	1995 - 1998

Appendix C. Side by Side Summary of Studies

Report	Program Description & Enrollment	Benefits	Enrollment	Savings
<b>State Studies</b>				
Arizona Medicaid - Competition Among Managed Care Plans Lowers Program Costs, U.S. General Accounting Office, October 1995	<p>1115 Waiver</p> <p>AHCCCS is Arizona's statewide Medicaid managed care program implemented in 1982. Prior to AHCCCS, Arizona did not operate a Medicaid program.</p> <p>Nine private or county health plans cover the AHCCCS population. Five of the health plans are not-for-profit entities.</p>	AHCCCS includes family planning, behavioral health, and LTC.	<p>As of February 2004, 767,857 individuals were enrolled in the acute care program.</p> <p>(Enrollment data from Acute Care Enrollment, By County By Health Plan, <a href="http://www.ahcccs.state.az.us/5tatistics/Enrollment/Acute/2004/enrollmnt.asp">http://www.ahcccs.state.az.us/5tatistics/Enrollment/Acute/2004/enrollmnt.asp</a>)</p>	<p>In FY1991, federal savings were \$37 M and state savings were \$15M in acute care costs.</p> <p>Arizona's capitation rate for Medicaid declined by 11% in 1994 even while other states' per capita costs grew.</p> <p>Arizona's administrative costs are higher than in other states.</p> <p>AHCCCS slowed the growth rate in Medicaid expenditure compared with the state might have experienced in a traditional FFS program. For the AFDC and SSI populations, the per capita growth rate from 1983 to 1991 was 6.8% versus an estimated 9.9% for a traditional Medicaid program.</p> <p>The biggest slow-down in AHCCCS growth rate was for SSI beneficiaries after 1987.</p> <p>Overall, AHCCCS spend 81% of what a traditional Medicaid program would have spent.</p>

Report	Program Description & Enrollment	Benefits	Enrollment	Savings
Wisconsin HMOs' Success in Medicaid and BadgerCare: Government Cost Savings and Better Health Care Quality, Milliman USA, Feb. 2002  Study funding not specified	<p>1115 waiver</p> <p>HMOs are present in nearly every WI county, and mandatory managed care enrollment has been implemented completely or partially in 47 counties. Voluntary managed care enrollment occurs in 21 counties. Enrollment is voluntary in counties where only 1 HMO is present.</p> <p>Eligibility: AFDC-children - Children who meet the requirements for the former AFDC program.</p> <p>BadgerCare - Parents and children under age 19 with incomes less than 185% FPL. Families income above 150% pay a premium of 3% of family income.</p> <p>Healthy Start - children and pregnant women with incomes up to 185% FPL, no asset limit.</p> <p>Dual eligibles are not enrolled.</p>	<p>Comprehensive benefits.</p> <p>BadgerCare Carve-outs include: LTC, transportation, family planning, prenatal care coordination, targeted case management, dental, chiropractic, school-based services, and TB-related services. Families with employer sponsored coverage, receive Medicaid wrap around services for those services excluded from the employer's benefits package.</p>	<p>Enrollment: AFDC/Healthy Start Children and Pregnant Women: 216,185 (as of report publication)</p> <p>BadgerCare: 64,036 (as of report publication)</p>	<p>2001: \$14M in state savings, \$21M in federal savings.</p> <p>2002: \$22M in state savings, \$34M in federal savings.</p> <p>The study attributes savings to MCO efforts such as a 24-hour nurse line, utilization management activities, and disease management programs. The 24-hour nurse line focused on reducing unnecessary emergency room visits, and the utilization efforts helped to reduce hospital inpatient admissions and number of inpatients days; which lead to reduced costs.</p>

Report	Program Description & Enrollment	Benefits	Enrollment	Savings
KY Region 3 Partnership Program, Milliman USA, December 2003	1115 Waiver Mandatory for TANF, foster care, SOBRA, SSI, KCHIP.	Standard Medicaid benefits are covered. Carve-outs include LTC, MH, and school-based services.	2003: 132,579 32% Sobra 29% TANF 17% SSI, no Medicare 10% Duals 9% KCHIP 4% Foster Care	<i>Total Savings:</i> FY1999: \$7.9M (2.8%) FY2000: \$16.1M (5.4%) FY2001: \$32.6M (9.5%) FY2002: \$35.8 M (9.5%) FY2003: \$17.7M (4.1%) - including savings from PCCM
Health plan-funded study	All non-institutionalized Medicaid beneficiaries are enrolled, including dual eligibles. Dual eligibles receive the Medicaid only benefits (Rx and transportation) under the Partnership, dba Passport Health Plan.  Passport Health Plan is a non-profit, provider-run, Medicaid health plan. AmeriHealth Mercy Health Plan administers Passport Health Plan.  Region 3 represents the state's largest urban area, including Louisville in Jefferson County and 15 surrounding counties. This area makes up 20% of the state's Medicaid population.	Non-emergency transportation services are covered only for enrollees who need transport by stretcher only.  There are no cost-sharing requirements.	(Enrollment data provided by University Health Care Inc, dba Passport Health Plan presentation, provided to The Lewin Group on 2/27/04.)	<i>PMPM Savings:</i> FY2000 TANF: \$6.69 Foster Care: \$15.17 Preg. Women: \$4.60 SSI/Medicare: \$19.41 SSI/No Medicare: \$31.91 Composit: \$11.67  Sources of savings are not identified, but Passport attributes its savings to disease and utilization management (personal communication with Jill Bell of Passport Health Plan on 2/27/04).

Report	Program Description & Enrollment	Benefits	Enrollment	Savings
<p>Independent Assessment for the Ohio Medicaid Managed Care Program, Mercer Government Human Services Consulting, March 2003</p> <p>State-funded study</p>	<p>1915(b) waiver</p> <p>Healthy Families (parents and kids up to 100% FPL) and Healthy Start (kids up to age 19 up to 200% FPL and pregnant women up to 150% FPL).</p> <p>6 health plans participate in 15 counties (as of July 03).</p> <p>MCO enrollment is mandatory in 4 counties, and voluntary in 5 counties. 6 counties are "Preferred Option" where only 1 MCO operates. In "Preferred Option" counties, beneficiaries choose either the MCO or FFS.</p>	<p>Standard Medicaid benefits are covered. The majority of mental health and substance abuse, and non-emergency transportation are paid under FFS. LTC is carved-out.</p>	<p>Enrollment (as of February 2004):</p> <p>Total managed care: 495,555 (2004)</p> <p>Mandatory: 297,166 (2004)</p> <p>Voluntary: 2107 (2004)</p> <p>"Preferred Option": 196,292 (2004)</p> <p>(Enrollment data from Ohio Department of Job and Family Services, Fact Sheet 2.4, Medicaid Managed Care, <a href="http://jfs.ohio.gov/ohp/bcps/FactSheets/MedicaidManagedCare.pdf">http://jfs.ohio.gov/ohp/bcps/FactSheets/MedicaidManagedCare.pdf</a>)</p>	<p>\$26.4M in State FY2002 (2.2% of FFS)</p> <p>Cost effectiveness analysis compared projected FFS costs of the OH Medicaid program in managed care counties (w/o waiver) with the actual costs under the waiver.</p> <p>The main source of savings is from decreased use of inpatient hospital services.</p>

Report	Program Description & Enrollment	Benefits	Enrollment	Savings
Michigan Medicaid: New Directions Presentation by MIDCH, July 23, 2003	1915(b) Waiver	Carved-out services include dental, behavioral health, school based services provided to special education students, and long term care.	As of August 2003, 836,387 individuals were enrolled in a Michigan Medicaid MCO.	Medicaid Health Plans have lower costs and a slower rate of increase in PMPM costs. The difference in FFS and MCO PMPM costs as calculated by Lewin using data from the presentation are:
and	The Michigan capitated Medicaid program is statewide, in all but 19 counties. Managed care enrollment is mandatory in counties where the state can guarantee that 2 health plans will accept auto-assignment. Michigan has implemented the single plan rural option authorized under 42 C.F.R. 438.52.		As of June 30, 2006, 1.3 million individuals were enrolled in a Michigan Medicaid MCO ( <a href="http://www.statehealthfacts.org/profileind.jsp?ind=216&amp;cat=4&amp;rgn=24">http://www.statehealthfacts.org/profileind.jsp?ind=216&amp;cat=4&amp;rgn=24</a> ).	2001: -9% 2002: -14% 2003: -16% 2004: -19%
Michigan Medicaid: Relative Cost Effectiveness of Alternative Service Delivery Systems, prepared for the Michigan Department of Community Health, April 2005	Beneficiaries choose between at least 2 full-risk health MCOs in 54 of 83 counties; enrollment in a single MCO is voluntary in 7 counties; automatic enrollment into an MCO occurs in 4 counties; the single plan rural option occurs in 15 counties; MCO enrollment is not available in 3 counties.			MCO PMPM costs were 9% lower than FFS PMPM costs and so forth.
Center for Health Program Development and Management at the University of Maryland, Baltimore County	The voluntary population also includes: migrant individuals, Native Americans, individuals with TBI, pregnant women in their third trimester or who became Medicaid eligible because of their pregnancy.			When capitated managed care is compared to alternative delivery systems, Michigan would save between \$28 million and \$129 million in State funds for FY2006.
	Eligible populations include: TANF and related, SSI and related, and ABD.			Comparison of Estimated State costs - MCO vs. FFS (cumulative 2004-2006):  Without FY2006 MCO rate increase/With QAAP: FFS costs \$330 million more than MCO Without FY2006 MCO rate increase/Without QAAP: FFS costs \$152 million more than MCO With FY2006 MCO rate increase/With QAAP: FFS costs \$247 million more than MCO With FY2006 MCO rate increase/Without QAAP: FFS costs \$62 million more than MCO

Report	Program Description & Enrollment	Benefits	Enrollment	Savings
HealthChoice Evaluation, MD Dept. of Health and Mental Hygiene, January 2002	1115 Waiver	Carve-outs: specialty mental health, rare and expensive case management, long-term nursing facility benefit, health-related special education services under an IEP or IFSP, substance abuse treatment services in ICF-Additions for children under age 21, OT/PT, and speech therapy and audiology.	In CY2002, 455,000 were enrolled. Nearly 80% of MD Medicaid beneficiaries were enrolled in an MCO.	The 1115 waiver was found to be budget neutral. The state exceeded the BN cap in the 1 <sup>st</sup> 2 years of the waiver, but spending has been below the cap since. By the end of the third year, spending was about 2% below the cap.
State-funded study and	Enrollment is mandatory for children, pregnant and postpartum women, families receiving Temporary Cash Assistance (TCA), individuals receiving SSI, and foster children.		By June 2003, 487,073 individuals were enrolled in HealthChoice (Maryland HealthChoice Factsheet, January 2004, <a href="http://www.dhmd.state.md.us/mma/pdf/MdHC-fact-2004.pdf">http://www.dhmd.state.md.us/mma/pdf/MdHC-fact-2004.pdf</a> ).	HealthChoice met the budget neutrality test each year for FY2000 through FY2007.
Status Report on the Budget Neutrality Calculation for the Maryland HealthChoice Program, prepared for the Maryland Department of Health and Mental Hygiene, December 2007	Seven for-profit MCOs serve HealthChoice enrollees, of which 5 MCOs serve Medicaid enrollees only. The 4 largest MCOs are statewide.		By 2006, 491,800 individuals were enrolled in HealthChoice (Maryland HealthChoice Factsheet, January 2007, <a href="http://www.dhmd.state.md.us/mma/pdf/FINALHealthChoiceFactSheet.pdf">http://www.dhmd.state.md.us/mma/pdf/FINALHealthChoiceFactSheet.pdf</a> ).	By the end of FY2007, the State was about \$2 billion, or about 10 percentage points of margin under the budget cap.
Center for Health Program Development and Management at the University of Maryland, Baltimore County				Neither study identifies specific sources of savings.

Report	Program Description & Enrollment	Benefits	Enrollment	Savings
<p>Reforming Medicaid: The Experiences of Five Pioneering States with Mandatory Managed Care and Eligibility Expansions, Mathematica Policy Research, for CMS, April 2001</p> <p>Study funding from the federal government</p>	<p>MPR and Urban Institute conducted a 6 year evaluation of 5 Medicaid 1115 waiver programs - HI, MD, OK, RI, TN - the were implemented between 1994-1997.</p>	<p>Comprehensive Medicaid benefits, with some state by state variation.</p>	<p>Varied by state.</p>	<p>Demonstrations had little impact on state expenditures and states did not achieve a high level of savings. 3 of the 5 states had average annual growth rates close to the national average for the same years.</p> <p>HI: 3.0%, US: 2.9%, years: 1993 - 1998</p> <p>MD: -0.2%, US: 2.6%, years: 1996 - 1998</p> <p>OK: 2.8%, US: 2.4%, years: 1995 - 1998</p> <p>RI: 3.4%, US: 2.9%, years: 1993 - 1998</p> <p>TN: 2.8%, US: 2.9%, years: 1993 - 1998</p>

Report	Program Description & Enrollment	Benefits	Enrollment	Savings
Comparative Evaluation of Pennsylvania's HealthChoices Program and Fee-for-Service Program, by The Lewin Group, May 2005	HealthChoices is Pennsylvania's managed care program for Medical Assistance beneficiaries. This program was implemented in 1997 as mandatory in Pennsylvania's urban zones.	Comprehensive Medicaid benefit package.	As of December 2007: Southeast: 495,333 Southwest: 271,769 Lehigh/Capital: 243,920	Despite being implemented in urban settings with higher cost platforms, HealthChoices average annual medical cost increase was 7.4% between 2001-2004, while FFS medical costs increased 10.4% between 1999-2002.
Coalition of Medical Assistance Managed Care Organizations	In 2003, the Pennsylvania Department of Public Welfare terminated statewide expansion of HealthChoices in favor of the ACCESS Plus program, an enhanced primary care case management and FFS program.			While other states' managed care programs are unable to balance profits with saving the state money, HealthChoice has found the balance with approximate revenue ratios of 90% medical cost, 8% administrative, and 3% profit.  A conservative estimate has HealthChoices saving approximately \$2.7 billion between 2000 and 2004.
Independent Assessment of New Mexico's Medicaid Managed Care Program - Salud!, by The Lewin Group February, 2007	1915(b) waiver  Salud! is administered by 3 MCOs.	Comprehensive Medicaid benefit package.	Lovelace MCO Members: 66,450	Higher costs per eligible due to quality of coverage, provider gross receipt tax of 7% and a premium tax assessment.
New Mexico Medical Review Association	All 3 MCOs were rated "excellent" by the National Committee for Quality Assurance.  Physician fee schedules are high relative to other states.	Disease management, childhood immunization, adolescent outreach, and prenatal care programs.  Addresses cultural and linguistic barriers.	Molina MCO Members: 59,159  Presbyterian MCO Members: 1,237	Annual cost trends are aligned with national averages.  Estimated savings for FY2006 are between 3-5%, or \$33-\$56 million.

Report	Program Description & Enrollment	Benefits	Enrollment	Savings
<p>Medicaid Cost Containment Report No. 3, by The Lewin Group, January 2003</p> <p>The Washington State Legislature</p>	<p>Washington's Medicaid Utilization and Cost Containment Initiative (UCCI) is designed to find efficiencies and lower expenditures in Medicaid without reducing benefits or eligibility. One approach to cost containment has been the administering of care to the Medicaid population by 6 HMO's. The Lewin Group looked at the relationship between the HMO's and the State to find further opportunities for the State's cost saving efforts.</p>	<p>Comprehensive Medicaid benefit package.</p>	<p>In 2003, 403,162 Medicaid beneficiaries were enrolled in 1 of the 6 HMO's.</p> <p>The top 3 HMOs in terms of percentage of total enrollment were:</p> <p>Molina Healthcare - 38%</p> <p>Community Health Plan - 28%</p> <p>Premiera Blue Cross - 11%</p>	<p>Washington had been increasing managed care rates at a pace higher than inflation. As a result, the HMOs had gained a surplus of \$30M, or 2.8% of Medicaid premiums from their Medicaid business from 1999-2001. If the State had limited just the 3 most Medicaid-focused HMOs to the State average hospital operating margin of 1.5% during CY2002, the State would have saved about \$30.5M.</p> <p>With an expected increase of capitation payments from \$600M to \$700M in 2004, the State could save \$7M for each percentage point reduction in payments.</p>

Report	Program Description & Enrollment	Benefits	Enrollment	Savings
<b>Targeted Medicaid Managed Care Program Studies</b>				
STAR+PLUS Medicaid Managed Care Waiver Study: An Independent Assessment of Access, Quality, and Cost-Effectiveness, Texas A&M University, PPRI, October 1999	1915(b) Waiver for SSI and SSI-related populations in Harris County (Houston). These individuals are required to enroll in Medicaid managed care.  STAR+PLUS enrollees can choose between 2 MCOs or the PCCM, if the individual is not dually eligible.	All Medicaid primary care, acute and long-term care services are covered. Medicaid only enrollees also receive specialty, home health, medical equipment, lab, x-ray, and hospital services through MCOs.	About 55,000 were enrolled mandatorily during the first waiver period.  During the second waiver period, 57,000 individuals were enrolled.	<i>Cost savings in the first waiver period:</i> Waiver year 1: -\$1.97M, -\$2.68 PMPM  Waiver year 2: \$7.57 M, \$10.22 PMPM
and  Medicaid Managed Care Waiver Study: An Independent Assessment of Access, Quality, and Cost-Effectiveness of the STAR+PLUS Program, Public Policy Research Institute, June 2002 (Second waiver period)	94% of the population is over the age of 20, and 43% are age 65 or older.	Dually eligible enrollees receive acute care services from Medicare providers and LTC services through managed care, including personal care services, adult day care, and 1915(c) services.  Prescription drugs are carved out of managed care, but an enhanced benefit is available to managed care enrollees who choose the same MCO for Medicare and Medicaid services.	As of February 2004, 62,782 individuals were enrollee. (STAR+PLUS website, <a href="http://www.hhsc.state.tx.us/starplus/enrollmen_numbers/confirmed/confirm.htm">http://www.hhsc.state.tx.us/starplus/enrollmen_numbers/confirmed/confirm.htm</a> .)	Waiver years 1&2: \$6.05M, \$4.11 PMPM Savings were less than 1% of the cost for the two years combined.  <i>Cost savings in the second waiver period:</i> Waiver year 1: \$66M, \$100.95 per member month  Waiver year 2: \$56M, \$82.71 per member month  Waiver years 1 & 2: \$123M, \$91.67 per member month.
State-funded studies				This represents a nearly 17% reduction in state Medicaid expenditure for this population from what would have been spent absent the waiver.

Report	Program Description & Enrollment	Benefits	Enrollment	Savings
<p>Serving the Special Program/Aged, Blind and Disabled Population (in OK Medicaid managed care) by Schaller Anderson, April 2002</p> <p>Center for Health Care Strategies funded study</p>	<p>1115 Waiver</p> <p>Managed care enrollment became mandatory for the ABD Medicaid population in 1999. Managed care was implemented in 17 counties surrounding the urban centers of Oklahoma City, Tulsa, and Lawton. In other counties, the PCCM model was implemented.</p> <p>The study covered the SP/ABD population, i.e., the 583 individuals who were the top 10% of ABD service utilizers who were also enrolled in the Heartland Health Plan of Oklahoma.</p> <p>Individuals who are disabled and have incomes up to 100% FPL are eligible for Medicaid.</p> <p>**Effective Jan. 2004, the capitated managed care program was discontinued. In Nov. 2003, 1 of the 3 MCOs decided not to renew its contract with OHCA, prompting OHCA to terminate the MCO program. Individuals enrolled in an MCO are being transitioned into the PCCM program.</p>	<p>Behavioral health services are included in the MCOs benefits package with a \$10,000 per beneficiary limit. Beyond the limit the state pays 70% of additional claims. Carved out services include non-emergency transportation, services ordered through an IEP or IFSP, court-ordered treatment, non-state plan services ordered as a result of an EPSDT visit.</p>	<p>Claims savings were 15% of FFS. In assessing the full managed care payment costs in relation to FFS claims cost, overall PMPM costs were 4% lower in managed care. After removing the 10 most expensive enrollees, savings under managed care were 31%.</p>	
<p>How Managed Care Affects Medicaid Utilization A Synthetic Differences Zero-Inflated Count Model, Freund, D., Kniesner, T., LoSasso, A., April 1996</p> <p>AHRQ-funded study</p>	<p>The study analyzed the effects of managed care on doctor office visits, hospital outpatient dept. visits, ER visits, and hospital inpatient days.</p> <p>The study population included adult women.</p>	<p>Comprehensive Medicaid benefits were modeled.</p>	<p>Based on Hennepin County data used for the study.</p>	<p>Estimated economic savings totaled about 10%, which the authors state is lower than estimated savings reported in states' waiver applications.</p> <p>The 10% savings figure accounts for the initial effect of switching to managed care.</p>

Report	Program Description & Enrollment	Benefits	Enrollment	Savings
Assessment of HUSKY, Connecticut's Medicaid Managed Care Program, prepared for the four participating HUSKY managed care companies by The Lewin Group, January 2007	1915(b) waiver  Connecticut's mandatory capitated managed care program for the State's TANF (HUSKY A) and SCHIP (HUSKY B) populations.  HUSKY is statewide and is served by four different HMOs.	Comprehensive Medicaid benefits package.  Carve-out: behavioral health (January 2006), essentially creating a disease management initiative for behavioral health services.	Over 309,000 (HUSKY A - 292,852; HUSKY B - 16,579) enrolled as of December 2006  Anthem Blue Cross Blue Shield - 132,852  Community Health Network - 57,703  HealthNet - 82,678 (only HUSKY A)  WellCare - 36,198	HUSKY's per capita cost escalation is below the national rate for TANF cost escalation and the rate of inflation for selected non-HUSKY Medicaid subgroups.  HUSKY medical loss ratio is 90-91% compared to 84.5% nationally.  HUSKY administrative costs were between 8.8% and 10.2% between 2003 and 2005, low when compared to the national average of 12.2%.  Expenditures under HUSKY are at least 5% less than any new non-capitated Medicaid managed care model (annual Medicaid savings of at least \$37 million).
Anthem Blue Cross Blue Shield Community Health Network of Connecticut HealthNet of the Northeast WellCare of Connecticut	Over 80% of the State's TANF spending occurs through capitation payments to health plans.			

Report	Program Description & Enrollment	Benefits	Enrollment	Savings
Independent Assessment of New Mexico's Behavioral Health Program, by The Lewin Group, March 2007	Prior to establishing a single, comprehensive mental health system for Medicaid beneficiaries in 2006, New Mexico had a fragmented system.	Comprehensive behavioral health services for the New Mexico Medicaid population.	As of July 2006, 69,380 individuals were enrolled in New Mexico's ValueOptions behavioral health carve-out.	It is not yet possible to determine the cost effectiveness of the new program for two reasons. First, the program has only been in place a year, therefore a comparison of trends cannot be made. More importantly, the program was replacing an inadequate predecessor and thus had many additional costs in an attempt to strengthen the behavioral health delivery system and improve patient outcomes. As a result, behavioral health costs increased by 26.3% in total dollars and by 34.5% on a PMPM basis. Despite the inability to determine true cost effectiveness, there is evidence of improved service delivery under the new program.
New Mexico Medical Review Association	Under the new program, behavioral health was carved out from the services provided by the 3 Medicaid MCOs.  ValueOptions administered the program. The transitioning phase of the program was completed in 2006.			

