SB

74

<TARGET><BILL>SB 74</BILL><SUBJECT>SB
74</SUBJECT><COMM>SSTA29</COMM></TARGET>

SENATE COMMITTEE REPORT

DATE: 4/11/15

FURTHER: (Finance)

DATE TURNED IN TO OFFICE: 4/16/15

State Affairs Committee considered SENATE BILL NO. 74

SB 74-MEDICAID REFORM/PFD/HSAS/ER USE/STUDIES

"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."

and recommends:

[✓] be **replaced** with **CS** SCS/CS- Forthcoming _ (_____) *[ ] Same Title [ ] New Title*

[ ] adopt **previous CS** _____ (_____) *[ ] Same Title [ ] New Title*

[ ] attached amendment(s)

[ ] adopt _____ Letter of Intent

[ ] further referral to _____ Committee

NEW FISCAL NOTES COMM.

DHS	X			25
DHS	X			26
DHS	X			27
DHS	X			28

Dept Abbr.	
ADM	LWF
CED	LAW
COR	LEG
EED	MVA
DEC	DNR
DFG	DPS
GOV	REV
DHS	DOT
AJS	UA

NEW FISCAL NOTE(S)

Dept.	Fiscal	Indet.	Zero	FN #
DHS	✓			15
DHS	✓			16
DHS	✓			17
DHS	✓			18
DHS	✓			19
DHS	✓			20
DHS	✓			21
DHS	✓			22
DHS	✓			23
DHS	✓			24

PREVIOUS FISCAL NOTE(S)

Dept.	Fiscal	Indet.	Zero	FN #
LED			✓	14

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
	Wielechowski				✓
	Coghill	—			
	Huggins			✓	
CHAIR:	Stoltze			✓	

ALASKA STATE LEGISLATURE

SENATE STATE AFFAIRS COMMITTEE

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Official Business

April 16, 2015
Bill Packet Information

SB 74 MEDICAID REFORM/PFD/HSAS/ER USE/STUDIES

<Previously Scheduled 4/13, 4/14, 4/15; & Heard on 4/13 & 4/15>

Documents posted since last hearing:

- DHSS Position on CS(STA) - Email 4-15-15
- DHSS Response to Questions on Section 5 of CS(STA) – Email 4-15-15
- *New* Fiscal Note:
  - DHSS-PAA 4-15-15 **(Fiscal)**

HB 135 PUBLIC EMPLOYEE ROTH CONTRIBUTIONS

- Governor's Transmittal Letter 3-3-15
- Sectional Analysis by Department of Administration
- HB 135 version A
- Fiscal Note:
  - #1 – DOA-DRB 2-17-15 **(Zero)**
- Supporting Documents:
  - FAQ Sheet: Roth 457
  - DOA Press Release 3-12-15

HJR 22 STEWART-HYDER BORDER HOURS

- Sponsor Statement
- HJR 22 version A
- Fiscal Note:
  - #1 – LEG-SESS 4-8-15 **(Zero)**

<Bills Previously Heard/Scheduled>

ALASKA STATE LEGISLATURE

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Official Business

April 15, 2015
Bill Packet Information

SB 1 REGULATION OF SMOKING

<Previously Scheduled & Heard on 4/2 & 4/9>

Documents posted since last hearing:

- CS(STA) Workdraft **Version S – 4-14-15**
- Additional Letters of Support **(18)**
- Additional Letters of Opposition **(6)**

SB 74 MEDICAID REFORM/PFD/HSAS/ER USE/STUDIES

<Previously Scheduled 4/13 & 4/14; & Heard on 4/13/2015>

Documents posted since last hearing:

- **CS(STA) Workdraft Version F 4-14-15**
- DHSS Response to Committee Question re: Medicaid Enrollment & Spending

SB 89 PARENT RIGHTS: EDUCATION; SCHOOL ABSENCE

<Previously Scheduled 4/9 & 4/14; & Heard on 4/14/2015>

Documents posted since last hearing:

- Additional Letters of Support **(23)**
- Additional Letters of Opposition **(10)**

HB 142 ESTABLISH ELDERS' DAY

- Sponsor Statement
- HB 142 version W – ***Initial Version***
- Fiscal Note:
  - #1 - DOA-FAC 3-20-15 (**Zero**)
- Letters of Support:
  - Kawerak 3-23-15
  - DHSS – Division of Pioneer Homes 3-26-15
  - Alaska Commission on Aging 4-5-15

<Bills Previously Heard/Scheduled>

ALASKA STATE LEGISLATURE

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Official Business

April 14, 2015
Bill Packet Information

SB 58 TRANSPORT NETWORK SVES. & WORKERS COMP

<Previously Scheduled but Not Heard on 4/2/2015>

- Sponsor Statement
- Workdraft CS(STA) for SB 58 – ***Version P***
- Sectional Analysis – *Version N*
- SB 58 CS(L&C) – *Version N*
- SB 58 *Version A – Initial Version*
- Supporting Documents:
  - Letter Chugiak-Eagle River Chamber of Commerce 2-19-15
  - MOA Bus Service Change Proposal – 2015
- Fiscal Notes:
  - #1 – DOA-DMV 4-10-15 (**Zero**)
  - #2 – DOLWD-WC 2-27-15 (**Zero**)

SB 89 PARENT RIGHTS: EDUCATION; SCHOOL ABSENCE

<Previously Scheduled but Not Heard on 4/9/2015>

- Sponsor Statement
- Explanation of Changes from (S)EDC to (S)STA Workdraft
- Workdraft CS(STA) for SB 58 – ***Version G***
- Sectional Summary by Legal Services – Version I
- CS for SB 89(EDC) – Version I
- SB 89 – Initial Version
- Supporting Documents:
  - Emails of Support to SSTA from 4/8 to 4/13 **(37)**
  - Emails of Opposition to SSTA from 4/8 to 4/13 **(66)**
  - Emails of Support to SEDC Committee **(19)**
  - Emails of ***Support & Opposition*** from SEDC Committee **(104)**
- * Fiscal Note:
  - EED-SSA 4-10-15 (**Zero**)

SB 74 MEDICAID REFORM/PFD/HSAS/ER USE/STUDIES

<Previously Scheduled & Heard on 4/13/2015>

No additional documents at this time

SB 67 PUBLIC EMPLOYEE ROTH CONTRIBUTIONS

- Governor's Transmittal Letter 3-3-15
- Sectional Analysis by Department of Administration
- SB 67 version A
- Supporting Documents:
  - FAQ Sheet: Roth 457
  - DOA Press Release 3-12-15
- Fiscal Note:
  - #1 – DOA-DRB 2-17-15 **(Zero)**

SB 9 ELECTION PAMPHLETS

<Previously Scheduled & Heard on 2/26/2015>

No additional documents at this time

<Bills Previously Heard/Scheduled>

ALASKA STATE LEGISLATURE

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Official Business

April 13, 2015
Bill Packet Information

8:00 – 9:00 AM

SB 74 MEDICAID REFORM/PFD/HSAS/ER USE/STUDIES

- Sponsor Statement – ***Updated***
- Sectional Analysis by Sponsor – (***Version \S)***
- SB 74 version S – ***CS(HSS)***
- Summary of Changes by Sponsor
- SB 74 version H – ***Initial Version***
- Supporting Documents:
  - Letter AETNA 3-27-15
  - Report: Lewin Group "Medicaid Managed Care Cost Savings" 2009
  - Legislative Research Service Report 15.284 re: Medicaid
  - Graphs prepared by Legislative Finance Division (LFD) 3-13-15
  - Presentation by LFD: Medicaid History and Projection 3-30-15
  - Medicaid Fraud Press Release & News Article
- Public Testimony Documents:
  - Support Letters:
    - Hans Rodvik (Americans for Prosperity) 4-1-15
  - Other:
    - Congregation Sukkat Shalom - Resolution 3-16-15
- Fiscal Notes:
  - **A Fiscal Note Spreadsheet will be made available to the committee**
  - There were 14 published fiscal notes that applied to SB 74 (*Initial Version*)
  - There are now 15 applicable fiscal notes for the **CS(HSS)** – *Version S*
    - ***Only published note #14 still applies, all others are new notes.***

ALASKA STATE LEGISLATURE

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Official Business

April 2, 2015
Bill Packet Information

SB 74 MEDICAID REFORM/PFD/HSAS/ER USE/STUDIES

<Pending Referral>

- *Documents Forthcoming*

SB 1 REGULATION OF SMOKING

<Initial Presentation by Sponsor>

- Sponsor Statement – CS(HSS) Version
- Sectional Analysis – CS(HSS) Version
- Explanation of Changes from Initial to HSS Version
- SB 1 version \I – ***CS(HSS)***
- SB 1 version \E – Initial (*sponsor substitute*)
- Fiscal Notes:
  - #1 – DOT-MVO 2-6-15 (**Fiscal**)
  - #2 – DOT-IASO 2-6-15 (**Fiscal**)
  - #3 – DOT-SEF 2-6-15 (**Fiscal**)
  - #4 – DOT-TMS 2-6-15 (**Fiscal**)
  - #5 – DCCED-ABC 2-6-15 (**Zero**)
  - #6 – ACS-TRC 2-6-15 (**Zero**)
  - #7 – DHSS-CDPHP 2-6-15 (**Zero**)
  - #8 – DEC-FSS 3-6-15 (**Zero**)
- PowerPoint Presentation by Sponsor
- Supporting Documents:
  - Research Source Documents – Sponsor
  - E-Cigarettes – Sponsor
  - Legal Opinions – Provided by Sponsor
  - AS 44.29.020 – Lethal Effects of Secondhand Smoke
  - SoA Impacts
  - Dittman Research Public Opinion Poll (2012): Statewide Smoke-Free Workplace

Alaska State Legislature

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Sponsor Statement – CS Senate Bill 74 (HSS)

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

CS for Senate Bill 74 begins the process of reform and cost containment 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.

CSSB 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, significantly enhances fraud prevention, enforcement, and recovery, undertake additional 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).

Fraud prevention is further enhanced by adding civil penalties and damages for knowingly submitting submits false Medicaid payment claims (Section 1). The new damages and penalties set out in CSSB 74 are in addition to other legal remedies the State of Alaska and DHSS has available to utilize. The legislature would now receive an annual report relating to Medicaid fraud, abuse, errors, and vulnerabilities from DHSS and the attorney general (Section 4).

CSSB 74 directs DHSS to initiate one or more managed care or case management demonstration project for individuals enrolled in the Medicaid program (Section 5). 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. 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.

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 CSSB 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.

CSSB 74 begins the process to explore privatization (Section 6). 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 tribal organizations 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.

Alaska State Legislature

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Sectional Analysis – CS for Senate Bill 74

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

Section 1: Adds new sections establishing civil penalties for false claims for medical assistance and authorizing the Department of Health and Social Services (the department) to assess civil penalties against medical assistance providers.

Section 2: Requires the Department of Health and Social Services (the department) to design, adopt, and implement a medical assistance (Medicaid) reform program. Requires the department to prepare and submit a report about reforms, savings, and costs related to the Medicaid program. Provides for a definition of "telemedicine."

Section 3: Requires the department to design and implement a demonstration project to reduce nonurgent use of emergency departments by Medicaid recipients.

Section 4: Requires the department and the attorney general to annually prepare a report regarding fraud prevention, abuse, prosecution, and vulnerabilities in the Medicaid program.

Section 5: Requires the department to develop one or more managed care or case management demonstration projects through a contract with a third party. The managed care program would be for individuals enrolled in all Medicaid programs.

Section 6: Requires the department to conduct a study analyzing the feasibility of privatizing certain services.

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Section 7: 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. Requires the Commissioner of Health and Social Services to certify to the revisor of statutes federal approval of specified measures.

Section 8: Allows the department to adopt regulations necessary to implement the changes made by the Act. The regulations may not take effect before the dates the relevant provision of the Act takes effect.

Section 9: Conditional effects.

Sections 10 - 14: Provides for effective dates for provisos that require waiver and state plan amendment approvals from the United States Department of Health and Human Services.

Section 15: Provides an immediate effective date for sections 6, 7, and 8.

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Explanations of Changes

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

Version H to Version S (SHSS)

- Removed sections regarding health savings accounts (HSAs) for Medicaid beneficiaries and contributions to HSAs from the Permanent Fund Dividend.
- New Section 1 regarding false Medicaid claims and establishing civil penalties for fraud.
- Section 2
  - Added behavioral health for the expanded use of telemedicine (Page 3, line 14)
  - Changed the report due date to October 15 in subsection (c) (Page 4, line 7)
  - Expanded the report scope under subsection (c) regarding Medicaid reforms, savings, and costs (Page 4, line 11 through Page 5, line 9)
  - Added in a definition of "telemedicine" (Page5, lines 10-14)
- New Section 4 requiring an annual report to the legislature regarding DHSS efforts to reduce Medicaid fraud.
- Section 5
  - Allows the demonstration project to be focused on Medicaid managed care or case management
  - Changes the one or more demonstration projects from individuals enrolled in the Denali KidCare program to the entire Medicaid program.
  - Changed the start date to January 31, 2016
  - Requires the department to enter into contracts with one or more third-party for the demonstration projects.

Fiscal Note

State of Alaska
2015 Legislative Session

Bill Version:	SB 74
Fiscal Note Number:	1
(S) Publish Date:	4/11/2015

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				
OPERATING EXPENDITURES	**FY 2016**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits				(3,456.6)	(3,484.3)	(3,867.6)	(3,898.5)
Miscellaneous							
Total Operating	**0.0**	**0.0**	**0.0**	**(3,456.6)**	**(3,484.3)**	**(3,867.6)**	**(3,898.5)**
Fund Source (Operating Only)							
1003 G/F Match				(3,456.6)	(3,484.3)	(3,867.6)	(3,898.5)
Total	**0.0**	**0.0**	**0.0**	**(3,456.6)**	**(3,484.3)**	**(3,867.6)**	**(3,898.5)**
Positions							
Full-time							
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? 07/01/17

Why this fiscal note differs from previous version:

Not applicable, initial version.

Prepared By:	Albert E. Wall, Director	Phone:	(907)465-4841
Division:	Behavioral Health	Date:	03/21/2015 12:00 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

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:	2
(S) Publish Date:	4/11/2015

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 Appropriation Requested	Included in Governor's FY2016 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY 2016**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**
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							
Total Operating	**599.6**	**0.0**	**561.6**	**561.6**	**561.6**	**561.6**	**561.6**
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
Total	**599.6**	**0.0**	**561.6**	**561.6**	**561.6**	**561.6**	**561.6**
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

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

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:	3
(S) Publish Date:	4/11/2015

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 Appropriation Requested	Included in Governor's FY2016 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY 2016**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**
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							
Total Operating	**198.8**	**0.0**	**329.4**	**321.8**	**191.2**	**191.2**	**191.2**
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
Total	**198.8**	**0.0**	**329.4**	**321.8**	**191.2**	**191.2**	**191.2**
Positions							
Full-time	1.0		2.0	2.0	1.0	1.0	1.0
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? 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

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:	4
(S) Publish Date:	4/11/2015

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

Fund Source (Operating Only)

1002 Fed Rcpts	17.5						
1003 G/F Match	17.5						
Total	**35.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Positions

Full-time							
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? 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:	Ron Kreher, Acting Director	Phone:	(907)465-5847
Division:	Public Assistance	Date:	03/20/2015 03:50 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

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:	5
(S) Publish Date:	4/11/2015

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				
OPERATING EXPENDITURES	**FY 2016**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**
Personal Services	108.0		324.0	324.0	324.0	324.0	324.0
Travel	2.3		6.8	6.8	6.8	6.8	6.8
Services	186.8		193.9	540.8	10.6	10.6	10.6
Commodities	2.5		7.6	7.6	7.6	7.6	7.6
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	**299.6**	**0.0**	**532.3**	**879.2**	**349.0**	**349.0**	**349.0**
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
Total	**299.6**	**0.0**	**532.3**	**879.2**	**349.0**	**349.0**	**349.0**
Positions							
Full-time	1.0		3.0	3.0	3.0	3.0	3.0
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? 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 04:45 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

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:	6
(S) Publish Date:	4/11/2015

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 Appropriation Requested	Included in Governor's FY2016 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY 2016**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits				(4,494.3)	(4,494.3)	(4,494.3)	(4,494.3)
Miscellaneous							
Total Operating	**0.0**	**0.0**	**0.0**	**(4,494.3)**	**(4,494.3)**	**(4,494.3)**	**(4,494.3)**
Fund Source (Operating Only)							
1004 Gen Fund				(4,494.3)	(4,494.3)	(4,494.3)	(4,494.3)
Total	**0.0**	**0.0**	**0.0**	**(4,494.3)**	**(4,494.3)**	**(4,494.3)**	**(4,494.3)**
Positions							
Full-time							
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? 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

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.

Fiscal Note

State of Alaska
2015 Legislative Session

Bill Version:	SB 74
Fiscal Note Number:	7
(S) Publish Date:	4/11/2015

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				
OPERATING EXPENDITURES	**FY 2016**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits				(716.3)	(716.3)	(716.3)	(716.3)
Miscellaneous							
Total Operating	**0.0**	**0.0**	**0.0**	**(716.3)**	**(716.3)**	**(716.3)**	**(716.3)**
Fund Source (Operating Only)							
1004 Gen Fund				(716.3)	(716.3)	(716.3)	(716.3)
Total	**0.0**	**0.0**	**0.0**	**(716.3)**	**(716.3)**	**(716.3)**	**(716.3)**
Positions							
Full-time							
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? 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

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:	8
(S) Publish Date:	4/11/2015

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				
OPERATING EXPENDITURES	**FY 2016**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits				(11,635.8)	(11,635.8)	(11,635.8)	(11,635.8)
Miscellaneous							
Total Operating	**0.0**	**0.0**	**0.0**	**(11,635.8)**	**(11,635.8)**	**(11,635.8)**	**(11,635.8)**
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)
Total	**0.0**	**0.0**	**0.0**	**(11,635.8)**	**(11,635.8)**	**(11,635.8)**	**(11,635.8)**
Positions							
Full-time							
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? 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

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:	9
(S) Publish Date:	4/11/2015

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 Appropriation Requested	Included in Governor's FY2016 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY 2016**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**
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							
Total Operating	**317.3**	**0.0**	**302.1**	**302.1**	**302.1**	**302.1**	**302.1**
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
Total	**317.3**	**0.0**	**302.1**	**302.1**	**302.1**	**302.1**	**302.1**
Positions							
Full-time	2.0		2.0	2.0	2.0	2.0	2.0
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? 07/01/16

Why this fiscal note differs from previous version:

Not applicable, initial version.

Prepared By:	Sana Efird, Assistant Commissioner	Phone:	(907)465-1630
Division:	Finance and Management Services	Date:	03/21/2015 04:30 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

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 positon, 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 x 2 = $18.8
Software and licensing fees - $45.5
FY2016 Services total: $64.3

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

State of Alaska
2015 Legislative Session

Bill Version:	SB 74
Fiscal Note Number:	10
(S) Publish Date:	4/11/2015

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 Appropriation Requested	Included in Governor's FY2016 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY 2016**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**
Personal Services							
Travel	6.0						
Services	759.0						
Commodities							
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	**765.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Fund Source (Operating Only)							
1002 Fed Rcpts	20.0						
1003 G/F Match	20.0						
1004 Gen Fund	725.0						
Total	**765.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Positions							
Full-time							
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? 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: Sana Efird, Assistant Commissioner — Phone: (907)465-1630
Division: Finance and Management Services — Date: 03/20/2015 01:37 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

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.

<u>One-time costs:</u>

<u>72000 Travel: $6.0 ($3.0 GF/ $3.0 Fed)</u>
Travel to Wasilla, Barrow, Ketchikan and Kodiak for 1 staff and 1 contracted court reporter

<u>73000 Contractual Services: $34.0 ($17.0 GF/$17.0 Fed)</u>
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).

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:	11
(S) Publish Date:	4/11/2015

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 Appropriation Requested	Included in Governor's FY2016 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY 2016**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits				7,856.0	7,918.8	8,789.9	8,860.2
Miscellaneous							
Total Operating	**0.0**	**0.0**	**0.0**	**7,856.0**	**7,918.8**	**8,789.9**	**8,860.2**
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
Total	**0.0**	**0.0**	**0.0**	**7,856.0**	**7,918.8**	**8,789.9**	**8,860.2**
Positions							
Full-time							
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? 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
015 LEGISLATIVE SESSION

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:	12
(S) Publish Date:	4/11/2015

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				
OPERATING EXPENDITURES	**FY 2016**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**
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							
Total Operating	**(2,853.3)**	**0.0**	**(5,003.3)**	**(5,003.3)**	**(5,003.3)**	**(5,003.3)**	**(5,003.3)**
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)
Total	**(2,853.3)**	**0.0**	**(5,003.3)**	**(5,003.3)**	**(5,003.3)**	**(5,003.3)**	**(5,003.3)**
Positions							
Full-time							
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? 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 03:30 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

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 regiments 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,

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	
Months in a year		12
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 x 7,800 x 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 x $613.39 x 5 = $23,922.2 x 30% = $7,176.7

Fiscal Note

State of Alaska
2015 Legislative Session

Bill Version:	SB 74
Fiscal Note Number:	13
(S) Publish Date:	4/11/2015

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				
OPERATING EXPENDITURES	**FY 2016**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits				16,846.4	16,846.4	16,846.4	16,846.4
Miscellaneous							
Total Operating	**0.0**	**0.0**	**0.0**	**16,846.4**	**16,846.4**	**16,846.4**	**16,846.4**
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
Total	**0.0**	**0.0**	**0.0**	**16,846.4**	**16,846.4**	**16,846.4**	**16,846.4**
Positions							
Full-time							
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? 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 05:45 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

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

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:	14
(S) Publish Date:	4/11/2015

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 Appropriation Requested	Included in Governor's FY2016 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY 2016**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Fund Source (Operating Only)							
None							
Total	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Positions							
Full-time							
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? 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, intial version.

Prepared By:	Lori Wing-Heier, Director	Phone:	(907)465-2515
Division:	Division of Insurance	Date:	03/20/2015 11:04 AM
Approved By:	Catherine Reardon, Director	Date:	03/20/15
Agency:	Division of Administrative Services, DCCED		

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2015 LEGISLATIVE SESSION

Analysis

SB74 amends Title 43: Revenue and Taxation, and Title 47: Welfare, Social Services and Instititutions, 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: SB074CS(HSS)-DHSS-BHTRG-04-10-15
Title: MEDICAID REFORM/PFD/HSAS/ER USE/STUDIES
Sponsor: KELLY
Requester: Senate State Affairs 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				
OPERATING EXPENDITURES	**FY 2016**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits				(3,456.6)	(3,484.3)	(3,867.6)	(3,898.5)
Miscellaneous							
Total Operating	**0.0**	**0.0**	**0.0**	**(3,456.6)**	**(3,484.3)**	**(3,867.6)**	**(3,898.5)**
Fund Source (Operating Only)							
1003 G/F Match				(3,456.6)	(3,484.3)	(3,867.6)	(3,898.5)
Total	**0.0**	**0.0**	**0.0**	**(3,456.6)**	**(3,484.3)**	**(3,867.6)**	**(3,898.5)**
Positions							
Full-time							
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? 07/01/15

Why this fiscal note differs from previous version:

This fiscal note has been updated to reflect the bill sectional identifiers corresponding to the Committee Substitute for SB 74.

Prepared By: Albert E. Wall, Director — Phone: (907)465-4841
Division: Behavioral Health — Date: 04/10/2015 12:35 PM
Approved By: Sarah Woods, Deputy Director, Finance & Management Services — Date: 04/10/15
Agency: Health & Social Services

STATE OF ALASKA
2015 LEGISLATIVE SESSION

BILL NO. CSSB074(HSS)

Analysis

Section 2(5) directs the Department to reduce the cost of behavioral health, senior and disabilities services provided to recipients of medical assistance under the state's home and community-based waiver. **Section 7** requires the Department to apply for "any waivers necessary" to implement this bill.

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: SB074CS(HSS)-DHSS-MAA-04-10-15
Title: MEDICAID REFORM/PFD/HSAS/ER USE/STUDIES
Sponsor: KELLY
Requester: Senate State Affairs 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 Appropriation Requested	Included in Governor's FY2016 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY 2016**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**
Personal Services	201.2		201.2	201.2	201.2	201.2	201.2
Travel	2.0		2.0	2.0	2.0	2.0	2.0
Services	477.5		477.5	477.5	477.5	477.5	477.5
Commodities	19.2		4.0	4.0	4.0	4.0	4.0
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	**699.9**	**0.0**	**684.7**	**684.7**	**684.7**	**684.7**	**684.7**
Fund Source (Operating Only)							
1002 Fed Rcpts	350.0		342.4	342.4	342.4	342.4	342.4
1003 G/F Match	349.9		342.3	342.3	342.3	342.3	342.3
Total	**699.9**	**0.0**	**684.7**	**684.7**	**684.7**	**684.7**	**684.7**
Positions							
Full-time	2.0		2.0	2.0	2.0	2.0	2.0
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:

This fiscal note has been updated to reflect the bill sectional identifiers corresponding to the Committee Substitute for SB 74. Costs for Dept. of Law have been included, addressing Section 1 drafting of regulations and prosecuting providers who fail to pay assigned penalties. Staff costs for Section 2(a)(4) have been reduced through use of lower level positions. Section 2(c) requires the Department to prepare and submit to the legislature a comprehensive annual report on reform cost savings, results of demonstration projects, and other parameters that enhance or support Medicaid reform. The bill section creating an optional savings account was removed, as have been the associated costs for Accounting Technicians. Section 4 requires the Departments of Law and Health and Social Services to prepare an annual report on fraud and abuse, and errors in eligibility determinations and payments.

Prepared By: Margaret Brodie, Director — Phone: (907)334-2520
Division: Health Care Services — Date: 04/10/2015 05:00 PM
Approved By: Sarah Woods, Deputy Director, Finance & Management Services — Date: 04/10/15
Agency: Health & Social Services

STATE OF ALASKA
2015 LEGISLATIVE SESSION

BILL NO. CSSB074(HSS)

Analysis

Section 1 adds a false claims act to law, and authorizes the Department to adopt regulations to assess civil penalties against offending providers, and to refer non-payment cases to the attorney general for prosecution. DHSS would support this Dept. of Law effort via a reimbursable services agreement for a Dept. of Law attorney ($225.0), a paralegal ($140.0) and an investigator ($93.7), per Law's estimates of resources needed for drafting regulations and pursuing actions against violators.

Section 2(c) requires the Department to prepare and submit to the legislature a comprehensive annual report on reform cost savings, results of demonstration projects, and many other parameters that enhance or support Medicaid reform. The Department has determined that it can absorb the cost of preparing this report with its current appropriation. This assumes that the report will be made available on line with notification to the legislature on or before October 15 of each year.

Section2(a)(4) 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 II, range 18 - $100.6
1 Research Analyst III, range 18 - $100.6
FY2016 Personal services total $201.2

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

Section 4 requires the Departments of Law and Health and Social Services to prepare an annual report on fraud and abuse, and errors in eligibility determinations and payments, and many other parameters that enhance or support Medicaid reform. The Department has determined that it can absorb the cost of preparing this report with its current appropriation. This assumes that the report will be made available on line with notification to the legislature on or before October 15 of each year.

Fiscal Note

State of Alaska
2015 Legislative Session

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

Identifier: SB074CS(HSS)-DHSS-RR-04-10-15
Title: MEDICAID REFORM/PFD/HSAS/ER USE/STUDIES
Sponsor: KELLY
Requester: Senate State Affairs 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 Appropriation Requested	Included in Governor's FY2016 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY 2016**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**
Personal Services							
Travel							
Services	500.0		100.0	100.0	100.0	100.0	100.0
Commodities							
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	**500.0**	**0.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Fund Source (Operating Only)							
1002 Fed Rcpts	250.0		50.0	50.0	50.0	50.0	50.0
1003 G/F Match	250.0		50.0	50.0	50.0	50.0	50.0
Total	**500.0**	**0.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Positions							
Full-time							
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? 07/01/16

Why this fiscal note differs from previous version:

This fiscal note has been updated to reflect the bill sectional identifiers corresponding to the Committee Substitute for SB 74. With further research, the Department has determined that use of contracted actuarial services, rather than staff, would be more appropriate.

Prepared By: Margaret Brodie, Director — Phone: (907)334-2520
Division: Health Care Services — Date: 04/10/2015 02:00 PM
Approved By: Sarah Woods, Deputy Director, Finance & Management Services — Date: 04/10/15
Agency: Health & Social Services

STATE OF ALASKA
2015 LEGISLATIVE SESSION

BILL NO. CSSB074(HSS)

Analysis

Section 2(a)(8) requires the department to implement a reform program that redesigns the payment process by implementing fee agreements based on performance measures that include premium payments and penalties.

Section 5(a) requires the department to design and initiate one or more managed care or case management demonstration projects by January 31, 2016. The department must enter into a contract to implement the project, and the contract must provide a fee based on a per capita expense. Additionally, for primary care case managers, the fee agreement must include an incentive-based management fee system that must be based on performance measures.

Both sections involve payment reform in that the department is directed to change Medicaid reimbursement from a fee-for-service system to an outcome-based system. Outcome-based reimbursement is based on complex data analysis and calculations that require actuarial expertise. Once an outcome-based reimbursement system is established, administration of the system would still require actuarial expertise that is only available by contract.

Since the objectives from both sections require actuarial expertise, the department would likely use the same contractor for both projects. Specifically, the contractor will analyze and implement a payment model for managed care, and use those concepts to also redesign other payment processes. Upon implementing these payment models, the contractor will be retained for annual actuarial work and assistance with administration.

The initial and ongoing costs associated with hiring a contractor to perform this work are not fully known at this time. Based on consultation with other states, the department estimates a one-time $500.0 contract for a firm to analyze and implement one or more innovative payment models. Additionally, the department estimates an annual $100.0 contract for actuarial work and assistance with administration.

Fiscal Note

State of Alaska
2015 Legislative Session

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

Identifier: SB074CS(HSS)-DHSS-PAA-04-12-15
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 Appropriation Requested	Included in Governor's FY2016 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY 2016**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Fund Source (Operating Only)							
None							
Total	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Positions							
Full-time							
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? 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:

Section 3 of the original bill would have required the Department to develop and implement a personal health savings account program for Medicaid recipients that includes recipient cost-sharing and copayment structures. That provision has been removed from the CS so the cost to this component is now zero.

Prepared By: Ron Kreher, Acting Director — Phone: (907)465-5847
Division: Public Assistance — Date: 04/12/2015 03:50 PM
Approved By: Sarah Woods, Deputy Director Finance & Management Services — Date: 04/12/15
Agency: Health & Social Services

Fiscal Note

State of Alaska
2015 Legislative Session

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

Identifier: SB074CS(HSS)-DHSS-SDSA-04-10-15
Title: MEDICAID REFORM/PFD/HSAS/ER USE/STUDIES
Sponsor: KELLY
Requester: Senate State Affairs 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				
OPERATING EXPENDITURES	**FY 2016**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**
Personal Services	108.0		324.0	324.0	324.0	324.0	324.0
Travel	2.3		6.8	6.8	6.8	6.8	6.8
Services	186.8		193.9	540.8	10.6	10.6	10.6
Commodities	2.5		7.6	7.6	7.6	7.6	7.6
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	**299.6**	**0.0**	**532.3**	**879.2**	**349.0**	**349.0**	**349.0**
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
Total	**299.6**	**0.0**	**532.3**	**879.2**	**349.0**	**349.0**	**349.0**
Positions							
Full-time	1.0		3.0	3.0	3.0	3.0	3.0
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? 07/01/17

Why this fiscal note differs from previous version:

This fiscal note has been updated to reflect the bill sectional identifiers corresponding to the Committee Substitute for SB 74.

Prepared By: Duane Mayes, Director — Phone: (907)269-2083
Division: Senior and Disabilities Services — Date: 04/10/2015 03:00 PM
Approved By: Sarah Woods, Deputy Director, Finance & Management Services — Date: 04/10/15
Agency: Health & Social Services

STATE OF ALASKA
2015 LEGISLATIVE SESSION

BILL NO. CSSB074(HSS)

Analysis

Section 2(5) directs the Department to reduce the cost of behavioral health, senior and disabilities services provided to recipients of medical assistance under the state's home and community-based waiver. **Section 7** requires the Department to apply for "any waivers necessary" to implement this bill.

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 determine eligibility for these Medicaid programs, federal regulation requires the state to perform an annual "hands-on" functional eligibility determination. The current GF-funded grant programs do not require this determination; therefore SDS will need additional staff to perform functional eligibility assessments on the approximately 3,000 individuals transitioning from the state grant programs. These staff will be Health Program Manager II positions, one in FY2016 and two more starting in FY2017. Positions = $108.0 apiece. Travel = $2.3; Services = $3.5; Commodities = $2.5.

SDS requests the two additional staff in out-years to give the agency capacity for ongoing administration of a significantly larger Medicaid program. State and federal regulations mandate state responsibility for trained staff to perform annual functional eligibility assessments and review of each recipient's "plan of care" for home and community-based services. Because the State relies on a fully privatized workforce of over 1,300 for- and non-profit agencies, a larger program requires additional resources for ongoing provider certification and oversight, including regulatory compliance and fraud detection. Also, the State must ensure the health and safety of the most vulnerable and infirm members of the community with ongoing quality assurance actions, including on-site provider reviews and forensic activities. Finally, as the state mounts its performance evaluation activities, extensive data development, gathering and management add to the agency's responsibilities.

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: SB074CS(HSS)-DHSS-GRTAL-04-10-15
Title: MEDICAID REFORM/PFD/HSAS/ER USE/STUDIES
Sponsor: KELLY
Requester: Senate State Affairs 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 Appropriation Requested	Included in Governor's FY2016 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY 2016**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits				(4,494.3)	(4,494.3)	(4,494.3)	(4,494.3)
Miscellaneous							
Total Operating	**0.0**	**0.0**	**0.0**	**(4,494.3)**	**(4,494.3)**	**(4,494.3)**	**(4,494.3)**
Fund Source (Operating Only)							
1004 Gen Fund				(4,494.3)	(4,494.3)	(4,494.3)	(4,494.3)
Total	**0.0**	**0.0**	**0.0**	**(4,494.3)**	**(4,494.3)**	**(4,494.3)**	**(4,494.3)**
Positions							
Full-time							
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? 07/01/17

Why this fiscal note differs from previous version:

This fiscal note has been updated to reflect the bill sectional identifiers corresponding to the Committee Substitute for SB 74.

Prepared By: Duane Mayes, Director — Phone: (907)269-2083
Division: Senior and Disabilities Services — Date: 04/10/2015 03:00 PM
Approved By: Sarah Woods, Deputy Director, Finance & Management Services — Date: 04/10/15
Agency: Health & Social Services

STATE OF ALASKA
2015 LEGISLATIVE SESSION

BILL NO. CSSB074(HSS)

Analysis

Section 2(5) directs the Department to reduce the cost of behavioral health, senior and disabilities services provided to recipients of medical assistance under the state's home and community-based waiver. **Section 7** requires the Department to apply for "any waivers necessary" to implement this bill.

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.

Fiscal Note

State of Alaska
2015 Legislative Session

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

Identifier: SB074CS(HSS)-DHSS-SCBG-04-10-15
Title: MEDICAID REFORM/PFD/HSAS/ER USE/STUDIES
Sponsor: KELLY
Requester: Senate State Affairs 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				
OPERATING EXPENDITURES	**FY 2016**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits				(716.3)	(716.3)	(716.3)	(716.3)
Miscellaneous							
Total Operating	**0.0**	**0.0**	**0.0**	**(716.3)**	**(716.3)**	**(716.3)**	**(716.3)**
Fund Source (Operating Only)							
1004 Gen Fund				(716.3)	(716.3)	(716.3)	(716.3)
Total	**0.0**	**0.0**	**0.0**	**(716.3)**	**(716.3)**	**(716.3)**	**(716.3)**
Positions							
Full-time							
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? 07/01/17

Why this fiscal note differs from previous version:

This fiscal note has been updated to reflect the bill sectional identifiers corresponding to the Committee Substitute for SB 74.

Prepared By: Duane Mayes, Director — Phone: (907)269-2083
Division: Senior and Disabilities Services — Date: 04/10/2015 03:00 PM
Approved By: Sarah Woods, Deputy Director, Finance & Management Services — Date: 04/10/15
Agency: Health & Social Services

STATE OF ALASKA
2015 LEGISLATIVE SESSION

BILL NO. CSSB074(HSS)

Analysis

Section 2(5) directs the Department to reduce the cost of behavioral health, senior and disabilities services provided to recipients of medical assistance under the state's home and community-based waiver. **Section 7** requires the Department to apply for "any waivers necessary" to implement this bill.

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: SB074CS(HSS)-DHSS-CDDG-04-10-15
Title: MEDICAID REFORM/PFD/HSAS/ER USE/STUDIES
Sponsor: KELLY
Requester: Senate State Affairs 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				
OPERATING EXPENDITURES	**FY 2016**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits				(11,635.8)	(11,635.8)	(11,635.8)	(11,635.8)
Miscellaneous							
Total Operating	**0.0**	**0.0**	**0.0**	**(11,635.8)**	**(11,635.8)**	**(11,635.8)**	**(11,635.8)**
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)
Total	**0.0**	**0.0**	**0.0**	**(11,635.8)**	**(11,635.8)**	**(11,635.8)**	**(11,635.8)**
Positions							
Full-time							
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? 07/01/17

Why this fiscal note differs from previous version:

This fiscal note has been updated to reflect the bill sectional identifiers corresponding to the Committee Substitute for SB 74.

Prepared By: Duane Mayes, Director — Phone: (907)269-2083
Division: Senior and Disabilities Services — Date: 04/10/2015 03:00 PM
Approved By: Sarah Woods, Deputy Director, Finance & Management Services — Date: 04/10/15
Agency: Health & Social Services

STATE OF ALASKA **BILL NO.** CSSB074(HSS)
2015 LEGISLATIVE SESSION

Analysis

Section 2(5) directs the Department to reduce the cost of behavioral health, senior and disabilities services provided to recipients of medical assistance under the state's home and community-based waiver. **Section 7** requires the Department to apply for "any waivers necessary" to implement this bill.

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: SB074CS(HSS)-DHSS-QAA-04-10-15
Title: MEDICAID REFORM/PFD/HSAS/ER USE/STUDIES
Sponsor: KELLY
Requester: Senate State Affairs 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 Appropriation Requested	Included in Governor's FY2016 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY 2016**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**
Personal Services							
Travel							
Services	45.5		45.5	45.5	45.5	45.5	45.5
Commodities							
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	**45.5**	**0.0**	**45.5**	**45.5**	**45.5**	**45.5**	**45.5**
Fund Source (Operating Only)							
1002 Fed Rcpts	22.8		22.8	22.8	22.8	22.8	22.8
1003 G/F Match	22.7		22.7	22.7	22.7	22.7	22.7
Total	**45.5**	**0.0**	**45.5**	**45.5**	**45.5**	**45.5**	**45.5**
Positions							
Full-time							
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? 07/01/16

Why this fiscal note differs from previous version:

This fiscal note has been updated to reflect the bill sectional identifiers corresponding to the Committee Substitute for SB 74. With further research, the Department identified a software package with capability to enhance current fraud prevention and detection efforts, and has substituted this for staff costs.

Prepared By: Sana Efird, Assistant Commissioner — Phone: (907)465-1630
Division: Finance and Management Services — Date: 04/10/2015 02:00 PM
Approved By: Sarah Woods, Deputy Director, Finance & Management Services — Date: 04/10/15
Agency: Health & Social Services

STATE OF ALASKA
2015 LEGISLATIVE SESSION

BILL NO. CSSB074(HSS)

Analysis

Section 2(a)(4) 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. Enhanced fraud detection case tracking software needs to be purchased. License fees are estimated at $45.5 annually.

Software and licensing fees - $45.5

Fiscal Note

State of Alaska
2015 Legislative Session

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

Identifier: SB074CS(HSS)-DHSS-CO-04-10-15
Title: MEDICAID REFORM/PFD/HSAS/ER USE/STUDIES
Sponsor: KELLY
Requester: Senate State Affairs 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 Appropriation Requested	Included in Governor's FY2016 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY 2016**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**
Personal Services							
Travel	6.0						
Services	759.0						
Commodities							
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	**765.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Fund Source (Operating Only)							
1002 Fed Rcpts	20.0						
1003 G/F Match	20.0						
1004 Gen Fund	725.0						
Total	**765.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Positions							
Full-time							
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? 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:

This fiscal note has been updated to reflect the bill sectional identifiers corresponding to the Committee Substitute for SB 74.

Prepared By: Sana Efird, Assistant Commissioner Phone: (907)465-1630
Division: Finance and Management Services Date: 04/10/2015 04:00 PM
Approved By: Sarah Woods, Deputy Director, Finance & Management Services Date: 04/10/15
Agency: Health & Social Services

Analysis

Section 2(a)(9) 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.

Section 6 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).

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: SB074CS(HSS)-DHSS-BHMS-04-10-15
Title: MEDICAID REFORM/PFD/HSAS/ER USE/STUDIES
Sponsor: KELLY
Requester: Senate State Affairs 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 Appropriation Requested	Included in Governor's FY2016 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY 2016**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits				7,856.0	7,918.8	8,789.9	8,860.2
Miscellaneous							
Total Operating	**0.0**	**0.0**	**0.0**	**7,856.0**	**7,918.8**	**8,789.9**	**8,860.2**
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
Total	**0.0**	**0.0**	**0.0**	**7,856.0**	**7,918.8**	**8,789.9**	**8,860.2**
Positions							
Full-time							
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? 07/01/17

Why this fiscal note differs from previous version:

This fiscal note has been updated to reflect the bill sectional identifiers corresponding to the Committee Substitute for SB 74.

Prepared By: Albert Wall, Director — Phone: (907)465-4841
Division: Behavioral Health — Date: 04/10/2015 03:00 PM
Approved By: Sarah Woods, Deputy Director, Finance & Management Services — Date: 04/10/15
Agency: Health & Social Services

STATE OF ALASKA
2015 LEGISLATIVE SESSION

BILL NO. CSSB074(HSS)

Analysis

Section 2(5) directs the Department to reduce the cost of behavioral health, senior and disabilities services provided to recipients of medical assistance under the state's home and community-based waiver. **Section 7** requires the Department to apply for "any waivers necessary" to implement this bill.

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: SB074CS(HSS)-DHSS-HCMS-04-10-15
Title: MEDICAID REFORM/PFD/HSAS/ER USE/STUDIES
Sponsor: KELLY
Requester: Senate State Affairs 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				
OPERATING EXPENDITURES	**FY 2016**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**
Personal Services							
Travel							
Services	4,323.4		2,173.4	2,173.4	2,173.4	2,173.4	2,173.4
Commodities							
Capital Outlay							
Grants & Benefits	(7,201.7)		(7,226.7)	(7,226.7)	(7,226.7)	(7,226.7)	(7,226.7)
Miscellaneous							
Total Operating	**(2,878.3)**	**0.0**	**(5,053.3)**	**(5,053.3)**	**(5,053.3)**	**(5,053.3)**	**(5,053.3)**
Fund Source (Operating Only)							
1002 Fed Rcpts	(1,426.7)		(2,501.7)	(2,501.7)	(2,501.7)	(2,501.7)	(2,501.7)
1003 G/F Match	(1,426.6)		(2,501.6)	(2,501.6)	(2,501.6)	(2,501.6)	(2,501.6)
1108 Stat Desig	(25.0)		(50.0)	(50.0)	(50.0)	(50.0)	(50.0)
Total	**(2,878.3)**	**0.0**	**(5,053.3)**	**(5,053.3)**	**(5,053.3)**	**(5,053.3)**	**(5,053.3)**
Positions							
Full-time							
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? 07/01/17

Why this fiscal note differs from previous version:

This fiscal note has been updated to reflect the bill sectional identifiers corresponding to the Committee Substitute for SB 74. The collection of fines in section 1 of the bill was added, and the costs for the former Denali KidCare demonstration project were removed.

Prepared By: Margaret Brodie, Director — Phone: (907)334-2520
Division: Health Care Services — Date: 04/10/2015 05:00 PM
Approved By: Sarah Woods, Deputy Director Finance & Management Services — Date: 04/10/15
Agency: Health & Social Services

Analysis

Section 1 of this legislation grants the Department of Health and Social Services the authority to assess civil fines against Medicaid providers, in the event they are found to have violated AS 47.05, AS 47.07, or regulations adopted under these chapters. Fines are to be assessed within a range of from $100 to $25,000 per occurrence or offense. There is no additional cost to the department to implement fines under this section.

Recoveries based on implementing fines in this section are calculated by taking the estimated number of civil fines and applying an average fine amount. It is estimated the amount of fines imposed per recovery will increase over time, but the number of fines assessed will decrease over time. In addition there would be a phase-in for the first year. The estimated amount of the recoveries would be $25.0 in FY2016 and $50.0 in subsequent years.

Section 2(a)(2) 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)(3) of the bill expands use of telemedicine for primary, behavioral and urgent care. **Section 2(b)** requires the Department to improve access to telemedicine. **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. 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)(4) 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)(6) and Section 3(a)(6-7) 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.

Analysis Continued

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 regiments 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, Community and Economic Development.

Section 2(a)(7) 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 January 31, 2016. 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)(8) 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)(10) 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 3 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 (mentioned above)
- Increase Alaska Medicaid Coordinated Care Initiative contract (current contract cost is $3.85 per client per month) to manage this population: $3.85 x 7,800 x 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 x $613.39 x 5 = $23,922.2 x 30% = $7,176.7

Fiscal Note

State of Alaska
2015 Legislative Session

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

Identifier: SB074CS(HSS)-DHSS-SDMS-04-10-15
Title: MEDICAID REFORM/PFD/HSAS/ER USE/STUDIES
Sponsor: KELLY
Requester: Senate State Affairs 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				
OPERATING EXPENDITURES	**FY 2016**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits				16,846.4	16,846.4	16,846.4	16,846.4
Miscellaneous							
Total Operating	**0.0**	**0.0**	**0.0**	**16,846.4**	**16,846.4**	**16,846.4**	**16,846.4**
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
Total	**0.0**	**0.0**	**0.0**	**16,846.4**	**16,846.4**	**16,846.4**	**16,846.4**
Positions							
Full-time							
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? 07/01/17

Why this fiscal note differs from previous version:

This fiscal note has been updated to reflect the bill sectional identifiers corresponding to the Committee Substitute for SB 74.

Prepared By: Duane Mayes, Director — Phone: (907)269-2083
Division: Senior and Disabilities Services — Date: 04/10/2015 03:00 PM
Approved By: Sarah Woods, Deputy Director, Finance & Management Services — Date: 04/10/15
Agency: Health & Social Services

Analysis

Section 2(5) directs the Department to reduce the cost of behavioral health, senior and disabilities services provided to recipients of medical assistance under the state's home and community-based waiver. **Section 7** requires the Department to apply for "any waivers necessary" to implement this bill.

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.

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

Senior Community Based Grant component's Adult Day and Senior In-Home Services serve some individuals who are Medicaid eligible.