Report	Program Description and Enrollment	Benefits	Savings
<b>Service Specific Studies</b>			
<p>Comparison of Medicaid Pharmacy Costs of Usage between the Fee-for-Service and Capitated Setting, prepared for CHCS by The Lewin Group, January 2003</p> <p>Center for Health Care Strategies funded study</p>	<p>Reported data focus on TANF enrollees.</p>	<p>Prescription drugs only.</p>	<p>Lewin calculated average PMPM pharmacy costs using data provided by states. The average cost in FFS was \$20.46 PMPM and in managed care \$17.36 PMPM. Both figures are post rebate and take into the average rebates received. Pharmacy costs are 18% higher in FFS than in managed care.</p> <p>This difference in average pharmacy costs exists even though health plans initially have a 15% price disadvantage compared to states, largely due to the Medicaid drug rebate rules. However, once lower dispensing fees, high rate of substitution of lower cost drugs, and reduced number of prescriptions is factored in, health plans achieve better drug prices than stated do for FFS.</p>
<p>Analysis of Pharmacy Carve-Out Options for the Arizona Health Care Cost Containment System, prepared for CHCS by The Lewin Group, November 2003</p> <p>Center for Health Care Strategies funded study</p>	<p>AHCCCS is Arizona's Medicaid 1115 waiver program. Currently prescription drugs are included in the managed care benefit.</p>	<p>The study looked at prescription drugs only.</p>	<p>The AHCCCS system operates a cost-effective prescription drug benefit currently. The analysis demonstrates that the AHCCCS system is more cost-effective than other Medicaid programs, including in FFS. The study concludes that carving-out pharmacy from the capitation would increase program costs by \$3.5M.</p>

Report	Program Description and Enrollment	Benefits	Savings
<p>Preventing Unnecessary Hospitalization in Medi-Cal: Comparing Fee-for-Service with Managed Care, CHCF, February 2004</p> <p>California HealthCare Foundation funded study</p>	<p>Medi-Cal managed care was implemented on a county by county basis and included both voluntary and involuntary enrollment.</p> <p>During the study period, most of the large urban counties moved to mandatory managed care for CalWORKS (TANF) eligible Medi-Cal beneficiaries, if they hadn't already done so. The county operated health system (COHS) counties also moved to mandatory managed care for SSI-eligible beneficiaries.</p>	<p>Looked at preventable hospitalizations only.</p>	<p>The preventable hospitalization rate for Cal-WORKS eligible Medi-Cal beneficiaries was 7.2/1000 per year versus 11.4/1000 in FFS. The managed care rate was more than a third lower. Based on the average charge per preventable hospitalization, the cost to Medi-Cal was more than \$66M less in managed care than it would have been in FFS.</p> <p>The average annual rate of preventable hospitalization for SSI-eligible Medi-Cal beneficiaries was 57.5/1000 versus 76.4/1000 in FFS, about a third lower. The difference between FFS and managed care rates was about the same as for the CalWORKS population.</p>
<p>Comparison of Alcohol Treatment and Costs After Implementation of Medicaid Managed Care, May 2006.</p> <p>The American Journal of Managed Care</p>	<p>Philadelphia County: 400,000 enrolled (as of January 1998).</p> <p>The MCO is a carve-out agency that receives PMPM capitation fee for providing behavioral health services to the enrolled population.</p> <p>Allegheny County (Pittsburgh): 140,000 enrolled (as of January 1998) in the FFS program.</p> <p>During the study period, both sites were funded equally for public substance abuse treatment systems.</p>	<p>The study looked at behavioral health services for high-risk public-sector clients between 1995 and 1998 who were being treated for alcohol abuse or dependence problems.</p>	<p>The study looked at the pre- (1995) and the post-managed care period (1998) in both the managed care and FFS sites.</p> <p>Per person behavioral health costs decreased from \$7,662 to \$5,664 at the MC site per person, while they increased from \$4,871 to \$6,449 at the FFS site per person.</p> <p>Managed care site (Philadelphia County): \$1,200 reduction for alcohol abuse treatment; \$900 reduction for drug abuse treatment per person.</p> <p>FFS site (Allegheny County): \$400 reduction for alcohol costs; \$250 reduction for drug costs per person; increase of \$2000 per person for psychiatric inpatient costs.</p>

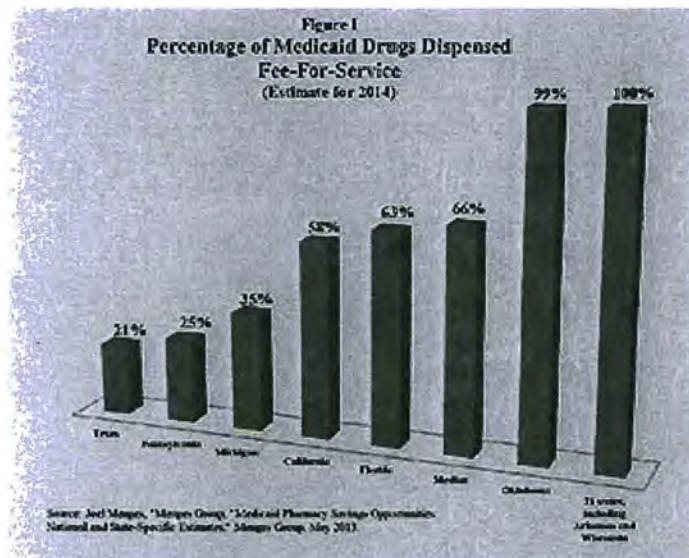
Issue Briefs | Health

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by Devon M. Herrick



Wisconsin has moved about two-thirds of its Medicaid enrollees into privately administered managed care plans, known as BadgerCare. However, the state has been very slow to move Medicaid enrollees into managed drug plans. Virtually all state Medicaid programs distribute some drugs on a fee-for-service (FFS) basis separately from enrollees' health plans.

A few states distribute almost all their Medicaid drugs this way; Wisconsin is one of them [see Figure 1].<sup>2</sup> This inefficient practice should change.



**Reforming Medicaid Drug Programs.** State Medicaid programs that carve out drug benefits often ignore drug therapy coordination and management. By contrast, integrating prescription drugs benefits with managed care health plans improves quality and increases efficiency. A Lewin Group analysis for Medicaid Health Plans of America, a trade association, found that integrating health and drug plans in 14 states that currently carve out drug benefits would collectively save nearly \$12 billion over a decade.<sup>3</sup>

Private health plans that provide medical care to Medicaid enrollees are the logical entities to manage drug benefits. The health plans are paid a set fee per enrollee to provide care; thus, the plans are liable for the cost of nondrug therapies, whereas a drug regime is often a less costly substitute for surgery or other treatment.

Drug therapies often reduce the need for hospitalization, and avoid expensive emergency room visits and medical complications - especially for such chronic conditions as asthma, diabetes and schizophrenia. An IMS Health analysis of Medicaid managed pharmacy benefits in several states found utilization rates for many of these therapies is higher under managed care than fee for service.<sup>4</sup>

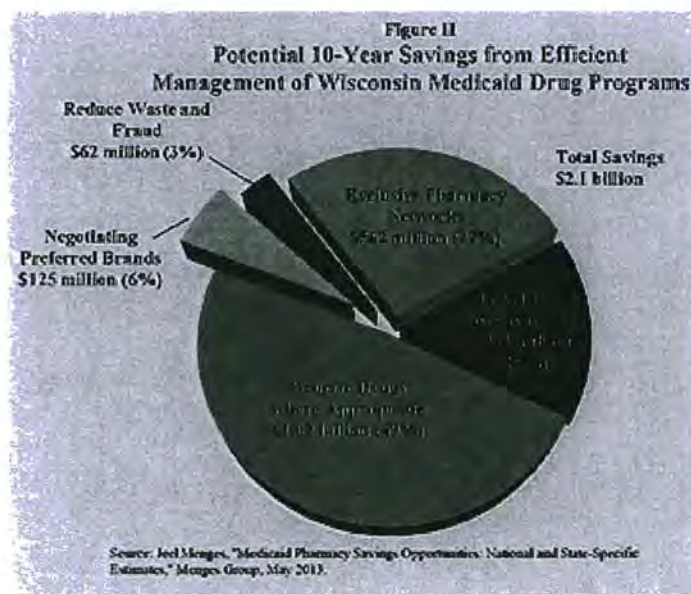
**The Role of Medicaid Drug Plan Administrators.** Private health plans use various techniques to control drug costs, including preferred-drug lists (PDL), formularies, required use of mail-order drug suppliers, negotiated prices with drug companies and drug distributors, and contracting with exclusive pharmacy network providers.<sup>5</sup> Private Medicaid managed care plans frequently contract with pharmacy benefit managers (PBMs), private firms that act as third-party prescription drug plan administrators. PBMs process and reimburse claims, and negotiate drug prices and rebates with drug manufacturers. They also negotiate dispensing fees - the amount paid to pharmacies for the service of filling a prescription. Regardless of how a drug program operates, Medicaid enrollees generally obtain prescriptions at local pharmacies, which are reimbursed for each prescription filled.<sup>6</sup>

A recent analysis by the Menges Group identified ways in which privately managed Medicaid drug plans are more efficient than state-administered drug benefit programs.<sup>7</sup> Rather than negotiating with pharmacy networks, state fee-for-service Medicaid programs often arbitrarily pay much higher dispensing fees than they would in a competitive market. These programs rarely utilize generic drugs. Moreover, FFS Medicaid faces political opposition to exclusive pharmacy network contracts.

For instance:

- Just over three-fourths (77 percent) of prescriptions in Wisconsin's fee-for-service Medicaid plan are filled with generic drugs; the national average for managed Medicaid drug benefits is about 80 percent.
- Wisconsin Medicaid programs pays pharmacies \$3.94 to dispense a prescription, whereas the average for private Medicare Part D plans is about one-half as much - about \$2.00.
- The number of prescriptions per enrollee is generally higher among enrollees in Medicaid compared to managed care.

According to Menges, integrating drug and health benefits in a statewide managed care program over the next 10 years could save Wisconsin Medicaid over \$2 billion in federal and state spending.<sup>8</sup> Specifically [Figure II]:



- Nearly one-sixth (16 percent) of the savings would come from paying market-based, competitive dispensing fees.
- About half (49 percent) would come from use of generic drugs where appropriate.
- More than one-fourth (27 percent) would come from negotiating steep discounts with exclusive networks.

Despite the potential savings, pharmacy trade associations often oppose moving from FFS Medicaid drug programs to privately managed drug programs. They advocate laws to prohibit exclusive Medicaid pharmacy networks. They also lobby lawmakers to discourage cost-efficient, mail-order drug programs

commonly found under managed care. The pharmacy industry has also launched another initiative in recent years to limit the ability of drug plans to audit pharmacies that bill for drug plan member prescriptions.<sup>9</sup> If taxpayers are to be protected from fraudulent operators, drug plans must be allowed to audit for compliance.

A few of these barriers to efficient Medicaid drug plans are discussed in greater detail below.

**Competitive Dispensing Fees.** Many state fee-for-service Medicaid drug programs pay dispensing fees that are more than double the negotiated rates paid by private Medicare Part D drug plans. This is the case in Wisconsin. Community pharmacies often specialize in serving Medicaid beneficiaries and depend on dispensing fees to boost their revenue. Small pharmacists cannot compete with PBMs on price and efficiency without cutting profitability, so they fight to maintain the status quo and lobby to keep dispensing fees artificially high.

**Barriers to Efficient Networks.** Many pharmacists are small business owners, and state legislators often view them sympathetically when they lobby for protection from competition.

For instance, PBMs and health plans are increasingly experimenting with limited or "narrow" pharmacy networks in order to negotiate lower drug prices and dispensing fees. Pharmacies compete to become one of the exclusive network drug providers.<sup>10</sup> Enrollees, insurers and employers share in the savings that result.<sup>11</sup> However, many states allow *any willing pharmacy* to participate in Medicaid drug programs, preventing the development of exclusive networks.

Supporters argue that open pharmacy networks offer enrollees more choices and more convenience, and promote competition. But open networks aren't competitive in the traditional sense. For instance, pharmacies are not offering lower prices to enrollees or state Medicaid programs in return for business. Pharmacies that compete with each other to be included in exclusive networks typically agree to deeper discounts that save taxpayers money.<sup>12</sup>

Any-willing-provider and freedom-of-choice laws reduce the drug plans' power to negotiate steeper discounts from pharmacies.<sup>13</sup> These regulations also prevent health plan sponsors from selectively negotiating and contracting with pharmacies.<sup>14</sup> The Federal Trade Commission (FTC) notes that these laws lead to higher drug prices and higher premiums by protecting less efficient pharmacies from competition.<sup>15</sup> Thus, they could be costly to taxpayers, employers and patients.<sup>16</sup> The Lewin Group calculated that if government enacted a nationwide any-willing-provider mandate, prescription mail-order pharmacy costs would increase 3 percent.<sup>17</sup> Thus, any-willing-provider and freedom-of-choice laws typically benefit local pharmacies rather than consumers.<sup>18</sup>

**Barriers to Mail-Order Pharmacies.** Drug plans offer incentives that encourage patients to use mail-order pharmacies for medications to treat chronic conditions, such as diabetes, hypertension and high cholesterol. Many plan sponsors charge higher deductibles for retail purchases, offer lower copayments for mail-order dispensing, or only reimburse patients for mail-order maintenance medications.<sup>19</sup> Some plans limit the number of times a prescription may be refilled at a retail pharmacy before patients are required to use the mail.

Unfortunately, lawmakers sometimes pursue unwise policies designed to benefit local constituents. This is accomplished by enacting laws that limit drug plans' ability to reward enrollees who use mail order. In 2011, New York State passed Assembly Bill 5502, which allows consumers to fill prescriptions at any pharmacy without incurring additional cost sharing or fees. The law benefits local community pharmacies - not consumers or taxpayers.

As one consultant described it: "Imagine that your local bookstore owner lobbied your state Senate to pass a law preventing you from buying a book less expensively via Amazon.com. You would immediately recognize that the bookstore was trying to protect its business at your expense. This is precisely what has happened for prescription drugs in New York."<sup>20</sup> The FTC agreed, stating, "By reducing competition between pharmacies, this legislation likely will raise prices for, and reduce access to, prescription drugs..."<sup>21</sup>

Retail-choice laws may increase convenience for some enrollees, but they drive up costs for all health plan members and plan sponsors. Maryland passed legislation similar to New York's. If retail choice was

required nationwide, mail-order prescription costs would rise more than 5 percent, according to the Lewin Group.<sup>22</sup>

Clearly, Wisconsin should avoid the mistake of allowing *any willing pharmacy* to participate in the Medicaid drug program rather than authorizing drug plan managers to negotiate lower prices with exclusive pharmacy networks. In addition, any-willing-pharmacy laws unnecessarily facilitate waste, fraud and abuse. For example, an unlimited supply of pharmacies allows unscrupulous patients to shop for multiple doctors willing to prescribe narcotics - avoiding detection by filling each prescription at a different pharmacy. Requiring Medicaid drug plans to reimburse large networks (with numerous small pharmacies) also makes it more difficult to detect billing fraud by pharmacy operators (or fake pharmacies). Wisconsin should also avoid calls by local pharmacies to interfere with mail-order programs.

**Pharmacy Board Regulation.** As in most states, the state insurance commissioner regulates insurance sold in Wisconsin, including health and drug plans. However, some states are transferring some regulatory authority over drug plans to their state board of pharmacy. This happened in Alabama, and a bill in Oklahoma would do likewise.<sup>23</sup> In Arkansas, House Bill 2100, introduced in the first session of the 54th Legislature, would require PBMs to obtain a license from the pharmacy board. Pharmacists and their allies typically dominate the membership of such boards; thus, Arkansas passed a law in 2011 requiring the approval of the Arkansas Pharmacy Association for gubernatorial appointments to the State Board of Pharmacy.<sup>24</sup> The law also grants the Board of Pharmacy the power to demand sensitive information on business practices, which could be disclosed to pharmacy trade groups, eroding the bargaining power of the drug plans. Indeed, when the Mississippi House of Representatives debated this issue in 2013, the FTC argued that shifting drug plan regulation to state pharmacy boards would harm consumers - concluding that more restrictive controls would reduce competition and raise costs for consumers.<sup>25</sup>

**Conclusion.** Medicaid will best serve Wisconsin taxpayers by providing drugs to enrollees at the lowest possible cost. Wisconsin has moved many of its Medicaid enrollees into managed care plans. The state should also integrate drug benefits into enrollees' health plans. In addition, legislators should avoid the temptation to enact protectionist regulations designed to limit competition among pharmacies participating in the Medicaid program. The state will likely find that drug plan managers will lower costs - if they allow drug plans to use the tools to do so. However, Wisconsin legislators will undoubtedly come under political pressure to protect local providers from the competition that could save taxpayers money.

*Devon M. Herrick is a senior fellow with the National Center for Policy Analysis.*

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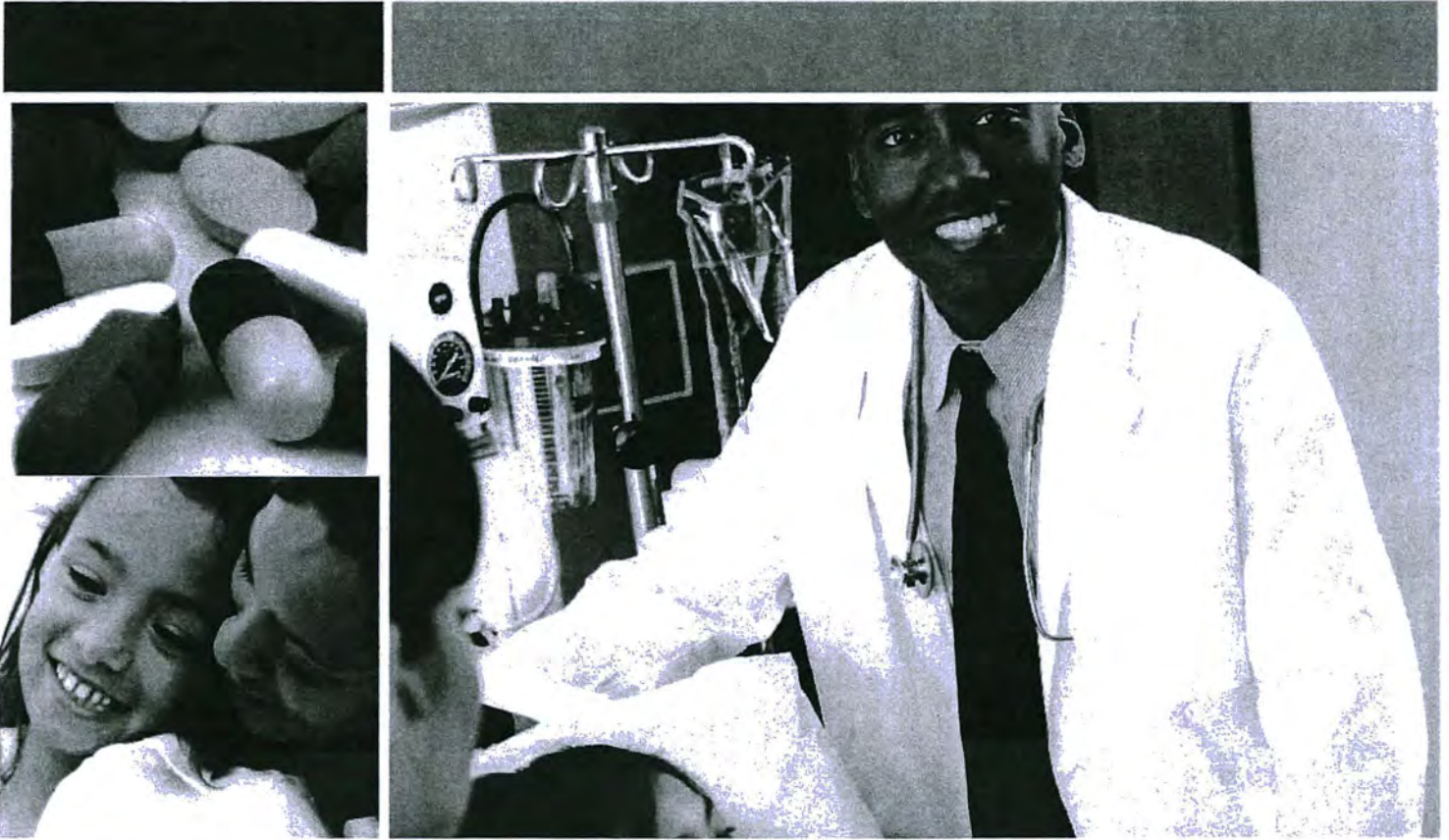
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HEALTH CARE AND HUMAN SERVICES POLICY, RESEARCH, AND CONSULTING—WITH REAL-WORLD PERSPECTIVE.

## Potential Federal and State-by-State Savings if Medicaid Pharmacy Programs were Optimally Managed

February 2011

**Commissioned by the Pharmaceutical Care Management Association**

**Prepared by:** Joel Menges  
Shirley Kang  
Chris Park

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## I. Executive Summary

While discussions about Medicaid prescription drug costs have often focused on the rebates received from brand name drug manufacturers, this study explores how more efficient pharmacy benefits management -- apart from rebates -- could save Medicaid an additional \$33 billion over the next decade.

Medicaid has become an outlier as one of the nation's few remaining pharmacy benefits programs that is mainly administered by public agencies using a fee-for-service (FFS) delivery model. In this model, which accounts for 73% of Medicaid pharmacy expenditures, dispensing fees, ingredient costs, and benefits management activities are determined by state officials. In most other programs, pharmacy reimbursements are determined through negotiations between pharmacy benefits managers (PBMs) and drug retailers.

Though states often use pharmacy benefits administrators (PBAs) to make their FFS program models operate more efficiently, states do not typically allow such organizations to negotiate payment terms directly with pharmacies. In contrast, Medicare Part D plans, Medicaid managed care organizations (MCOs), and state employee plans typically use PBMs to negotiate dispensing fees and ingredient cost reimbursements. PBMs negotiate directly with chain drug stores and indirectly with independent drug stores through drug wholesalers that collectively negotiate on their behalf.

The experience of Medicaid MCOs indicates that Medicaid pharmacy benefits can be more actively managed without compromising quality or access to medications for the unique and vulnerable populations that Medicaid serves. Likewise, widely varying payment levels -- and per member per month (PMPM) costs -- among state Medicaid fee-for-service programs serving similar populations suggest that substantial room exists to improve efficiency in most states.

### Savings Opportunities Exist In Four Key Areas

While Medicaid FFS programs and costs vary greatly state-by-state, we identified four key areas where pharmacy benefit management could generally be improved:

**Generic Drug Dispensing:** Medicaid FFS is less effective at encouraging the dispensing of generic drugs in place of brands. The generic dispensing rate in Medicaid FFS averages 68%, compared to an average 80% generic dispensing rate in Medicaid MCOs. While some of this difference is attributable to demographic differences between the Medicaid FFS and MCO populations, much of the generic dispensing difference persists when looking *within* each demographic subgroup.

**Dispensing Fees:** At \$4.81 per prescription, the national average dispensing fee that Medicaid FFS programs pay to retail pharmacies is more than double the average dispensing fees paid by Medicare Part D payers, Medicaid managed care organizations (MCOs), or health plans in the commercial sector.

**Ingredient Costs:** The rate at which retail pharmacies are reimbursed for the actual medication ingredients (pills, capsules, etc) is also higher, on average, in Medicaid FFS programs than in Medicare Part D or the commercial sector.

**Drug Utilization:** The number of prescriptions dispensed per person is typically higher for similar demographic subgroups in Medicaid FFS programs than in Medicaid MCOs for similar demographic subgroups due to less effective controls on polypharmacy, fraud, waste, abuse, and other factors in the FFS setting.

### **States With High Dispensing Fees Also Often Pay High Ingredient Costs**

Contrary to conventional wisdom, we did not find that Medicaid FFS programs with low dispensing fees paid high ingredient costs. On the contrary, we found that many state programs paying high dispensing fees often also paid high ingredient costs. Likewise, we found no relationship between pharmacy reimbursement levels and the generic dispensing rate among Medicaid FFS programs, suggesting that benefits management rather than pharmacy reimbursement most strongly influences the generic dispensing rate.

### **Estimated Federal and State Medicaid Savings**

If all state Medicaid programs used a market-based approach such that dispensing fees, ingredient costs, drug utilization, and generic drug dispensing were brought in-line with norms for state employee health plans, Medicare Part D, and Medicaid MCOs, we estimate:

- Medicaid FFS prescription costs could be reduced by approximately 15%
- Combined federal and state savings to the Medicaid program would total \$32.7 billion over the next decade
- Per member per month (PMPM) costs for Medicaid FFS pharmacy benefits could be reduced by \$12 in 2012 under optimal management

In constructing our model we used data published by the Centers for Medicare and Medicaid Services (CMS) provided by individual state Medicaid programs. Estimated savings vary greatly from state to state and depend on the volume of prescriptions paid for in the FFS setting and how actively each individual Medicaid program currently manages pharmacy benefits (see Exhibit ES-1). Active pharmacy benefit management would incur higher administrative costs, but these costs would not outweigh the substantial savings opportunities and have been accounted for in our estimates. Our model, however, does not estimate specific impacts that would be associated with greater care coordination, clinical specialty pharmacy management, or the use of mail-service pharmacies.

### **Estimates Reflect Changes Involving AMP and AWP Drug Price Benchmarks**

Our savings estimates take into account recent changes to drug price benchmarks that influence pharmacy ingredient cost reimbursement levels in some cases. Recent changes to the determination of Federal Upper Limits (FULs) using the Average Manufacturer Price (AMP) may result in lower pharmacy ingredient cost reimbursement for some generic drugs in some states, so to be conservative we have not assumed that more active pharmacy management would result in any ingredient cost savings for FUL drugs in any state.

**Exhibit ES-1. Estimated Savings if Medicaid Pharmacy Programs Were Optimally Managed  
(Figures represent ten-year timeframe CY2012-CY2021)**

State	Federal Share of Net Savings	State Share of Net Savings	10 Year Total Net Savings, 2012-2021
Alabama	\$541,589,986	\$212,693,864	\$754,283,850
Alaska	\$123,277,462	\$92,518,227	\$215,795,688
Arizona	\$0	\$0	\$0
Arkansas	\$333,582,219	\$97,833,858	\$431,416,077
California	\$2,664,470,481	\$2,102,278,271	\$4,766,748,752
Colorado	\$145,129,408	\$92,104,295	\$237,233,703
Connecticut	\$195,163,881	\$172,490,345	\$367,654,226
Delaware	\$60,468,563	\$57,138,977	\$117,607,540
District of Columbia	\$51,606,201	\$20,541,747	\$72,147,948
Florida	\$832,251,989	\$472,600,872	\$1,304,852,861
Georgia	\$558,368,644	\$265,978,908	\$824,347,552
Hawaii	\$6,784,074	\$3,320,416	\$10,104,490
Idaho	\$138,704,585	\$45,072,321	\$183,776,906
Illinois	\$804,866,203	\$613,459,114	\$1,418,325,317
Indiana	\$413,221,714	\$213,536,536	\$626,758,250
Iowa	\$265,600,337	\$115,936,750	\$381,537,087
Kansas	\$104,786,220	\$62,038,990	\$166,825,210
Kentucky	\$489,938,125	\$173,966,438	\$663,904,563
Louisiana	\$879,404,642	\$280,728,542	\$1,160,133,184
Maine	\$124,678,825	\$60,777,993	\$185,456,818
Maryland	\$196,475,409	\$171,141,358	\$367,616,767
Massachusetts	\$87,191,071	\$87,880,524	\$175,071,595
Michigan	\$304,054,861	\$149,518,302	\$453,573,163
Minnesota	\$114,704,650	\$102,194,619	\$216,899,269
Mississippi	\$280,410,076	\$66,449,179	\$346,859,255
Missouri	\$559,461,818	\$281,744,973	\$841,206,791
Montana	\$54,131,730	\$17,138,337	\$71,270,067
Nebraska	\$99,486,235	\$49,575,402	\$149,061,637
Nevada	\$58,357,006	\$37,057,311	\$95,414,317
New Hampshire	\$28,623,415	\$21,459,624	\$50,083,040
New Jersey	\$271,482,125	\$248,960,390	\$520,442,515
New Mexico	\$9,922,916	\$1,806,984	\$11,729,900
New York	\$2,289,876,858	\$2,271,962,894	\$4,561,839,751
North Carolina	\$1,338,796,858	\$578,706,077	\$1,917,502,934
North Dakota	\$48,423,763	\$19,695,075	\$68,118,838
Ohio	\$638,373,638	\$351,241,692	\$989,615,330
Oklahoma	\$370,950,440	\$154,599,115	\$525,549,555
Oregon	\$76,014,671	\$36,835,822	\$112,850,493
Pennsylvania	\$224,596,327	\$164,502,469	\$389,098,796
Rhode Island	\$12,701,582	\$8,156,214	\$20,857,795
South Carolina	\$510,973,952	\$175,730,508	\$686,704,460
South Dakota	\$67,541,553	\$30,319,022	\$97,860,575
Tennessee	\$410,240,570	\$173,319,372	\$583,559,943
Texas	\$2,600,124,983	\$1,186,927,145	\$3,787,052,128
Utah	\$107,339,203	\$29,932,965	\$137,272,168
Vermont	\$73,796,325	\$50,408,289	\$124,204,614
Virginia	\$209,806,945	\$152,536,246	\$362,343,191
Washington	\$136,396,587	\$112,023,642	\$248,420,229
West Virginia	\$314,304,332	\$94,833,184	\$409,137,515
Wisconsin	\$267,986,623	\$161,999,644	\$429,986,267
Wyoming	\$35,929,608	\$23,774,779	\$59,704,387
<b>US TOTAL</b>	<b>\$20,532,369,685</b>	<b>\$12,167,447,620</b>	<b>\$32,699,817,305</b>

Note: Nearly all of Arizona's Medicaid prescriptions are paid for by the managed care organizations (MCOs) contracting with the State. Given the Arizona MCOs' many years of experience managing the pharmacy benefit on a full-risk basis, we assume that further pharmacy benefits management savings are not attainable in this state.

In addition, a 2009 legal settlement resulted in a lowering of the Average Wholesale Price benchmark, which is commonly used in calculating pharmacy ingredient cost reimbursement for brand name drugs. While most commercial sector plans adjusted their ingredient cost formulas to minimize the impact on pharmacies, most Medicaid programs did not. This dynamic has been accounted for in our estimates.

### **Rebates from Brand Name Manufacturers Have No Impact on Pharmacy Ingredient Cost Reimbursements or Dispensing Fees**

The statutory and supplemental rebates paid to Medicaid by brand name manufacturers are determined separately from pharmacy dispensing fees and ingredient costs. This means that manufacturer rebates have no impact on the savings that more active management of dispensing fees and ingredient costs could achieve. Though improved management of drug utilization increases generic drug dispensing (and thereby reduces the use of brand drugs and the related rebate income they generate for states) the net savings to Medicaid FFS programs would still be large, as reflected in our savings estimates.

### **Conclusion**

Over the past decade, many Medicaid FFS programs have placed emphasis on maximizing drug manufacturer rebates while less actively managing other aspects of the pharmacy benefit relative to what occurs in the private sector. If Medicaid pharmacy programs used approaches employed by Medicare Part D, Medicaid MCOs, state employee health plans, and the commercial sector to determine dispensing fees, ingredient costs, drug utilization, and generic drug dispensing, approximately \$33 billion in overall savings could be achieved during the next decade.

## II. Introduction

States continue to face extreme fiscal pressure to achieve Medicaid savings. Most states have experienced a massive influx of new Medicaid enrollees during the past three years as a result of the recession. While the Federal government has increased its financial support to states during this timeframe, as of July 2011 the enhanced Federal Medicaid match rates will revert to “normal” levels. When it does, states will see their share of Medicaid expenditures increase substantially, while revenues are likely to remain depressed.<sup>1</sup> In addition, the eligibility expansion provisions of the Affordable Care Act (ACA) will result in an enormous influx of new enrollees (more than 16 million persons nationally are projected). Nearly all of the costs for these new enrollees will initially be paid by the Federal government, but states will be strained to take on the added administrative burden of the expansion and pay their share of the costs.

In this environment, state Medicaid programs need to consider all available opportunities to reduce Medicaid costs in a manner that is not detrimental to the impoverished beneficiary population the program serves. Several opportunities exist in the area of pharmacy costs. Over the past several years, Medicaid fee-for-service (FFS) pharmacy programs have expanded their cost management of prescription drugs, but most FFS programs still have not achieved the same level of pharmacy benefits management as found in either Medicare Part D, Medicaid MCOs, or the commercial sector.

Medicaid FFS programs commonly reimburse pharmacies more for dispensing fees and ingredient costs than do MCOs and Part D plans. Additionally, Medicaid MCOs have demonstrated lower utilization and higher generic fill rates than in the Medicaid FFS setting.<sup>2</sup> Medicaid FFS programs could achieve substantial savings if they were to move toward the reimbursement and utilization levels found in Medicaid and commercial MCOs and Medicare Part D plans. Improving management of the FFS pharmacy benefit would likely entail more austere pricing policies as well as stronger management of the Medicaid FFS pharmacy benefit as typically occurs in the private sector. While there would be new costs associated with increasing management functions, the potential savings would more than offset these new administrative costs.

To estimate the potential impact of increased pharmacy benefit management in the Medicaid FFS setting, we modeled the impact of moving Medicaid FFS to levels typically found in Medicaid and commercial MCOs and Part D plans in four key areas: dispensing fees, ingredient cost, generic fill rates, and utilization. Additionally, we calculated an offsetting increase in administrative costs associated with more active benefit management activities. We modeled these changes in a step-wise fashion so that the savings attributable to that step reflect the impact of changes made in prior steps. For example, the savings estimated for improving the generic mix reflect the decrease in dispensing fees and ingredient costs made in prior steps. The estimated share of overall savings attributable to each benefits management component are summarized in Exhibit 1. Nationwide, the largest single component of the estimated savings

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<sup>1</sup> Kaiser Commission on Medicaid and the Uninsured, “Hoping for Economic Recovery, Preparing for Health Reform: A Look at Medicaid Spending, Coverage and Policy Trends,” September 2010.

<sup>2</sup> Comparison of Medicaid Pharmacy Costs and Usage Between the Fee-for-Service and Capitated Setting, Lewin Group, 2003 (funded by Center for Health Care Strategies)

(47%) would be derived from greater use of generic medications. Lowering payments to pharmacies for both dispensing fees and ingredient costs would collectively yield 40% of the overall savings (with dispensing fees creating the largest *price* savings opportunity). The remaining 13% of the savings would accrue through reductions in the volume of prescriptions in the FFS setting.

Exhibit 2 conveys state-specific Medicaid baseline information on fee-for-service (FFS) pharmacy costs, pharmacy payment levels, and generic utilization. Exhibit 2 also presents the estimated savings from optimal management of FFS pharmacy benefits. Nationwide FFS pharmacy costs are estimated at \$18.3 billion in CY2012 (after rebates are collected<sup>3</sup>). Overall, we estimate that Medicaid could realize a net CY2012 savings of \$2.6 billion if FFS prescriptions were optimally managed. Such optimal management is estimated to reduce Medicaid FFS prescription drug costs by approximately 15%.

**Exhibit 1. Share of Overall Benefits Management Savings by Component, Across 10-Year Timeframe CY2012-CY2021**

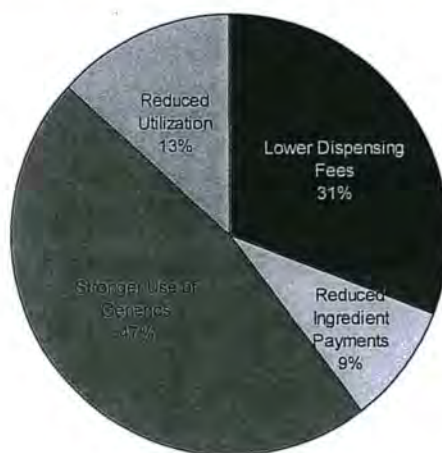


Exhibit 2 presents baseline pharmacy statistics and potential CY2012 savings for each state. States have vastly different baseline FFS pharmacy costs due to the size of their Medicaid programs and the degree to which they use capitation contracting with managed care organizations (MCOs) which includes a pharmacy “carve-in” approach. States also have differing maximum percentage savings opportunities depending on their current dispensing fee and ingredient cost structures, and their existing brand and generic mix of Medicaid medications. The savings figures are expressed in net terms to account for the impacts of Medicaid’s large rebates.

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<sup>3</sup> Figures shown in this document generally represent net Medicaid costs and cost savings after rebates are collected. Rebates now represent approximately 40% of initial Medicaid payments to pharmacies. Thus gross pharmacy costs are considerably higher. We have presented only net costs except in the case of per member per month (PMPM) data because PMPM cost statistics are traditionally focused on the initial payments being made to pharmacies.

**Exhibit 2. State-Specific Medicaid FFS Pharmacy Expenditures and Savings Opportunities**

State	% of Total Rx Costs in FFS Setting	Medicaid FFS Dispensing Fee	Generic Dispensing Rate	% Savings from Optimal Rx Benefits Management	Net Savings from Optimal Rx Benefits Management, 2012
Alabama *	100%	*	72%	18.1%	\$60,228,367
Alaska	100%	\$7.46	64%	21.7%	\$17,636,453
Arizona **	1%	\$2.00	0%	0.0%	\$0
Arkansas	100%	\$5.51	66%	14.2%	\$32,750,788
California	76%	\$7.25	64%	19.0%	\$380,873,331
Colorado	83%	\$4.00	69%	9.8%	\$16,686,692
Connecticut	100%	\$3.15	64%	11.0%	\$31,250,369
Delaware	59%	\$3.65	67%	12.0%	\$10,395,627
District of Columbia	100%	\$4.50	67%	17.9%	\$6,202,639
Florida	71%	\$3.73	67%	12.4%	\$99,168,293
Georgia	52%	\$4.63	67%	17.4%	\$69,037,036
Hawaii	56%	\$4.67	79%	12.3%	\$691,455
Idaho	100%	\$4.94	68%	17.0%	\$13,550,994
Illinois	100%	\$4.27	73%	13.1%	\$111,857,318
Indiana	100%	\$4.90	73%	12.2%	\$53,960,616
Iowa	100%	\$4.57	69%	16.5%	\$28,781,116
Kansas	63%	\$3.40	67%	10.6%	\$14,184,388
Kentucky	80%	\$4.87	73%	14.2%	\$54,266,177
Louisiana	100%	\$5.77	64%	16.0%	\$92,372,081
Maine	100%	\$3.35	65%	12.9%	\$15,725,867
Maryland	41%	\$3.31	62%	12.9%	\$31,005,971
Massachusetts	56%	\$3.00	77%	5.4%	\$15,921,464
Michigan	45%	\$2.75	67%	10.3%	\$36,795,008
Minnesota	46%	\$3.65	72%	10.9%	\$18,514,773
Mississippi	100%	\$4.37	71%	11.3%	\$25,387,412
Missouri	76%	\$4.09	71%	14.2%	\$71,913,520
Montana	100%	\$5.04	71%	11.3%	\$4,933,241
Nebraska	100%	\$3.27	75%	10.7%	\$11,386,486
Nevada	76%	\$4.76	71%	10.7%	\$7,087,982
New Hampshire	100%	\$1.75	70%	5.4%	\$3,887,877
New Jersey	62%	\$3.73	63%	12.5%	\$45,104,577
New Mexico	5%	\$3.65	70%	8.9%	\$571,334
New York	100%	\$4.13	63%	15.1%	\$411,615,383
North Carolina	100%	\$5.05	65%	19.0%	\$150,337,202
North Dakota	100%	\$5.29	69%	19.7%	\$4,921,642
Ohio	39%	\$3.70	71%	9.6%	\$86,980,666
Oklahoma	100%	\$4.15	70%	11.2%	\$42,566,846
Oregon *	43%	*	71%	8.3%	\$8,955,460
Pennsylvania	24%	\$4.00	70%	10.4%	\$32,975,428
Rhode Island	46%	\$3.40	71%	19.6%	\$1,559,716
South Carolina	85%	\$4.05	65%	17.2%	\$53,634,426
South Dakota	100%	\$4.75	68%	18.1%	\$7,367,152
Tennessee	100%	\$2.74	47%	10.2%	\$45,600,589
Texas	100%	\$7.50	69%	19.0%	\$272,613,603
Utah	100%	\$3.90	73%	9.7%	\$9,574,517
Vermont	100%	\$4.75	64%	16.0%	\$11,260,858
Virginia	49%	\$3.75	73%	14.5%	\$27,635,251
Washington	66%	\$4.75	76%	8.4%	\$20,931,842
West Virginia	100%	\$4.38	67%	14.2%	\$33,361,338
Wisconsin	58%	\$3.76	65%	13.6%	\$36,880,813
Wyoming	100%	\$5.00	69%	16.5%	\$4,307,317
US Total	73%	\$4.81	68%	14.5%	\$2,645,209,301

\* Alabama and Oregon recently adopted a payment model whereby pharmacies are paid at their average acquisition cost plus a dispensing fee of more than \$10.00. To the extent these initiatives lower net prices, less savings will be achievable in these two states than the figures indicated in the right-hand column. Roughly 65% of Alabama's total potential savings and 30% of Oregon's were projected to occur through reductions in the unit prices paid to pharmacies.

\*\* Since nearly all of Arizona's Medicaid prescriptions are paid for by the MCOs with which the State contracts, we assume that further pharmacy benefits management savings are not attainable in this state.

### III. Savings Estimate Derivation

The starting point for our analyses involved drawing upon publicly available CMS Medicaid pharmacy data on FFS expenditures for brand and generic medications in each state.<sup>4</sup> The most recent year's FFS costs (2009 for nearly all states) were trended to CY2011. These baseline costs and usage figures are shown in detail in Appendix A. These figures exclude Medicaid prescriptions purchased by Medicaid MCOs, and represent the amounts paid to pharmacies prior to the receipt of rebates from drug manufacturers.

The assumptions used to estimate the savings from each pharmacy cost management technique are described below, along with an overview of how these assumptions were derived.

#### A. Reduced Dispensing Fees

On average, Medicaid FFS programs pay pharmacies a dispensing fee of \$4.60 for brand drugs and \$4.90 for generic drugs, more than twice the amount paid by private sector health plans. For states with Medicaid FFS dispensing fees above average Medicare Part D dispensing fees, we assumed that under PBM management the Medicaid dispensing fees will decrease to the typical Medicare Part D levels (estimated at \$1.90 for brand drugs and \$2.20 for generic drugs).<sup>5</sup>

#### B. Reduced Ingredient Costs

The rate at which retail pharmacies are reimbursed for the actual medication ingredients (pills, capsules, etc) is also higher, on average, in Medicaid FFS programs than in Medicare Part D or the commercial sector. The ingredient cost reimbursement amount is computed based on either a published price benchmark, such as Average Wholesale Price (AWP), or on a fixed price per unit, such as a Maximum Allowable Cost (MAC). Pharmacies earn revenue on the difference or "spread" between their acquisition cost and ingredient cost reimbursement amount. This revenue source is often greater than revenues from dispensing fees.

Many Medicaid FFS programs pay higher ingredient costs to pharmacies for brand and generic drugs than do other programs.<sup>6</sup> Our model projects that if Medicaid FFS programs more actively managed their pharmacy benefits, ingredient costs would go down due to the negotiated pharmacy price reductions for both brand and generic drugs.

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<sup>4</sup> Available Online: <http://www.cms.gov/MedicaidDrugRebateProgram/SDUD/list.asp>. Data for Indiana, Ohio, Tennessee and Wisconsin were derived from a separate source (CMS MSIS website data) given that the baseline FFS costs in the first source were found to be incomplete for purposes of future trending - often due to a recent adoption of a pharmacy carve-out model within the state's Medicaid managed care program.

<sup>5</sup> "Memorandum Report: Medicare Part D Pharmacy Discounts for 2008, OEI-02-10-00120," DHHS Office of the Inspector General, November 2010.

<sup>6</sup> "Comparing Pharmacy Reimbursement: Medicare Part D to Medicaid," DHHS Office of the Inspector General, February 2009; "Comparing Pharmacy Reimbursement: Medicare Part D to Medicaid," DHHS Office of the Inspector General, February 2009; CMS Medicaid Pharmacy Reimbursement Information, Available Online: <http://www.cms.gov/Reimbursement/>, Accessed July 2010.

For brand drugs, we estimated that the AWP “discount rates” (the payment amounts negotiated below full AWP pricing levels) for some states will increase to reflect brand discount rates for Medicare Part D and commercial MCO plans. While prior data have shown Part D and commercial plans reimburse approximately 16% off of AWP, the recent reductions made in the calculation of AWP has changed the current discount rates.<sup>7</sup> Many Part D and commercial plans did not alter their reimbursement rates in lock-step with the AWP reductions, so the discount rate has decreased for many plans. Lewin’s analysis of proprietary Part D data found average discount rates of approximately 13% off of AWP, which we used for our benchmark. For states with a brand AWP discount rate below 13%, we brought them up to 13%; we did not make any changes to the brand discount if a state’s current brand AWP discount is higher than 13%.

Most Medicaid FFS programs have multiple pricing points for generic drugs and generally choose the lower of: 1) Federal Upper Limit (FUL) amount, 2) State Maximum Allowable Charge (MAC), 3) discount off of AWP, 4) usual and customary charges. Several OIG reports have shown Medicaid reimbursement for generic drugs to be well above that of Part D and commercial plans.<sup>8</sup> For generic drugs on the FUL list, the OIG reported that states paid in aggregate an estimated 84% more than Part D. However, the recent change in the FUL calculation to be no less than 175% of AMP will likely bring these drugs closer to those of other payers.<sup>9</sup> As the new FULs will likely bring generic ingredient cost down on several drugs, we have not assumed any additional savings would occur for drugs on the FUL list as reimbursement for several of these drugs will be reduced regardless of a state’s actions. Approximately 53% of Medicaid FFS generic drug expenditures were for drugs on the FUL.<sup>10</sup>

For drugs not on the FUL list, there would still be opportunities to bring Medicaid generic ingredient costs in line with other payers. The OIG’s analysis on a selection of top generic drugs found that the average Medicaid pharmacy reimbursement amount exceeded Part D by at least 10% for the majority of drugs in their sample, with the median being 17% higher than Part D. Using this information, we took a conservative approach and estimated that states could reduce generic ingredient costs up to 10% for generic drugs not on the FUL list. We used the states’ published AWP discounts for generic drugs as a proxy to indicate their current aggressiveness

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<sup>7</sup> “2009-2010 Prescription Drug Benefit Cost and Plan Design Report,” Pharmacy Benefit Management Institute and Lewin analysis of proprietary Part D data.

<sup>8</sup> “Comparing Pharmacy Reimbursement: Medicare Part D to Medicaid,” DHHS Office of the Inspector General, February 2009; “A Comparison of Medicaid Federal Upper Limit Amounts to Acquisition Costs, Medicare Payment Amounts, and Retail Prices,” DHHS Office of the Inspector General, August 2009

<sup>9</sup> The OIG found that the AMP-based FUL amounts for ingredient costs under the DRA-mandated method (never implemented due to an injunction) were slightly less than average Part D payments. With the new definition of AMP and formula for determining FULs projected to increase FULs over the DRA amounts, it is likely that the new FULs will be at or above average Part D payments.

<sup>10</sup> Coster, John, “Trends in Generic Drug Reimbursement in Medicaid and Medicare”, *US Pharmacist*, 2010; 35(6)(Generic Drug Review suppl):14-19; US Government Accountability Office, “Medicaid Outpatient Prescription Drugs: Second Quarter 2008 Federal Upper Limits for Reimbursement Compared with Average Retail Pharmacy Acquisition Costs,” GAO-10-118R Medicaid Federal Upper Limit, November 30, 2009.

on generic pricing.<sup>11</sup> We applied up to a 10 percentage point increase on generic AWP discount rates, on a sliding-scale basis, to the state's current level of generic drug reimbursement. We estimated a greater increase in generic discount for states currently with lower generic discount rates. For example, a state with a 5% generic AWP discount rate would move to 15%; a state with a 50% generic AWP discount rate would move only slightly to 51%. We applied these savings only to the estimated generic drug ingredient costs on drugs not on the FUL list (on average, 47% of the generic drug ingredient costs).<sup>12</sup>

### C. Increased Generic Dispensing Rate

Medicaid MCOs have consistently demonstrated a generic dispensing rate several percentage points above that achieved directly by Medicaid FFS programs for the Temporary Assistance for Needy Families (TANF) and Supplemental Security Income (SSI) populations.<sup>13, 14</sup> While generic dispensing rates have been several percentage points higher for TANF subgroups than for SSI subgroups due to the different mix of medications used, all available data indicates that MCOs have used more generics than the FFS setting for *both* subgroups.

MCOs tend to have more restrictive PDLs and enforce them more diligently. Most state FFS programs have preferred drug lists but their content is politically changeable and it is generally easier to get the non-PDL medications prescribed in FFS than in the MCO setting. MCOs are better able to remain focused on clinical and cost dynamics with regard to their PDL content and exception processes.

We modeled the savings on a sliding scale in each state. Each state was moved from its observed baseline generic dispensing rate to a target of 70-80%. States with lower generic fill rates were assumed to make greater improvements. For example, a state with a generic dispensing rate of 65% was shifted to 70%; a state with a 70% generic dispensing rate was shifted to 73%.