STATE OF ALASKA
2015 LEGISLATIVE SESSION

BILL NO. CSSB074(HSS)

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:	14
(S) Publish Date:	4/11/2015

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 Appropriation Requested	Included in Governor's FY2016 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY 2016**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Fund Source (Operating Only)							
None							
Total	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Positions							
Full-time							
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? 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, intial version.

Prepared By: Lori Wing-Heier, Director — Phone: (907)465-2515
Division: Division of Insurance — Date: 03/20/2015 11:04 AM
Approved By: Catherine Reardon, Director — Date: 03/20/15
Agency: Division of Administrative Services, DCCED

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2015 LEGISLATIVE SESSION

Analysis

SB74 amends Title 43: Revenue and Taxation, and Title 47: Welfare, Social Services and Instititutions, 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: SB074CS(HSS)-DHSS-BHA-04-10-15
Title: MEDICAID REFORM/PFD/HSAS/ER USE/STUDIES
Sponsor: KELLY
Requester: Senate State Affairs Committee

Department: Department of Health and Social Services
Appropriation: Behavioral Health
Allocation: Behavioral Health Administration
OMB Component Number: 2665

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				
OPERATING EXPENDITURES	**FY 2016**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**
Personal Services	100.9		100.9	100.9	100.9	100.9	100.9
Travel	2.0		2.0	2.0	2.0	2.0	2.0
Services	9.4		9.4	9.4	9.4	9.4	9.4
Commodities	8.1		0.5	0.5	0.5	0.5	0.5
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	**120.4**	**0.0**	**112.8**	**112.8**	**112.8**	**112.8**	**112.8**
Fund Source (Operating Only)							
1002 Fed Rcpts	60.2		56.4	56.4	56.4	56.4	56.4
1003 G/F Match	60.2		56.4	56.4	56.4	56.4	56.4
Total	**120.4**	**0.0**	**112.8**	**112.8**	**112.8**	**112.8**	**112.8**
Positions							
Full-time	1.0		1.0	1.0	1.0	1.0	1.0
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? 07/01/17

Why this fiscal note differs from previous version:

Not applicable, initial version. (Through an oversight, the Department failed to include these costs during submission of original fiscal notes for SB74.)

Prepared By: Albert Wall, Director — Phone: (907)465-4841
Division: Behavioral Health — Date: 04/10/2015 03:25 PM
Approved By: Sarah Woods, Deputy Director Finance & Management Services — Date: 04/10/15
Agency: Health & Social Services

STATE OF ALASKA
2015 LEGISLATIVE SESSION

BILL NO. CSSB074(HSS)

Analysis

Section 2(5) directs the Department to reduce the cost of behavioral health, senior and disabilities services provided to recipients of medical assistance under the state's home and community-based waiver. **Section 7** requires the Department to apply for "any waivers necessary" to implement this bill.

The 1915(i) option provides a federal match of 50%, reducing general fund needed by 50%.

One position, Health Program Manager II (GP, Range 19, in Anchorage at $100.9 annually) will be required for intensive application and program development starting in FY2016, and coordination and program oversight beginning in FY2018. Funding for this position will be 50% federal and 50% GF match.

Alaska State Legislature

Senator Pete Kelly

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Explanation of Changes - Work Draft F for SB 74

Version S (SHSS) to Version F (SSTA)

- New Section 1 – Page 1, line 10 through Page 2, line 3
  - This sections allows DHSS to enter into a contract through the competitive bidding process under the State Procurement Code for durable medical equipment or specific medical services provided in the Medicaid program.

- New Section 2 – Page 2, lines 4 through 16
  - Subsection (a) directs the department to establish a computerized income, asset, and identity eligibility verification system for the purposed of verifying eligibility, eliminating duplication of public assistance payments, and deterring waste and fraud in public assistance programs.
  - Subsection (b) directs the department to enter into a competitively bid contract with a third-party vendor for the eligibility verification system. The department may also contract with a third-party vendor to provide information to facilitate reviews of recipient eligibility conducted by the department.

- Section 4 (Section 2 in Version S)
  - Page 4, line 14 through 22 – (8) redesigning the payment process - Changes specifically list payment reforms that should be included:
    - (A) premium payments for centers of excellence;
    - (B) penalties for hospital-acquired infections, readmissions, and outcome failures;
    - (C) bundled payments for specific episodes of care; and
    - (D) global payments for contracted payer, primary care manages, and case manages for a recipient or for care related to a specific diagnosis
  - Page 6, Lines 7 & 8 – adds new (14) to the annual report related to Medicaid reform. DHSS will also report on the cost, in state and federal funds, for providing options services under AS 47.07.030(b), the Medicaid program

- New Section 5 – Page 6, lines 14 through 19
    - Requires the legislature to approve any new additional groups added to the Medicaid program on or after March 23, 2010

- Section 12 – (Section 9 in Version S)
    - At the request of Legislative Legal, made technical fixes to the conditional effect language in Subsections (a) through (e) by replacing "that section" with the specific provision reference of the bill

- Made conforming changes to renumber sections and references to specific sections

29-LS0692\F
Glover
4/14/15

CS FOR SENATE BILL NO. 74(STA)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-NINTH LEGISLATURE - FIRST SESSION

BY THE SENATE STATE AFFAIRS COMMITTEE

Offered:
Referred:

Sponsor(s): SENATORS KELLY, Giessel

A BILL

FOR AN ACT ENTITLED

"An Act relating to competitive bidding for medical assistance products and services; relating to verification of eligibility for public assistance programs administered by the Department of Health and Social Services; relating to eligibility for medical assistance; relating to a medical assistance reform program; relating to the duties of the Department of Health and Social Services; establishing medical assistance demonstration projects; relating to civil penalties for medical assistance fraud; relating to studies by the Department of Health and Social Services; relating to cost-containment measures for medical assistance; and providing for an effective date."

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

*** Section 1.** AS 47.05.015 is amended by adding a new subsection to read:

(e) Notwithstanding (c) of this section, the department may enter into a contract through the competitive bidding process under AS 36.30 (State Procurement

Code) for medical assistance products and services offered under AS 47.07.030 if the contract is for durable medical equipment or specific medical services that can be delivered on a statewide basis.

* **Sec. 2.** AS 47.05 is amended by adding a new section to article 1 to read:

Sec. 47.05.105. Computerized eligibility verification system. (a) The department shall establish a computerized income, asset, and identity eligibility verification system for the purposes of verifying eligibility, eliminating duplication of public assistance payments, and deterring waste and fraud in public assistance programs administered by the department under AS 47.05.010.

(b) The department shall enter into a competitively bid contract with a third-party vendor for the purpose of developing a system under this section for verifying an applicant's eligibility for public assistance before the payment of benefits and for periodically verifying eligibility between eligibility redeterminations and during eligibility redeterminations and reviews under AS 47.05.110 - 47.05.120. The department may also contract with a third-party vendor to provide information to facilitate reviews of recipient eligibility conducted by the department.

* **Sec. 3.** AS 47.05 is amended by adding new sections to read:

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

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

(2) knowingly make, use, or cause to be made or used, a false record or statement to get a false or fraudulent claim for payment paid or approved by the medical assistance program under AS 47.07;

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

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

(b) A violation under this section is punishable by a civil penalty of not less than $100 and not more than $25,000 in addition to the costs and fees associated with

an enforcement action brought under AS 37.10.090 and 37.10.100.

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

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

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

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

(1) has actual knowledge of the information;

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

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

Sec. 47.05.203. Department authority to impose civil penalties. The department may adopt regulations to assess the civil penalties provided under AS 47.05.202(b) against a medical assistance provider, and, if the penalties are not paid, the department may refer the case to the attorney general for prosecution under AS 47.05.202.

* **Sec. 4.** AS 47.05 is amended by adding a new section to read:

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

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

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

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

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

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

(6) pharmacy initiatives;

(7) enhanced care management;

(8) redesigning the payment process by implementing fee agreements that include

(A) premium payments for centers of excellence;

(B) penalties for hospital-acquired infections, readmissions, and outcome failures;

(C) bundled payments for specific episodes of care; and

(D) global payments for contracted payers, primary care managers, and case managers for a recipient or for care related to a specific diagnosis;

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

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

(b) The department shall identify the areas of the state where improvements in access to telemedicine would be most effective in reducing the costs of medical assistance and improving access to health care services for medical assistance recipients. The department shall make efforts to improve access to telemedicine for

recipients in those locations. The department may enter into agreements with Indian Health Service providers, if necessary, to improve access by medical assistance recipients to telemedicine facilities and equipment.

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

(1) realized cost savings related to reform efforts under this section;

(2) realized cost savings related to medical assistance reform efforts undertaken by the department other than the reform efforts described in this Act;

(3) a statement of whether the Department of Health and Social Services has met annual targets for quality and cost-effectiveness;

(4) recommendations for legislative or budgetary changes related to medical assistance reforms during the next fiscal year;

(5) changes in federal laws that the department expects will result in a cost or savings to the state of more than $1,000,000;

(6) a description of any medical assistance grants, options, or waivers the department applied for in the previous fiscal year;

(7) the results of demonstration projects the department has implemented;

(8) legal and technological barriers to the expanded use of telemedicine, improvements in the use of telemedicine in the state, and recommendations for changes or investments that would allow cost-effective expansion of telemedicine;

(9) the percentage decrease in costs of travel for medical assistance recipients compared to the previous fiscal year;

(10) the percentage decrease in the number of medical assistance recipients identified as frequent users of emergency departments compared to the previous fiscal year;

(11) the percentage increase or decrease in the number of hospital readmissions within 30 days after a hospital stay for medical assistance recipients

compared to the previous fiscal year;

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

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

(14) the cost, in state and federal funds, for providing optional services under AS 47.07.030(b).

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

* **Sec. 5.** AS 47.07.020(d) is amended to read:

(d) **Notwithstanding (a) of this section, additional** [ADDITIONAL] groups**, including groups added on or after March 23, 2010, to the list of persons for whom the Social Security Act requires Medicaid coverage under 42 U.S.C. 1396 - 1396p (Title XIX, Social Security Act),** may not be added unless approved by the legislature.

* **Sec. 6.** AS 47.07 is amended by adding a new section to read:

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

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

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

(3) a procedure for educating patients about the use of emergency

departments and appropriate alternative services and facilities for nonurgent care;

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

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

(6) strict guidelines for the prescribing of narcotics;

(7) a prescription monitoring program;

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

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

* **Sec. 7.** AS 47.07 is amended by adding a new section to read:

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

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

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

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

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

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

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

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

(8) estimated payment error rate measurement for the medical assistance program;

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

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

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

MEDICAID MANAGED CARE OR CASE MANAGEMENT DEMONSTRATION PROJECT. (a) On or before January 31, 2016, the Department of Health and Social Services shall design and initiate one or more managed care or case management demonstration projects. The department shall contract with a third party to provide managed care or case management services for a group or groups of individuals who qualify for medical assistance under AS 47.07 and may separate a group or groups of individuals into different managed care or case management demonstration projects based on efficiency and cost savings. The purpose of a 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. A project or projects developed under this section may include

(1) comprehensive care management;

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

(3) health promotion;

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

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

(6) individual and family support;

(7) referral to community and social support services, including career and

education training services available through the Department of Labor and Workforce Development under AS 23.15, the University of Alaska, or other sources.

(b) The department shall enter into contracts with one or more third-party primary care case managers, managed care organizations, prepaid ambulatory health plans, or prepaid inpatient health plans to implement the project established under this section. The contract must provide for a fee based on a per capita expense that is fair and economical. The department or administrator shall develop a comprehensive system of prior authorizations for payment of services under the project. However, prior authorization may not be required for mental health or primary care services.

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

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

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

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

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

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

DEPARTMENT OF HEALTH AND SOCIAL SERVICES FEASIBILITY STUDY. (a) The department shall conduct a study analyzing the feasibility of privatizing services delivered at Alaska Pioneers' Homes, the Alaska Psychiatric Institute, and select facilities of the division of juvenile justice. The department shall deliver a report summarizing the department's conclusions to the senate secretary and the chief clerk of the house of

representatives and notify the legislature that the report is available within 10 days after the convening of the Second Regular Session of the Twenty-Ninth Alaska State Legislature.

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

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

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

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

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

* **Sec. 12.** The uncodified law of the State of Alaska is amended by adding a new section to read:

CONDITIONAL EFFECT. (a) AS 47.05.260(a)(5), enacted by sec. 4 of this Act, takes effect only if the commissioner of health and social services certifies to the revisor of statutes under sec. 10 of this Act, on or before October 1, 2017, that all of the provisions added by AS 47.05.260(a)(5) have been approved by the United States Department of Health and Human Services.

(b) AS 47.05.260(a)(8), enacted by sec. 4 of this Act, takes effect only if the commissioner of health and social services certifies to the revisor of statutes under sec. 10 of this Act, on or before October 1, 2017, that all of the provisions added by AS 47.05.260(a)(8) have been approved by the United States Department of Health and Human Services.

(c) AS 47.05.260(a)(10), enacted by sec. 4 of this Act, takes effect only if the commissioner of health and social services certifies to the revisor of statutes under sec. 10 of this Act, on or before October 1, 2017, that all of the provisions added by AS 47.05.260(a)(10) have been approved by the United States Department of Health and Human Services.

(d) AS 47.07.038, enacted by sec. 6 of this Act, takes effect only if the commissioner of health and social services certifies to the revisor of statutes under sec. 10 of this Act, on or before October 1, 2017, that all of the provisions added by AS 47.07.038 have been approved by the United States Department of Health and Human Services.

(e) Section 8 of this Act takes effect only if the commissioner of health and social services certifies to the revisor of statutes under sec. 10 of this Act, on or before October 1, 2017, that all of the provisions added by sec. 8 of this Act have been approved by the United States Department of Health and Human Services.

* **Sec. 13.** If AS 47.05.260(a)(5), enacted by sec. 4 of this Act, takes effect, it takes effect on the day after the date the commissioner of health and social services makes a certification to the revisor of statutes under secs. 10 and 12(a) of this Act.

* **Sec. 14.** If AS 47.05.260(a)(8), enacted by sec. 4 of this Act, takes effect, it takes effect on the day after the date the commissioner of health and social services makes a certification to the revisor of statutes under secs. 10 and 12(b) of this Act.

* **Sec. 15.** If AS 47.05.260(a)(10), enacted by sec. 4 of this Act, takes effect, it takes effect on the day after the date the commissioner of health and social services makes a certification to the revisor of statutes under secs. 10 and 12(c) of this Act.

* **Sec. 16.** If AS 47.07.038, enacted by sec. 6 of this Act, takes effect, it takes effect on the day after the date the commissioner of health and social services makes a certification to the revisor of statutes under secs. 10 and 12(d) of this Act.

* **Sec. 17.** If sec. 8 of this Act takes effect, it takes effect on the day after the date the commissioner of health and social services makes a certification to the revisor of statutes under secs. 10 and 12(e) of this Act.

* **Sec. 18.** Sections 9 - 12 of this Act take effect immediately under AS 01.10.070(c).

Fiscal Note

State of Alaska
2015 Legislative Session

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

Identifier: SB074CS(STA)-DHSS-PAA-04-15-15
Title: MEDICAID REFORM/PFD/HSAS/ER USE/STUDIES
Sponsor: KELLY
Requester: Senate Finance 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 Appropriation Requested	Included in Governor's FY2016 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY 2016**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**
Personal Services							
Travel							
Services	430.6		574.1	574.1	574.1	574.1	574.1
Commodities							
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	**430.6**	**0.0**	**574.1**	**574.1**	**574.1**	**574.1**	**574.1**
Fund Source (Operating Only)							
1002 Fed Rcpts	185.2		246.9	246.9	246.9	246.9	246.9
1003 G/F Match	245.4		327.2	327.2	327.2	327.2	327.2
Total	**430.6**	**0.0**	**574.1**	**574.1**	**574.1**	**574.1**	**574.1**
Positions							
Full-time							
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? 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:

This fiscal note addresses a new provision in the Senate State Affairs Committee Substitute for SB 74 - Section 2, requiring the Department to pursue purchase of a computerized income, asset and identity verification system to work in tandem with the Division of Public Assistance's eligibility determination system.

Prepared By: Ron Kreher, Acting Director — Phone: (907)465-5847
Division: Public Assistance — Date: 04/15/2015 05:00 PM
Approved By: Sarah Woods, Deputy Director Finance & Management Services — Date: 04/15/15
Agency: Health & Social Services

STATE OF ALASKA
2015 LEGISLATIVE SESSION

BILL NO. CSSB074(STA)

Analysis

Sec. 2 of the proposed legislation adds a new section to AS 47.05 directing the Department to establish a computerized income, asset and identity verification system. The department will contract for the system development. The Department is further directed to use the system "periodically" to verify eligibility between and during recertification periods.

Assumptions:

The system will be web-enabled and capable of providing access for individual eligibility technicians, fraud investigators, quality assurance, and other designated staff.

The system costs will largely be based on number of inquiries (encounters) submitted to the system, though other costs (licensing, system support, etc.) are likely. The estimated cost per encounter is 60 cents.

Following a competitive procurement process, the selected system will be implemented 10/1/2016. First year costs are based on 9 months of use.

Verification will occur at initial intake, at recertification or renewal of eligibility, and at least once between certification for each program recipient and applicant.

The Division anticipates approximately 956,840 encounters annually:

In FY2014 the Division received approximately 169,200 applications. Assuming an average household of 2.7 people per application = 456,840 annual encounters.

An estimated 250,000 recipients would be screened for verification at least twice per year = 500,000 encounters.

Daniel George

From: Newman, Anthony (HSS) <anthony.newman@alaska.gov>
Sent: Wednesday, April 15, 2015 6:06 PM
Daniel George
Heather Shadduck; Laughlin, Wilda J (HSS); Sherwood, Jon (HSS); Ashenbrenner, Chris (HSS); Peterson, Darwin R (GOV)
Subject: DHSS response to S-SA issues
Attachments: Medicaid Support letter Stedman.pdf

Follow Up Flag: Follow up
Flag Status: Flagged

Daniel: This is in response to two issues raised in the Senate State Affairs hearing this morning. Please distribute this information to the committee.

1. Commissioner Val Davidson and Deputy Commissioner Jon Sherwood discussed the Department's concerns with Section 5 of the CS for Senate Bill 74 (Version F) in the hearing. Here is more background about the Department's concerns with this section:

   The Department is concerned with Section 5 because it would require legislative approval anytime federal law was changed to mandate coverage of a new eligibility group under Medicaid. While the Supreme Court determined that the Medicaid expansion group added by the Affordable Care Act was effectively optional to states, even though it is mandated under federal law, this is not typically the case with new federally mandated groups. If a state fails to comply with the mandatory coverage group requirements, it can be subject to federal sanction, including loss of federal funding.

   Section 5 as written would require the approval of any federally mandated group added by the Affordable Care Act or by subsequent legislation. Currently, the Alaska Medicaid program covers the federally mandated group for individuals under the age of 26 who age out of state or tribal foster care in Alaska. This group has never been approved by the Alaska Legislature.

2. Testimony from a representative of the Americans for Prosperity organization included reference to concerns by Alaska physicians with the Governor's Medicaid expansion and reform legislation. Note that the Alaska State Medical Association, the nonprofit organization that advocates on behalf of Alaska's physicians, submitted the attached letter to the chair of the Senate Health and Social Services Committee in support of this legislation.

Tony Newman
Legislative Liaison
Alaska Department of Health and Social Services
Juneau, Alaska
(907)465-1611 (desk)
(907)321-3989 (cell)
(907)465-3068 (fax)
anthony.newman@alaska.gov

Daniel George

From: Newman, Anthony (HSS) <anthony.newman@alaska.gov>
Sent: Wednesday, April 15, 2015 7:41 AM
Daniel George; Heather Shadduck
Laughlin, Wilda J (HSS); Wilcox, Lacy J (GOV); Peterson, Darwin R (GOV)
Subject: CS on SB 74

Follow Up Flag: Follow up
Flag Status: Completed

Daniel and Heather, here is some feedback on the CS for SB 74/Version F, which we may speak to if given the opportunity this morning in S-SA. Sorry for the last minute notice.

Section 2 is confusing to us because the Department has a new computerized public assistance system, ARIES, that does pretty much everything that is expected of such a system in this section. The only feature it does not have is an "income, asset, and identity eligibility verification system," and we are contacting our vendor to ask what it would cost to add such a feature (a "plug-in" to the existing system). So we anticipate a fiscal note for this piece. If the sponsor is proposing that we go with an entirely new system we will have a much larger fiscal note. We would recommend removal of the new section 2.

On page 4, lines 17-22, new expectations for a redesigned payment process in Medicaid are added. We suggest changing the word "and" on line 19 to "or" as expecting fee agreements to require both bundled payments and global payments from the same vendor would be problematic.

And finally the new Section 5, which would appear to prohibit Medicaid expansion, is not something we can support.