### D. Decreased Utilization

Medicaid MCOs have additionally demonstrated a lower prescription utilization rate than Medicaid FFS programs with similar demographic subgroups.<sup>15</sup> There are several causes for unnecessary and inappropriate prescription usage including fraud, prescription drug abuse,

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<sup>11</sup> CMS Medicaid Pharmacy Reimbursement Information, Available Online: <<http://www.cms.gov/Reimbursement/>>, Accessed July 2010.

<sup>12</sup> US Government Accountability Office, "Medicaid Outpatient Prescription Drugs: Second Quarter 2008 Federal Upper Limits for Reimbursement Compared with Average Retail Pharmacy Acquisition Costs," GAO-10-118R Medicaid Federal Upper Limit, November 30, 2009. We used the 53% reported in the US Pharmacist article and state-level information on FUL drugs from the GAO report to estimate state-level ingredient costs for non-FUL drugs.

<sup>13</sup> Programmatic Assessment of Carve-In and Carve-Out Arrangements for Medicaid Prescription Drugs, The Lewin Group, 2007 (funded by Association for Community Affiliated Plans)

<sup>14</sup> Comparison of Medicaid Pharmacy Costs and Usage Between the Fee-for-Service and Capitated Setting, The Lewin Group, 2003 (funded by Center for Health Care Strategies), page 7.

<sup>15</sup> Programmatic Assessment of Carve-In and Carve-Out Arrangements for Medicaid Prescription Drugs, Lewin Group, 2007 (funded by Association for Community Affiliated Plans)

inefficient prescribing, and other factors. Collectively these problem areas seem to be more pronounced in the Medicaid FFS setting than in a more closely managed environment. While we have evidence of rather large-scale usage rate differentials between the Medicaid FFS and Medicaid managed care settings, we have conservatively assumed a 3% decrease in utilization from PBM management practices (relative to FFS) for this report.

#### **E. Increased Administrative Costs**

These changes in reimbursement and utilization management will require an increase in administrative functions and oversight. We assumed that payments to external contractors (or increased operating costs if the state "self-performs" the enhanced pharmacy management functions) would represent 3% of gross pharmacy costs.

## IV. Ten-Year Savings Estimates

Savings estimates were initially derived for calendar year 2010. These figures were then projected forward across a ten-year timeframe CY2012 – CY2021 using the following assumptions.

An annual pharmacy cost trend factor of 2.18% was used to estimate the regular growth of annual Medicaid FFS spending. This percentage is a “roll-up” of additional assumptions regarding population growth and general inflation in pharmacy costs and usage. The trend factor also includes an assumption that the use of capitated MCOs will steadily increase in the Medicaid program (which reduces the amount of FFS pharmacy spending that is available for enhanced management).

The ten-year projections also factor in expected Medicaid enrollment growth created by the coverage expansion features of the Affordable Care Act (ACA). The increased FFS pharmacy costs anticipated to accompany the ACA’s Medicaid coverage expansion were derived through the following steps:

- Lewin Group estimates of the size of the Medicaid expansion population in each state were drawn upon as a starting point.
- Total pharmacy costs for each expansion enrollee were estimated based on observed pharmacy costs for selected covered adults in Tennessee. This state already provides coverage to a large population of adults that is demographically similar to the Medicaid expansion population that will enroll in most other states.
- FFS pharmacy costs were derived based on the degree to which Medicaid TANF costs in each state were paid via capitation or via FFS during 2008.
- The Medicaid expansion population was estimated to enroll 50% in the initial year (CY2014) and to be fully enrolled from CY2015 onward.

Exhibit 3 presents the net savings estimates across the 10 year timeframe 2012-2021. These net savings are estimated to be \$32.7 billion across CY2012 – CY2021, with nationwide annual savings starting at \$2.6 billion in CY2012 and reaching \$3.7 billion in CY2021.

**Exhibit 3.  
Nationwide Annual Savings if Medicaid Pharmacy Were Optimally Managed, 2012-2021**

Calendar Year	Total Savings
2012	\$2,645,209,301
2013	\$2,702,821,959
2014	\$2,976,671,958
2015	\$3,261,168,728
2016	\$3,332,196,983
2017	\$3,404,772,233
2018	\$3,478,928,173
2019	\$3,554,699,228
2020	\$3,632,120,577
2021	\$3,711,228,164
10 Year Total, 2012-2021	\$32,699,817,305

Note: Figures from CY2014 forward include the estimated impacts of Medicaid enrollment expansion related to the recently enacted health reform legislation.

On average, we estimate that a savings of approximately 15% is achievable if Medicaid pharmacy programs used approaches employed by Medicare Part D payers, Medicare MCOs, state employee health plans, and the commercial sector to determine dispensing fees, ingredient costs, drug utilization, and generic drug dispensing.

## V. The Role of Manufacturer Rebates

It is important to note that Medicaid receives statutory rebates from pharmaceutical manufacturers that substantially lower the program's net costs per prescription. However, these rebates are determined separately from pharmacy dispensing fees and ingredient costs, and occur regardless of levels set for these pharmacy payments. Rebates do not diminish or otherwise impact the savings that are achieved from dispensing fee savings and ingredient cost reductions.

Improved management of *drug mix* - pushing utilization towards medications that are clinically appropriate but which offer Medicaid the lowest net cost - often represents the largest-scale savings opportunity for states. However, since rebates are often largest (in percentage and raw dollar terms) on relatively high-cost medications, the savings created by moving usage from a \$100 brand drug to a \$30 generic drug needs to be derived net of rebates. (There are some instances where the brand rebate is so large that the lowest net cost involves using the brand medication, for example.) The estimates in this document are therefore all conveyed on a net cost basis, after accounting for rebates. In general, pharmaceutical rebates are estimated to average 40% of initial prescription drug spending under the Affordable Care Act's (ACA) enhanced rebate provisions, and this level of rebates has been applied to the utilization reduction savings component in our calculations.

## VI. Relationship Between Dispensing Fees, Ingredient Costs and Generic Dispensing Rates

We found a positive correlation between dispensing fees and ingredient costs, with states having relatively high dispensing fees also having fairly low average ingredient discounts.

Thus, several states were high-end payers to retail pharmacies for both dispensing fees and ingredient costs.

Lewin examined the state-by-state statistical data to assess:

- whether dispensing fees and ingredient payments appeared to be correlated in some fashion; and
- whether states with relatively high dispensing fees (and relatively high ingredient payments for generics) were achieving a relatively high use of generic medications.

We found no evidence of such a correlation in either case, although with regard to the first issue there are many states with high payment levels for *both* dispensing fees and ingredient costs.

Exhibit 4 shows that the average usage of generics was almost constant when states were grouped by their different dispensing fees. Similarly, Exhibit 5 shows that the use of generics did not vary when states were grouped by their published ingredient discount levels.

Exhibit 4. Relationship of Dispensing Fees to Generic Dispensing Rates

Dispensing Fee Range	Number of States	Average Generic Dispensing Rate	Average Ingredient Discount
\$5.00 +	10	67.3%	12.3%
\$3.50 - \$4.99	30	69.5%	14.1%
< \$3.50	10	66.4%	14.7%
<b>Total</b>	<b>50</b>	<b>68.5%</b>	<b>13.8%</b>

Exhibit 5. Relationship of Ingredient Discounts to Generic Dispensing Rates

Ingredient Discount Range	Number of States	Average Generic Dispensing Rate	Average Dispensing Fee
16% +	10	68.5%	\$4.14
12% - 15.9%	27	68.0%	\$4.17
< 12%	13	69.4%	\$4.76
<b>Total</b>	<b>50</b>	<b>68.5%</b>	<b>\$4.81</b>

Appendix B presents a scatter plot showing each state's generic dispensing rate, its dispensing fee, and its ingredient discount percentage relative to AWP. This diagram visually shows the absence of any correlation between making higher up-front payments to pharmacies and achieving a relatively high use of generics in return.

We also assessed whether there was greater use of generics in states that utilized a higher dispensing fee for generics than they used for brand drugs. Again, no correlation was found. Among the nine states that paid a higher dispensing fee for generic drugs than for brands, the average generic dispensing rate was 65% versus 69% in all states where the same dispensing fee was used for both brand and generics.

## VII. State-Specific Savings Estimates by Eligibility Category

This section calculates state-specific savings by major eligibility category. Per member per month (PMPM) savings have been derived for each of the following eligibility groups (all of which exclude Medicare/Medicaid dual eligibles given that these individuals' pharmacy costs are paid for by the Medicare program):

Blind/Disabled

Children (non-disabled)

Adults (non-disabled)

Foster Children

The PMPM analyses portray baseline (gross) costs and cost savings, since PMPM pharmacy cost assessments are typically conducted focusing on the initial amounts paid to the pharmacies, not the state's net prescription drug expenditures after accounting for manufacturer rebates. Baseline FFS pharmacy costs by state and eligibility category are shown in Exhibit 6 for CY2012. Nationwide, the majority (62%) of Medicaid FFS pharmacy costs are incurred by the Blind/Disabled subgroup. This is due to two factors: first, the Blind/Disabled subgroup experiences very high per capita pharmacy costs; second the TANF population is enrolled in Medicaid MCOs more fully than is the Blind/Disabled population in many states.

Baseline PMPM FFS costs are shown for CY2012 in Exhibit 7. PMPM pharmacy costs for each eligibility subgroup vary considerably - national averages are \$273 for the Blind/Disabled, \$28 for TANF Children, \$55 for TANF Adults, and \$82 for Foster Care Children.

Estimated potential PMPM savings against the FFS baseline are shown in Exhibit 8 for each state for CY2012. The PMPM savings average \$41 for the Blind/Disabled subgroup, \$4 for TANF Children, \$8 for TANF Adults, and \$12 for Foster Care Children.

Exhibit 6. Estimated Baseline Medicaid FFS Pharmacy Costs by Eligibility Category, CY2012

State	Estimated 2012 Total \$				
	Blind/Disabled	Children	Adults	Foster Care Children	Total
Alabama	\$352,946,008	\$156,216,033	\$33,853,812	\$10,674,196	\$553,690,050
Alaska	\$75,808,071	\$27,262,779	\$27,769,747	\$4,606,543	\$135,447,139
Arizona	\$0	\$0	\$0	\$0	\$0
Arkansas	\$211,023,428	\$139,366,127	\$24,006,517	\$9,146,853	\$383,542,925
California	\$2,492,361,695	\$271,502,655	\$467,606,414	\$107,026,027	\$3,338,496,790
Colorado	\$162,384,429	\$56,815,195	\$40,808,804	\$23,548,637	\$283,557,065
Connecticut	\$271,287,105	\$92,396,083	\$103,754,536	\$8,112,613	\$475,550,337
Delaware	\$50,901,576	\$22,766,427	\$68,368,696	\$2,830,038	\$144,866,737
District of Columbia	\$48,042,649	\$353,646	\$7,624,843	\$1,726,970	\$57,748,108
Florida	\$910,997,340	\$238,149,738	\$142,314,827	\$41,302,576	\$1,332,764,480
Georgia	\$578,414,836	\$23,910,583	\$14,004,592	\$46,009,822	\$662,339,833
Hawaii	\$9,054,924	\$92,139	\$239,040	\$9,651	\$9,395,754
Idaho	\$88,102,893	\$26,934,324	\$14,993,144	\$3,006,044	\$133,036,403
Illinois	\$704,512,657	\$377,574,143	\$271,414,720	\$69,260,783	\$1,422,762,303
Indiana	\$365,910,971	\$196,105,095	\$140,967,834	\$35,972,782	\$738,956,682
Iowa	\$154,467,875	\$72,465,965	\$48,138,386	\$16,214,077	\$291,286,303
Kansas	\$171,669,588	\$15,480,390	\$5,100,154	\$31,182,930	\$223,433,061
Kentucky	\$408,219,118	\$134,911,322	\$77,814,634	\$16,548,255	\$637,493,328
Louisiana	\$498,089,955	\$346,888,378	\$99,354,138	\$18,766,169	\$963,098,640
Maine	\$91,097,033	\$33,444,496	\$72,911,351	\$5,804,369	\$203,257,249
Maryland	\$266,559,163	\$72,803,099	\$30,536,298	\$29,314,741	\$399,213,302
Massachusetts	\$330,373,003	\$56,544,682	\$108,163,022	\$580,771	\$495,661,477
Michigan	\$357,634,716	\$116,095,976	\$83,588,387	\$38,621,605	\$595,940,684
Minnesota	\$224,837,769	\$22,866,595	\$24,662,246	\$9,710,286	\$282,076,897
Mississippi	\$217,857,468	\$115,855,934	\$36,171,688	\$5,331,016	\$375,216,107
Missouri	\$611,868,174	\$145,058,255	\$57,482,585	\$30,807,353	\$845,216,367
Montana	\$45,050,930	\$12,372,737	\$11,696,505	\$3,732,542	\$72,852,714
Nebraska	\$73,773,337	\$61,940,568	\$23,126,396	\$19,129,523	\$177,969,823
Nevada	\$88,382,863	\$6,115,766	\$6,493,859	\$9,710,235	\$110,702,722
New Hampshire	\$53,814,127	\$42,530,899	\$18,303,176	\$4,961,969	\$119,610,172
New Jersey	\$552,433,118	\$12,811,404	\$15,184,285	\$20,597,905	\$601,026,711
New Mexico	\$6,348,285	\$1,830,390	\$2,534,651	\$43,050	\$10,756,376
New York	\$2,478,591,458	\$605,270,130	\$1,419,762,584	\$44,825,693	\$4,548,449,865
North Carolina	\$704,869,682	\$355,481,160	\$227,512,460	\$31,073,453	\$1,318,936,756
North Dakota	\$21,001,803	\$10,005,740	\$8,632,371	\$1,981,745	\$41,621,659
Ohio	\$1,175,454,416	\$100,113,434	\$78,959,631	\$148,278,626	\$1,502,806,106
Oklahoma	\$336,285,436	\$221,871,326	\$59,838,923	\$16,683,603	\$634,679,288
Oregon	\$120,052,556	\$11,697,511	\$37,442,690	\$10,537,137	\$179,729,893
Pennsylvania	\$372,484,854	\$67,699,028	\$64,627,323	\$23,787,174	\$528,598,379
Rhode Island	\$12,695,423	\$118,789	\$208,755	\$206,244	\$13,229,211
South Carolina	\$262,238,434	\$151,800,163	\$90,474,866	\$14,771,278	\$519,284,741
South Dakota	\$31,251,196	\$21,326,908	\$10,044,955	\$5,243,821	\$67,866,880
Tennessee	\$371,736,632	\$206,949,104	\$148,672,553	\$17,645,138	\$745,003,427
Texas	\$1,229,112,328	\$893,207,566	\$156,726,698	\$113,285,749	\$2,392,332,340
Utah	\$87,931,736	\$27,096,665	\$39,731,253	\$9,947,870	\$164,707,525
Vermont	\$39,906,122	\$18,592,361	\$54,523,041	\$4,235,857	\$117,257,381
Virginia	\$201,061,918	\$51,873,577	\$25,933,145	\$38,605,185	\$317,473,825
Washington	\$361,256,748	\$18,903,373	\$22,038,157	\$12,857,089	\$415,055,366
West Virginia	\$272,844,798	\$67,549,704	\$42,225,444	\$9,466,536	\$392,086,481
Wisconsin	\$272,234,260	\$53,214,936	\$107,424,163	\$20,426,794	\$453,300,153
Wyoming	\$20,845,569	\$13,368,384	\$5,800,239	\$3,383,030	\$43,397,222
US Total	\$18,846,080,471	\$5,795,601,681	\$4,679,568,535	\$1,151,532,353	\$30,472,783,039

Note: Figures in Exhibits 6-8 represent gross (pre-rebate) payments to pharmacies. Savings estimates derived throughout this report, conversely, are net of all collected rebates.

**Exhibit 7. Estimated Baseline PMPM Medicaid FFS Pharmacy Costs  
by Eligibility Category, CY2012**

State	2012 Base PMPM				Total
	Blind /Disabled	Children	Adults	Foster Care Children	
Alabama	\$256	\$51	\$57	\$97	\$107
Alaska	\$442	\$24	\$78	\$71	\$77
Arizona	\$0	\$0	\$0	\$0	\$0
Arkansas	\$223	\$28	\$57	\$109	\$60
California	\$304	\$27	\$57	\$55	\$118
Colorado	\$314	\$24	\$55	\$176	\$75
Connecticut	\$546	\$29	\$82	\$85	\$94
Delaware	\$301	\$25	\$88	\$96	\$77
District of Columbia	\$297	\$27	\$63	\$58	\$178
Florida	\$283	\$24	\$38	\$70	\$76
Georgia	\$228	\$27	\$57	\$82	\$157
Hawaii	\$475	\$28	\$57	\$94	\$352
Idaho	\$310	\$19	\$70	\$73	\$67
Illinois	\$271	\$19	\$44	\$73	\$48
Indiana	\$302	\$27	\$57	\$92	\$161
Iowa	\$309	\$27	\$34	\$103	\$62
Kansas	\$321	\$21	\$38	\$167	\$141
Kentucky	\$261	\$38	\$77	\$95	\$101
Louisiana	\$284	\$39	\$50	\$124	\$75
Maine	\$296	\$26	\$73	\$108	\$77
Maryland	\$257	\$26	\$43	\$112	\$82
Massachusetts	\$109	\$25	\$53	\$115	\$67
Michigan	\$313	\$24	\$51	\$78	\$74
Minnesota	\$311	\$23	\$53	\$84	\$124
Mississippi	\$178	\$29	\$57	\$75	\$63
Missouri	\$430	\$47	\$65	\$86	\$147
Montana	\$333	\$23	\$78	\$77	\$84
Nebraska	\$368	\$37	\$68	\$115	\$75
Nevada	\$303	\$27	\$57	\$85	\$149
New Hampshire	\$325	\$32	\$79	\$111	\$68
New Jersey	\$510	\$27	\$36	\$63	\$261
New Mexico	\$46	\$27	\$57	\$12	\$42
New York	\$377	\$24	\$63	\$57	\$82
North Carolina	\$315	\$32	\$71	\$111	\$78
North Dakota	\$317	\$26	\$62	\$74	\$67
Ohio	\$196	\$27	\$57	\$83	\$117
Oklahoma	\$289	\$28	\$37	\$68	\$58
Oregon	\$343	\$27	\$103	\$75	\$140
Pennsylvania	\$216	\$38	\$70	\$76	\$111
Rhode Island	\$206	\$27	\$57	\$17	\$162
South Carolina	\$229	\$29	\$42	\$69	\$59
South Dakota	\$253	\$23	\$51	\$88	\$52
Tennessee	\$183	\$26	\$52	\$84	\$58
Texas	\$262	\$32	\$36	\$132	\$64
Utah	\$361	\$28	\$61	\$94	\$83
Vermont	\$312	\$26	\$93	\$120	\$80
Virginia	\$196	\$27	\$45	\$153	\$85
Washington	\$305	\$27	\$30	\$55	\$145
West Virginia	\$302	\$33	\$97	\$96	\$113
Wisconsin	\$133	\$27	\$39	\$41	\$62
Wyoming	\$299	\$26	\$60	\$84	\$60
<b>US Total</b>	<b>\$273</b>	<b>\$28</b>	<b>\$55</b>	<b>\$82</b>	<b>\$83</b>

**Exhibit 8. Estimated PMPM Pharmacy Benefit Management Savings Against Baseline Medicaid FFS Pharmacy Costs, by State and Eligibility Category, CY2012**

State	2012 Base PMPM Savings				
	Blind/Disabled	Children	Adults	Foster Care Children	Total
Alabama	\$39	\$8	\$9	\$15	\$16
Alaska	\$75	\$4	\$13	\$12	\$13
Arizona					
Arkansas	\$32	\$4	\$8	\$16	\$9
California	\$57	\$5	\$11	\$10	\$22
Colorado	\$36	\$3	\$6	\$20	\$9
Connecticut	\$75	\$4	\$11	\$12	\$13
Delaware	\$41	\$3	\$12	\$13	\$11
District of Columbia	\$50	\$5	\$11	\$10	\$30
Florida	\$42	\$4	\$6	\$10	\$11
Georgia	\$39	\$5	\$10	\$14	\$27
Hawaii	\$48	\$3	\$6	\$9	\$36
Idaho	\$53	\$3	\$12	\$12	\$11
Illinois	\$35	\$2	\$6	\$9	\$6
Indiana	\$39	\$4	\$7	\$12	\$21
Iowa	\$51	\$5	\$6	\$17	\$10
Kansas	\$42	\$3	\$5	\$22	\$18
Kentucky	\$35	\$5	\$10	\$13	\$14
Louisiana	\$46	\$6	\$8	\$20	\$12
Maine	\$45	\$4	\$11	\$16	\$12
Maryland	\$38	\$4	\$6	\$16	\$12
Massachusetts	\$6	\$1	\$3	\$7	\$4
Michigan	\$41	\$3	\$7	\$10	\$10
Minnesota	\$36	\$3	\$6	\$10	\$14
Mississippi	\$20	\$3	\$6	\$8	\$7
Missouri	\$56	\$6	\$8	\$11	\$19
Montana	\$37	\$3	\$9	\$9	\$9
Nebraska	\$38	\$4	\$7	\$12	\$8
Nevada	\$34	\$3	\$6	\$10	\$17
New Hampshire	\$26	\$3	\$6	\$9	\$5
New Jersey	\$75	\$4	\$5	\$9	\$38
New Mexico	\$5	\$3	\$6	\$1	\$4
New York	\$65	\$4	\$11	\$10	\$14
North Carolina	\$55	\$6	\$12	\$19	\$14
North Dakota	\$56	\$4	\$11	\$13	\$12
Ohio	\$22	\$3	\$6	\$9	\$13
Oklahoma	\$35	\$3	\$5	\$8	\$7
Oregon	\$34	\$3	\$10	\$7	\$14
Pennsylvania	\$24	\$4	\$8	\$9	\$13
Rhode Island	\$35	\$5	\$10	\$3	\$27
South Carolina	\$40	\$5	\$7	\$12	\$10
South Dakota	\$44	\$4	\$9	\$15	\$9
Tennessee	\$23	\$3	\$7	\$11	\$7
Texas	\$45	\$6	\$6	\$23	\$11
Utah	\$38	\$3	\$6	\$10	\$9
Vermont	\$54	\$5	\$16	\$21	\$14
Virginia	\$27	\$4	\$6	\$21	\$11
Washington	\$24	\$2	\$2	\$4	\$11
West Virginia	\$46	\$5	\$15	\$15	\$17
Wisconsin	\$20	\$4	\$6	\$6	\$9
Wyoming	\$47	\$4	\$9	\$13	\$9
US Total	\$41	\$4	\$8	\$12	\$12

## VIII. Federal and State Share of Savings

This section portrays the degree to which net savings on prescription drugs (after manufacturer rebates are taken into account) will accrue to each state government versus the Federal government. The share of overall savings between state and the Federal governments is driven by Federal matching rates. We have assumed the Federal match rates will revert to "normal" levels during the 2012-2021 timeframe, given that under current law the enhanced Federal match rates will be discontinued effective July CY2011.

Due to the Affordable Care Act (ACA), the Medicaid expansion population will be funded almost entirely by the Federal government. Therefore, we assumed the pharmacy savings attributable to the Medicaid expansion population during 2014-2021 will be 100% Federal savings.

There are also some complexities between the Federal and state match regarding "clawback" provisions of the ACA related to drug manufacturer rebates. These dynamics have not been factored into our estimates and will have only a minor impact on the share of the savings yielded from enhanced pharmacy benefits management activities.

The estimated ten-year savings in each state, and the Federal and state share of those savings, is presented in Exhibit 9. The Federal government would realize the majority of the savings (62% on average nationwide), since its matching rate is at least 50% in each state. State fund savings from strengthened Medicaid FFS pharmacy benefits management practices would nonetheless be very large in magnitude, particularly in consideration of the fiscal environment confronting nearly all state governments. The ten-year state fund savings potential exceeds \$2 billion in California and New York, exceeds \$1 billion in Texas, and exceeds \$100 million in 22 other states.

**Exhibit 9. Estimated Ten-Year Pharmacy Benefits Management Savings Against Baseline Medicaid FFS Costs, Showing State and Federal Share of Savings, CY2012-CY2021**

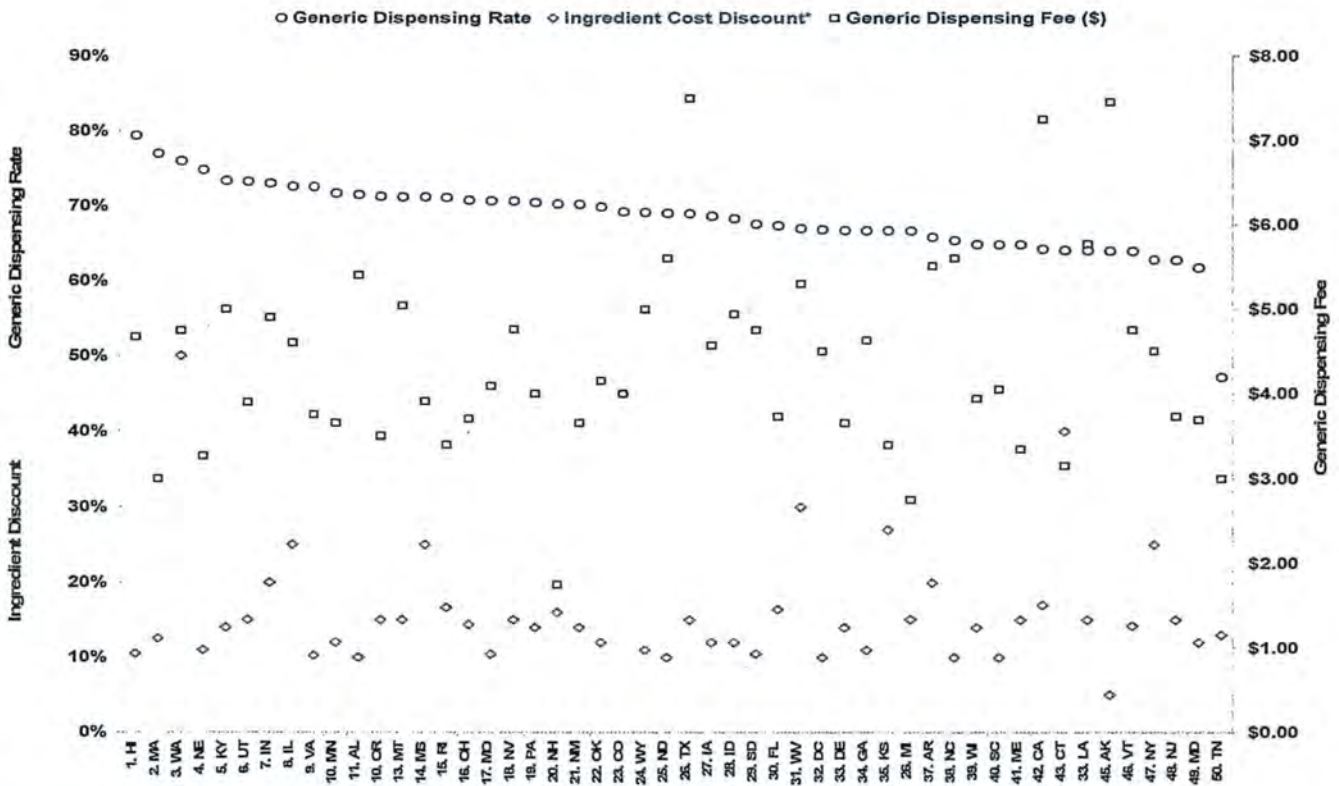
State	10 Year Total Net Savings, 2012-2021	Regular Federal Match Rate (Existing Medicaid)	Federal Share of Net Savings (%)	Federal Share of Net Savings	State Share of Net Savings
Alabama	\$754,283,850	68.01%	71.39%	\$541,589,986	\$212,693,864
Alaska	\$215,795,688	52.48%	56.61%	\$123,277,462	\$92,518,227
Arizona	\$0			\$0	\$0
Arkansas	\$431,416,077	72.94%	76.86%	\$333,582,219	\$97,833,858
California	\$4,766,748,752	50.00%	55.25%	\$2,664,470,481	\$2,102,278,271
Colorado	\$237,233,703	50.00%	60.08%	\$145,129,408	\$92,104,295
Connecticut	\$367,654,226	50.00%	52.73%	\$195,163,881	\$172,490,345
Delaware	\$117,607,540	50.21%	51.27%	\$60,468,563	\$57,138,977
District of Columbia	\$72,147,948	70.00%	71.35%	\$51,606,201	\$20,541,747
Florida	\$1,304,852,861	56.83%	63.05%	\$832,251,989	\$472,600,872
Georgia	\$824,347,552	65.10%	67.43%	\$558,368,644	\$265,978,908
Hawaii	\$10,104,490	56.50%	66.12%	\$6,784,074	\$3,320,416
Idaho	\$183,776,906	69.87%	74.90%	\$138,704,585	\$45,072,321
Illinois	\$1,418,325,317	50.32%	56.05%	\$804,866,203	\$613,459,114
Indiana	\$381,476,268	65.93%	68.39%	\$262,094,024	\$119,382,245
Iowa	\$381,537,087	63.51%	68.98%	\$265,600,337	\$115,936,750
Kansas	\$166,825,210	60.38%	62.53%	\$104,786,220	\$62,038,990
Kentucky	\$663,904,563	70.96%	73.48%	\$489,938,125	\$173,966,438
Louisiana	\$1,160,133,184	72.47%	75.44%	\$879,404,642	\$280,728,542
Maine	\$185,456,818	64.99%	66.97%	\$124,678,825	\$60,777,993
Maryland	\$367,616,767	50.00%	53.05%	\$196,475,409	\$171,141,358
Massachusetts	\$175,071,595	50.00%	49.83%	\$87,191,071	\$87,880,524
Michigan	\$453,573,163	63.19%	66.61%	\$304,054,861	\$149,518,302
Minnesota	\$216,899,269	50.00%	52.55%	\$114,704,650	\$102,194,619
Mississippi	\$346,859,255	76.29%	80.38%	\$280,410,076	\$66,449,179
Missouri	\$841,206,791	64.51%	66.27%	\$559,461,818	\$281,744,973
Montana	\$71,270,067	68.53%	75.24%	\$54,131,730	\$17,138,337
Nebraska	\$149,061,637	60.56%	66.09%	\$99,486,235	\$49,575,402
Nevada	\$95,414,317	52.64%	60.28%	\$58,357,006	\$37,057,311
New Hampshire	\$50,083,040	50.00%	56.39%	\$28,623,415	\$21,459,624
New Jersey	\$520,442,515	50.00%	51.91%	\$271,482,125	\$248,960,390
New Mexico	\$11,729,900	71.35%	83.67%	\$9,922,916	\$1,806,984
New York	\$4,561,839,751	50.00%	50.17%	\$2,289,876,858	\$2,271,962,894
North Carolina	\$1,917,502,934	65.13%	69.31%	\$1,338,796,858	\$578,706,077
North Dakota	\$68,118,838	63.75%	70.35%	\$48,423,763	\$19,695,075
Ohio	\$989,615,330	63.42%	65.75%	\$638,373,638	\$351,241,692
Oklahoma	\$525,549,555	67.10%	70.20%	\$370,950,440	\$154,599,115
Oregon	\$112,850,493	62.74%	66.85%	\$76,014,671	\$36,835,822
Pennsylvania	\$389,098,796	54.81%	57.39%	\$224,596,327	\$164,502,469
Rhode Island	\$20,857,795	52.63%	60.05%	\$12,701,582	\$8,156,214
South Carolina	\$686,704,460	70.32%	73.97%	\$510,973,952	\$175,730,508
South Dakota	\$97,860,575	62.72%	68.36%	\$67,541,553	\$30,319,022
Tennessee	\$583,559,943	65.57%	87.09%	\$410,240,570	\$173,319,372
Texas	\$3,787,052,128	60.56%	67.85%	\$2,600,124,983	\$1,186,927,145
Utah	\$137,272,168	71.68%	77.56%	\$107,339,203	\$29,932,965
Vermont	\$124,204,614	59.45%	59.42%	\$73,796,325	\$50,408,289
Virginia	\$362,343,191	50.00%	57.07%	\$209,806,945	\$152,536,246
Washington	\$248,420,229	51.52%	54.52%	\$136,396,587	\$112,023,642
West Virginia	\$409,137,515	74.25%	76.53%	\$314,304,332	\$94,833,184
Wisconsin	\$429,986,267	60.21%	62.25%	\$267,986,623	\$161,999,644
Wyoming	\$59,704,387	50.00%	59.16%	\$35,929,608	\$23,774,779
<b>US Total</b>	<b>\$32,454,535,323</b>	<b>58.08%</b>	<b>62.26%</b>	<b>\$20,381,241,995</b>	<b>\$12,073,293,328</b>

## Appendix A. Baseline Pharmacy Costs, CY2011

State	2011 FFS Rx Reimbursement			2011 FFS Rx Scripts		
	Brand	Generic	Total	Brand	Generic	Total
Alabama	\$394,250,595	\$147,637,139	\$541,887,735	2,375,986	5,973,081	8,349,068
Alaska	\$78,922,265	\$53,637,717	\$132,559,982	362,218	643,002	1,005,220
Arizona	\$0	\$0	\$0	-	-	-
Arkansas	\$288,982,365	\$86,385,058	\$375,367,423	1,643,686	3,165,193	4,808,879
California	\$2,753,907,069	\$513,427,181	\$3,267,334,250	12,336,101	22,151,313	34,487,414
Colorado	\$217,320,675	\$60,192,161	\$277,512,836	999,645	2,248,514	3,248,159
Connecticut	\$376,586,576	\$88,827,053	\$465,413,629	1,911,195	3,408,484	5,319,679
Delaware	\$116,699,273	\$25,079,522	\$141,778,795	629,570	1,262,635	1,892,206
District of Columbia	\$45,114,447	\$11,402,716	\$56,517,164	215,901	435,620	651,521
Florida	\$1,135,737,595	\$168,618,020	\$1,304,355,615	4,859,794	10,030,041	14,889,835
Georgia	\$553,142,795	\$95,078,772	\$648,221,567	2,610,131	5,230,197	7,840,327
Hawaii	\$7,045,583	\$2,149,894	\$9,195,476	25,727	99,168	124,895
Idaho	\$109,669,206	\$20,531,428	\$130,200,634	542,856	1,171,197	1,714,053
Illinois	\$1,113,299,362	\$279,135,705	\$1,392,435,067	6,541,253	17,350,303	23,891,556
Indiana	\$625,908,363	\$97,296,908	\$723,205,271	2,486,099	6,739,690	9,225,789
Iowa	\$244,214,095	\$40,863,224	\$285,077,319	1,342,965	2,941,186	4,284,151
Kansas	\$183,730,695	\$34,939,725	\$218,670,420	720,962	1,443,319	2,164,281
Kentucky	\$479,160,920	\$144,743,764	\$623,904,684	3,007,443	8,282,184	11,289,627
Louisiana	\$712,986,194	\$229,583,283	\$942,569,477	4,033,918	7,177,591	11,211,509
Maine	\$175,479,953	\$23,444,717	\$198,924,670	1,062,090	1,955,984	3,018,074
Maryland	\$304,682,101	\$86,021,673	\$390,703,774	1,082,670	1,745,146	2,827,816
Massachusetts	\$383,307,071	\$101,789,013	\$485,096,084	1,874,014	6,278,369	8,152,382
Michigan	\$506,152,892	\$77,084,873	\$583,237,765	2,350,182	4,699,337	7,049,518
Minnesota	\$224,515,281	\$51,548,938	\$276,064,218	1,001,395	2,541,868	3,543,263
Mississippi	\$267,541,603	\$99,676,494	\$367,218,097	1,540,225	3,809,825	5,350,051
Missouri	\$650,115,928	\$177,084,025	\$827,199,952	3,220,939	7,768,991	10,989,930
Montana	\$52,571,613	\$18,728,191	\$71,299,804	260,791	645,309	906,101
Nebraska	\$135,617,813	\$38,558,452	\$174,176,264	700,828	2,084,214	2,785,042
Nevada	\$88,499,332	\$19,843,680	\$108,343,011	374,608	902,747	1,277,355
New Hampshire	\$95,761,440	\$21,299,152	\$117,060,592	462,776	1,093,395	1,556,171
New Jersey	\$462,067,065	\$126,148,315	\$588,215,380	2,167,290	3,651,024	5,818,314
New Mexico	\$8,700,630	\$1,826,466	\$10,527,096	40,519	95,612	136,131
New York	\$3,810,717,623	\$640,778,652	\$4,451,496,276	19,580,270	33,032,611	52,612,881
North Carolina	\$1,055,482,753	\$235,339,886	\$1,290,822,638	5,748,271	10,859,038	16,607,309
North Dakota	\$32,761,096	\$7,973,366	\$40,734,463	181,885	405,096	586,981
Ohio	\$1,261,923,056	\$208,849,621	\$1,470,772,678	6,281,091	15,212,591	21,493,682
Oklahoma	\$534,811,995	\$86,338,632	\$621,150,627	1,638,741	3,807,588	5,446,330
Oregon	\$143,588,227	\$32,310,590	\$175,898,817	575,027	1,427,839	2,002,866
Pennsylvania	\$441,250,820	\$76,080,092	\$517,330,912	2,277,308	5,433,030	7,710,338
Rhode Island	\$10,908,571	\$2,038,649	\$12,947,220	253,065	624,150	877,215
South Carolina	\$438,277,123	\$69,938,678	\$508,215,801	1,554,056	2,862,281	4,416,336
South Dakota	\$54,464,946	\$11,955,302	\$66,420,247	269,019	560,724	829,743
Tennessee	\$583,298,500	\$145,824,625	\$729,123,125	3,424,030	6,908,063	10,332,093
Texas	\$1,822,064,765	\$519,273,234	\$2,341,337,999	9,780,449	21,757,305	31,537,754
Utah	\$117,970,728	\$43,225,933	\$161,196,661	622,020	1,706,988	2,329,008
Vermont	\$97,089,134	\$17,668,819	\$114,757,953	511,565	907,218	1,418,783
Virginia	\$245,550,616	\$65,156,019	\$310,706,635	1,346,212	3,563,736	4,909,949
Washington	\$336,729,545	\$69,478,608	\$406,208,153	1,610,940	5,100,337	6,711,276
West Virginia	\$317,423,734	\$66,305,132	\$383,728,866	1,974,146	4,007,930	5,982,076
Wisconsin	\$366,036,547	\$77,601,177	\$443,637,724	2,552,967	4,708,613	7,261,580
Wyoming	\$34,854,404	\$7,617,774	\$42,472,178	169,067	379,120	548,187
<b>US Total</b>	<b>\$24,496,894,975</b>	<b>\$5,326,338,049</b>	<b>\$29,823,233,024</b>	<b>123,133,908</b>	<b>260,288,796</b>	<b>383,422,703</b>

Source: CY2009 CMS website data. Available Online: <http://www.cms.gov/MedicaidDrugRebateProgram/SDUD/list.asp>. Lewin trend factors used to estimate 2011 costs and usage.

## Appendix B. Scatter Diagram Assessing Correlation Between Higher Payments to Pharmacies and Generic Dispensing Rates



Note: FFS Medicaid Programs Ranked by Generic Dispensing Rate (GDR). Arizona excluded because nearly all Medicaid beneficiaries are in managed care.



# Presentation Organization

- Why Duals Initiatives are so Important and Exciting
- Six Public Policy Linchpins
- Key Challenges for Each Party in Three-Way Contracts



## Expansion of Integrated Care for Duals is Important and Exciting

- Duals currently account for roughly \$300 billion in annual health spending
  - 11% of all US health spending
  - 30% of all Medicaid spending
  - 27% of all Medicare spending
- Annual costs average approximately \$40,000 per person per year for “full duals”
- Duals have stable, long-lasting eligibility in both programs



## Duals Create A Unique Opportunity to Serve Persons for the Remainder of Their Lives

- One MCO reported that of the 13,000 duals passively enrolled as of January 2006, 10,000 – 11,000 remain enrolled as of early CY2012
- We believe MCOs will serve their duals on average for 10-20 years and that an MCO's *average* per enrollee lifetime revenue will approach or exceed \$500,000
  - this creates unique care coordination opportunities
  - changes the game regarding what forms of outreach are cost-effective and optimal to undertake



## Presentation Organization

- Why Duals Initiatives are so Important and Exciting
- Six Public Policy Linchpins
- Key Challenges for Each Party in Three-Way Contracts



## Six Policy Lynchpins to an Optimal Program

- Mandatory Enrollment
- Fully Integrated Model
- Large Savings Opportunity for States
- Selective Contracting with MCOs
- Effective Transition of Duals into Program
- Strong Program Oversight

SNCS' report on these policy dynamics, including extensive state-specific data on duals, is available at no cost at:

<http://www.sncservices.com/Achieving%20Optimal%20Care%20Coordination%20for%20Dual%20Eligibles-%20FINAL.pdf> (or navigate to it at [www.sncservices.com](http://www.sncservices.com))



## Presentation Organization

- Why Duals Initiatives are so Important and Exciting
- Six Public Policy Linchpins
- Key Challenges for Each Party in Three-Way Contracts



## Key Steps/Challenges for CMS

- Provide Medicare claims history data (Parts A, B and D) to states on the demo's target population
- Keep pushing for best model
  - encourage enrollment phase-in and start each program when it is ready to go (whether or not this is on January 1)
  - resist allowing Part D policies to inhibit program
    - “tail is wagging the dog” at times -- Part D annual cycle and coverage tiers are not terribly relevant for duals (who essentially pay \$0 for all medications)
    - MCOs should ideally be at full risk, not limited risk, for pharmacy
  - hang tough against the naysayers; fully integrated coordinated care is terrific policy for duals and for US taxpayer



## Key Steps and Challenges for States

- Produce and share data during development period
  - data book on duals' Medicare and Medicaid claims, condition mix, etc.
  - reports on each provider's volume of services to duals (# of duals seen, Medicaid and Medicare dollars received), by category of service and county
- Use your leverage to attain optimal program design
  - as comprehensive and integrated as possible
  - don't let unconstructive Medicare processes "drive the bus"
  - consider shared risk arrangements with MCOs in early years
- Put sufficient thought/care into MCO procurement
- Once operational, provide MCOs with history on their demo enrollees' Medicaid and Medicare claims
- Monitor program effectively
  - Demos are conducive to pre versus post enrollment analyses of duals' claims, satisfaction, etc.



## Key Steps and Challenges for MCOs

- “Bring it” with your planning, procurement response, implementation, and operations
  - earning a slot in the demos will not be easy
  - demos are in a fishbowl -- it’s critical to this revolution that the early experience be successful
  - traditional FFS deserves the pink slip, but MCOs still have to show they are delivering a superior mix of compassion and cost-effectiveness for duals
  - many stakeholders *want* these demos to fail
- Innovate and learn
  - establish *relationships* with enrollees & caregivers; each dual has own set of needs, support system dynamics, etc.
  - innovating involves much more than being a smart “copycat”



# Contact Information

Joel Menges

202-507-7574

[jmenges@sncservices.com](mailto:jmenges@sncservices.com)

SNCS

1150 18<sup>th</sup> Street, Suite 775

Washington, DC 20036

Website: [www.sncservices.com](http://www.sncservices.com)

Approved in other states

**A bill to reform Medicaid and to ensure sustainability while reducing costs, increasing access and improving quality; and expanding Medicaid to 133% of the Federal Poverty Level.**

Medicaid Reforms:

1) Rates

- a. Diagnosis related group rates
- b. Bundled payments
- c. Pay for Performance
  - i. Premium payments for Centers of excellence according to National Criteria
  - ii. Penalties for hospital acquired infections, readmissions, and failures to deliver.

***This reform will allow for and encourage cost efficiencies in payment structures that have become bloated with the highest Medicaid rates in the nation. More importantly, while revising rate structures, it will reward quality and efficiencies while discouraging and penalizing poor quality and efficiency. \$5M annually after the first year.***

2) Steerage

- a. Tribal members receiving care in tribal facilities
  - i. Receiving savings by using a choice waiver to eliminate choice. Applied to through the Centers for Medicaid and Medicare (CMS)
- b. expansion population assigned to health plan
- c. Direct DHSS to apply to CMS for choice waiver

***Steerage will ensure maximization of tribal services by tribal members and recovery of the higher FMAP (100%) for tribal members. Health plan management will allow for assignment of expansion population members to a commercial health plan with a negotiated global fee per member, allowing for greater predictability in budgeting. A choice waiver will allow for directing of tribal members to tribal providers. \$20M annually minimally***

3) Delivery System Reform

- a. Primary care management and fully integrated behavioral health for population
  - i. Everyone is assigned to a primary care provider. This keeps individuals out of the ER, self-referring to specialists, etc.

***Primary care management allows for a wide variety of gate keeping options to ensure the right care is provided to the right population in the right setting for the right price. Since behavioral health services face the greatest challenge to integrated care, the integration results in significant benefits.***

4) Privatization of selective state services

- a. The Department of Health and Social Services and the Department of Administration will perform feasibility studies for privatizing services delivered at the Pioneer Homes, Alaska Psychiatric Institute, and select Division of Juvenile Justice Facilities. Where privatization is a cost savings, the department will do so.

***The Department has opportunity for savings in this area that may be substantial. For instance, closing one DJJ facility and repurposing it to a tribal youth facility will save upwards of \$1.5M GF in the first***

**year and \$2.5M GF in subsequent years. Similar savings are in API through a complete privatization of the facility to a private forensic behavioral health provider. More and more states are moving in this direction for cost savings and reduced liability. Finally, there are several opportunities around the Pioneer Homes and public/private partnerships to reduce some of state GF costs. \$5M or greater.**

- 5) Create Health Savings Accounts (HSA) for co-payments and deductibles for Medicaid recipients established with a 10% withholding on the recipients Permanent Fund Dividend.
  - a. Can be used to cover price difference between generic and brand names drugs, ER visit penalties for non-emergencies, doctor co-pays

***This reform may meet with some controversy around using the Permanent Fund, but recipient engagement is lacking and this engages them in their utilization of services. The HSA can be used for penalties around inappropriate use of Emergency Services or copays on those services. Negligible savings for first two years. Thereafter, unknown at this point.***

- 6) Establish a Healthcare Provider Tax effective July 1, 2017

***The two year lead time on this is to deal with the many potential issues around the tax and to get it right. The tribal hospitals are almost certain to resist the tax and assert they are exempt. We believe we can present an argument to counter their assertion and their participation could be a condition of expansion if we proceed in that direction. The strategy as to how to implement, what and how much to tax and a host of other issues have to be worked out with the industry. Up to \$40M annually***

- 7) Capitalize on Innovations and reducing travel, including:
  - a. Expanded telehealth for primary care and patient management
    - i. Use telehealth before travel approved
    - ii. Need to expand current telehealth regulations to broaden
  - b. Waivers for long-term care, specifically 1915K waiver.
    - i. Waivers allow for services at home that would otherwise require a nursing home level of care. This particular option could allow for remote/telehealth management of patients. Daily video check in for taking meds, reminders , etc.

***Telehealth services, while widely discussed and touted for their efficiency, are not fully utilized and should be expanded. A study by the Alaska Native Tribal Health Consortium showed that 40% of all telehealth visit averted a need to otherwise travel. This is significant and barriers to full utilization need to be reviewed, assessed and addressed where possible. The State should pursue a 1915K waiver for services, as the federal gain on reimbursement is substantial for services otherwise already provided. \$10-15M savings***

- 8) Administrative simplification to support providers
  - a. Streamline audit process
  - b. Streamline payment process
  - c. Stakeholder engagement

***This item is included to show that the State is committed to reducing unnecessary paperwork, streamlining billing processes, requiring performance accountability and services. Not much money, but intended for good will and benefit.***



- 9) With detailed reform strategies, savings and timeline for implementation, along with provider system buy-in, expand Medicaid
  - a. Assign entire expansion population to health plan or management
  - b. Offering choice to general Medicaid population to opt into managed health care plan within one year.
  - c. The expansion will terminate if federal funding drops below 90%
  - d. This legislation will sunset on October 01, 2022, unless extended by the legislature



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Health Insurance Cost Statistics



Statistic Verification Source: Kaiser Family Foundation, National Conference of State Legislatures Research Date: 7.8.2014 Back in 1970s, the United States looked a lot like other countries when it came to health care spending.

Table with 3 columns: Health Care Cost Statistics, Single Coverage, Family Coverage. Includes data for average costs, states with highest/lowest costs, and historic spending statistics from 1970 to 2013.

statistics on health care costs ? what is the average cost of health insurance premiums ? what is the average cost to an employee for health benefits ?

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Statistic Brain Weekly Infograp

MINIMUM PRISON FOUR (Infographic with a bomb icon)

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Take a Tour





# Medicaid Expansion in Alaska and Some Related Points to Ponder

Ted Helvoigt, Ph.D.