Thank you,

ony Newman
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CSSB 74 - MEDICAID REFORM/PFD/HSAS/ER USE/STUDIES
April 16, 2015
Senate State Affairs

Sponsor: Senator Kelly
Prepared by OMB

		OMB Component	FY16 Appropriation Requested	FY16 Total	FY17 Base	FY17 New	FY17 Total	FY18 Base	FY18 New	FY18 Total	FY19 Base	FY19 New	FY19 Total	FY20 Base	FY20 New	FY20 Total	FY21 Base	FY21 New	FY21 Total
Department of Health and Social Services																			
1	Senior & Disabilities Med Svcs	2662	$ -	$ -	$ -	$ -	$ -	$ -	$ 16,846.4	$ 16,846.4	$ 16,846.4	$ -	$ 16,846.4	$ 16,846.4	$ -	$ 16,846.4	$ 16,846.4	$ -	$ 16,846.4
2	Health Care Medicaid Services	2077	$ (2,878.3)	$ (2,878.3)	$ (2,878.3)	$ (2,175.0)	$ (5,053.3)	$ (5,053.3)	$ -	$ (5,053.3)	$ (5,053.3)	$ -	$ (5,053.3)	$ (5,053.3)	$ -	$ (5,053.3)	$ (5,053.3)	$ -	$ (5,053.3)
3	Behavioral Health Medicaid Svcs	2660	$ -	$ -	$ -	$ -	$ -	$ -	$ 7,856.0	$ 7,856.0	$ 7,856.0	$ 62.8	$ 7,918.8	$ 7,918.8	$ 871.1	$ 8,789.9	$ 8,789.9	$ 70.3	$ 8,860.2
4	Commissioner's Office	317	$ 765.0	$ 765.0	$ 765.0	$ (765.0)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5	Quality Assurance	2880	$ 45.5	$ 45.5	$ 45.5	$ -	$ 45.5	$ 45.5	$ -	$ 45.5	$ 45.5	$ -	$ 45.5	$ 45.5	$ -	$ 45.5	$ 45.5	$ -	$ 45.5
6	Comm Dev. Disabilities Grants	309	$ -	$ -	$ -	$ -	$ -	$ -	$ (11,635.8)	$ (11,635.8)	$ (11,635.8)	$ -	$ (11,635.8)	$ (11,635.8)	$ -	$ (11,635.8)	$ (11,635.8)	$ -	$ (11,635.8)
7	Senior & Community Based Grants	2787	$ -	$ -	$ -	$ -	$ -	$ -	$ (716.3)	$ (716.3)	$ (716.3)	$ -	$ (716.3)	$ (716.3)	$ -	$ (716.3)	$ (716.3)	$ -	$ (716.3)
8	General Relief/Temp Ast. Living	2875	$ -	$ -	$ -	$ -	$ -	$ -	$ (4,494.3)	$ (4,494.3)	$ (4,494.3)	$ -	$ (4,494.3)	$ (4,494.3)	$ -	$ (4,494.3)	$ (4,494.3)	$ -	$ (4,494.3)
9	Senior & Disabilities Svcs Admin	2663	$ 299.6	$ 299.6	$ 299.6	$ 232.7	$ 532.3	$ 532.3	$ 346.9	$ 879.2	$ 879.2	$ (530.2)	$ 349.0	$ 349.0	$ -	$ 349.0	$ 349.0	$ -	$ 349.0
10	Rate Review	2696	$ 500.0	$ 500.0	$ 500.0	$ (400.0)	$ 100.0	$ 100.0	$ -	$ 100.0	$ 100.0	$ -	$ 100.0	$ 100.0	$ -	$ 100.0	$ 100.0	$ -	$ 100.0
11	Medical Assistance Administration	242	$ 699.9	$ 699.9	$ 699.9	$ (15.2)	$ 684.7	$ 684.7	$ -	$ 684.7	$ 684.7	$ -	$ 684.7	$ 684.7	$ -	$ 684.7	$ 684.7	$ -	$ 684.7
12	BH Treatment & Recovery Grants	3099	$ -	$ -	$ -	$ -	$ -	$ -	$ (3,456.6)	$ (3,456.6)	$ (3,456.6)	$ (27.7)	$ (3,484.3)	$ (3,484.3)	$ (383.3)	$ (3,867.6)	$ (3,867.6)	$ (30.9)	$ (3,898.5)
13	Behavioral Health Administration	2665	$ 120.4	$ 120.4	$ 120.4	$ (7.6)	$ 112.8	$ 112.8	$ -	$ 112.8	$ 112.8	$ -	$ 112.8	$ 112.8	$ -	$ 112.8	$ 112.8	$ -	$ 112.8
14	Public Assistance	233	$ 430.6	$ 430.6	$ 430.6	$ 143.5	$ 574.1	$ 574.1	$ -	$ 574.1	$ 574.1	$ -	$ 574.1	$ 574.1	$ -	$ 574.1	$ 574.1	$ -	$ 574.1
	Health & Social Services Total:		**$ (17.3)**	**$ (17.3)**	**$ (17.3)**	**$ (2,986.6)**	**$ (3,003.9)**	**$ (3,003.9)**	**$ 4,746.3**	**$ 1,742.4**	**$ 1,742.4**	**$ (495.1)**	**$ 1,247.3**	**$ 1,247.3**	**$ 487.8**	**$ 1,735.1**	**$ 1,735.1**	**$ 39.4**	**$ 1,774.5**
	Postions:		**4**	**4**	**4**	**2**	**6**	**6**	**0**	**6**	**6**	**0**	**6**	**6**	**0**	**6**	**6**	**0**	**6**

Cumulative by Fund Source (FY16-FY21)		FY16 Appropriation Requested	FY16 Total	FY17 Base	FY17 New	FY17 Total	FY18 Base	FY18 New	FY18 Total	FY19 Base	FY19 New	FY19 Total	FY20 Base	FY20 New	FY20 Total	FY21 Base	FY21 New	FY21 Total
$71,054.7	**Fed**	$ (348.6)	$ (348.6)	$ (348.6)	$ (1,128.4)	$ (1,477.0)	$ (1,477.0)	$ 19,645.9	$ 18,168.9	$ 18,168.9	$ (270.1)	$ 17,898.8	$ 17,898.8	$ 487.8	$ 18,386.6	$ 18,386.6	$ 39.4	$ 18,426.0
($641.0)	**GF Match**	$ (368.7)	$ (368.7)	$ (368.7)	$ (1,108.2)	$ (1,476.9)	$ (1,476.9)	$ 1,946.8	$ 469.9	$ 469.9	$ (225.0)	$ 244.9	$ 244.9	$ (0.0)	$ 244.9	$ 244.9	$ 0.0	$ 244.9
($40,117.4)	**UGF**	$ 725.0	$ 725.0	$ 725.0	$ (725.0)	$ -	$ -	$ (10,210.6)	$ (10,210.6)	$ (10,210.6)	$ -	$ (10,210.6)	$ (10,210.6)	$ -	$ (10,210.6)	$ (10,210.6)	$ -	$ (10,210.6)
($26,543.2)	**GF/MH**	$ -	$ -	$ -	$ -	$ -	$ -	$ (6,635.8)	$ (6,635.8)	$ (6,635.8)	$ -	$ (6,635.8)	$ (6,635.8)	$ -	$ (6,635.8)	$ (6,635.8)	$ -	$ (6,635.8)
$0.0	**AMHTAAR**	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
$0.0	**IA**	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
($275.0)	**SDPR**	$ (25.0)	$ (25.0)	$ (25.0)	$ (25.0)	$ (50.0)	$ (50.0)	$ -	$ (50.0)	$ (50.0)	$ -	$ (50.0)	$ (50.0)	$ -	$ (50.0)	$ (50.0)	$ -	$ (50.0)
$3,478.1		**$ (17.3)**	**$ (17.3)**	**$ (17.3)**	**$ (2,986.6)**	**$ (3,003.9)**	**$ (3,003.9)**	**$ 4,746.3**	**$ 1,742.4**	**$ 1,742.4**	**$ (495.1)**	**$ 1,247.3**	**$ 1,247.3**	**$ 487.8**	**$ 1,735.1**	**$ 1,735.1**	**$ 39.4**	**$ 1,774.5**

Fund Source Switch from General Funds to Federal Receipts

$71,054.7	Fed	($348.6)	($348.6)	($348.6)	($1,128.4)	($1,477.0)	($1,477.0)	$19,645.9	$18,168.9	$18,168.9	($270.1)	$17,898.8	$17,898.8	$487.8	$18,386.6	$18,386.6	$39.4	$18,426.0
($67,301.6)	Net GF	$356.3	$356.3	$356.3	($1,833.2)	($1,476.9)	($1,476.9)	($14,899.6)	($16,376.5)	($16,376.5)	($225.0)	($16,601.5)	($16,601.5)	($0.0)	($16,601.5)	($16,601.5)	$0.0	($16,601.5)

Fiscal Note

Replaces #1

State of Alaska
2015 Legislative Session

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

Identifier: SB074CS(STA)-DHSS-BHTRG-04-14-15
Title: MEDICAID REFORM/PFD/HSAS/ER USE/STUDIES
Sponsor: KELLY
Requester: Senate Finance 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				
OPERATING EXPENDITURES	**FY 2016**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits				(3,456.6)	(3,484.3)	(3,867.6)	(3,898.5)
Miscellaneous							
Total Operating	**0.0**	**0.0**	**0.0**	**(3,456.6)**	**(3,484.3)**	**(3,867.6)**	**(3,898.5)**
Fund Source (Operating Only)							
1003 G/F Match				(3,456.6)	(3,484.3)	(3,867.6)	(3,898.5)
Total	**0.0**	**0.0**	**0.0**	**(3,456.6)**	**(3,484.3)**	**(3,867.6)**	**(3,898.5)**
Positions							
Full-time							
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? 07/01/15

Why this fiscal note differs from previous version:

This fiscal note has been updated to reflect the bill sectional identifiers corresponding to the Senate State Affairs Committee Substitute for SB 74.

Prepared By: Albert E. Wall, Director — Phone: (907)465-4841
Division: Behavioral Health — Date: 04/14/2015 05:00 PM
Approved By: Sarah Woods, Deputy Director, Finance & Management Services — Date: 04/14/15
Agency: Health & Social Services

STATE OF ALASKA
2015 LEGISLATIVE SESSION

BILL NO. CSSB074(STA)

Analysis

Section 4(5) directs the Department to reduce the cost of behavioral health, senior and disabilities services provided to recipients of medical assistance under the state's home and community-based waiver. **Section 10** requires the Department to apply for "any waivers necessary" to implement this bill.

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.

Replaces #2

Fiscal Note

State of Alaska
2015 Legislative Session

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

Identifier: SB074CS(STA)-DHSS-MAA-04-14-15
Title: MEDICAID REFORM/PFD/HSAS/ER USE/STUDIES
Sponsor: KELLY
Requester: Senate Finance 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 Appropriation Requested	Included in Governor's FY2016 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY 2016**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**
Personal Services	201.2		201.2	201.2	201.2	201.2	201.2
Travel	2.0		2.0	2.0	2.0	2.0	2.0
Services	477.5		477.5	477.5	477.5	477.5	477.5
Commodities	19.2		4.0	4.0	4.0	4.0	4.0
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	**699.9**	**0.0**	**684.7**	**684.7**	**684.7**	**684.7**	**684.7**
Fund Source (Operating Only)							
1002 Fed Rcpts	350.0		342.4	342.4	342.4	342.4	342.4
1003 G/F Match	349.9		342.3	342.3	342.3	342.3	342.3
Total	**699.9**	**0.0**	**684.7**	**684.7**	**684.7**	**684.7**	**684.7**
Positions							
Full-time	2.0		2.0	2.0	2.0	2.0	2.0
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:

This fiscal note has been updated to reflect the bill sectional identifiers corresponding to the Senate State Affairs Committee Substitute for SB 74.

Prepared By: Margaret Brodie, Director — Phone: (907)334-2520
Division: Health Care Services — Date: 04/14/2015 05:00 PM
Approved By: Sarah Woods, Deputy Director, Finance & Management Services — Date: 04/14/15
Agency: Health & Social Services

Analysis

Section 3 adds a false claims act to law, and authorizes the Department to adopt regulations to assess civil penalties against offending providers, and to refer non-payment cases to the attorney general for prosecution. DHSS would support this Dept. of Law effort via a reimbursable services agreement for a Dept. of Law attorney ($225.0), a paralegal ($140.0) and an investigator ($93.7), per Law's estimates of resources needed for drafting regulations and pursuing actions against violators.

Section 4(c) requires the Department to prepare and submit to the legislature a comprehensive annual report on reform cost savings, results of demonstration projects, and many other parameters that enhance or support Medicaid reform. The Department has determined that it can absorb the cost of preparing this report with its current appropriation. This assumes that the report will be made available on line with notification to the legislature on or before October 15 of each year.

Section 4(a)(4) 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 II, range 18 - $100.6
1 Research Analyst III, range 18 - $100.6
FY2016 Personal services total $201.2

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

Section 7 requires the Departments of Law and Health and Social Services to prepare an annual report on fraud and abuse, and errors in eligibility determinations and payments, and many other parameters that enhance or support Medicaid reform. The Department has determined that it can absorb the cost of preparing this report with its current appropriation. This assumes that the report will be made available on line with notification to the legislature on or before October 15 of each year.

Fiscal Note

Replaces #3

State of Alaska
2015 Legislative Session

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

Identifier: SB074CS(STA)-DHSS-RR-04-14-15
Title: MEDICAID REFORM/PFD/HSAS/ER USE/STUDIES
Sponsor: KELLY
Requester: Senate Finance 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 Appropriation Requested	Included in Governor's FY2016 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY 2016**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**
Personal Services							
Travel							
Services	500.0		100.0	100.0	100.0	100.0	100.0
Commodities							
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	**500.0**	**0.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Fund Source (Operating Only)							
1002 Fed Rcpts	250.0		50.0	50.0	50.0	50.0	50.0
1003 G/F Match	250.0		50.0	50.0	50.0	50.0	50.0
Total	**500.0**	**0.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Positions							
Full-time							
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? 07/01/16

Why this fiscal note differs from previous version:

This fiscal note has been updated to reflect the bill sectional identifiers corresponding to the Senate State Affairs Committee Substitute for SB 74.

Prepared By: Margaret Brodie, Director — Phone: (907)334-2520
Division: Health Care Services — Date: 04/14/2015 05:00 PM
Approved By: Sarah Woods, Deputy Director, Finance & Management Services — Date: 04/14/15
Agency: Health & Social Services

STATE OF ALASKA
2015 LEGISLATIVE SESSION

BILL NO. CSSB074(STA)

Analysis

Section 4(a)(8) requires the department to implement a reform program that redesigns the payment process by implementing fee agreements based on performance measures that include premium payments and penalties.

Section 8(a) requires the department to design and initiate one or more managed care or case management demonstration projects by January 31, 2016. The department must enter into a contract to implement the project, and the contract must provide a fee based on a per capita expense. Additionally, for primary care case managers, the fee agreement must include an incentive-based management fee system that must be based on performance measures.

Both sections involve payment reform in that the department is directed to change Medicaid reimbursement from a fee-for-service system to an outcome-based system. Outcome-based reimbursement is based on complex data analysis and calculations that require actuarial expertise. Once an outcome-based reimbursement system is established, administration of the system would still require actuarial expertise that is only available by contract.

Since the objectives from both sections require actuarial expertise, the department would likely use the same contractor for both projects. Specifically, the contractor will analyze and implement a payment model for managed care, and use those concepts to also redesign other payment processes. Upon implementing these payment models, the contractor will be retained for annual actuarial work and assistance with administration.

The initial and ongoing costs associated with hiring a contractor to perform this work are not fully known at this time. Based on consultation with other states, the department estimates a one-time $500.0 contract for a firm to analyze and implement one or more innovative payment models. Additionally, the department estimates an annual $100.0 contract for actuarial work and assistance with administration.

Fiscal Note

Replaces #4

State of Alaska
2015 Legislative Session

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

Identifier: SB074CS(STA)-DHSS-PAA-04-15-15
Title: MEDICAID REFORM/PFD/HSAS/ER USE/STUDIES
Sponsor: KELLY
Requester: Senate Finance 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 Appropriation Requested	Included in Governor's FY2016 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY 2016**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**
Personal Services							
Travel							
Services	430.6		574.1	574.1	574.1	574.1	574.1
Commodities							
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	**430.6**	**0.0**	**574.1**	**574.1**	**574.1**	**574.1**	**574.1**
Fund Source (Operating Only)							
1002 Fed Rcpts	185.2		246.9	246.9	246.9	246.9	246.9
1003 G/F Match	245.4		327.2	327.2	327.2	327.2	327.2
Total	**430.6**	**0.0**	**574.1**	**574.1**	**574.1**	**574.1**	**574.1**
Positions							
Full-time							
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? 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:

This fiscal note addresses a new provision in the Senate State Affairs Committee Substitute for SB 74 - Section 2, requiring the Department to pursue purchase of a computerized income, asset and identity verification system to work in tandem with the Division of Public Assistance's eligibility determination system.

Prepared By: Ron Kreher, Acting Director — Phone: (907)465-5847
Division: Public Assistance — Date: 04/15/2015 05:00 PM
Approved By: Sarah Woods, Deputy Director Finance & Management Services — Date: 04/15/15
Agency: Health & Social Services

STATE OF ALASKA
2015 LEGISLATIVE SESSION

BILL NO. CSSB074(STA)

Analysis

Sec. 2 of the proposed legislation adds a new section to AS 47.05 directing the Department to establish a computerized income, asset and identity verification system. The department will contract for the system development. The Department is further directed to use the system "periodically" to verify eligibility between and during recertification periods.

Assumptions:

The system will be web-enabled and capable of providing access for individual eligibility technicians, fraud investigators, quality assurance, and other designated staff.

The system costs will largely be based on number of inquiries (encounters) submitted to the system, though other costs (licensing, system support, etc.) are likely. The estimated cost per encounter is 60 cents.

Following a competitive procurement process, the selected system will be implemented 10/1/2016. First year costs are based on 9 months of use.

Verification will occur at initial intake, at recertification or renewal of eligibility, and at least once between certification for each program recipient and applicant.

The Division anticipates approximately 956,840 encounters annually:

In FY2014 the Division received approximately 169,200 applications. Assuming an average household of 2.7 people per application = 456,840 annual encounters.

An estimated 250,000 recipients would be screened for verification at least twice per year = 500,000 encounters.

Fiscal Note

Replaces #5

State of Alaska
2015 Legislative Session

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

Identifier: SB074CS(STA)-DHSS-SDSA-04-14-15
Title: MEDICAID REFORM/PFD/HSAS/ER USE/STUDIES
Sponsor: KELLY
Requester: Senate Finance 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				
OPERATING EXPENDITURES	**FY 2016**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**
Personal Services	108.0		324.0	324.0	324.0	324.0	324.0
Travel	2.3		6.8	6.8	6.8	6.8	6.8
Services	186.8		193.9	540.8	10.6	10.6	10.6
Commodities	2.5		7.6	7.6	7.6	7.6	7.6
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	**299.6**	**0.0**	**532.3**	**879.2**	**349.0**	**349.0**	**349.0**
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
Total	**299.6**	**0.0**	**532.3**	**879.2**	**349.0**	**349.0**	**349.0**
Positions							
Full-time	1.0		3.0	3.0	3.0	3.0	3.0
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? 07/01/17

Why this fiscal note differs from previous version:

This fiscal note has been updated to reflect the bill sectional identifiers corresponding to the Senate State Affairs Committee Substitute for SB 74.

Prepared By: Duane Mayes, Director — Phone: (907)269-2083
Division: Senior and Disabilities Services — Date: 04/14/2015 05:00 PM
Approved By: Sarah Woods, Deputy Director, Finance & Management Services — Date: 04/14/15
Agency: Health & Social Services

Analysis

Section 4(5) directs the Department to reduce the cost of behavioral health, senior and disabilities services provided to recipients of medical assistance under the state's home and community-based waiver. **Section 10** requires the Department to apply for "any waivers necessary" to implement this bill.

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 determine eligibility for these Medicaid programs, federal regulation requires the state to perform an annual "hands-on" functional eligibility determination. The current GF-funded grant programs do not require this determination; therefore SDS will need additional staff to perform functional eligibility assessments on the approximately 3,000 individuals transitioning from the state grant programs. These staff will be Health Program Manager II positions, one in FY2016 and two more starting in FY2017. Positions = $108.0 apiece. Travel = $2.3; Services = $3.5; Commodities = $2.5.

SDS requests the two additional staff in out-years to give the agency capacity for ongoing administration of a significantly larger Medicaid program. State and federal regulations mandate state responsibility for trained staff to perform annual functional eligibility assessments and review of each recipient's "plan of care" for home and community-based services. Because the State relies on a fully privatized workforce of over 1,300 for- and non-profit agencies, a larger program requires additional resources for ongoing provider certification and oversight, including regulatory compliance and fraud detection. Also, the State must ensure the health and safety of the most vulnerable and infirm members of the community with ongoing quality assurance actions, including on-site provider reviews and forensic activities. Finally, as the state mounts its performance evaluation activities, extensive data development, gathering and management add to the agency's responsibilities.

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

Replaces #6

State of Alaska
2015 Legislative Session

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

Identifier: SB074CS(STA)-DHSS-GRTAL-04-14-15
Title: MEDICAID REFORM/PFD/HSAS/ER USE/STUDIES
Sponsor: KELLY
Requester: Senate Finance 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 Appropriation Requested	Included in Governor's FY2016 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY 2016**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits				(4,494.3)	(4,494.3)	(4,494.3)	(4,494.3)
Miscellaneous							
Total Operating	**0.0**	**0.0**	**0.0**	**(4,494.3)**	**(4,494.3)**	**(4,494.3)**	**(4,494.3)**
Fund Source (Operating Only)							
1004 Gen Fund				(4,494.3)	(4,494.3)	(4,494.3)	(4,494.3)
Total	**0.0**	**0.0**	**0.0**	**(4,494.3)**	**(4,494.3)**	**(4,494.3)**	**(4,494.3)**
Positions							
Full-time							
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? 07/01/17

Why this fiscal note differs from previous version:

This fiscal note has been updated to reflect the bill sectional identifiers corresponding to the Senate State Affairs Committee Substitute for SB 74.

Prepared By: Duane Mayes, Director — Phone: (907)269-2083
Division: Senior and Disabilities Services — Date: 04/14/2015 05:00 PM
Approved By: Sarah Woods, Deputy Director, Finance & Management Services — Date: 04/14/15
Agency: Health & Social Services

STATE OF ALASKA
2015 LEGISLATIVE SESSION

BILL NO. CSSB074(STA)

Analysis

Section 4(5) directs the Department to reduce the cost of behavioral health, senior and disabilities services provided to recipients of medical assistance under the state's home and community-based waiver. **Section 10** requires the Department to apply for "any waivers necessary" to implement this bill.

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.

Fiscal Note

Replaces #7

State of Alaska
2015 Legislative Session

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

Identifier: SB074CS(STA)-DHSS-SCBG-04-14-15
Title: MEDICAID REFORM/PFD/HSAS/ER USE/STUDIES
Sponsor: KELLY
Requester: Senate Finance 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				
OPERATING EXPENDITURES	**FY 2016**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits				(716.3)	(716.3)	(716.3)	(716.3)
Miscellaneous							
Total Operating	**0.0**	**0.0**	**0.0**	**(716.3)**	**(716.3)**	**(716.3)**	**(716.3)**
Fund Source (Operating Only)							
1004 Gen Fund				(716.3)	(716.3)	(716.3)	(716.3)
Total	**0.0**	**0.0**	**0.0**	**(716.3)**	**(716.3)**	**(716.3)**	**(716.3)**
Positions							
Full-time							
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? 07/01/17

Why this fiscal note differs from previous version:

This fiscal note has been updated to reflect the bill sectional identifiers corresponding to the Senate State Affairs Committee Substitute for SB 74.

Prepared By: Duane Mayes, Director — Phone: (907)269-2083
Division: Senior and Disabilities Services — Date: 04/14/2015 05:00 PM
Approved By: Sarah Woods, Deputy Director, Finance & Management Services — Date: 04/14/15
Agency: Health & Social Services

Analysis

Section 4(5) directs the Department to reduce the cost of behavioral health, senior and disabilities services provided to recipients of medical assistance under the state's home and community-based waiver. **Section 10** requires the Department to apply for "any waivers necessary" to implement this bill.

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

Replaces #8

State of Alaska
2015 Legislative Session

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

Identifier: SB074CS(STA)-DHSS-CDDG-04-14-15
Title: MEDICAID REFORM/PFD/HSAS/ER USE/STUDIES
Sponsor: KELLY
Requester: Senate Finance 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				
OPERATING EXPENDITURES	**FY 2016**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits				(11,635.8)	(11,635.8)	(11,635.8)	(11,635.8)
Miscellaneous							
Total Operating	**0.0**	**0.0**	**0.0**	**(11,635.8)**	**(11,635.8)**	**(11,635.8)**	**(11,635.8)**
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)
Total	**0.0**	**0.0**	**0.0**	**(11,635.8)**	**(11,635.8)**	**(11,635.8)**	**(11,635.8)**
Positions							
Full-time							
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? 07/01/17

Why this fiscal note differs from previous version:

This fiscal note has been updated to reflect the bill sectional identifiers corresponding to the Senate State Affairs Committee Substitute for SB 74.

Prepared By: Duane Mayes, Director — Phone: (907)269-2083
Division: Senior and Disabilities Services — Date: 04/14/2015 05:00 PM
Approved By: Sarah Woods, Deputy Director, Finance & Management Services — Date: 04/14/15
Agency: Health & Social Services

STATE OF ALASKA
2015 LEGISLATIVE SESSION

BILL NO. CSSB074(STA)

Analysis

Section 4(5) directs the Department to reduce the cost of behavioral health, senior and disabilities services provided to recipients of medical assistance under the state's home and community-based waiver. **Section 10** requires the Department to apply for "any waivers necessary" to implement this bill.

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.

Replaces #9

Fiscal Note

State of Alaska
2015 Legislative Session

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

Identifier: SB074CS(STA)-DHSS-QAA-04-14-15
Title: MEDICAID REFORM/PFD/HSAS/ER USE/STUDIES
Sponsor: KELLY
Requester: Senate Finance 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 Appropriation Requested	Included in Governor's FY2016 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY 2016**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**
Personal Services							
Travel							
Services	45.5		45.5	45.5	45.5	45.5	45.5
Commodities							
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	**45.5**	**0.0**	**45.5**	**45.5**	**45.5**	**45.5**	**45.5**
Fund Source (Operating Only)							
1002 Fed Rcpts	22.8		22.8	22.8	22.8	22.8	22.8
1003 G/F Match	22.7		22.7	22.7	22.7	22.7	22.7
Total	**45.5**	**0.0**	**45.5**	**45.5**	**45.5**	**45.5**	**45.5**
Positions							
Full-time							
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? 07/01/16

Why this fiscal note differs from previous version:

This fiscal note has been updated to reflect the bill sectional identifiers corresponding to the Senate State Affairs Committee Substitute for SB 74.

Prepared By: Sana Efird, Assistant Commissioner — Phone: (907)465-1630
Division: Finance and Management Services — Date: 04/14/2015 05:00 PM
Approved By: Sarah Woods, Deputy Director, Finance & Management Services — Date: 04/14/15
Agency: Health & Social Services

STATE OF ALASKA
2015 LEGISLATIVE SESSION

BILL NO. CSSB074(STA)

Analysis

Section 4(a)(4) 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. Enhanced fraud detection case tracking software needs to be purchased. License fees are estimated at $45.5 annually.

Software and licensing fees - $45.5

Replaces #10

Fiscal Note

State of Alaska
2015 Legislative Session

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

Identifier: SB074CS(STA)-DHSS-CO-04-14-15
Title: MEDICAID REFORM/PFD/HSAS/ER USE/STUDIES
Sponsor: KELLY
Requester: Senate Finance 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 Appropriation Requested	Included in Governor's FY2016 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY 2016**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**
Personal Services							
Travel	6.0						
Services	759.0						
Commodities							
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	**765.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Fund Source (Operating Only)							
1002 Fed Rcpts	20.0						
1003 G/F Match	20.0						
1004 Gen Fund	725.0						
Total	**765.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Positions							
Full-time							
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? 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:

This fiscal note has been updated to reflect the bill sectional identifiers corresponding to the Senate State Affairs Committee Substitute for SB 74.

Prepared By: Sana Efird, Assistant Commissioner — Phone: (907)465-1630
Division: Finance and Management Services — Date: 04/14/2015 05:00 PM
Approved By: Sarah Woods, Deputy Director, Finance & Management Services — Date: 04/14/15
Agency: Health & Social Services

Analysis

Section 4(a)(9) 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.

Section 9 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).

STATE OF ALASKA
2015 LEGISLATIVE SESSION

BILL NO. CSSB074(STA)

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.

Replaces # 11

Fiscal Note

State of Alaska
2015 Legislative Session

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

Identifier: SB074CS(STA)-DHSS-BHMS-04-14-15
Title: MEDICAID REFORM/PFD/HSAS/ER USE/STUDIES
Sponsor: KELLY
Requester: Senate Finance 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 Appropriation Requested	Included in Governor's FY2016 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY 2016**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits				7,856.0	7,918.8	8,789.9	8,860.2
Miscellaneous							
Total Operating	**0.0**	**0.0**	**0.0**	**7,856.0**	**7,918.8**	**8,789.9**	**8,860.2**
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
Total	**0.0**	**0.0**	**0.0**	**7,856.0**	**7,918.8**	**8,789.9**	**8,860.2**
Positions							
Full-time							
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? 07/01/17

Why this fiscal note differs from previous version:

This fiscal note has been updated to reflect the bill sectional identifiers corresponding to the Senate State Affairs Committee Substitute for SB 74.

Prepared By: Albert Wall, Director — Phone: (907)465-4841
Division: Behavioral Health — Date: 04/14/2015 05:00 PM
Approved By: Sarah Woods, Deputy Director, Finance & Management Services — Date: 04/14/15
Agency: Health & Social Services

STATE OF ALASKA
2015 LEGISLATIVE SESSION

BILL NO. CSSB074(STA)

Analysis

Section 4(5) directs the Department to reduce the cost of behavioral health, senior and disabilities services provided to recipients of medical assistance under the state's home and community-based waiver. **Section 10** requires the Department to apply for "any waivers necessary" to implement this bill.

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.

Replaces #12

Fiscal Note

State of Alaska
2015 Legislative Session

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

Identifier: SB074CS(STA)-DHSS-HCMS-04-14-15
Title: MEDICAID REFORM/PFD/HSAS/ER USE/STUDIES
Sponsor: KELLY
Requester: Senate Finance 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				
OPERATING EXPENDITURES	**FY 2016**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**
Personal Services							
Travel							
Services	4,323.4		2,173.4	2,173.4	2,173.4	2,173.4	2,173.4
Commodities							
Capital Outlay							
Grants & Benefits	(7,201.7)		(7,226.7)	(7,226.7)	(7,226.7)	(7,226.7)	(7,226.7)
Miscellaneous							
Total Operating	**(2,878.3)**	**0.0**	**(5,053.3)**	**(5,053.3)**	**(5,053.3)**	**(5,053.3)**	**(5,053.3)**
Fund Source (Operating Only)							
1002 Fed Rcpts	(1,426.7)		(2,501.7)	(2,501.7)	(2,501.7)	(2,501.7)	(2,501.7)
1003 G/F Match	(1,426.6)		(2,501.6)	(2,501.6)	(2,501.6)	(2,501.6)	(2,501.6)
1108 Stat Desig	(25.0)		(50.0)	(50.0)	(50.0)	(50.0)	(50.0)
Total	**(2,878.3)**	**0.0**	**(5,053.3)**	**(5,053.3)**	**(5,053.3)**	**(5,053.3)**	**(5,053.3)**
Positions							
Full-time							
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? 07/01/17

Why this fiscal note differs from previous version:

This fiscal note has been updated to reflect the bill sectional identifiers corresponding to the Senate State Affairs Committee Substitute for SB 74. Additionally, Section 4(a)(8) includes several new parameters, addressed in the analysis below.

Prepared By: Margaret Brodie, Director — Phone: (907)334-2520
Division: Health Care Services — Date: 04/14/2015 05:00 PM
Approved By: Sarah Woods, Deputy Director Finance & Management Services — Date: 04/14/15
Agency: Health & Social Services

Analysis

Section 3 of this legislation grants the Department of Health and Social Services the authority to assess civil fines against Medicaid providers, in the event they are found to have violated AS 47.05, AS 47.07, or regulations adopted under these chapters. Fines are to be assessed within a range of from $100 to $25,000 per occurrence or offense. There is no additional cost to the department to implement fines under this section.

Recoveries based on implementing fines in this section are calculated by taking the estimated number of civil fines and applying an average fine amount. It is estimated the amount of fines imposed per recovery will increase over time, but the number of fines assessed will decrease over time. In addition there would be a phase-in for the first year. The estimated amount of the recoveries would be $25.0 in FY2016 and $50.0 in subsequent years.

Section 4(a)(2) 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 4(a)(3) of the bill expands use of telemedicine for primary, behavioral and urgent care. **Section 4(b)** requires the Department to improve access to telemedicine. **Section 8(d)(1)** requires the department to identify legal barriers that prevent the expanded use of telemedicine as part of a managed care demonstration project. 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 4(a)(4) 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 4(a)(6) and Section 6(a)(6-7) 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.

Analysis Continued

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 regiments 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, Community and Economic Development.

Section 4(a)(7) of the bill requires the Department to implement enhanced care management. In **Section 8**, this legislation proposes to design and initiate a managed care demonstration project on or before January 31, 2016. 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 4(a)(8) 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. This section now also requires premium payments for centers of excellence, penalties for certain poor hospital outcomes, bundled payments and global payments. At this time, the Department is unable to comment on what impact these new provisions will have. $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 4(a)(10) 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 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 (mentioned above)
- Increase Alaska Medicaid Coordinated Care Initiative contract (current contract cost is $3.85 per client per month) to manage this population: $3.85 x 7,800 x 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 x $613.39 x 5 = $23,922.2 x 30% = $7,176.7

Replaces #13

Fiscal Note

State of Alaska
2015 Legislative Session

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

Identifier: SB074CS(STA)-DHSS-SDMS-04-14-15
Title: MEDICAID REFORM/PFD/HSAS/ER USE/STUDIES
Sponsor: KELLY
Requester: Senate Finance 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				
OPERATING EXPENDITURES	**FY 2016**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits				16,846.4	16,846.4	16,846.4	16,846.4
Miscellaneous							
Total Operating	**0.0**	**0.0**	**0.0**	**16,846.4**	**16,846.4**	**16,846.4**	**16,846.4**
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
Total	**0.0**	**0.0**	**0.0**	**16,846.4**	**16,846.4**	**16,846.4**	**16,846.4**
Positions							
Full-time							
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? 07/01/17

Why this fiscal note differs from previous version:

This fiscal note has been updated to reflect the bill sectional identifiers corresponding to the Senate State Affairs Committee Substitute for SB 74.

Prepared By: Duane Mayes, Director — Phone: (907)269-2083
Division: Senior and Disabilities Services — Date: 04/14/2015 05:00 PM
Approved By: Sarah Woods, Deputy Director, Finance & Management Services — Date: 04/14/15
Agency: Health & Social Services

Analysis

Section 4(5) directs the Department to reduce the cost of behavioral health, senior and disabilities services provided to recipients of medical assistance under the state's home and community-based waiver. **Section 10** requires the Department to apply for "any waivers necessary" to implement this bill.

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.

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

Senior Community Based Grant component's Adult Day and Senior In-Home Services serve some individuals who are Medicaid eligible.

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:	14
(S) Publish Date:	4/11/2015

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 Appropriation Requested	Included in Governor's FY2016 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY 2016**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Fund Source (Operating Only)							
None							
Total	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Positions							
Full-time							
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? 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, intial version.

Prepared By:	Lori Wing-Heier, Director	Phone:	(907)465-2515
Division:	Division of Insurance	Date:	03/20/2015 11:04 AM
Approved By:	Catherine Reardon, Director	Date:	03/20/15
Agency:	Division of Administrative Services, DCCED		

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2015 LEGISLATIVE SESSION

Analysis

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

Fiscal Note

New Note

State of Alaska
2015 Legislative Session

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

Identifier: SB074CS(STA)-DHSS-BHA-04-14-15
Title: MEDICAID REFORM/PFD/HSAS/ER USE/STUDIES
Sponsor: KELLY
Requester: Senate Finance Committee

Department: Department of Health and Social Services
Appropriation: Behavioral Health
Allocation: Behavioral Health Administration
OMB Component Number: 2665

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				
OPERATING EXPENDITURES	**FY 2016**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**
Personal Services	100.9		100.9	100.9	100.9	100.9	100.9
Travel	2.0		2.0	2.0	2.0	2.0	2.0
Services	9.4		9.4	9.4	9.4	9.4	9.4
Commodities	8.1		0.5	0.5	0.5	0.5	0.5
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	**120.4**	**0.0**	**112.8**	**112.8**	**112.8**	**112.8**	**112.8**
Fund Source (Operating Only)							
1002 Fed Rcpts	60.2		56.4	56.4	56.4	56.4	56.4
1003 G/F Match	60.2		56.4	56.4	56.4	56.4	56.4
Total	**120.4**	**0.0**	**112.8**	**112.8**	**112.8**	**112.8**	**112.8**
Positions							
Full-time	1.0		1.0	1.0	1.0	1.0	1.0
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? 07/01/17

Why this fiscal note differs from previous version:

This fiscal note has been updated to reflect the bill sectional identifiers corresponding to the Senate State Affairs Committee Substitute for SB 74.

Prepared By: Albert Wall, Director — Phone: (907)465-4841
Division: Behavioral Health — Date: 04/14/2015 05:00 PM
Approved By: Sarah Woods, Deputy Director Finance & Management Services — Date: 04/14/15
Agency: Health & Social Services

STATE OF ALASKA
2015 LEGISLATIVE SESSION

BILL NO. CSSB074(STA)

Analysis

Section 4(5) directs the Department to reduce the cost of behavioral health, senior and disabilities services provided to recipients of medical assistance under the state's home and community-based waiver. **Section 10** requires the Department to apply for "any waivers necessary" to implement this bill.

The 1915(i) option provides a federal match of 50%, reducing general fund needed by 50%.

One position, Health Program Manager II (GP, Range 19, in Anchorage at $100.9 annually) will be required for intensive application and program development starting in FY2016, and coordination and program oversight beginning in FY2018. Funding for this position will be 50% federal and 50% GF match.

aetna

March 27, 2015

Senator Pete Kelly
State of Alaska Legislature
120 4th Street
State Capitol Room 156
Juneau, Alaska 99801

RE: Value of Medicaid Managed Care

Dear Senator Kelly,

Aetna Medicaid applauds the Alaska State Legislature for taking the time to consider the value of a Managed Medicaid program for the State. Aetna has been a leader in Medicaid managed care since 1986 and currently serves nearly three million members across 16 states. We have more than 28 years of experience in managing the care of the most medically fragile and vulnerable populations, using innovative approaches to achieve successful health care results and favorable cost outcomes.

Medicaid Managed Care is a proven vehicle to achieve the reform mandates that the State of Alaska is trying to achieve. The purpose of this letter is to share the value of managed care. We recognize that the State of Alaska is unique in geography, population, and healthcare needs, and so we offer our experience from other unique states across our nation that have shown Medicaid managed care to be a consistent pathway to achieve high quality integrated healthcare while controlling costs.

National Trends and Medicaid Managed Care Overview

Medicaid is the single largest source of health coverage in the U.S., with over 60 million beneficiaries and $450 billion in annual spending.[1] A staggering one-fifth of the total US population is enrolled in Medicaid today, consuming 15% of all national health expenditures. Within the next 10 years enrollment will reach 80 million enrollees with an $850 billion annual price tag.[2]

States are not exempt from these tremendous growths in enrollment and costs. Here in Alaska, total Medicaid spending is approximately $1.6 billion annually and is projected to double in the next 10 years.[3] Uncontrolled growth in Medicaid diverts dollars that otherwise could be invested in education, infrastructure, and other priority initiatives. States across the country facing extreme budget pressure are increasingly turning to capitated managed care for a solution to achieve budget predictability, quality assurance, access to care, ease of navigation, and integrated whole-person healthcare - the goals this Group is charged with.

Currently, thirty-eight states and Washington, D.C. contract with Medicaid Managed Care Organizations (MCO) to deliver care to beneficiaries in their states. Today roughly two thirds of all Medicaid

[1] http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Downloads/medicaid-actuarial-report-2013.pdf#page=9
[2] http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Downloads/medicaid-actuarial-report-2013.pdf#page=10
[3] http://dhss.alaska.gov/fms/Documents/MESA/MESA_2012-32.pdf#page=28

beneficiaries receive some form of care through an MCO.[4] This figure will grow to 75% by 2015.[5] Over 70% of Children's Health Insurance Plan beneficiaries are receiving their services through Medicaid health plans.[6] The clear nationwide trend of moving to Medicaid managed care models signals the value states are receiving from MCOs. Alaska should weigh the potential benefits as they relate to the Reform Advisory Group's goals.

2/3 of all Medicaid beneficiaries receive care through an MCO

Benefits of Managed Care

Matching the benefits of managed care to Alaska's reform goals

1. Stability and Predictability in Budgeting

Risk-based managed care transfers financial risk away from the state budget and places it directly on MCOs. As a result, state funds are not subject to the variability and overruns that arise under a fee-for-service (FFS) model, creating a more stable and predictable budget.

Additionally, states have reported cost savings under Medicaid managed care models. A 2010 industry report found that over an eight-year period states could save up to 5% of FFS costs by enrolling children and low-income families in Medicaid managed care, and could realize up to 8% in savings over current costs by expanding managed care to seniors and people with disabilities.[7] This study also found that Alaska could save $260 million over the same period.[8] A separate well known survey of 24 states, completed by The Lewin Group, found that each state saved from half of one percent up to twenty percent through managed care.[9] Medicaid health plans saved Pennsylvania $5.0-$5.9 billion over a 10-year period, and Kentucky is on track to see $1.3 billion in savings after moving over 500,000 beneficiaries from FFS to managed care.[10,11] A 2012 report by the Robert Wood Johnson Foundation indicated that states which find most value from managed care are those with the highest Medicaid FFS reimbursement rates, and the rates here in Alaska are the highest in the nation.[12]

Cost savings can also be achieved through significant reduction in fraud, waste, and abuse. CMS reports show that payment error rates for Medicaid FFS are significantly higher than those in Managed Care.[13] For example, the FY2013 payment error rate for Medicaid FFS was 3.6% compared to Managed Care's 0.3% - a $6.6 billion difference.[14]

2. Increasing the ease and efficiency of navigating the system

Managed care models help both providers and beneficiaries navigate a traditionally complex and fragmented health care system. MCOs, for example, specialize in provider relations. Most state Medicaid managed care contracts require MCOs to have dedicated staff to liaison with providers for educational purposes and the resolution of issues. Direct face-to-face partnership with the provider community increases the ease and efficiency with which providers navigate the system.

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[4] http://www.gao.gov/assets/670/663306.pdf#page=13
[5] http://avalere.com/expertise/managed-care/insights/analysis-medicaid-plans-expected-to-grow-20-this-year-under-aca-expansion
[6] http://www.mhpa.org/_upload/Medicaid%20Managed%20Care%20Primer%20February%202013.pdf#page=2
[7] http://www.unitedhealthgroup.com/~/media/UHG/PDF/2010/UNH-Working-Paper-3.ashx#page=59
[8] http://www.unitedhealthgroup.com/~/media/UHG/PDF/2010/UNH-Working-Paper-3.ashx#page=30
[9] *Lewin Group, "Medicaid Managed Care – A Synthesis of 24 Studies," July 2004, Updated March 2009, accessed at http://www.lewin.com/publications/Publication/395/*
[10] *Lewin Group, "An Evaluation of Medicaid Savings from Pennsylvania's HealthChoices Program," May 2011*
[11] *"Gov. Beshear: Aggressive Action Plan for Managed Care Paying Off", accessed at* http://migration.kentucky.gov/newsroom/governor/20131024managedcare.htm
[12] http://www.rwjf.org/content/dam/farm/reports/reports/2012/rwjf401106/subassets/rwjf401106_1#page=2
[13] https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/PERM/Downloads/PERM-MedicaidErrorRates.pdf
[14] http://www.hhs.gov/afr/2013-hhs-agency-financial-report.pdf#page=175

Under a managed care model, MCOs are further able to eliminate fragmentation by investing in and implementing provider information systems where health care professionals can easily and quickly file claims, receive payments, and access necessary information. Most MCOs have the advantage of bringing years of national experience in managing provider concerns and needs through their information systems' platforms to provide a seamless system that enables providers to focus their time on what they do best - caring for their patients.

Managed care also improves navigation of the healthcare system for beneficiaries by increasing access to quality healthcare.[15,16] A core competency and requirement of an MCO is to contract with the provider community to form a network of healthcare professionals that members can access. In a FFS delivery system, Medicaid beneficiaries often have difficulty finding providers willing to treat them. Estimates suggest that only about half of primary care providers nationally are accepting new Medicaid patients.[17] Under a risk-based managed care model, states can address this access problem by requiring MCOs to meet specified network adequacy standards for primary and specialty care that can include requirements such as state-determined minimum provider-to-population ratios, distance travel time maximums, and limits on appointment wait times. Compared to FFS models, MCOs have greater flexibility to structure provider contracts to incentivize provider participation in areas where access to care is a particular concern. MCOs have provider directories and toll-free phone lines to assist enrollees in finding a provider. If an enrollee needs to see a specialist, a MCO will facilitate access to that service and provide transportation if necessary. A Kaiser Commission study found that improved access to care was one of the biggest benefits states cited in their use of managed care over FFS.[18]

3. Providing whole care for the patient by uniting physical and behavioral health treatment

Aetna Medicaid agrees with the Reform Group's goal of achieving integrated, whole-person care. Most healthcare providers and MCOs would agree that a successful delivery system model must consider a beneficiary's physical, behavioral and psychosocial needs to be effective. Aetna Medicaid, for example, has developed the Integrated Care Management (ICM) model that looks at the totality of each member's needs to determine both root cause and proximate cause of health care issues. The goal of our ICM model, regardless of the member's physical or behavioral health needs, is to provide them with the right care, in the right place, at the right time.

Managed care organizations also create a "medical home" by coordinating care with beneficiaries, their families, and their physicians. They support physician practice management systems that emphasize prevention, early diagnosis, treatment, and coordinated management of whole-person care. This integrated approach to providing care isn't feasible under a disjointed FFS model.

Improved Outcomes through Accountability

Quality assurance and quality improvement is one of the most significant benefits of Medicaid Managed Care. According to the Medicaid Health Plans of America, an industry trade association, 25% of Medicaid health plans have achieved accreditation through the National Committee for Quality Assurance (NCQA).[19] Federal regulations require annual quality reviews of Medicaid health plans and specify state oversight expectations. Most states conduct additional reviews of Medicaid health plans to ensure that they meet state rules and regulations in areas such as utilization review and grievances and appeals. Medicaid health plans are required to report performance measures, such as HEDIS, to the state. These performance measures provide valuable data to health plans, states, researchers, and policymakers for

[15] http://dss.mo.gov/mhd/oversight/pdf/ffs-medcare10feb18.pdf#page=39
[16] http://www.ncbi.nlm.nih.gov/pubmed/16679438
[17] Peter Cunningham and Ann O'Malley, "Do Reimbursement Delays Discourage Participation by Physicians? Data Watch," Health Affairs, November 18, 2008.
[18] http://www.amcp.org/WorkArea/DownloadAsset.aspx?id=12745#page=9
[19] http://www.mhpa.org/_upload/Medicaid%20Managed%20Care%20Primer%20February%202013.pdf#page=4

assessing the quality of care in Medicaid programs, identifying gaps in care, and creating quality improvement projects.

Holding providers and managed care plans accountable through HEDIS quality data provides the state with a tool that has been shown to consistently improve quality metrics in challenging environments. Many of the 25 Leading Health Indicators listed in the Healthy Alaskans 2020 plan are HEDIS requirements for NCQA accredited plans. Several of the indicators that are proving a challenge to the State – such as decreasing preventable hospitalizations, increasing prenatal care in the 1st trimester, and reducing the number of children not receiving ACIP recommended vaccinations – are areas where managed Medicaid plans excel. [20,21,22] Using managed care would provide the State with an accountable and nationally-recognized system to track and improve outcomes for all Alaskans.

MCO Quality Snapshot

- Increased prenatal care rates
- Decreased preventable hospitalizations
- Increased number of children receiving ACIP vaccinations

Considerations for Implementing Medicaid Managed Care

Several issues must be considered as Alaska evaluates Medicaid reform and managed care. The following areas should be discussed to determine the best solution for Alaska's unique needs:

Risk Model

The Medicaid Reform Group must determine the optimal point for Alaska on the managed care continuum considering state goals and population.

Primary Care Case Management (PCCM)	Built on the FFS delivery system where the state typically pays providers a small fee per member per month (PMPM) for case management
Prepaid Health Plans (PHPs)	Plans at financial risk for a limited set of benefits such as dental or mental health services
Risk-based managed care	The most common form of managed care. States contract with MCOs on a capitated basis for a comprehensive benefit package

Risk-based managed care is the only alternative that will yield budget predictability/stability, administrative efficiency for providers, and holistic physical and behavioral health treatment for members.

Program design: Benefits, enrollment, and populations

Implementation of a successful program is dependent on the planning and design of several key areas including:

[20] http://www.masonbay.com/clients/dev2/cahp-html-3/pdfs/MC-ManagedCareValueRotsFS012009.pdf
[21] http://www.hrsa.gov/quality/toolbox/508pdfs/prenatalmoduleaccess.pdf
[22] http://www.ncqa.org/Portals/0/Newsroom/SOHC/2013/SOHC-web_version_report.pdf

Benefits	**Determining covered benefits is a critical decision point. Integrated whole-person care cannot be achieved if, for example, behavioral health or dental benefits are provided outside of the managed care contract.**
Enrollment	**Enrollment rules are another critical program design area. Deciding if enrollment is mandatory, voluntary, or has an opt-out will determine a program's success. Mandatory enrollment with lock-in periods will yield the most cost savings and quality outcomes.**
Populations	**Populations that will be enrolled in managed care must be carefully weighed. Extending managed care to populations with challenging medical needs, such as the aged and disabled, is encouraged to maximize savings but must be balanced with rate-setting practices to properly adjust for health status and risk.**

Special Financing Programs and Supplemental FFS Payments

The existence of special financing programs and supplemental FFS payments such as Upper Payment Limits (UPL), which are relied upon by hospitals and safety net providers, may appear to be a complicating factor standing in the way of states considering implementation of a capitated managed care model. There are, however, a number of methods for resolving this issue and increasing the amount providers receive through these supplemental payments while still implementing managed care. Some states have used federal waivers as well as the inclusion of provider tax and intergovernmental transfer funding in managed care rates to solve this funding issue.[23] We encourage Alaska to look at how other states have handled this issue if this is of concern to the State.