*March 19, 2015*



# Today's Agenda

---

- Medicaid Expansion
  - How large is the newly eligible population?
  - How many will enroll?
  - What will they cost?
- Welcome Mat Effect
  - What is it?
  - Why do we care?
- Bending the Medicaid Cost Curve



## But First Some Terminology

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- **Medicaid Enrollee:** A person enrolled in Medicaid
- **Annual Unduplicated Count of Medicaid Enrollees:** The number of persons enrolled for any length of time during the (fiscal) year
- There is constant “churn” in Medicaid enrollment, so Medicaid enrollment in any given month is less than the annual unduplicated count of Medicaid enrollment
- **Medicaid Recipient:** A Medicaid enrollee who received Medicaid services during a particular period of time (generally a fiscal year)
- While it varies year-to-year, about 92% of Medicaid enrollees are also recipients



# How Large is the Newly Eligible Population?

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- **Lewin Group: 64,713 persons in CY2015**
  - Aggregate *Current Population Survey* (CPS) data for 2008 – 2010
  - Proprietary Model (HBSM), Technical Details not Provided
- **Urban Institute: Does not Report**
  - Aggregate *American Community Survey* (ACS) data for 2008 – 2010
  - Proprietary Model (HIPSA), Technical Details not Provided
- **Evergreen Economics: 41,910 in FY2016**
  - Alaska *Behavioral Risk Factor Surveillance System* (BRFSS) data for 2012 & 2013 from Division of Public Health;  
  
Population Estimates and Projections from the Alaska Department of Labor and Workforce Development (DLWD)
  - Direct Estimation of Size of Newly Eligible Population



# “Back of Envelope” Calculation

## How Many Working-Age Adults Not Caring For Dependent Children live in Poverty?

- All Alaskans:

- Poverty Rate = 9.3%
- Population = 735,601
- Living in Poverty = 69,411

- Children:

- Poverty Rate = 14.0%
- Population = 197,895
- Living in Poverty = 27,705

- Seniors:

- Poverty Rate = 17.0%
- Population = 71,080
- Living in Poverty = 12,080

- Single Parent w/Children:

- Poverty Rate = 23.0%
- Population = 24,545
- Living in Poverty = 5,645

Back of Envelope Estimate:  $69,411 - 27,705 - 12,080 - 5,645 = \underline{22,977}$

BRFSS Estimate of Newly Eligible Population in Poverty = 23,338

\*Sources: <http://www.spotlightonpoverty.org/map-detail.aspx?state=Alaska>

<http://datacenter.kidscount.org/data/tables/106-children-in-single-parent-families#detailed/2/2-52/false/36,868,867,133,38/any/429,430>



# Growth in the Expansion Population

The Lewin Group reports far greater growth in the newly eligible population than Alaska DLWD projects for all working-age adults

Year	Lewin Group Estimate of Expansion Population	ADLWD Population Projection, Ages 19-64
2014	63,986	470,574
2015	64,713	471,257
2016	65,619	471,668
2017	66,571	472,394
2018	67,496	472,483
2019	68,560	471,937
2020	69,684	471,391
<b>Annual Growth:</b>	<b>1.43%</b>	<b>0.03%</b>
<b>Change 2014 to 2020:</b>	<b>5,698</b>	<b>817</b>

\* Sources: Lewin Group report; ADLWD Population Projections 2012-2042.



# Enrollment by the Newly Eligible

The Evergreen analysis accepted the “take-up” rate assumption used in the Lewin Report

Year	Lewin Estimate of Expansion Enrollment (CY2014 – CY2019)	Evergreen Estimate of Expansion Enrollment (FY2016 – FY2021)
1	30,806	20,066
2	35,944	23,273
3	41,286	26,492
4	41,853	26,535
5	42,401	26,580
6	43,029	26,623
<b>Annual Growth (Year 3 to Year 6)</b>	<b>1.39%</b>	<b>0.16%</b>

\* Sources: Reports to DHSS from Lewin Group (2013) and Evergreen Economics (2015).



# Spending Per Newly Eligible Enrollee

Evergreen estimated spending based on comparable current Medicaid enrollees

Year	Lewin Group Estimate of Cost Per Enrollee (CY)	Evergreen Estimate of Cost Per Enrollee (FY)
2014	\$9,191	\$6,779
2015	\$9,222	\$7,009
2016	\$9,708	\$7,248
2017	\$10,208	\$7,495
2018	\$10,730	\$7,752
2019	\$11,272	\$8,018
2020	\$11,839	\$8,293
<b>Annual Growth:</b>	<b>4.3%</b>	<b>3.4%</b>
<b>Change 2014 to 2020:</b>	<b>\$2,648</b>	<b>\$1,514</b>

Between 2009 and 2013, the average growth in spending for non-disabled, working-age adults grew from \$6,453 to \$6,712 (1.0% average annual growth)



# Total Spending on Medicaid Services

With a smaller estimated (newly eligible) population and lower per-enrollee spending, Evergreen projects lower spending on the expansion population than Lewin.

Year	Lewin Group Estimate of Total Cost of Services (CY)	Evergreen Estimate of Total Cost of Services (FY)
2014	\$283,147,943	NA
2015	\$331,468,851	NA
2016	\$400,787,147	\$145,434,961
2017	\$427,221,539	\$174,437,699
2018	\$454,961,724	\$205,368,069
2019	\$484,997,562	\$212,746,716
2020	\$517,227,696	\$220,433,260



## Welcome Mat Effect

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Welcome Mat Effect refers to increasing participation among populations that are currently eligible for Medicaid but not enrolled

The welcome mat effect occurs with or without Medicaid expansion

The welcome mat effect is largely due to the insurance mandate associated with ACA and the “no wrong door” interface

Based on forecasts conducted in 2012 that assumed no welcome mat effect, we estimated enrollment would be just under 154,000 in CY2014

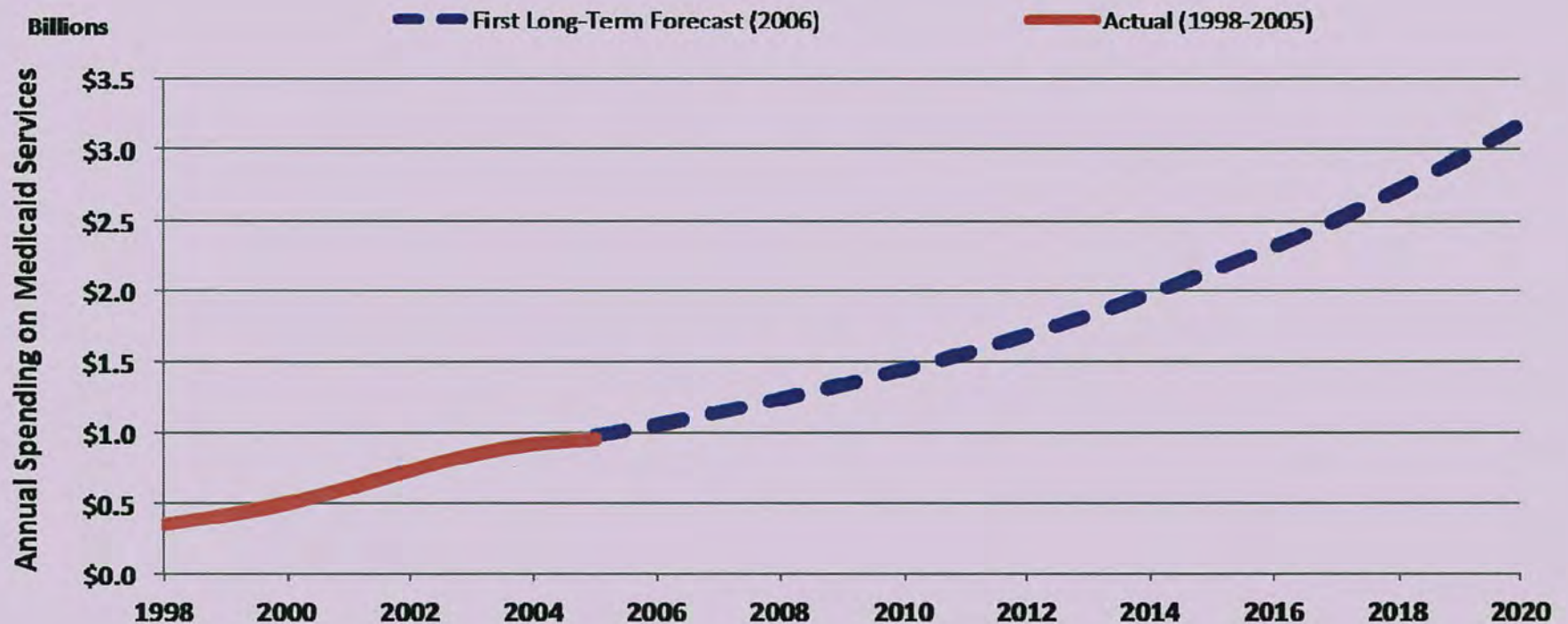
**Actual enrollment for CY2014 was more than 160,000**



# Bending the Medicaid Cost Curve

Between 1998 & 2005, spending on Medicaid increased 15% per year

In 2005, The Lewin Group projected spending on Medicaid would grow at 8.2% between 2005 and 2020.



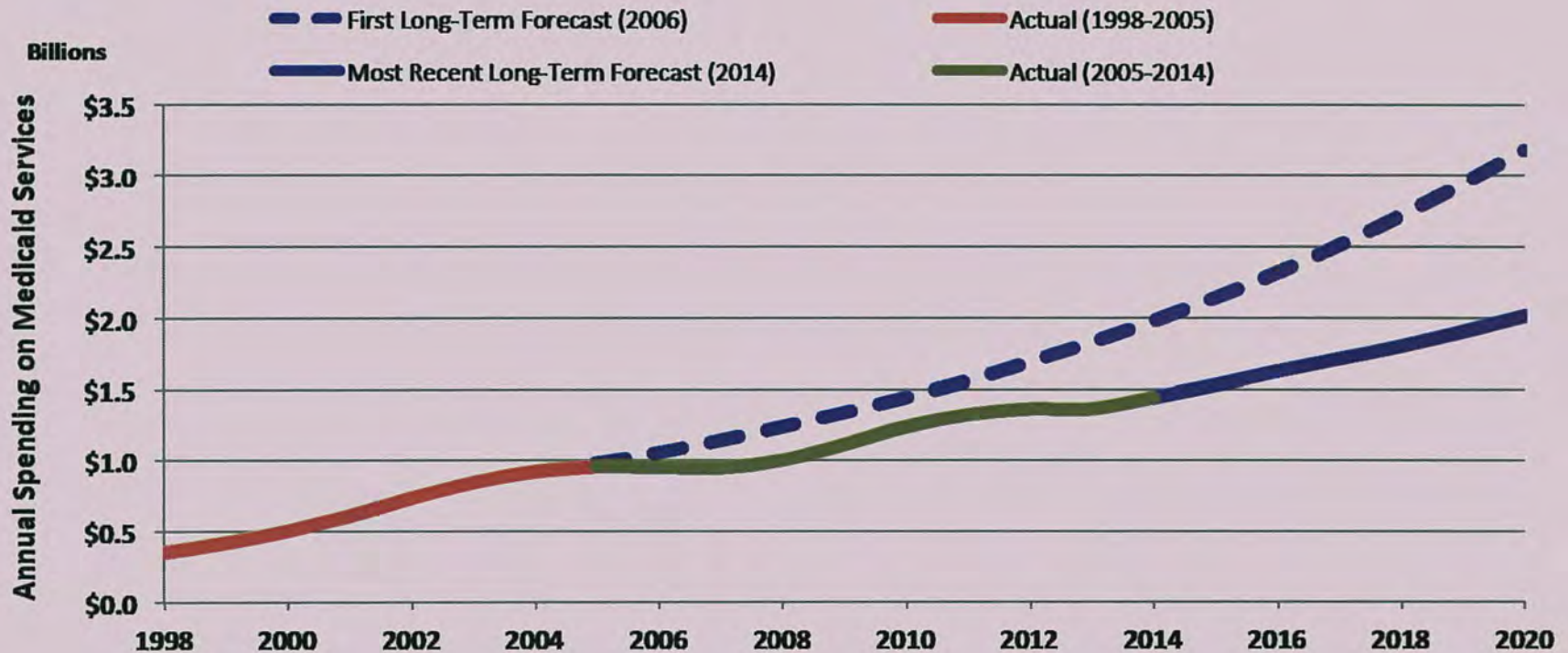
\* Long Term Forecast of Medicaid Enrollment and Spending in Alaska, 2005-2025, Lewin Group & ECONorthwest, Feb 15, 2006



# Bending the Medicaid Cost Curve

In fact, spending on Medicaid grew at a significantly slower pace between 2005 and 2014.

By 2014, spending was \$500 million lower than projected.

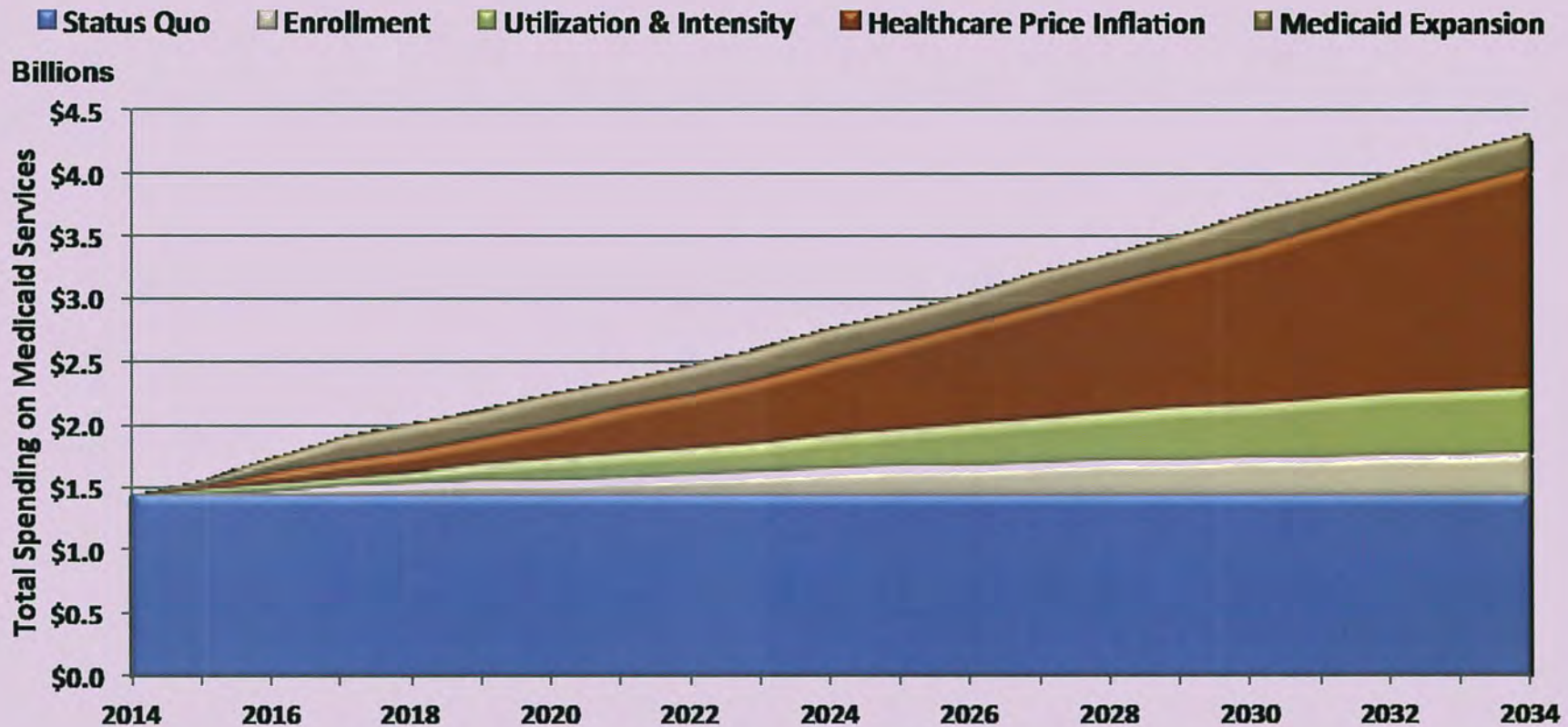




# Inflation is the Biggest Driver of Cost

Over the long run, healthcare price inflation is the primary driver of growth in spending on Medicaid services

## 20-Year Forecast of Spending on Medicaid Services





# Medicaid Expansion in Alaska

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For more information, please contact:

Ted Helvoigt, Ph.D.  
Evergreen Economics  
[helvoigt@evergreenecon.com](mailto:helvoigt@evergreenecon.com)

## Health Provider Taxes

### Overview

Every state except Alaska has some type of Medicaid-related provider tax or fee. According to NCSL, these taxes become much more common in the 2000s, rising from 21 states in FY 2003 to 47 plus the District of Columbia in FY 2007.

The base for this tax and the rates vary greatly across states, but all tax systems are designed to raise revenue to pay some portion of the state's share of Medicaid funding. Federal rules allow for up to 25% of the state share of Medicaid expenditures to be provided for by these taxes. Up to a 6% tax can be returned to providers by the state (using a combination of state funds and federal match) so that providers are held harmless while the state receives additional federal matching funds (which reduce general fund costs). According to the Congressional Research Service, most states use this tax revenue and the federal matching funds to increase reimbursement rates, which would then flow back to the providers. However, the tax could also be imposed simply to reduce a state's general fund obligation for Medicaid without losing federal funding or to fund an expansion of Medicaid under the Affordable Care Act.

### Federal Rules

Federal law limits states' use of provider taxes. These rules (bulleted below) are primarily aimed at preventing states from guaranteeing that providers will receive the entire tax back with increased federal funding.

- The tax must be 6% or less of net patient service revenues received by the taxpayers.
- The "75/75 rule" prohibits the tax if more than 75% of the taxpayers receive 75% or more of the cost of the tax back through enhanced Medicaid payments.
- The state cannot directly repay providers for their tax payments.

If the tax meets these rules, the state can use the tax revenue to replace up to 25% of state matching funds.

In practice, these rules mean that the tax should be set at 6% or less and be cannot be levied solely on providers that receive Medicaid payments. If a state used the tax to increase repayment rates or expand coverage, most providers could receive additional net funding, but imposing the tax without increasing repayment rates would leave the tax burden on the providers.

### Provider Taxes in Other States

As of 2014, every state except Alaska has some sort of health provider tax that is used to pay for Medicaid. Forty states tax hospitals, 37 tax intermediate care facilities, 44 tax nursing facilities, and 21 tax other medical providers.

One state, Arizona, adopted a provider tax explicitly to pay for Medicaid expansion, but most states adopted the tax before 2007. Arizona's Hospital Provider Tax is a 6% tax on hospitals (the maximum allowed under federal rules). It took effect in 2013 and is expected to bring in \$233 million in FY 2015, the first full year that the tax will be in effect. This will offset increased Medicaid costs to the state associated with accepting federal Medicaid expansion.

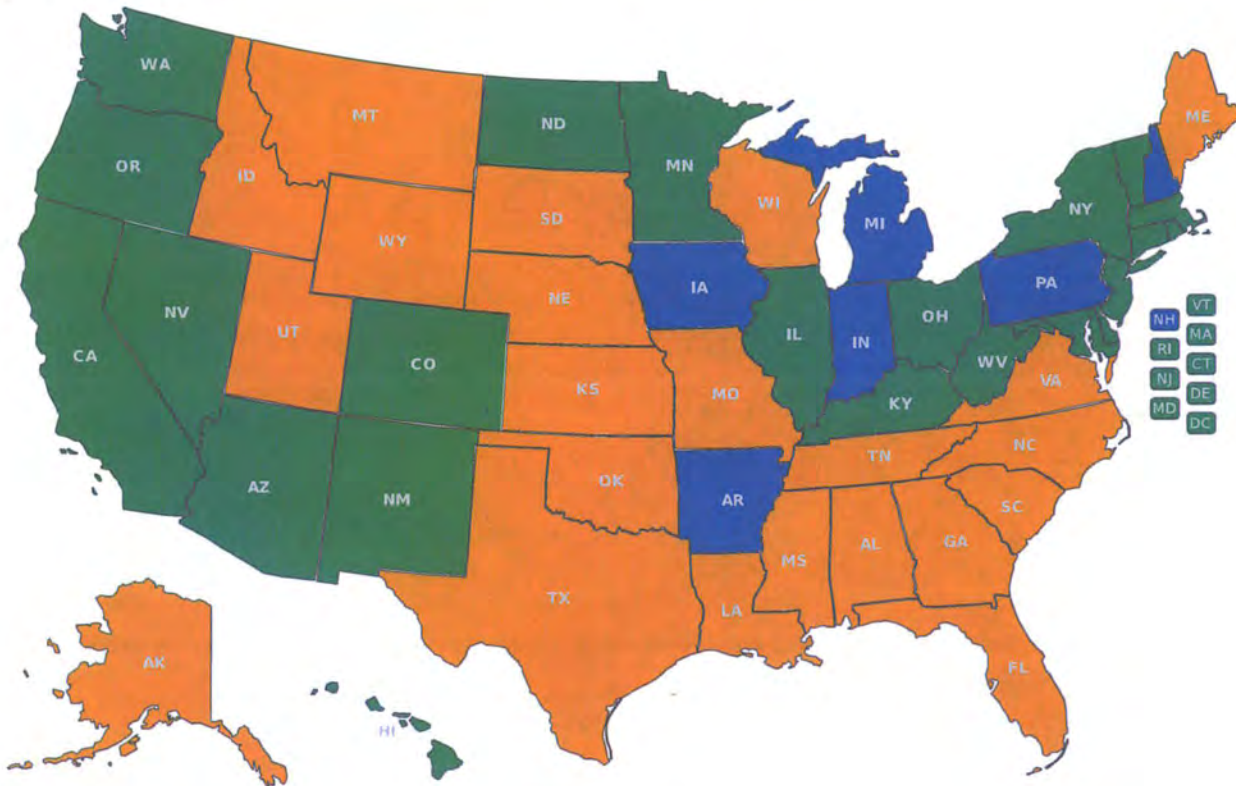
For providers, the tax may be an acceptable trade for an expansion of Medicaid because of the resulting decrease in uncompensated care. In Arizona, the decrease in uncompensated care after Medicaid expansion was \$76 million in the first four months, while providers paid \$75 million via the new tax.

Arizona's population is approximately nine times that of Alaska, so the \$233 million tax in Arizona scales to about \$26 million in Alaska. However, provider taxes across states raise vastly different revenue amounts due to differences in the tax structure and in the health care markets in the states. Vermont, with a population similar to Alaska, has a 5.9% tax on hospitals and raised \$117 million in FY 2013, for example. The District of Columbia has two separate provider taxes that raised \$30.3 million in FY 2013. South Dakota taxes only intermediate care facilities, raising just \$1.3 million in FY 2013.

For more information, see the NCSL report [Health Provider and Industry State Taxes and Fees](#) or the Congressional Research Service report [Medicaid Provider Taxes](#).

# Map: Where States Stand on Medicaid Expansion Decisions

\*Map updated March 3, 2015



Produced by:  
**statereforum**

**Key:**

- 22 states are not expanding Medicaid
- 23 states (count includes the District of Columbia) are expanding Medicaid
- 6 states are expanding Medicaid, but using an alternative to traditional expansion

{1} This map provides a record of legislation introduced, but does not track the exact status of bills moving in state legislatures. Map is updated when bills pass chambers and/or are signed by the Governor.

{2} CMS approved WI's proposal to modify existing Medicaid eligibility; under the waiver, all childless adults ages 19-64 with income up to 100% FPL will be covered through BadgerCare Plus beginning 4/1/14.

Map produced by [Anita Cardwell](#) and [Kaitlin Sheedy](#)

**Topics:**  
Medicaid

Updated February 2015 | Issue Brief

## The ACA and Medicaid Expansion Waivers

Robin Rudowitz, Samantha Artiga and MaryBeth Musumeci

### Executive Summary

Under the Affordable Care Act (ACA), Medicaid plays a key role in efforts to reduce the number of uninsured by expanding eligibility to nearly all low income adults with incomes at or below 138% FPL (\$16,242 per year for an individual in 2015); however, the Supreme Court ruling on the ACA's constitutionality effectively made the expansion a state option. As of February 2015, 29 states including DC are implementing the expansion. Nearly all states (24 of 29) are implementing the expansion as set forth by law, but a limited number of states have obtained or are seeking approval through Section 1115 waivers to implement the expansion in ways that extend beyond the flexibility provided by the law. More states are discussing alternative models through waivers as a politically viable way to implement expansion in order to extend coverage and capture federal dollars.