Timeline and Critical Planning Steps

Medicaid reform and implementation of managed care must be conducted in a responsible and methodical manner. It is common to see states take 18 months to move to managed care. This allows time to:

- **Receive stakeholder and advocacy input into program design**
  - **Proactively engage with community based organizations, member advocate groups, and providers to ensure all parties participate in the process to make program implementation successful**
  - **Customize the program to drive cultural competency-tailored solutions to health disparity gaps found across unique Alaskan populations**
- **Design the program: populations included, benefits offered, enrollment mechanisms, etc.**
- **Write and receive approval of CMS waiver and prepare state plan amendment documentation**
- **Prepare the provider community for transition to a managed care model**
- **Draft and release a competitive procurement that will ensure transparent MCO selection and foster free market competition**
- **Select plans and implement program**

In Closing

Aetna Medicaid would like to thank you for the opportunity to contribute to the Medicaid reform dialogue in Alaska. We believe Medicaid managed care is a viable option for Alaska and we offer support and encouragement as Alaska navigates the complexities of Medicaid Reform.

[23] http://hcr.amerigroupcorp.com/wp-content/uploads/2013/04/Achieving_the_Benefits_of_Managed_Care_While_Preserving_Funds_From_Upper_Payment_Limit_Programs.pdf

The LEWIN GROUP

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.[1] 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

[1] 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.[2] However, there is still substantial opportunity for states to expand Medicaid enrollment in managed care plans.

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[2] 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), 45.6percent 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.[3]

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.

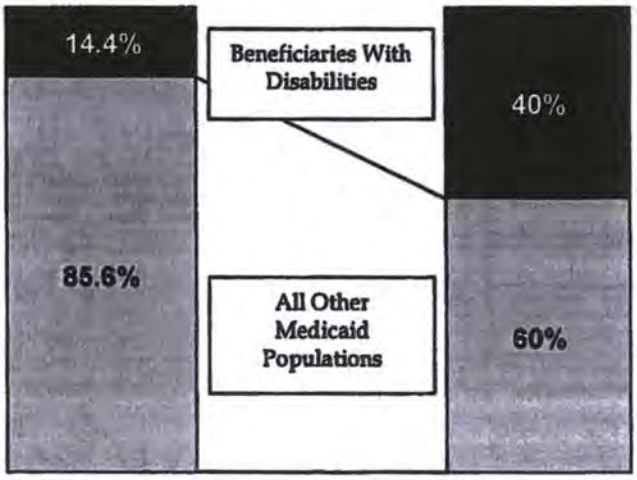
The findings from this study demonstrate that the managed care model achieves access and quality improvements while at the same time yielding Medicaid program savings. Further, it is clear that – through carefully crafted managed care program design that is tailored to the state's Medicaid populations 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.

[3] 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[4] 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[5] – 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.[6]

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.

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[4] 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.

[5] 2005 Medicaid Quarterly Statement, Centers for Medicare and Medicaid Services, http://msis.cms.hhs.gov/.

[6] 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[7], 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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[7] 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.[8] 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.[9] 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.

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[8] U.S. General Accounting Office, Arizona Medicaid – Competition Among Managed Care Plans Lowers Program Costs, October 1995.

[9] 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.[10]

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.[11] 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

[10] Milliman USA, Kentucky Region 3 Partnership Program, December 2003.

[11] 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.[12,13]

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.[14] 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

Expenditures	Upper Payment Limit (estimated FFS costs in absence of capitated program)	Costs Under the Capitated Managed Care Program	Savings
Medical Services	$1,551,922,277	$1,497,108,886	$54,813,391
Administrative	$54,456,231	$36,902,780	$17,553,451
Total Program	$1,606,378,508	$1,534,011,666	$72,366,842

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.[15]

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

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12 Passport Health Plan presentation, transmitted to Lewin on February 27, 2004 from AmeriHealth Mercy staff.

13 Quality Compass is a database of health plan quality performance and enrollee satisfaction, as measured using HEDIS and CAHPS.

14 Independent Assessment of Cost-Effectiveness for the Ohio Medicaid Managed Care Program, Mercer Government Human Services Consulting, March 2006.

15 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)[16] 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.[17]

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.[18] 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.[19]

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16 Individuals are first classified as ABD by the SSA, then must meet certain criteria (e.g. income level) to be classified by the state.

17 Michigan Department of Consumer and Industry Services, Michigan HMO Enrollment Information, http://www.michigan.gov/documents/hmo_enrl_25290_7.html.

18 Michigan Department of Community Health, Presentation – Michigan Medicaid: New Direction, July 23, 2003.

19 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)[20]

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)[21]

	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).

[20] This 12.4% rate increase was not implemented by the State.

[21] 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.[22] 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.[23]

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.[24,25] The report states that the during the first two years of the waiver, the State exceeded its budget neutrality cap.[26] 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.[27]

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.[28]

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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[22] 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.

[23] 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.

[24] Maryland Department of Health and Mental Hygiene, HealthChoice Evaluation Final Report & Recommendations, January 2002.

[25] The HealthChoice evaluation began in January 2001, during its fourth waiver year.

[26] Initially, Maryland experienced a problem in setting appropriate capitation payment rates, effectively overpaying MCOs for SSI recipients and driving up total program costs.

[27] Maryland HealthChoice Program Factsheet, January 2007, http://www.dhmh.state.md.us/mma/pdf/FINALHealthChoiceFactSheet.pdf.

[28] 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).[29]

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.[30] 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

[29] 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.

[30] 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.[31]

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.

[31] 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![32] 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.

[32] 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
Approximate Average Enrollment	245,000
Approximate member months, FY2006	2,940,000
Estimated Salud! Costs, Total Dollars, FY2006	$1,056,959,400
Savings Percentage Versus FFS	
Low Estimate	3%
Midpoint Estimate	4%
High Estimate	5%
Estimated FFS Costs in Absence of Salud!	
Low Estimate	$1,089,648,866
Midpoint Estimate	$1,100,999,375
High Estimate	$1,112,588,842
Estimated Salud! Savings, FY2006	
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.[33] 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.

[33] 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[34] 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[35] population residing in Harris County (Houston), including those who are dually eligible for Medicaid and Medicare.[36] 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.[37] (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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[34] 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.

[35] 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.

[36] 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.

[37] 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.[38]

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.[39] 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[40] 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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38 Ibid.

39 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.

40 "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.[41] 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.[42] 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.[43] 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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[41] 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/.

[42] Center for Health Care Strategies, Serving the Special Program/Aged, Blind, and Disabled Population, April 2002.

[43] Ibid.

Minnesota.[44] 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.[45] 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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[44] Freund, D., Kniesner, T., LoSasso, A., How Managed Care Affects Medicaid Utilization A Synthetic Difference-in-Difference Zero-Inflated Model, April 1996.

[45] 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).[46] 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.

[46] 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
State FY2005			
Total Dollars, MCOs, FY2005	3,139,978	$131,693,246	$151,447,233
PMPM, MCOs, FY2006		$41.94	$48.23
State FY2006			
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,[47] specifically for the TANF population.[48] 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.[49] 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

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[47] States were requested to provide data from CY2001.

[48] 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.

[49] 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) 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.[50]

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.[51] 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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[50] 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.

[51] 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[52] 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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[52] 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[53] 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.[54]

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.[55]

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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[53] Wisconsin, Kentucky, Maryland, Tennessee, Texas, New Mexico, Connecticut, Pennsylvania, and Oklahoma.

[54] Milliman USA, Inc. Wisconsin HMOs' Success in Medicaid and BadgerCare: Government Cost Savings and Better Health Care Quality, February 2002.

[55] 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.[56] 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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[56] 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
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- 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
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- 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
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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
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- 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
State Programs		
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
Targeted Medicaid Managed Care Programs		
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
Service Specific Studies		
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
State Studies				
Arizona Medicaid - Competition Among Managed Care Plans Lowers Program Costs, U.S. General Accounting Office, October 1995	1115 Waiver AHCCCS is Arizona's statewide Medicaid managed care program implemented in 1982. Prior to AHCCCS, Arizona did not operate a Medicaid program. Nine private or county health plans health plans cover the AHCCCS population. Five of the health plans are not-for-profit entities.	AHCCCS includes family planning, behavioral health, and LTC.	As of February 2004, 767,857 individuals were enrolled in the acute care program. (Enrollment data from Acute Care Enrollment, By County By Health Plan, http://www.ahcccs.state.az.us/Statistics/Enrollment/Acute/2004/enrollmnt.asp)	In FY1991, federal savings were $37 M and state savings were $15M in acute care costs. Arizona's capitation rate for Medicaid declined by 11% in 1994 even while other states' per capita costs grew. Arizona's administrative costs are higher than in other states. 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. The biggest slow-down in AHCCCCS growth rate was for SSI beneficiaries after 1987. Overall, AHCCCS spend 81% of what a traditional Medicaid program would have spent.

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	1115 waiver 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. Eligibility: AFDC-children - Children who meet the requirements for the former AFDC program. 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. Healthy Start - children and pregnant women with incomes up to 185% FPL, no asset limit. Dual eligibles are not enrolled.	Comprehensive benefits. 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.	Enrollment: AFDC/Healthy Start Children and Pregnant Women: 216,185 (as of report publication) BadgerCare: 64,036 (as of report publication)	2001: $14M in state savings, $21M in federal savings. 2002: $22M in state savings, $34M in federal savings. 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.

Report	Program Description & Enrollment	Benefits	Enrollment	Savings
KY Region 3 Partnership Program, Milliman USA, December 2003 Health plan-funded study	1115 Waiver Mandatory for TANF, foster care, SOBRA, SSI, KCHIP. 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.	Standard Medicaid benefits are covered. Carve-outs include LTC, MH, and school-based services. Non-emergency transportation services are covered only for enrollees who need transport by stretcher only. There are no cost-sharing requirements.	2003: 132,579 32% Sobra 29% TANF 17% SSI, no Medicare 10% Duals 9% KCHIP 4% Foster Care (Enrollment data provided by University Health Care Inc, dba Passport Health Plan presentation, provided to The Lewin Group on 2/27/04.)	*Total Savings:* 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 *PMPM Savings:* FY2000 TANF: $6.69 Foster Care: $15.17 Preg. Women: $4.60 SSI/Medicare: $19.41 SSI/No Medicare: $31.91 Composite: $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
Independent Assessment for the Ohio Medicaid Managed Care Program, Mercer Government Human Services Consulting, March 2003 State-funded study	1915(b) waiver 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). 6 health plans participate in 15 counties (as of July 03). 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.	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.	Enrollment (as of February 2004): Total managed care: 495,555 (2004) Mandatory: 297,166 (2004) Voluntary: 2107 (2004) "Preferred Option": 196,292 (2004) (Enrollment data from Ohio Department of Job and Family Services, Fact Sheet 2.4, Medicaid Managed Care, http://jfs.ohio.gov/ohp/bcps/FactSheets/MedicaidManagedCare.pdf)	$26.4M in State FY2002 (2.2% of FFS) 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. The main source of savings is from decreased use of inpatient hospital services.

Report	Program Description & Enrollment	Benefits	Enrollment	Savings
Michigan Medicaid: New Directions Presentation by MDCH, July 23, 2003 and Michigan Medicaid: Relative Cost Effectiveness of Alternative Service Delivery Systems, prepared for the Michigan Department of Community Health, April 2005 Center for Health Program Development and Management at the University of Maryland, Baltimore County	1915(b) Waiver 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. 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. 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. Eligible populations include: TANF and related, SSI and related, and ABD.	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 in enrolled in a Michigan Medicaid MCO. As of June 30, 2006, 1.3 million individuals were enrolled in a Michigan Medicaid MCO (http://www.statehealthfacts.org/profileind.jsp?ind=216&cat=4&rgn=24).	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: 2001: -9% 2002: -14% 2003: -16% 2004: -19% MCO PMPM costs were 9% lower than FFS PMPM costs and so forth. When capitated managed care is compared to alternative delivery systems, Michigan would save between $28 million and $129 million in State funds for FY2006. 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 State-funded study and Status Report on the Budget Neutrality Calculation for the Maryland HealthChoice Program, prepared for the Maryland Department of Health and Mental Hygiene, December 2007 Center for Health Program Development and Management at the University of Maryland, Baltimore County	1115 Waiver Enrollment is mandatory for children, pregnant and postpartum women, families receiving Temporary Cash Assistance (TCA), individuals receiving SSI, and foster children. Seven for-profit MCOs serve HealthChoice enrollees, of which 5 MCOs serve Medicaid enrollees only. The 4 largest MCOs are statewide.	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. By June 2003, 487,073 individuals were enrolled in HealthChoice (Maryland HealthChoice Factsheet, January 2004, http://www.dhmh.state.md.us/mma/pdf/MdHC-fact-2004.pdf.). By 2006, 491,800 individuals were enrolled in HealthChoice (Maryland HealthChoice Factsheet, January 2007, http://www.dhmh.state.md.us/mma/pdf/FINALHealthChoiceFactSheet.pdf.).	The 1115 waiver was found to be budget neutral. The state exceeded the BN cap in the 1st 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. HealthChoice met the budget neutrality test each year for FY2000 through FY2007. By the end of FY2007, the State was about $2 billion, or about 10 percentage points of margin under the budget cap. Neither study identifies specific sources of savings.

Report	Program Description & Enrollment	Benefits	Enrollment	Savings
Reforming Medicaid: The Experiences of Five Pioneering States with Mandatory Managed Care and Eligibility Expansions, Mathematica Policy Research, for CMS, April 2001 Study funding from the federal government	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.	Comprehensive Medicaid benefits, with some state by state variation.	Varied by state.	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. HI: 3.0%, US: 2.9%, years: 1993 - 1998 MD: -0.2%, US: 2.6%, years: 1996 - 1998 OK: 2.8%, US 2.4%, years: 1995 - 1998 RI: 3.4%, US: 2.9%, years: 1993 - 1998 TN: 2.8%, US: 2.9%, years: 1993 - 1998

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 Coalition of Medical Assistance Managed Care Organizations	HealthChoices is Pennsylvania's managed care program for Medical Assistance beneficiaries. This program was implemented in 1997 as mandatory in Pennsylvania's urban zones. 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.	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. 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 New Mexico Medical Review Association	1915(b) waiver Salud! is administered by 3 MCOs. All 3 MCOs were rated "excellent" by the National Committee for Quality Assurance. Physician fee schedules are high relative to other states.	Comprehensive Medicaid benefit package. Disease management, childhood immunization, adolescent outreach, and prenatal care programs. Addresses cultural and linguistic barriers.	Lovelace MCO Members: 66,450 Molina MCO Members: 59,159 Presbyterian MCO Members: 1,237	Higher costs per eligible due to quality of coverage, provider gross receipt tax of 7% and a premium tax assessment. 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
Medicaid Cost Containment Report No. 3, by The Lewin Group, January 2003 The Washington State Legislature	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.	Comprehensive Medicaid benefit package.	In 2003, 403,162 Medicaid beneficiaries were enrolled in 1 of the 6 HMO's. The top 3 HMOs in terms of percentage of total enrollment were: Molina Healthcare - 38% Community Health Plan - 28% Premera Blue Cross - 11%	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. 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.

Report	Program Description & Enrollment	Benefits	Enrollment	Savings
Targeted Medicaid Managed Care Program Studies				
STAR+PLUS Medicaid Managed Care Waiver Study: An Independent Assessment of Access, Quality, and Cost-Effectiveness, Texas A&M University, PPRI, October 1999 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) State-funded studies	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. 94% of the population is over the age of 20, and 43% are age 65 or older.	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. 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.	About 55,000 were enrolled mandatorily during the first waiver period. During the second waiver period, 57,000 individuals were enrolled. As of February 2004, 62,782 individuals were enrollee. (STAR+PLUS website, http://www.hhsc.state.tx.us/starplus/enrollmen_numbers/confirmed/confirme.htm.)	*Cost savings in the first waiver period:* Waiver year 1: -$1.97M, -$2.68 PMPM Waiver year 2: $7.57 M, $10.22 PMPM Waiver years 1&2: $6.05M, $4.11 PMPM Savings were less than 1% of the cost for the two years combined. *Cost savings in the second waiver period:* 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. 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
Serving the Special Program/Aged, Blind and Disabled Population (in OK Medicaid managed care) by Schaller Anderson, April 2002 Center for Health Care Strategies funded study	1115 Waiver 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. 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. Individuals who are disabled and have incomes up to 100% FPL are eligible for Medicaid. **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.	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.	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%.	
How Managed Care Affects Medicaid Utilization A Synthetic Differences Zero-Inflated Count Model, Freund, D., Kniesner, T., LoSasso, A., April 1996 AHRQ-funded study	The study analyzed the effects of managed care on doctor office visits, hospital outpatient dept. visits, ER visits, and hospital inpatient days. The study population included adult women.	Comprehensive Medicaid benefits were modeled.	Based on Hennepin County data used for the study.	Estimated economic savings totaled about 10%, which the authors state is lower than estimated savings reported in states' waiver applications. The 10% savings figure accounts for the initial effect of switching to managed care.

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 Anthem Blue Cross Blue Shield Community Health Network of Connecticut HealthNet of the Northeast WellCare of Connecticut	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. Over 80% of the State's TANF spending occurs through capitation payments to health plans.	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).

Report	Program Description & Enrollment	Benefits	Enrollment	Savings
Independent Assessment of New Mexico's Behavioral Health Program, by The Lewin Group, March 2007 New Mexico Medial Review Association	Prior to establishing a single, comprehensive mental health system for Medicaid beneficiaries in 2006, New Mexico had a fragmented system. 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.	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.

Report	Program Description and Enrollment	Benefits	Savings
Service Specific Studies			
Comparison of Medicaid Pharmacy Costs of Usage between the Fee-for-Service and Capitated Setting, prepared for CHCS by The Lewin Group, January 2003 Center for Health Care Strategies funded study	Reported data focus on TANF enrollees.	Prescription drugs only.	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. 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.
Analysis of Pharmacy Carve-Out Options for the Arizona Health Care Cost Containment System, prepared for CHCS by The Lewin Group, November 2003 Center for Health Care Strategies funded study	AHCCCS is Arizona's Medicaid 1115 waiver program. Currently prescription drugs are included in the managed care benefit.	The study looked at prescription drugs only.	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.

Report	Program Description and Enrollment	Benefits	Savings
Preventing Unnecessary Hospitalization in Medi-Cal: Comparing Fee-for-Service with Managed Care, CHCF, February 2004 California HealthCare Foundation funded study	Medi-Cal managed care was implemented on a county by county basis and included both voluntary and involuntary enrollment. 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.	Looked at preventable hospitalizations only.	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. 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.
Comparison of Alcohol Treatment and Costs After Implementation of Medicaid Managed Care, May 2006. The American Journal of Managed Care	Philadelphia County: 400,000 enrolled (as of January 1998). The MCO is a carve-out agency that receives PMPM capitation fee for providing behavioral health services to the enrolled population. Allegheny County (Pittsburgh): 140,000 enrolled (as of January 1998) in the FFS program. During the study period, both sites were funded equally for public substance abuse treatment systems.	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.	The study looked at the pre- (1995) and the post-managed care period (1998) in both the managed care and FFS sites. 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. Managed care site (Philadelphia County): $1,200 reduction for alcohol abuse treatment; $900 reduction for drug abuse treatment per person. 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.

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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

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.

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.[1] 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.[2]

Use of Private Managed Care Organizations in Medicaid[3]

"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.

[1] 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*.

[2] The KFF tracks state actions on expansion of Medicaid under the ACA at *http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-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.

[3] 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.[4]

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.[5] 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.[6] 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.

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[4] *http://medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-site.html.*

[5] 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.*

[6] 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.*

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.[7] 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).[8] 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)].[9] 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.[10]

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.[11]

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[7] Legislative Research calculations based on data provided by Gottlieb, PwC, pp. 13-14.

[8] 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/.*

[9] 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.*

[10] Act No. 107, 2013, Section 105d(1)((4), *http://www.legislature.mi.gov/documents/2013-2014/publicact/pdf/2013-PA-0107.pdf.*

[11] 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[1]	Private MCO Enrollment[2] (Thousands)	Private MCO as a Percent of Total Enrollment	Fiscal Years 2014-2015[3]		
				New Geographic Areas Added	New Eligibility Groups Added	New Mandatory Enrollment
United States	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)

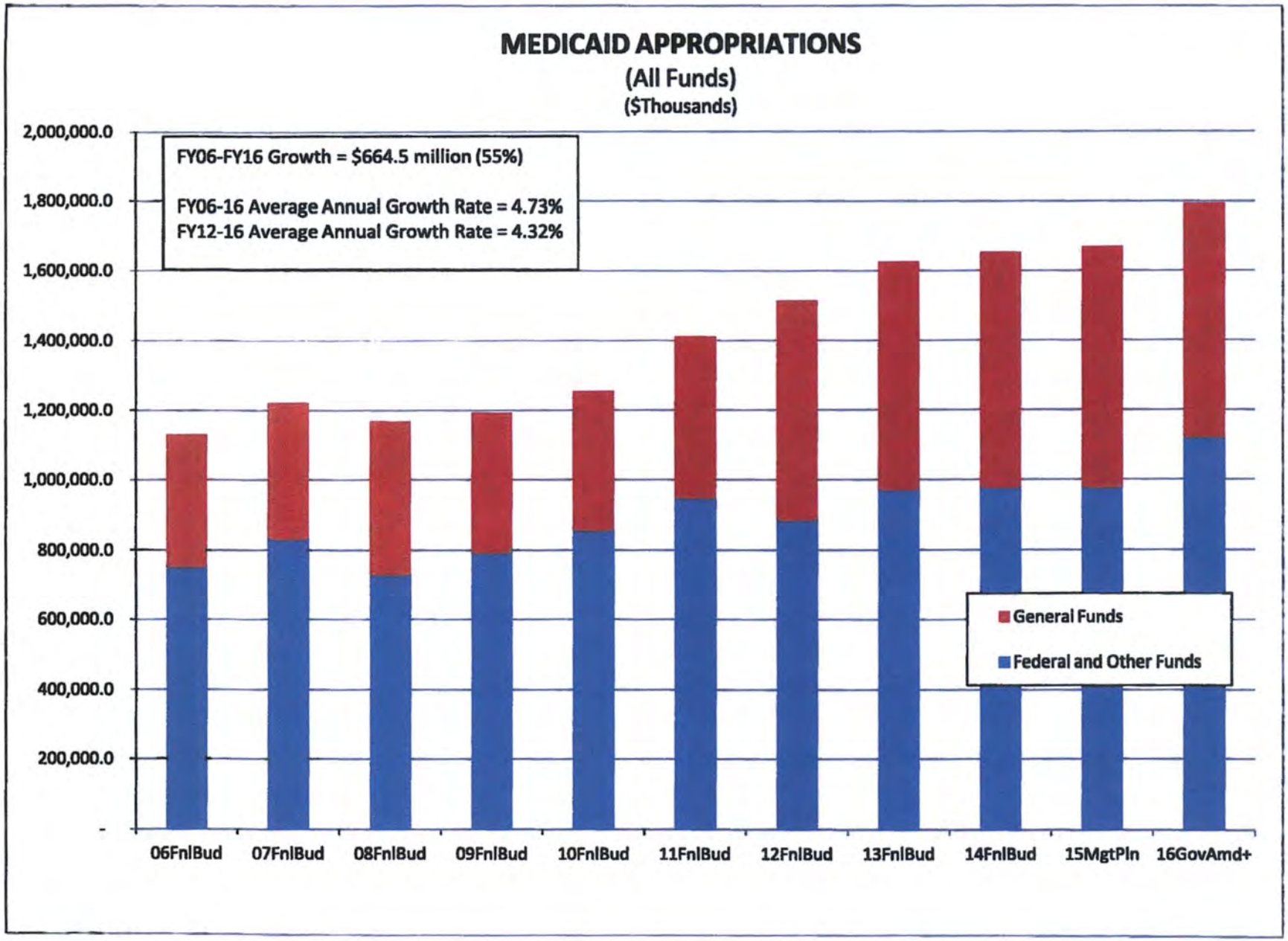
Location	Status of Medicaid Expansion Under the Affordable Care Act[1]	Private MCO Enrollment[2] (Thousands)	Private MCO as a Percent of Total Enrollment	Fiscal Years 2014-2015[3]		
				New Geographic Areas Added	New Eligibility Groups Added	New Mandatory Enrollment
North Carolina	Rejected	0	0%			
North 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.

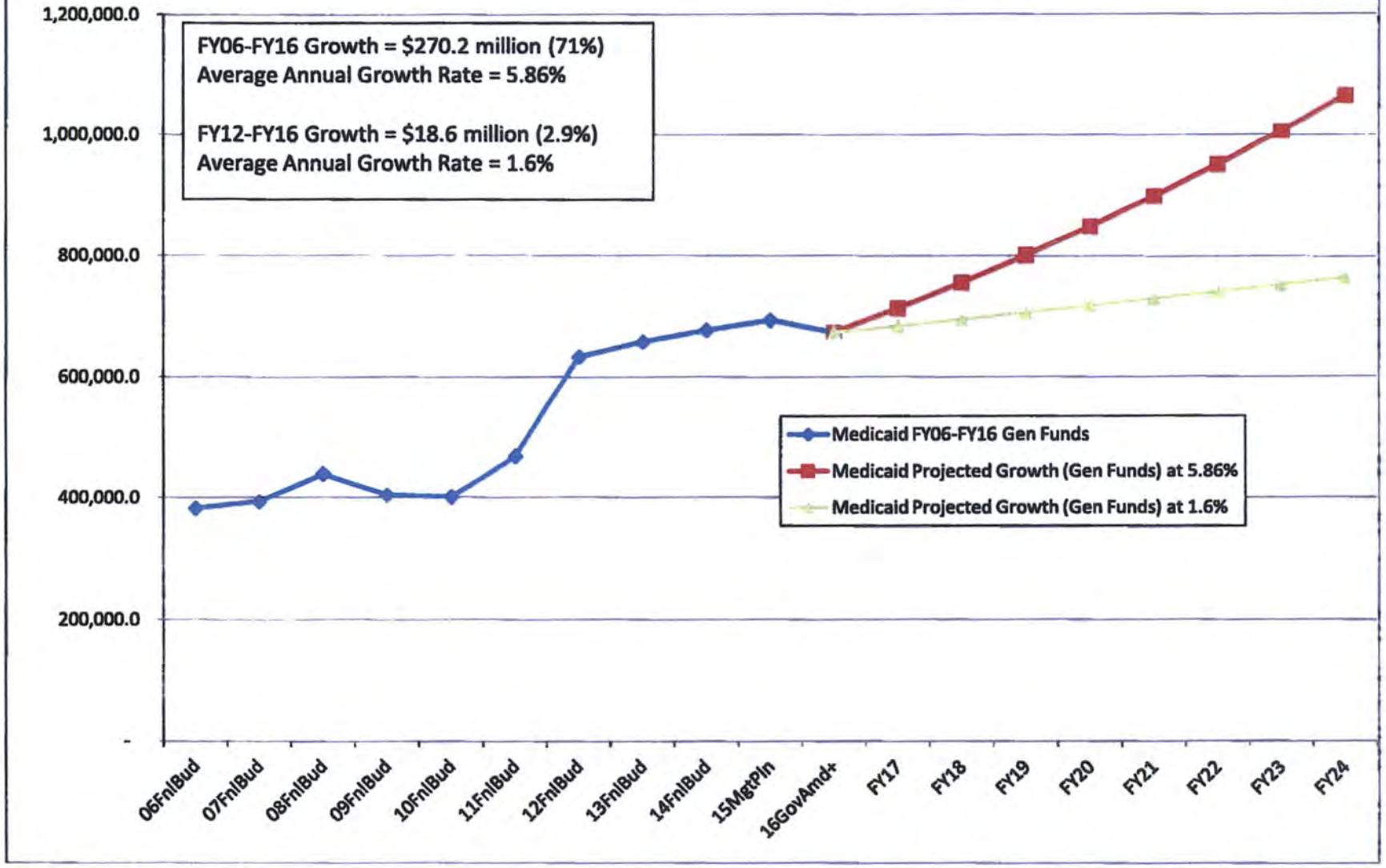
3) These three columns indicate whether states have expanded the geographical scope and eligibility of Medicaid MCO plans, and if mandatory enrollment in an MCO has been implemented, during fiscal years 2014 and 2015.

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.mhpo.org/_upload/201501StateofMedicaid2014.pdf* .

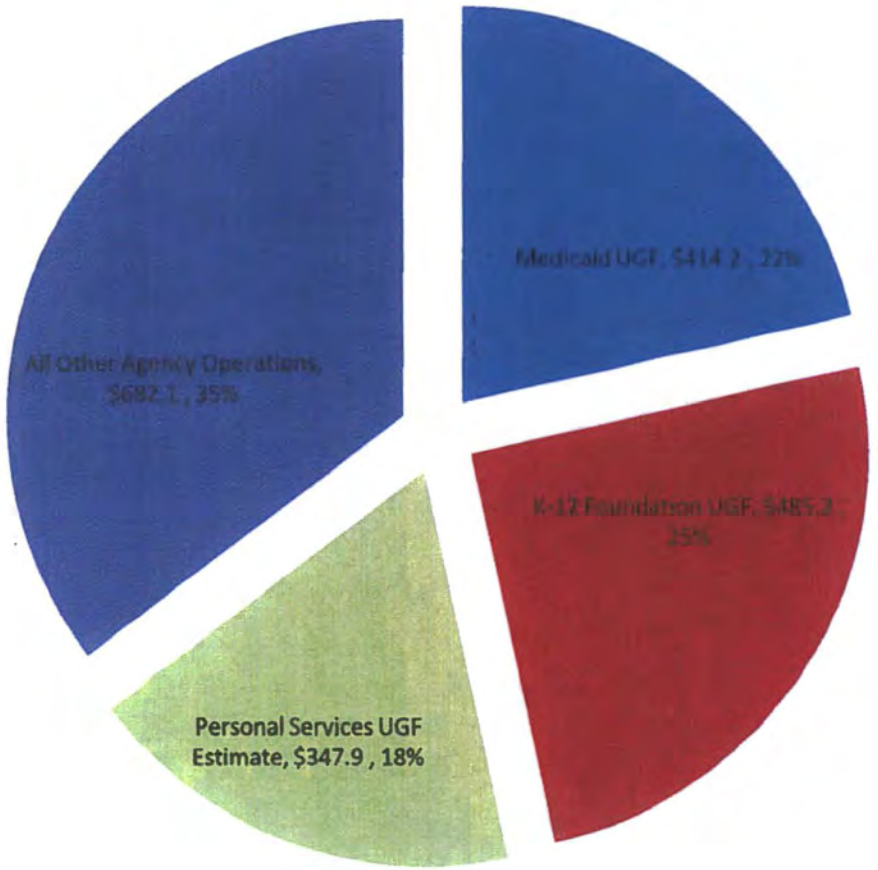

MEDICAID APPROPRIATIONS
(All Funds)
($Thousands)
FY06-FY16 Growth = $664.5 million (55%)
FY06-16 Average Annual Growth Rate = 4.73%
FY12-16 Average Annual Growth Rate = 4.32%
2,000,000.0
1,800,000.0
1,600,000.0
1,400,000.0
1,200,000.0
1,000,000.0
800,000.0
600,000.0
400,000.0
200,000.0
-
General Funds
Federal and Other Funds
06FnlBud
07FnlBud
08FnlBud
09FnlBud
10FnlBud
11FnlBud
12FnlBud
13FnlBud
14FnlBud
15MgtPln
16GovAmd+

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



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

Senate Health and Social Services Committee

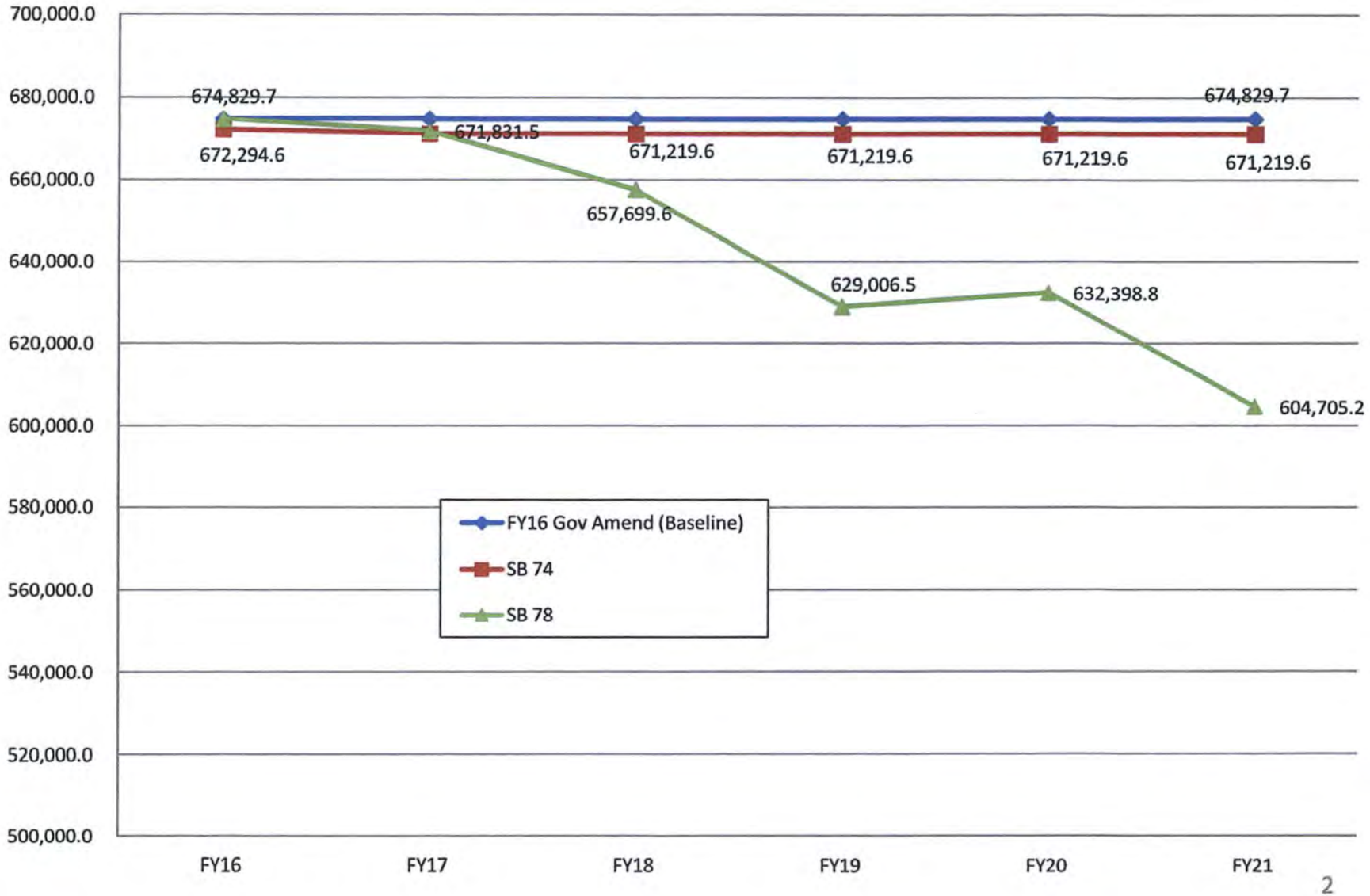
Monday, March 30, 2015

Amanda Ryder, Senior Fiscal Analyst
Legislative Finance Division

Medicaid Fiscal Note Comparison: SB 74 & SB 78

(GF Only)

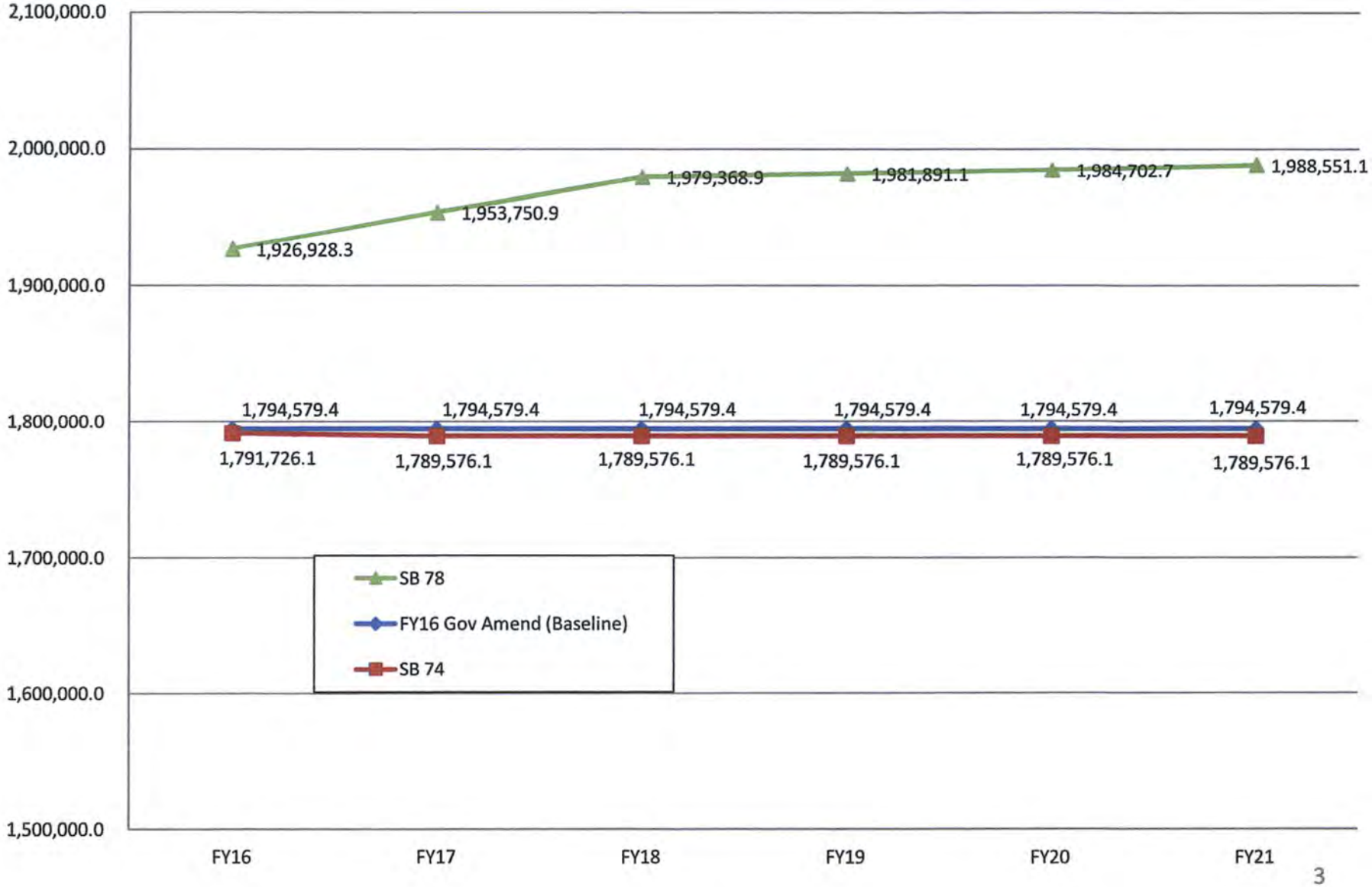
($Thousands)



Medicaid Fiscal Note Comparison: SB 74 & SB 78

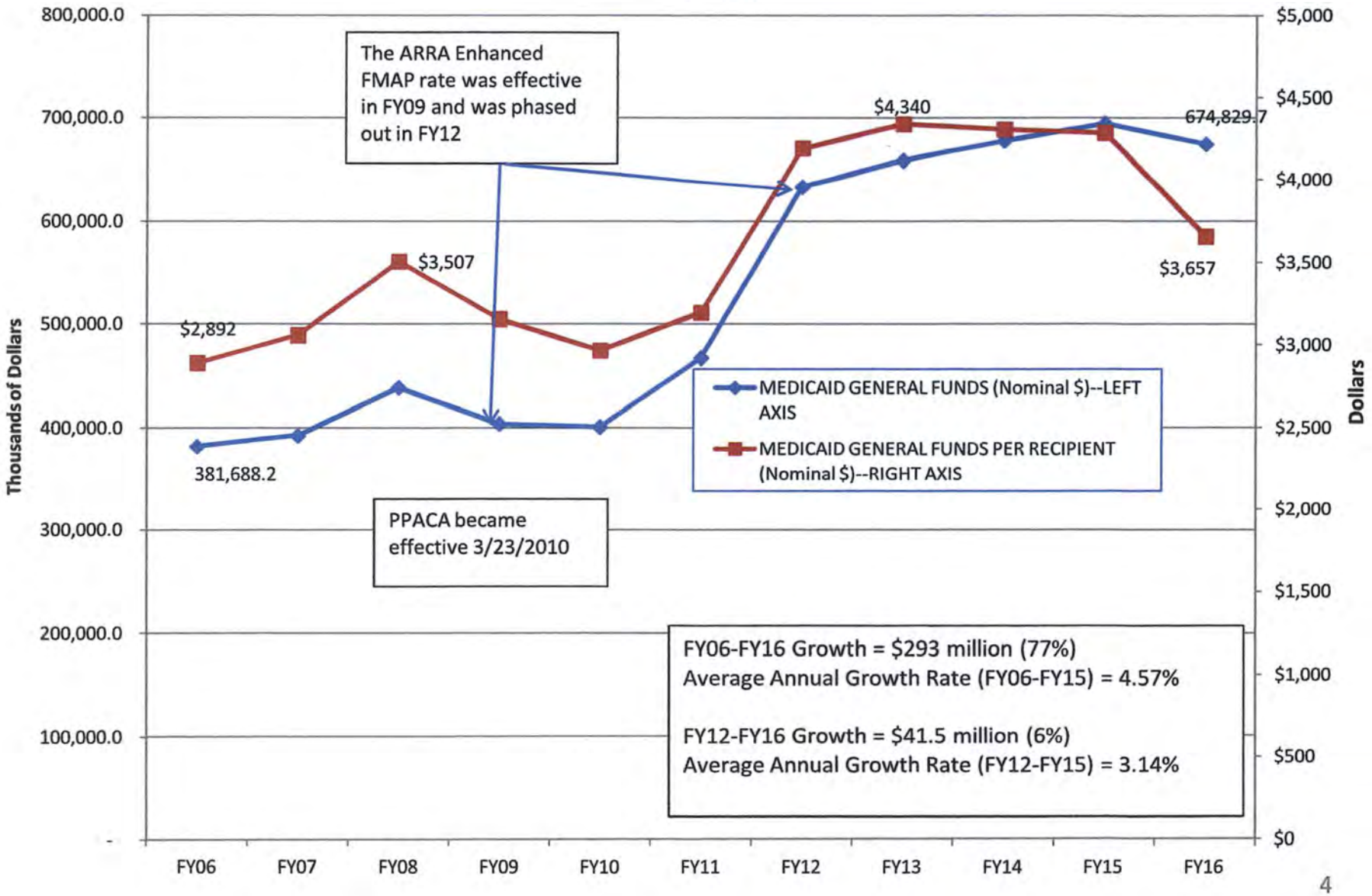
(All Funds)

($Thousands)



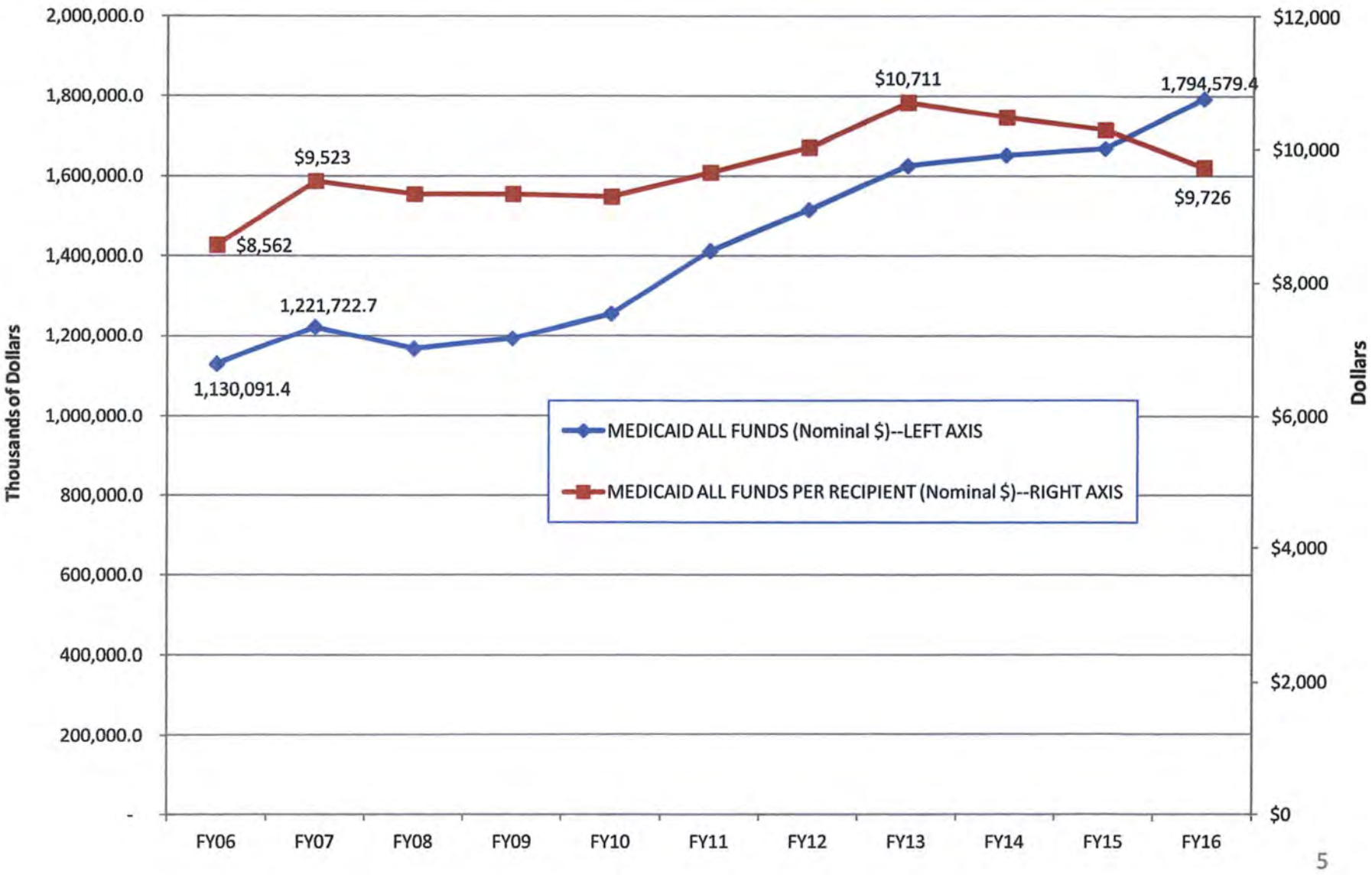
Historical Medicaid Growth

FY14 $
(GF Only)