This brief provides an overview of the role of Section 1115 waivers in expanding coverage since the enactment of the ACA. The brief also highlights key themes in these waivers including implementing the Medicaid expansion through a premium assistance model, charging premiums, eliminating certain required benefits (most notably non-emergency medical transportation), and using healthy behavior incentives as well as provisions that CMS has not approved.

**To date, five states have received approval of a Section 1115 waiver to implement the Medicaid expansion ([Arkansas](#), [Iowa](#), [Michigan](#), [Pennsylvania](#) and most recently [Indiana](#)).** These waivers allow the states to implement the Medicaid expansion in ways that do not meet federal rules and still access enhanced federal matching funds for newly eligible adults. Under the ACA, the federal government will pay 100% of the costs of those newly eligible for 2014-2016 and then the federal share phases down to 90% in 2020 and beyond. While the waivers are each unique, they include some common provisions such as implementing the Medicaid expansion through a premium assistance model, charging premiums, eliminating certain required benefits (most notably non-emergency medical transportation), and using healthy behavior incentives. The Pennsylvania waiver was approved under Governor Corbett, but the current Governor Wolf announced that Pennsylvania will transition to a traditional Medicaid expansion plan and he will not implement the benefit and work changes that the previous Governor had initiated.

**The most recent waiver approval in Indiana includes provisions that had not been approved in other states.** These new provisions include allowing the state not to provide retroactive eligibility; to make coverage effective beginning on the date of the first premium payment, rather than on the date of application; and to bar certain expansion adults from re-enrolling in coverage for six months if they are dis-enrolled for unpaid premiums. In addition, under separate waiver authority (§1916(f)), Indiana received approval to charge

higher cost sharing for non-emergency use of the emergency room than otherwise allowed under federal rules (Table 1).

**Several states have waiver proposals pending or in development.** There is no deadline for states to participate in the Medicaid expansion and moving into the legislative sessions for 2015, other states continue to explore opportunities to implement the Medicaid expansion. Governors in both [Tennessee](#) and [Utah](#) have been negotiating plans with CMS, but these plans also need to be approved by the state legislature. In a special session in early February, the legislature in Tennessee rejected the Governor’s expansion plan. In Utah, a legislative taskforce did not endorse the Governor’s plan but legislative debate continues. The Wyoming Department of Health published its recommendation for an alternative Medicaid Expansion plan, called the SHARE plan, in November 2014; however, the state Senate voted against the plan in early February 2015. [New Hampshire](#), a state that had implemented the expansion, also has a waiver pending with CMS to continue the expansion through a premium assistance model.

Table 1: Key Themes in ACA Expansion Waivers and Proposals

	Premium Assistance	Premiums / Monthly Contributions	Healthy Behavior Incentives	Benefits	Work Referral	Co-Payments*	Waivers of Retroactive Eligibility / Reasonable Promptness
<b>Approved Waivers</b>							
Arkansas <sup>1</sup>	Mandatory for QHPs	X					
Iowa	Optional for QHPs	X	X	X			
Indiana <sup>2</sup>	Optional for ESI	X	X	X		X	X
Michigan		X	X				
Pennsylvania <sup>3</sup>		X	X	X			
<b>Waiver Proposals</b>							
New Hampshire <sup>4</sup>	Mandatory for QHPs				X		X
Tennessee <sup>5</sup>	Optional for ESI	X	X	X		X	X
Utah <sup>5</sup>	Mandatory for QHPs and ESI	X	X	X		X	

\*Cost-sharing waivers were approved in Indiana and are proposed in Tennessee and Utah through §1916(f) not §1115 waiver authority.

<sup>1</sup> The monthly contributions in AR are in lieu of cost-sharing requirements.

<sup>2</sup> Indiana may administer a voluntary state-run work search and job training program, which is separate from the Medicaid waiver.

<sup>3</sup> The Pennsylvania expansion waiver was approved under Governor Corbett who also had intended to restrict benefits through a SPA and to implement a state-only work-referral program. Governor Wolf (the new governor) announced that PA will transition to a traditional Medicaid expansion plan and will not implement the benefit and work changes.

<sup>4</sup> New Hampshire implemented the Medicaid expansion through a SPA, but has a waiver pending to move to a mandatory Marketplace premium assistance model by 1/2016.

<sup>5</sup> The Governors in Utah and Tennessee have waiver proposals that have not been officially submitted to CMS and are under debate in the state legislatures.

## Introduction

To date, the majority of states (24 of 29) that have adopted the Medicaid expansion have done so under the existing rules and options provided by the Medicaid program. However, five states have obtained Section 1115 waiver approvals to implement the expansion in ways that extend beyond the flexibility provided by the law, and additional states are considering waiver approaches to adopt the expansion. This brief provides an overview of the role of Section 1115 waivers in expanding coverage since the enactment of the ACA and key themes in recently approved and proposed coverage expansion waivers. Detailed summaries of approved and proposed waivers are available at [www.kff.org](http://www.kff.org).

## Context for Understanding Expansion Waivers

**Section 1115 Medicaid waivers provide states with an avenue to test new approaches in Medicaid that differ from federal program rules.** These waivers are intended to allow for “experimental, pilot, or demonstration projects” that, in the view of the HHS Secretary, “promote the objectives” of the Medicaid program. Waivers can provide states with additional flexibility in how they operate their programs, beyond the flexibility already available to states under federal law, and can have a considerable impact on program financing. Under long-standing federal policy (not statute), federal spending under a state’s waiver must not exceed projected federal spending without the waiver. Budget neutrality is established using a cap on federal matching funds over the life of the waiver. Federal law requires that waivers be formally evaluated.

**Prior to the enactment of the ACA, a number of states used Section 1115 waivers to expand coverage to childless adults, who could not otherwise be covered under federal rules.** Before the ACA, Medicaid coverage was limited to individuals who met income and other eligibility requirements and fell into one of several specified groups, including children, pregnant women, parents, seniors and people with disabilities. Adults without dependent children, often referred to as childless adults, who did not qualify for Medicaid based on age or disability were ineligible for coverage, and federal law did not authorize federal Medicaid matching funds to cover these adults, regardless of how low their incomes were. The only way a state could extend Medicaid coverage to these adults was through a Section 1115 waiver. Because these waivers must be budget neutral for federal spending, states could not receive additional federal funds to expand coverage to these adults and, as such, needed to redirect existing federal funds or find offsetting program savings to finance such coverage.

**The ACA expands Medicaid to adults with significant federal funding.** The expansion eliminates the historic exclusion of adults without dependent children from the program and provides federal statutory authority to make millions of adults newly eligible for the program. The federal government is funding 100% of the cost of covering newly eligible adults for the first three years of the expansion, gradually phasing down to 90% by 2020 and beyond. The 90% match is significantly higher than the traditional Medicaid matching rate that ranges from a floor of 50% to a high of 73% based on a state’s relative per capita income. Under the ACA, the Medicaid expansion was intended to occur nationwide. However, the Supreme Court’s ruling on the ACA’s constitutionality effectively made the expansion a state option. As of February 2015, a total of 29 states (including the District of Columbia) have implemented the Medicaid expansion, and adoption of the expansion is under discussion in a number of other states.<sup>1</sup> There is no deadline for states to adopt the Medicaid

**CMS has denied a number of provisions included in Section 1115 Waiver proposals.** Provisions that CMS had denied waiver authority for include:

- Premiums for individuals with incomes < 100% FPL as a condition of eligibility;
- Requirements to provide wrap-around benefits for EPSDT and free choice of family planning provider to the extent that Marketplace plans do not offer coverage for these services; and
- Work requirements as a condition of Medicaid eligibility.

**To ensure Section 1115 waivers fulfill their purpose as research and demonstrations projects, it will be important to evaluate their effects.** Waivers are intended to be research and demonstration projects, and federal law requires that they be formally evaluated to measure how well they achieve objectives including the effects on access to care and outcomes for beneficiaries. Particularly as waiver designs become increasingly more complex, the evaluations will help inform policy makers if such policies can be effectively administered and if beneficiaries understand the policies. Ensuring that evaluations are timely and that findings are publicly available will be important for enabling researchers, policymakers, and other stakeholders to identify and examine lessons learned from these waiver experiences.

What happens with waivers between 2014 and 2016 also will be important to inform the use of the new state innovation waiver authority (Section 1332) available in 2017, which will allow states to waive Marketplace coverage provisions and combine those waivers with Medicaid and CHIP waivers. As more states seek waivers to implement the expansion, what we learn from their experiences will help inform the future direction of coverage for low-income adults and families. In addition, in states where Medicaid expansion without a waiver is not politically viable, large numbers of people are likely to remain without coverage. CMS, states, and other stakeholders will continue to navigate the balance between state waiver requests in an effort to reduce the number of uninsured adults while preserving key beneficiary protections and requirements in the Medicaid program.

# A Look at Medicaid Expansion Waivers Post 2014

To date, a few states have sought Section 1115 waivers to implement the Medicaid expansion, in part because they could not otherwise secure political support to expand coverage. As of February 2015, CMS has approved waivers to implement the Medicaid expansion in five states ([Arkansas](#), [Iowa](#), [Michigan](#), [Pennsylvania](#) and most recently [Indiana](#)). Governors in [Utah](#) and [Tennessee](#) have been negotiating waivers with CMS, but formal waiver applications have not yet been submitted. These plans also need state legislative approval, and Tennessee’s legislature recently did not vote a bill authorizing Medicaid expansion out of committee during a special session. [New Hampshire](#) has implemented the Medicaid expansion pursuant to a SPA, but has a pending waiver application to continue its Medicaid expansion through mandatory Marketplace premium assistance beginning in January 2016, as required by state law.<sup>3</sup> The Pennsylvania waiver was approved under Governor Corbett, but the current Governor Wolf announced that Pennsylvania will transition to a traditional Medicaid expansion plan and he will not implement the benefit and work changes that the previous Governor had initiated.

Each of the approved and proposed expansion waivers is unique, in many cases reflecting variations in the states’ underlying Medicaid programs, but there are some common themes across the waivers. The following sections examine waiver provisions that have been approved and denied by CMS to date.

Table 1: Key Themes in ACA Expansion Waivers and Proposals

	Premium Assistance	Premiums / Monthly Contributions	Healthy Behavior Incentives	Benefit Changes	Work Referral	Co-Payments*	Waivers of Retroactive Eligibility / Reasonable Promptness
<b>Approved Waivers</b>							
Arkansas <sup>1</sup>	Mandatory for QHPs	X					
Iowa	Optional for QHPs	X	X	X			
Indiana <sup>2</sup>	Optional for ESI	X	X	X		X	X
Michigan		X	X				
Pennsylvania <sup>3</sup>		X	X	X			
<b>Waiver Proposals</b>							
New Hampshire <sup>4</sup>	Mandatory for QHPs				X		X
Tennessee <sup>5</sup>	Optional for ESI	X	X	X		X	X
Utah <sup>5</sup>	Mandatory for QHPs and ESI	X	X	X		X	

\*Cost-sharing waivers were approved in Indiana and are proposed in Tennessee and Utah through §1916(f) not §1115 waiver authority.

<sup>1</sup> The monthly contributions in AR are in lieu of cost-sharing requirements.

<sup>2</sup> Indiana may administer a voluntary state-run work search and job training program, which is separate from the Medicaid waiver.

<sup>3</sup> The Pennsylvania expansion waiver was approved under Governor Corbett who also had intended to restrict benefits through a SPA and to implement a state-only work-referral program. Governor Wolf (the new governor) announced that PA will transition to a traditional Medicaid expansion plan and will not implement the benefit and work changes.

<sup>4</sup> New Hampshire implemented the Medicaid expansion through a SPA, but has a waiver pending to move to a mandatory Marketplace premium assistance model by 1/2016.

<sup>5</sup> The Governors in Utah and Tennessee have waiver proposals that have not been officially submitted to CMS and are under debate in the state legislatures.

expansion. In states expanding Medicaid, most individuals with incomes above 138% up to 400% FPL (above Medicaid levels) are eligible for tax credits to purchase coverage in the Marketplaces. In states that do not implement the Medicaid expansion, Medicaid eligibility for adults is quite limited. Because the ACA envisioned low-income people receiving coverage through Medicaid, it does not provide financial assistance to people below poverty for other coverage options. As a result, in states that do not expand Medicaid, many adults will fall into a “coverage gap” of having incomes above Medicaid eligibility limits but below the lower limit for Marketplace premium tax credits.

**The ACA’s Medicaid expansion eliminates the need for a state to obtain a Section 1115 waiver to cover childless adults, but a small number of states have still used Section 1115 waivers to implement the Medicaid expansion in ways that differ from options provided to states under federal law.** CMS has issued guidance that establishes some parameters for such waivers. Through this guidance, CMS has indicated that states cannot receive the enhanced federal funding available for newly eligible adults unless they implement the full expansion to cover all newly eligible adults through 138% FPL; it also will not approve enrollment caps for the adult expansion group. CMS indicated it will approve a limited number of premium assistance waivers to test the use of Medicaid funds to purchase Marketplace coverage for the Medicaid expansion population, subject to certain requirements.

**Medicaid expansion waivers are subject to new rules about transparency, public input and evaluation.** As a result of longstanding concerns about the lack of public input and transparency in the waiver approval process, the ACA required the Department of Health and Human Services (HHS) to issue regulations designed to ensure that the public has meaningful opportunities to provide input into the Section 1115 waiver approval process. The rules, issued in February 2012, require public notice and comment periods at the state and federal levels before new waivers and extensions of existing waivers are approved by CMS.<sup>2</sup> The transparency regulations also require states to have an approved evaluation strategy in place that is publicly available. States must also submit an annual report to HHS that includes, among other things, a description of the changes occurring and their impact on outcomes, quality, and access; beneficiary satisfaction surveys; grievance and appeals data; financial data; audits; and other relevant developments. A federal contract has been awarded to conduct an evaluation of a number of Section 1115 waivers (related to the ACA Medicaid expansion as well as other demonstration waivers).

## MONTHLY CONTRIBUTIONS AND PREMIUMS

**CMS has approved waivers that allow states to charge premiums or monthly contributions primarily for expansion adults between 100 and 138% FPL.** Under federal law, Medicaid beneficiaries with incomes below 150% FPL (\$17,655 per year for an individual in 2015) cannot be charged premiums. Premiums in the Medicaid program are limited because a large body of research shows that premiums and enrollment fees act as barriers to obtaining and maintaining coverage for people with low-incomes.<sup>8</sup> Each of the five approved expansion waivers allows the states to impose premiums or monthly contributions for newly eligible beneficiaries with incomes between 101-138% FPL. These premiums (equal to about 2% of income) are about the same level as those allowed for individuals at these incomes who are eligible for tax credits to purchase coverage through the Marketplace in states not expanding Medicaid.

**The consequences of non-payment of premiums for adults with incomes above poverty vary across states, but only Indiana includes a six month lock-out for beneficiaries dis-enrolled due to unpaid premiums.** In Michigan, payment of premiums is not a condition of eligibility. In Iowa, beneficiaries have a 90 day grace period to pay past-due premiums in full before they are dis-enrolled from Medicaid, and the state must waive premiums for beneficiaries who self-attest to financial hardship. Individuals can re-enroll at any time. Similarly, in the approved Pennsylvania waiver, there is a 90-day grace period before disenrollment for unpaid premiums, and beneficiaries may re-enroll without a lock-out period. Indiana's waiver is different than others approved to date in that it allows the state to impose a six month lock-out period for non-medically frail individuals above poverty who are dis-enrolled due to unpaid premiums after a 60 day grace period. Individuals who never make their initial premium payment are not subject to the 6 month lock-out.

**In Arkansas, Iowa and Indiana, the waivers allow the states to charge monthly contributions for individuals below poverty; however, failure to pay these charges cannot result in the termination of Medicaid coverage.** Arkansas received approval through a waiver amendment to require monthly income-based contributions to health savings accounts, ranging from \$5 to \$25 per month, for beneficiaries with incomes between 50-138% FPL to be used for co-payments and co-insurance. In Arkansas, those with incomes below poverty cannot be denied services for failure to pay. In Iowa, the waiver allows the state to impose monthly contributions of \$5 per month for beneficiaries with incomes between 50-100% FPL beginning in year two; however, premiums can be waived by completing healthy behavior activities and Medicaid eligibility cannot be terminated for non-payment of premiums for beneficiaries at or below 100% FPL.

The waiver in Indiana imposes monthly contributions to a Personal Wellness and Responsibility (POWER) health savings account for most newly eligible adults with incomes between 0-138% FPL. Those with incomes between 0-5% FPL (up to \$589 per year for an individual in 2015) must pay \$1.00 per month. If individuals with incomes at or below poverty do not pay the monthly POWER account contributions, they receive a less generous benefit package.

**In Indiana, the waiver allows the state not to begin coverage until the first premium is paid.** Under the Indiana waiver, beneficiaries who pay premiums will be eligible for an HIP Plus benefit package, which includes expanded benefits and co-payments only for non-emergency use of the ER. Coverage in HIP

## WAIVER PROVISIONS APPROVED BY CMS

### PREMIUM ASSISTANCE

**Two states have received approval to implement the Medicaid expansion through a premium assistance model using mandatory enrollment in private coverage through Marketplace plans (Arkansas and Iowa).** According to guidance released by CMS, it will approve a limited number of waivers to allow state to use Medicaid funds to purchase coverage for some or all newly eligible beneficiaries in Marketplace Qualified Health Plans (QHPs) as a “private approach” to expansion. States can implement premium assistance programs without a waiver, subject to certain rules. Arkansas and Iowa received waivers to allow them to mandatorily enroll beneficiaries in premium assistance. In Arkansas all newly eligible adults, including childless adults between 0-138% FPL and parents between 17-138% FPL, are enrolled in premium assistance. In Iowa, only newly eligible adults with incomes above 100% up to 138% FPL were enrolled in premium assistance.<sup>4</sup> With the loss of one of the two Marketplace QHPs serving Medicaid beneficiaries in Iowa, beneficiaries instead are enrolled in Medicaid managed care as of December 2014, with the option to choose Marketplace premium assistance as an alternative (instead of imposing mandatory premium assistance) .

These states indicate that they are using premium assistance to test how private coverage works for Medicaid beneficiaries and whether enrolling beneficiaries in Marketplace coverage will increase provider access and reduce churn between Medicaid and Marketplace coverage due to income fluctuations. How premium assistance affects continuity of care, the impact on access to benefits, how well wrap-around coverage will work, how states will exempt people who are medically frail from their demonstrations, what the impact of premiums and cost sharing will be, and whether the demonstrations will be cost effective are key issues to monitor and are included in the evaluation requirements of these waivers.<sup>5</sup> Consistent with CMS guidance, the premium assistance waivers in Arkansas and Iowa were approved through 2016.<sup>6</sup>

**The waiver proposals in New Hampshire and Utah would also provide premium assistance for Marketplace coverage to some Medicaid expansion enrollees.** The New Hampshire proposal includes mandatory enrollment in Marketplace QHPs for Medicaid expansion adults beginning January 1, 2016. Utah’s proposal similarly would require most newly eligible adults to enroll in Marketplace QHPs. Expansion adults who have access to employer-sponsored insurance (ESI) in Utah would receive premium assistance for enrollment in their ESI.

**Indiana and Tennessee include optional premium assistance programs for beneficiaries with access to ESI.** The Tennessee proposal would offer newly eligible adults with access to ESI the option of receiving premium assistance to enroll in their ESI plan in the form of a defined contribution from the state. Under this Volunteer Plan, costs and benefits not covered by the defined contribution would be the responsibility of the beneficiary.<sup>7</sup>

## WAIVERS OF REQUIRED BENEFITS

**CMS has approved limited waivers of required Medicaid benefits that allow states not to cover non-emergency medical transportation (NEMT).** In implementing the ACA, states have considerable flexibility in determining benefits packages for those newly eligible for coverage by the ACA's Medicaid expansion. States must cover the ten ACA-required Essential Health Benefits (EHBs) along with certain other mandatory Medicaid services. States also must meet mental health parity requirements. Beyond these requirements, states have flexibility to choose a benchmark plan for coverage that may include one of several specified private insurance options or "Secretary-Approved Coverage" which can include a state's current Medicaid benefits package for adults. However, some states have sought waiver approval for greater flexibility in the provision of benefits.

Iowa was the first state to receive approval to waive NEMT for newly eligible adults. The original NEMT waiver applied through December 31, 2014, and extension is conditioned on an evaluation of the waiver's impact on beneficiary access to care. In December 2014, CMS approved a waiver amendment extending the NEMT waiver through July 1, 2015, while noting that Iowa had submitted preliminary data that "raised concerns about beneficiary access[,] particularly for those with incomes below 100 percent of the FPL." CMS will consider additional data collected by the state as of May 31, 2015 in determining whether to further extend the NEMT waiver. Iowa provides NEMT to beneficiaries who are medically frail and those under age 21.

Following the original approval in Iowa, Pennsylvania was authorized to waive NEMT for newly eligible adults in 2015, with this benefit to be provided beginning in 2016. Most recently, Indiana was also allowed to waive NEMT for most newly eligible adults for one year, to be extended based on the results of an evaluation assessing the impact on access to care. Arkansas also sought waiver authority to limit NEMT to 8 trip legs per year for non-medically frail beneficiaries. Instead, the state will establish a prior authorization process for NEMT for newly eligible adults (a change that does not require waiver authority).

**The Indiana plan allows for different benefit packages for individuals below poverty who do not pay premiums.** Under the Indiana waiver, newly eligible adults 0-138% FPL who pay monthly POWER account contributions receive HIP Plus, which includes the ACA's essential health benefits and covers more services than the HIP Basic benefit package. Newly eligible adults at or below 100% FPL who do not pay premiums receive HIP Basic, an ABP that includes the ACA's essential health benefits but with fewer covered services (no vision or dental coverage) compared to HIP Plus. HIP Basic includes all EPSDT services for 19 and 20 year olds, consistent with federal law.

## COST SHARING WAIVERS

**Indiana has received approval to impose cost sharing in amounts greater than those allowed under federal law under separate Section 1916(f) authority.** Section 1115 waiver authority does not extend to Medicaid cost-sharing requirements. In order to impose higher cost sharing than otherwise allowed under federal law, a state needs to meet separate cost sharing waiver requirements under Section 1916(f). Section 1916(f) permits a state to seek a demonstration waiver to charge cost sharing above otherwise allowable amounts if the state meets specific requirements and criteria, including testing a unique and previously untested use of copayments and limiting the demonstration to no longer than two years.

Plus begins the first day of the month in which a beneficiary pays a premium, instead of the date of Medicaid application. To allow coverage to begin on the first day of the month in which a beneficiary pays a premium, instead of the date of Medicaid application, the state needed waivers of reasonable promptness and retroactive eligibility. Under federal law, Medicaid benefits must be provided with “reasonable promptness” to eligible beneficiaries, and coverage extends to bills incurred retroactively for three months prior to the month of application, if the individual would have been eligible during the retroactive period.<sup>9</sup> Indiana’s waiver also includes FQHCs, RHCs, CMHCs, and health department sites in an expanded presumptive eligibility program. Presumptive eligibility enables applicants to receive Medicaid-covered services as of the date that a qualified provider entity preliminarily determines that the applicant eligible for Medicaid, while the final determination is pending. To maintain the reasonable promptness waiver, the state must make final eligibility determinations for a certain percentage of presumptively eligible applicants (out of eligibility determinations made on all types of applications).

## HEALTHY BEHAVIOR INCENTIVES

**CMS has approved the use of healthy behavior incentives to reduce or eliminate beneficiaries’ out-of-pocket expenses.** The approved waivers in Iowa, Michigan, Pennsylvania and Indiana all include healthy behavior programs. Under these four waivers, individuals who complete specified healthy behaviors will have their premiums and cost sharing waived or reduced. Separate protocols must be approved by CMS to implement these health behavior programs. The protocols are required to: (1) specify the types of healthy behaviors (such as health risk assessments); (2) include a diverse set of behaviors as well as a strategy to measure access to providers to ensure that all beneficiaries have an opportunity to receive healthy behavior incentives; (3) engage stakeholders and the public in developing the healthy behavior standards; (4) show how healthy behaviors will be tracked and monitored at the enrollee and provider level; (5) include a beneficiary and provider education strategy; and (6) include the methodology describing how healthy behavior incentives will be applied to reduce premiums or copayments.

In Iowa, beneficiary premiums were waived for the first year of enrollment. In subsequent years, premiums are waived if beneficiaries complete specified healthy behavior activities. In the first year of the healthy behavior program, these include completing an online health risk assessment and obtaining a wellness examination. Iowa has retroactively broadened the definition of a qualifying wellness exam to allow providers to choose a routine medical exam in lieu of a more comprehensive annual physical, depending on the beneficiary’s individual needs.

In Michigan, demonstration beneficiaries have cost-sharing obligations based on their prior six months of copays. Cost-sharing will be paid into health accounts and can be reduced through compliance with healthy behaviors. The cost-sharing amounts are based on the state plan amounts and not changed from what would have been collected without the waiver. Beneficiaries cannot lose or be denied Medicaid eligibility, be denied health plan enrollment, or be denied access to services, and providers may not deny services for failure to pay copays or premiums. Similarly, under the approved waiver in Pennsylvania, beginning in demonstration year 2, beneficiaries can reduce their premiums or copayments by completing healthy behaviors including an annual wellness exam.

waiver request to impose higher than statutorily allowed cost sharing amounts for non-emergency use of the ER.

**CMS has not approved a waiver to include a work requirement or referral as a condition of Medicaid eligibility.** Pennsylvania initially sought a work requirement as a condition of Medicaid eligibility (later amended to a voluntary work search program) for current and newly eligible beneficiaries as part of its waiver application, but none of these elements were included as part of the demonstration approved by CMS. Indiana sought waiver authority to require a work referral as a condition of eligibility, which was not approved by CMS. Instead, Indiana may administer a voluntary state-run work search and job training program, which is separate from the Medicaid expansion demonstration. Utah's proposal includes a provision to automatically enroll able-bodied adults in a concurrent work program when newly eligible beneficiaries apply for Medicaid. The work program would include an online assessment and access to training opportunities and job postings. Utah is exploring possible sanctions related to benefits available under other state programs for non-compliance with the work program but is not proposing that work program participation be a condition of Medicaid eligibility and is not seeking federal waiver authority for the work program. New Hampshire's waiver proposal includes a referral to state job counseling services for unemployed applicants.

## Key Issues Looking Forward

To date, 29 states (including DC) are implementing the ACA's Medicaid expansion including five states that are implementing the expansion under waiver authority. Examining what provisions CMS has approved and denied in recent waiver approvals can shed light on what may be approved for other states considering waivers moving forward. A number of states currently debating moving forward with the expansion are considering implementing the expansion through a waiver.

To ensure Section 1115 waivers fulfill their purpose as research and demonstrations projects, it will be important to evaluate their effects. Waivers are intended to be research and demonstration projects, and federal law requires that they be formally evaluated to measure how well they achieve objectives and the effects on access to care and outcomes for beneficiaries. Particularly as waiver designs become increasingly more complex, the evaluations will help inform policy makers if such policies can be effectively administered and if beneficiaries understand the policies. Ensuring that evaluations are timely and that findings are publicly available will be important for enabling researchers, policymakers, and other stakeholders to identify and examine lessons learned from these waiver experiences.

What happens with waivers between 2014 and 2016 also will be important to inform the use of the new state innovation waiver authority (Section 1332) available in 2017, which will allow states to waive Marketplace coverage provisions and combine those waivers with Medicaid and CHIP waivers. As more states seek waivers to implement the expansion, what we learn from their experiences will help inform the future direction of coverage for low-income adults and families. In addition, in states where Medicaid expansion without a waiver is not politically viable, large numbers of people are likely to remain without coverage. CMS, states, and other stakeholders will continue to navigate the balance between state waiver requests in an effort to reduce the number of uninsured adults while preserving key beneficiary protections and requirements in the Medicaid program.

In July 2013, final regulations were released that streamlined and simplified existing rules around premiums and cost-sharing in Medicaid, increased the nominal rate for cost-sharing, and increased allowable cost-sharing amounts for non-preferred drugs and non-emergency use of the emergency room. Indiana received Section 1916(f) waiver authority to charge cost sharing that exceeds the \$8 maximum allowed for non-emergency use of the emergency room under these federal rules. This waiver allows the state to implement a two-year demonstration (until Jan. 31, 2017) to test whether graduated co-payments (\$8 for first visit and \$25 for subsequent visits in the same year) discourage non-emergency use of the emergency room. This authority applies to both newly eligible adults and previously eligible parents. By May 1, 2015, the state must establish a control group with a minimum of 5,000 beneficiaries who will not be subject to the increased co-payments; selection of the control group will be detailed in the state's protocol submitted to CMS.

A few of the other recent ACA expansion waivers include cost sharing provisions. However, they do not increase beneficiary cost sharing amounts beyond what is allowed under current law. In Arkansas, beneficiaries between 50-138% FPL have cost-sharing consistent with existing Medicaid state plan and Marketplace QHP rules (as discussed above, monthly contributions are paid into an account used to pay for co-payments and co-insurance). In Michigan, after six months, all beneficiaries will have cost-sharing obligations based on their prior six months of copays, billed at the end of each quarter. Cost-sharing will be paid into health savings accounts and can be reduced through compliance with certain healthy behaviors. However, the cost-sharing amounts are the same as what the state would have been able to collect without a waiver. The Michigan waiver terms and conditions specify that beneficiaries cannot lose or be denied Medicaid eligibility, be denied health plan enrollment, or be denied access to services, and providers may not deny services for failure to pay copays or premiums.

## WAIVER PROVISIONS DENIED BY CMS

**CMS has not approved waiver requests proposing premiums for individuals with incomes below 100% FPL where payment is a condition of eligibility.** As noted above, Arkansas, Iowa and Indiana do impose monthly contributions for individuals with incomes below poverty; however, for Medicaid eligibility cannot be terminated for non-payment.

**CMS has denied requests to waive certain Medicaid benefits.** In their waiver proposals, some states requested additional changes in benefits that were not approved. Specifically, CMS denied Iowa and Indiana's requests to waive the provision of EPSDT services for newly eligible 19 and 20 year olds and requests from Iowa and Pennsylvania to waive the provision of free choice of family planning providers for newly eligible adults. Pennsylvania's original waiver proposal also sought benefits package changes for current and newly eligible beneficiaries, seeking to replace current state plan benefits with a "high risk" package for people who are medically frail and a "low risk" package for other beneficiaries. These changes are not included in the waiver approval and the state instead submitted a SPA to implement these changes. The state's new governor subsequently withdrew the pending SPA seeking a reduced benefit package.

**CMS has denied waivers for states seeking to impose cost sharing in amounts greater than those allowed under federal law.** While Indiana recently received waiver authority to impose higher than statutory cost-sharing under Section 1916(f), CMS did not approve a § 1916(f) waiver request to allow Arizona to impose a \$200 co-pay for non-emergency use of the emergency room.<sup>10</sup> Pennsylvania was also denied a

# Endnotes

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<sup>1</sup> Status of State Action on the Medicaid Expansion Decision, Jan. 27, 2015. (Kaiser Family Foundation). <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>

<sup>2</sup> *The New Review and Approval Process Rule for Section 1115 Medicaid and CHIP Demonstration Waivers*. (Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, March 2012) <http://kff.org/health-reform/fact-sheet/the-new-review-and-approval-process-rule/>

<sup>3</sup> See N.H. Sen. Bill 413, available at <http://www.gencourt.state.nh.us/legislation/2014/SB0413.pdf>.

<sup>4</sup> As of December 1, 2015, Iowa beneficiaries from 101-138% FPL are no longer required to enroll in Marketplace premium assistance as a condition of eligibility because one of the two QHPs covering Medicaid beneficiaries is no longer participating. Instead, these beneficiaries can choose to receive coverage through the state's Medicaid managed care delivery system or enroll in the remaining QHP with premium assistance. As of January 1, 2015, beneficiaries from 101-138% FPL are enrolled in Medicaid managed care unless they opt to enroll in the remaining QHP. The state is submitting a waiver amendment about this program change to CMS after the required public notice and comment periods.

<sup>5</sup> MaryBeth Musumeci. *Medicaid Expansion Through Marketplace Premium Assistance* (Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, September 2013), <http://www.kff.org/medicaid/fact-sheet/medicaid-expansion-through-marketplace-premium-assistance/>.

<sup>6</sup> The shorter approval periods were designed to allow CMS use states' experience in these models to inform the new §1332 Marketplace innovation waiver authority available to states beginning in 2017.

<sup>7</sup> Instead of utilizing premium assistance models, approved waivers in Michigan, Pennsylvania, Indiana and Iowa for beneficiaries below 100% FPL, rely on Medicaid managed care organizations (MCOs) to delivery care to those newly eligible for coverage. Some of these states had considered premium assistance, but instead relied on existing delivery systems and MCOs to delivery care to the new population.

<sup>8</sup> Laura Snyder and Robin Rudowitz, *Premiums and Cost-Sharing in Medicaid: A Review of Research Findings*. (Kaiser Commission on Medicaid and the Uninsured, February 2013). <http://kff.org/medicaid/issue-brief/premiums-and-cost-sharing-in-medicaid-a-review-of-research-findings/>

<sup>9</sup> 42 U.S.C. §§ 1396a(a)(8), 1396a(a)(34); 42 C.F.R. § 435.914.

<sup>10</sup> Letter from Cindy Mann to Thomas Betlach, December 15, 2014. <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/az-hccc-ca.pdf>

## Medicaid Expansion: questions and choices

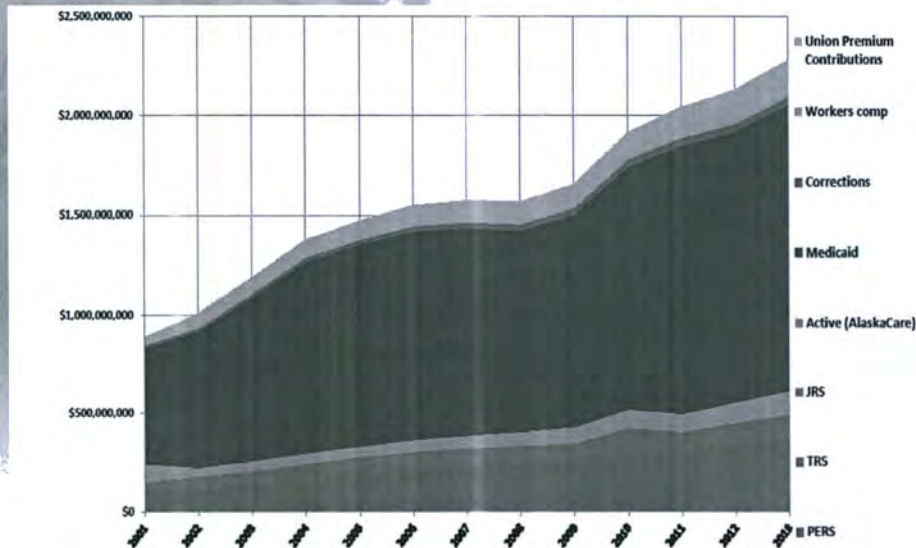
Becky Hultberg, President/CEO  
Alaska State Hospital and Nursing Home Association

March 19, 2015

ASHNHA

ALASKA STATE HOSPITAL &  
NURSING HOME ASSOCIATION

## State health care costs



## Alice's choice....

"Alice: Would you tell me, please, which way I ought to go from here?  
The Cheshire Cat: That depends a good deal on where you want to get to.  
Alice: I don't much care where.  
The Cheshire Cat: Then it doesn't much matter which way you go.  
Alice: ...So long as I get somewhere.  
The Cheshire Cat: Oh, you're sure to do that, if only you walk long enough."

- Lewis Carroll, *Alice in Wonderland*



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## Hate "Obamacare?"

Repeal is unlikely:

- Requires Republican majorities in both the House of Representatives and the Senate, a Republican President *and an alternative*.
- Insurance market today has been profoundly changed by the ACA. Not a simple rollback.
- Some of the elements that drive cost (pre-existing condition limitation) are among the most popular with the public.
- *We must move forward based on the reality of the current landscape.*



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# Addressing the questions

- Deficit driver?
- Able-bodied adults?
- Crowd-out?
- The Arkansas experience?
  - Impact on uncompensated care
  - ER utilization
- Can't opt out?

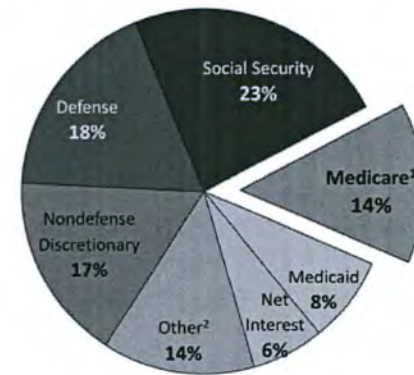


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# Deficit-driver?

Exhibit 1

## Medicare as a Share of the Federal Budget, 2013



Total Federal Outlays, 2013 = \$3.5 Trillion  
Net Federal Medicare Outlays, 2013 = \$492 Billion

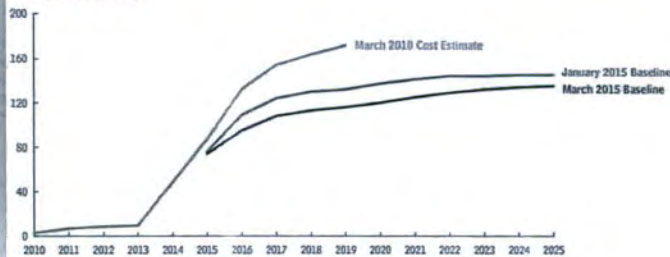
NOTE: All amounts are for federal fiscal year 2013. <sup>1</sup>Consists of Medicare spending minus income from premiums and other offsetting receipts. <sup>2</sup>Other category includes spending on other mandatory outlays minus income from offsetting receipts). SOURCE: Congressional Budget Office, Updated Budget Projections: 2014 to 2024 (April 2014).



# Deficit driver?

## CBO and JCT's Estimates of the Net Budgetary Effects of the Insurance Coverage Provisions of the Affordable Care Act

Billions of Dollars, by Fiscal Year



Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

Note: Effects on the deficit of provisions of the Affordable Care Act that are not related to insurance coverage and effects on discretionary spending of the coverage provisions are not shown.



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# Able-bodied adults?

## Medicare

- We subsidize health care for other groups of able-bodied (and more affluent) adults
- People become Medicare-eligible at 65
- Medicare payroll taxes cover only a third of the cost of the program



## Working – but low income

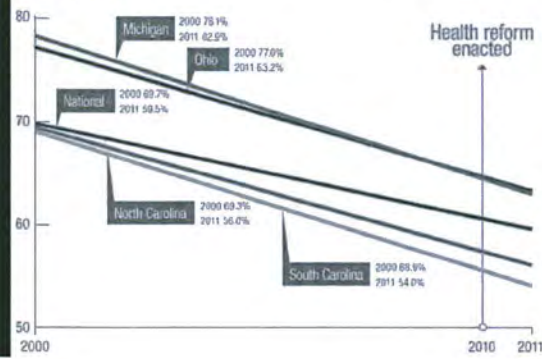
- 73.6% of the newly-eligible are either working or looking for work but can't afford health insurance.
- If individuals go over the Medicaid threshold, they are eligible for subsidized insurance in the exchange – they do not lose coverage.



# Crowd-out: private insurance?

Health Insurance Through Work Was Steadily Declining Nationwide Before the Affordable Care Act

Source: SHADAC.org

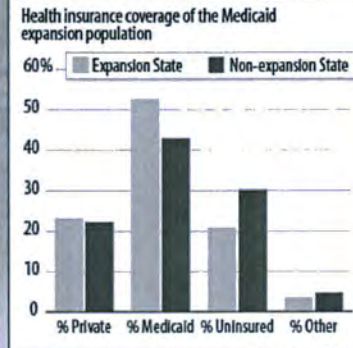


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# Crowd-out: private insurance?

Figure 1: Private Coverage Rates Are Not Lower In States with Medicaid Expansions



Source: Center on Budget and Policy Priorities analysis of 2009 Current Population Survey data. chpp.org

## Center on Budget and Policy Priorities:

“The existing body of research and the results of new analysis show that claims that the new law’s Medicaid expansions will lead to extensive crowd-out are highly exaggerated. Crowd-out rates among the low-income population are best estimated at between 10 percent and 20 percent, significantly less than the analyses touted by critics assume.”

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# Crowd-out: Medicare beneficiaries & kids?

## Medicare beneficiaries

- Evidence that this has happened elsewhere?
- When private physicians have not taken Medicare patients, hospitals have met this need

## Kids

- The Medicaid population is comprised of childless adults. There would be no “crowding out” based on availability of pediatricians.



PeaceHealth Medical Group • Ketchikan/Craig, Alaska  
for Travel & Family, Medical/Surgical Services & Support, Post & Discharge, Community Health & Wellness

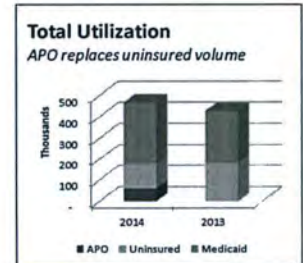
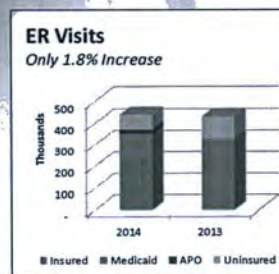
# The Arkansas experience?

## Impact on utilization

- Total visits to emergency rooms increased less than 2%
- Hospitals recorded 36,400 fewer ER visits by uninsured patients, a 35.5% decline
- Non-urgent visits to hospital outpatient clinics increased 5.8%

## Impact on the uninsured

- Number of people hospitalized without insurance fell 46.5%
- Overall hospital admissions remained relatively stable



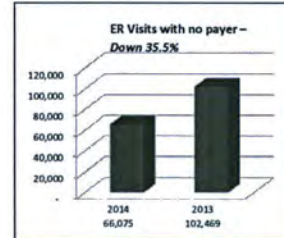
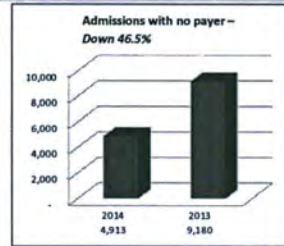
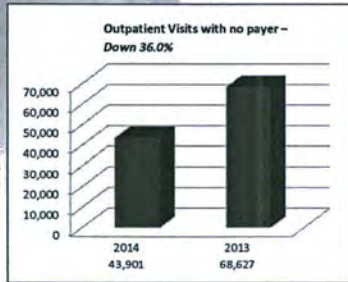
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# The Arkansas experience?

## Impact on uncompensated care

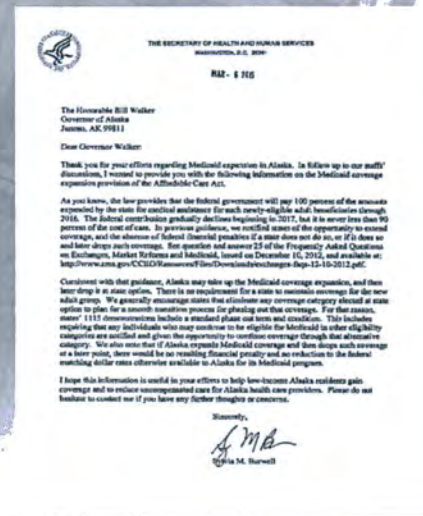
- Losses responding hospitals incurred caring for low-income Arkansans decreased by \$69 million



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# Can't opt out?



March 6 letter to Gov. Walker from Secretary Burwell:

“There is no requirement for a state to maintain coverage for the new adult group.”

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# The choices at the fork in the road

- Economic choices
- Moral choices
- Fiscal choices
- Health care service choices
- The “Alice choice”



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# Economic choices

Tim Bradner, Alaska Economic Report

- “There are growing signs of a flattening state economy. The state Dept. of Labor and Workforce Development reported March 3 that employment in the third quarter of 2014 dipped marginally below employment in the same period of 2013, mainly because of public sector job cuts and slower private-sector growth.” – Alaska Economic Report, March 10

Jonathan King, Northern Economics

- The economy is headed toward a recession, and Medicaid expansion is one of the few bright spots on the horizon. – Governor’s transition conference, November 2014

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## Moral choices

- Our views on what is a moral choice can be different.
- Health care organizations often view access to health care as a basic human right.
- Many of our not-for-profit hospital systems were established because of this commitment.
- From the Catholic Health Association:

*"We are inspired by the wisdom of the social doctrine of the Church, which teaches that each person is created in the image of God; that each human life is sacred and possesses inalienable worth; and that health care is essential to promoting and protecting the inherent dignity of every individual....."*

*The Catholic Health Association supports the expansion of the Medicaid program to everyone under 138 percent of the Federal poverty level. Access to Medicaid can mean the difference between life and death."*



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## Fiscal choices

- State expenditures for Medicaid would increase by only 2% to support Medicaid expansion.
- Net positive fiscal impact even when federal matching percentage (FMAP) goes to 90%.
  - 2016: (\$6.1) million
  - 2017: (\$8.1) million
  - 2018: (\$6.0) million
  - 2019: (\$7.9) million
  - 2020: (\$6.5) million
  - 2021: (\$3.2) million



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From the State of Alaska's Healthy Alaska plan:  
[http://dhs.alaska.gov/HealthyAlaska/Documents/Healthy\\_Alaska\\_Plan\\_FINAL.pdf](http://dhs.alaska.gov/HealthyAlaska/Documents/Healthy_Alaska_Plan_FINAL.pdf)

## Health care service choices

Enacted Cuts as a Percent of Total FFS Medicare Revenue  
 15 year summary value **-10.0%**

Cuts Enacted (2010-2024): Legislative	
ACA Marketbasket Cuts	(\$266,013,300)
Sequestration	(93,961,800)
Medicare DSH Cuts	(79,844,200)
Quality	(6,743,300)
ATRA Coding	(9,932,500)
Bad Debt at 65%	(2,180,700)
<b>Total Legislative Cuts</b>	<b>(\$458,675,800)</b>

Cuts Enacted (2010-2024): Regulatory	
Coding Cuts	(\$127,744,400)
2-Midnight Offset	(4,769,600)
<b>Total Regulatory Cuts</b>	<b>(\$132,514,000)</b>
<b>Total Cuts Enacted</b>	<b>(\$591,189,800)</b>

Cuts Under Consideration (2015-2024)	
Rural Cuts	(\$228,923,000)
OPD Cuts	(46,733,800)
IME/DGME Cuts	(14,218,200)
Bad Debt Elimination	(10,567,500)
CMS Coding Cut	(9,821,600)
Post Acute Cuts	(9,500,700)
<b>Total Cuts Under Consideration</b>	<b>(\$319,764,800)</b>



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## The Alice choice

Alice's question: "Would you tell me please, which way I ought to go from here?"

Our question: What is our vision for health care?

- We have to understand our destination.
- Which path we takes matters.
- If we don't understand our destination, we will end up somewhere, but it might not be where we want to be.



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## Health care of the future

Old way of doing things	New way of doing things
Pay for volume (fee for service)	Pay for outcomes (value = quality + cost)
Fragmented care delivery	Integrated, aligned care delivery
Decisions made on training and experience	Evidence-based best practice
"Sick care"	Population health management
Paper charts, fragmented IT systems	Integrated information systems
No data transparency	Transparency in quality and cost
Cost-cutting	Process improvement and efficiency
Unmanaged care	Care coordination



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## It works: PeaceHealth Ketchikan

- CMS innovation grant for care coordination: \$750,000/year
- All payers were included, even though grant came from CMS (Medicaid program benefited)
- Results:
  - 15% reduction in payments
  - 27% reduction in all-cause readmissions
  - Improvement in select clinical outcome areas
- Under the current payment model, had PeaceHealth Ketchikan implemented this project without the grant, *the organization would have spent money, to lose money, to improve care.*
- *Our model must change.*



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## How do we get there?

- Payers drive behavior
- In Alaska, we have few large non-governmental payers.
  - In other markets, large payers are driving change (e.g. Boeing Seattle).
- What does that mean:
  - Health care transformation must be a partnership between the industry, private sector payers and the State of Alaska, through Medicaid and its commercial plans.
- How does Medicaid expansion fit into this vision?
  - Risk capital through reduction in uncompensated care.
  - Changing how Medicaid pays and what it pays for.
  - Medicaid expansion can be the engine of health care system transformation.



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## Our choices.....



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