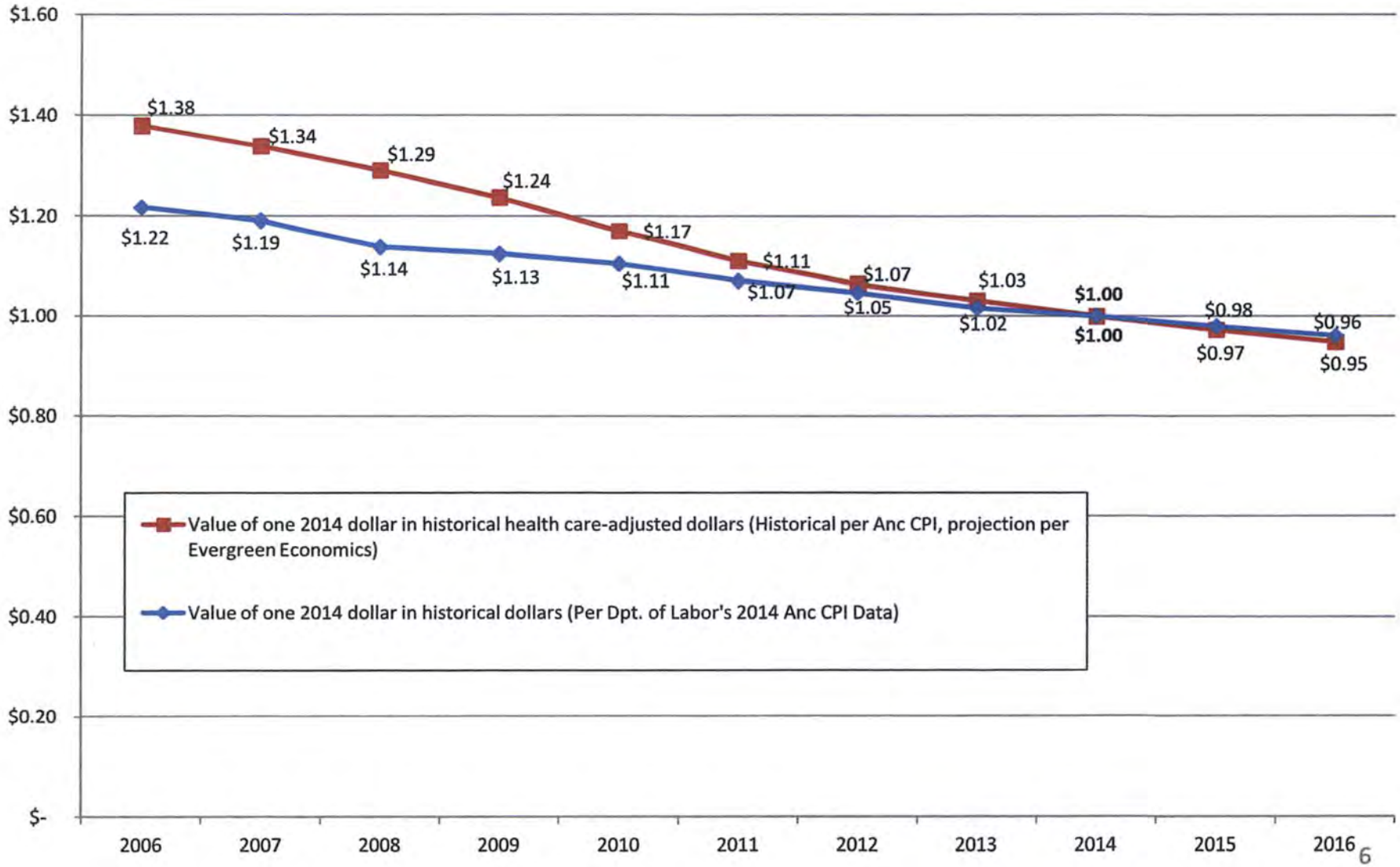


Historical Medicaid Growth

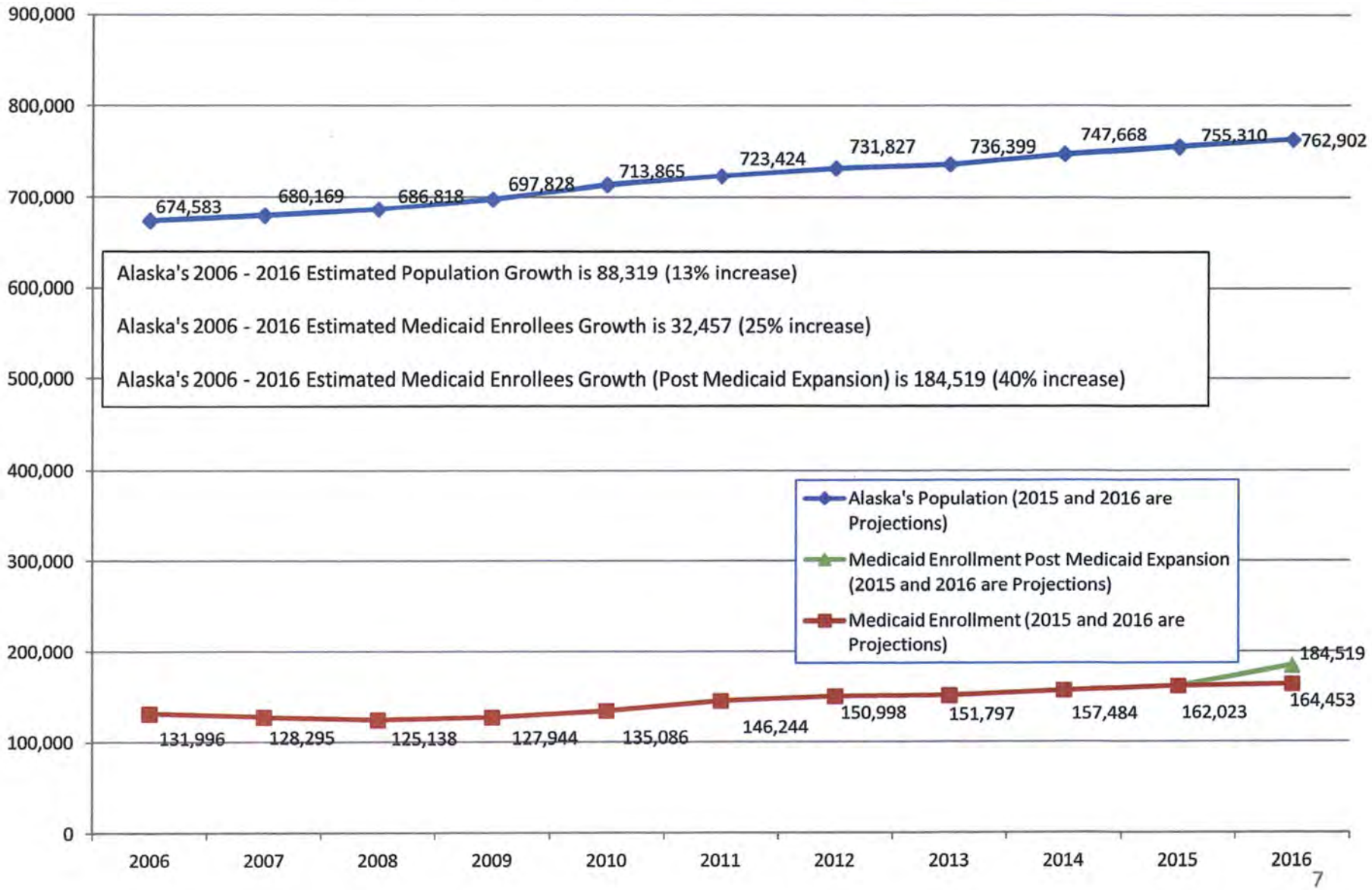
(All Funds)
Nominal $



Anchorage CPI vs. Anchorage Health Care CPI

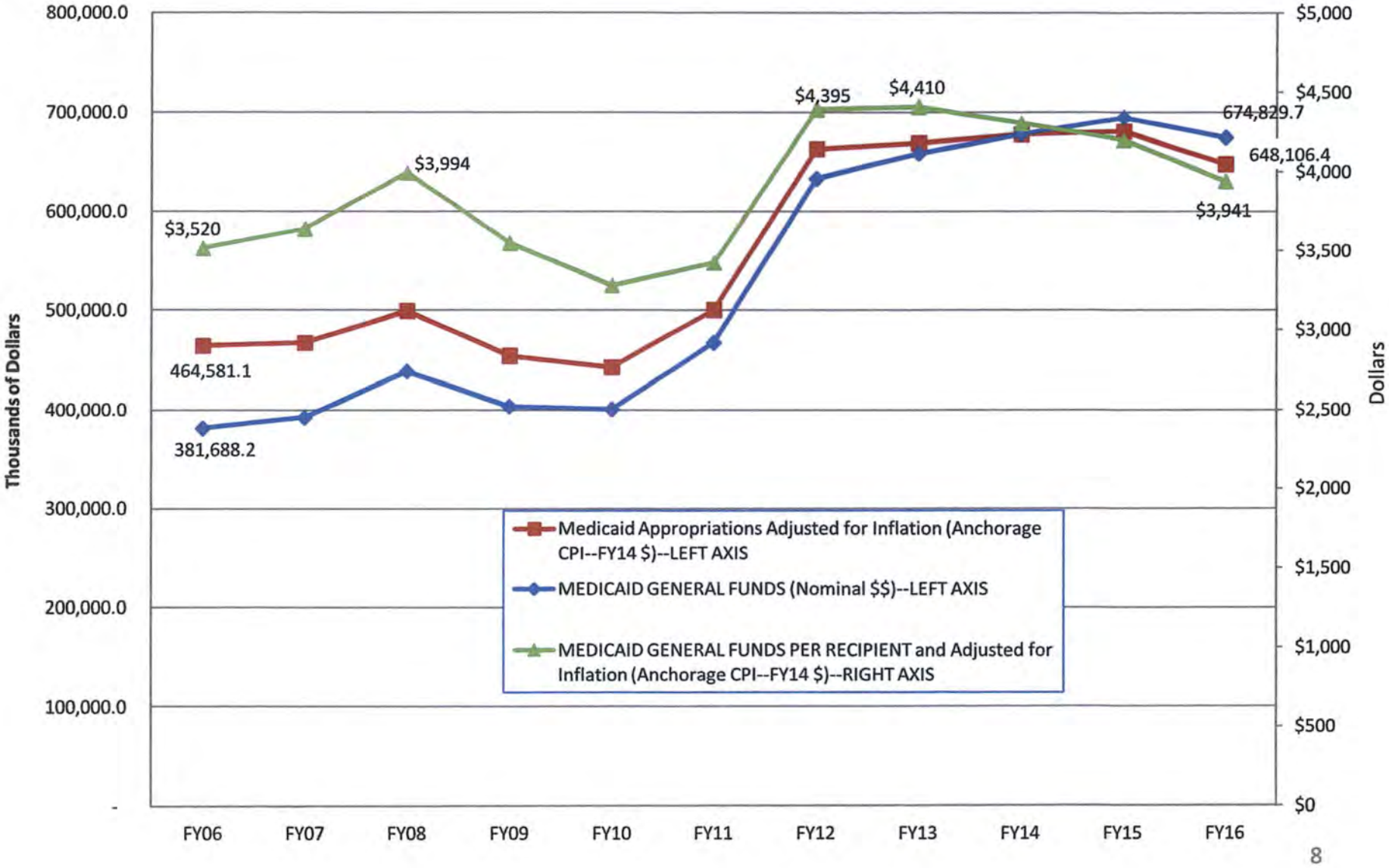


Alaska's Population Growth and Medicaid Enrollee Growth



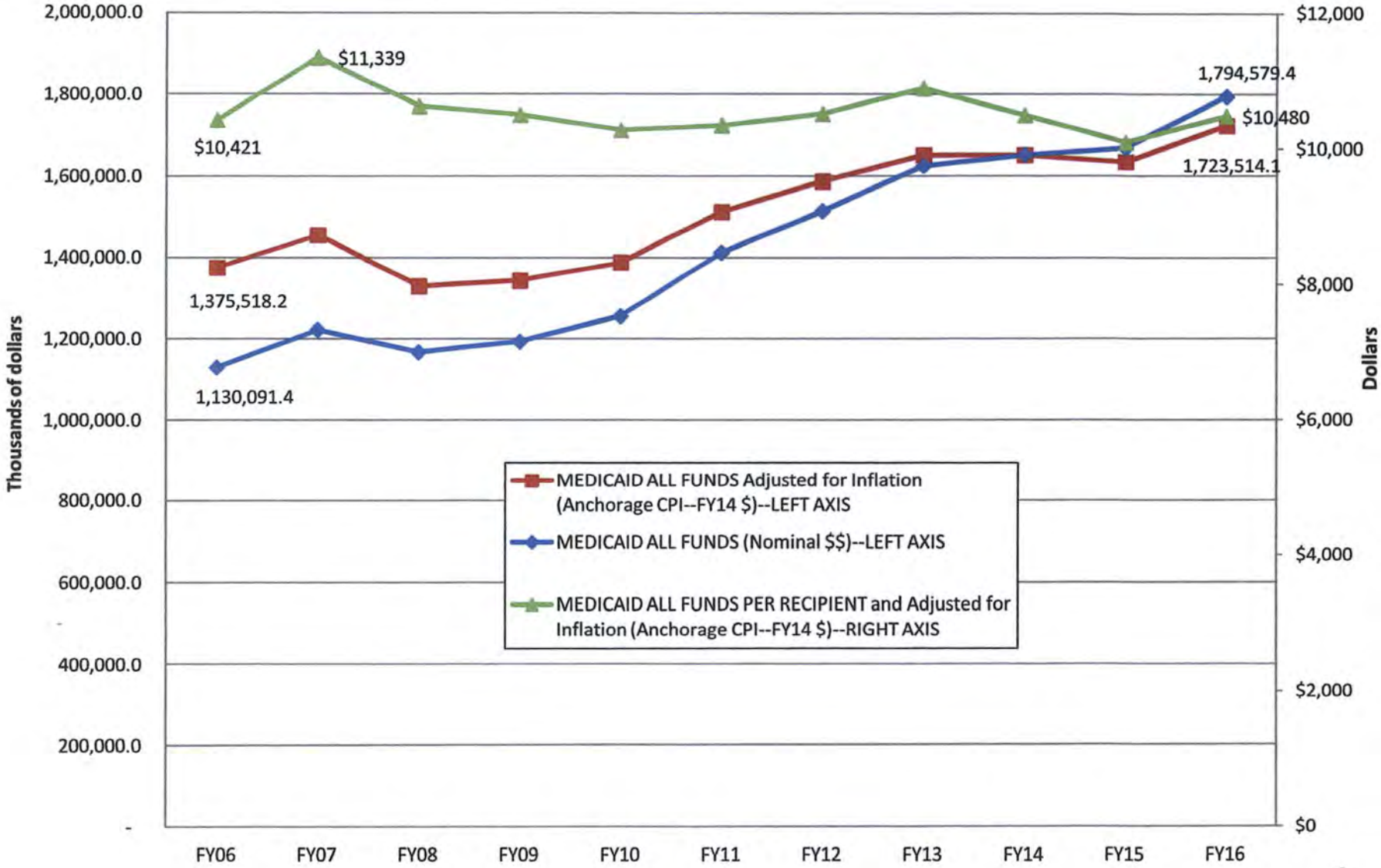
Historical Medicaid Growth

Anchorage CPI Inflation Adjusted FY14 $
(GF Only)



Historical Medicaid Growth

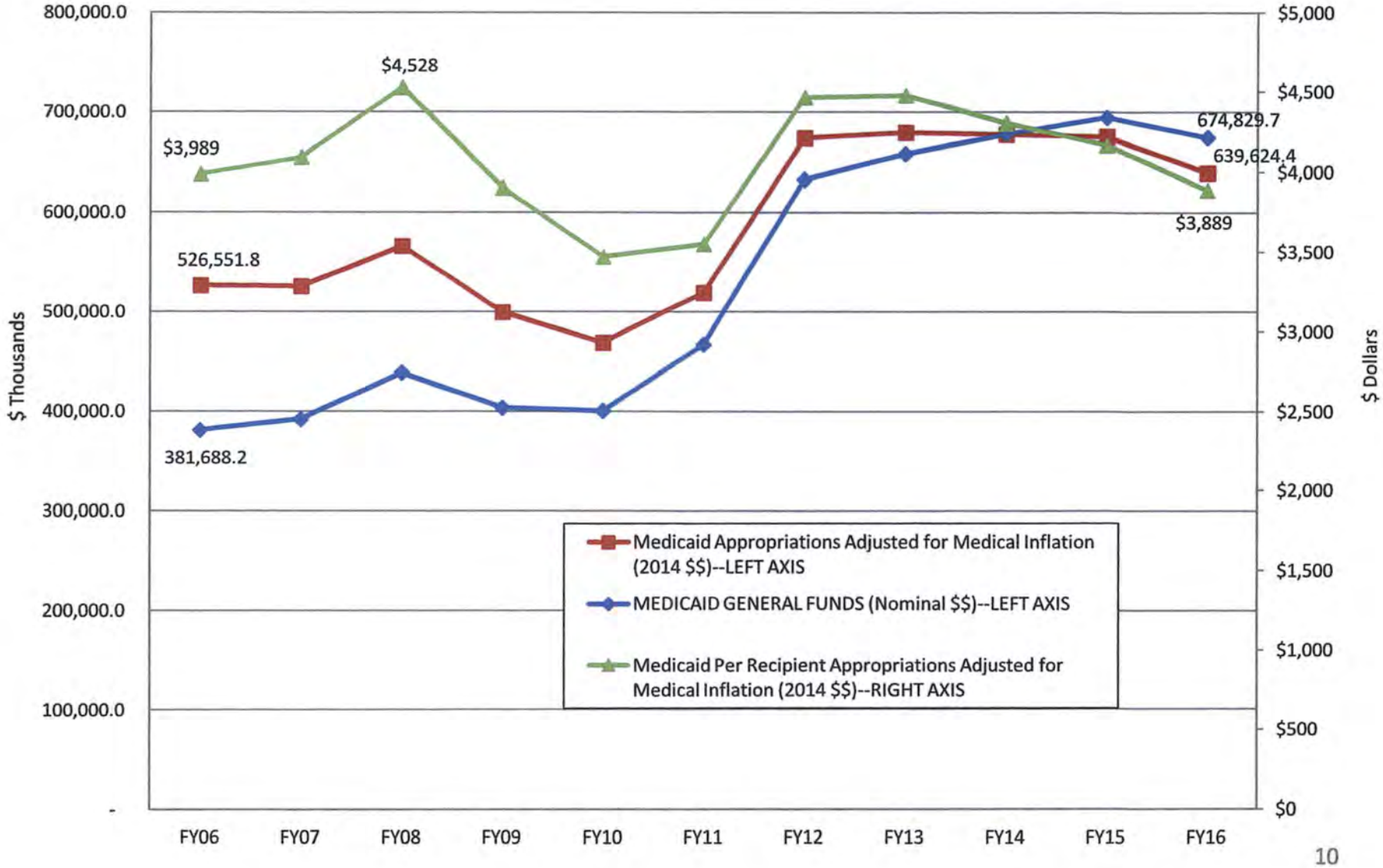
Anchorage CPI Inflation Adjusted FY14 $
(All Funds)



Historical and Projected Medicaid Growth

Anchorage Health Care CPI Inflation Adjusted 2014 $

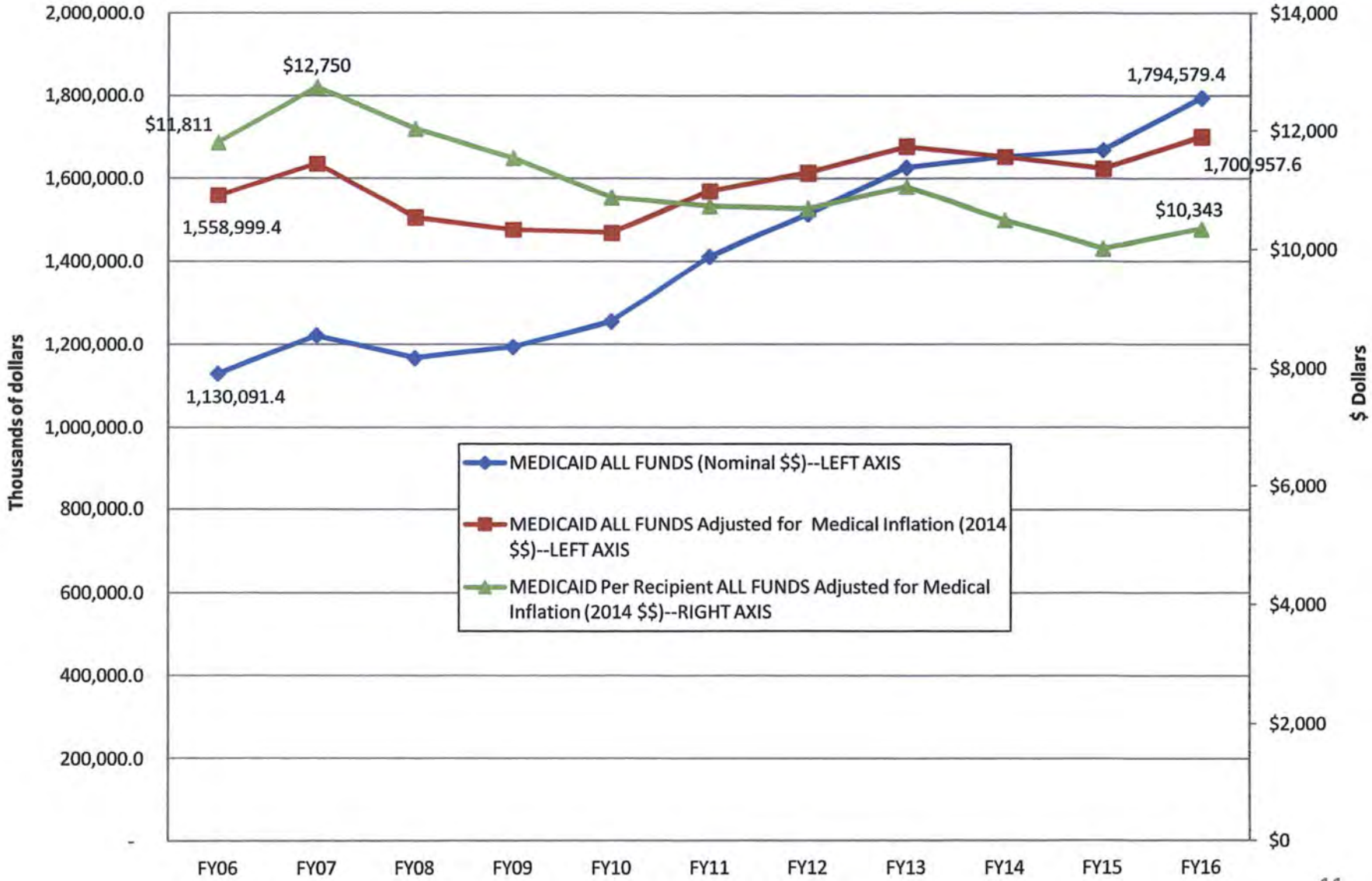
(GF Only)



Historical and Projected Medicaid Growth

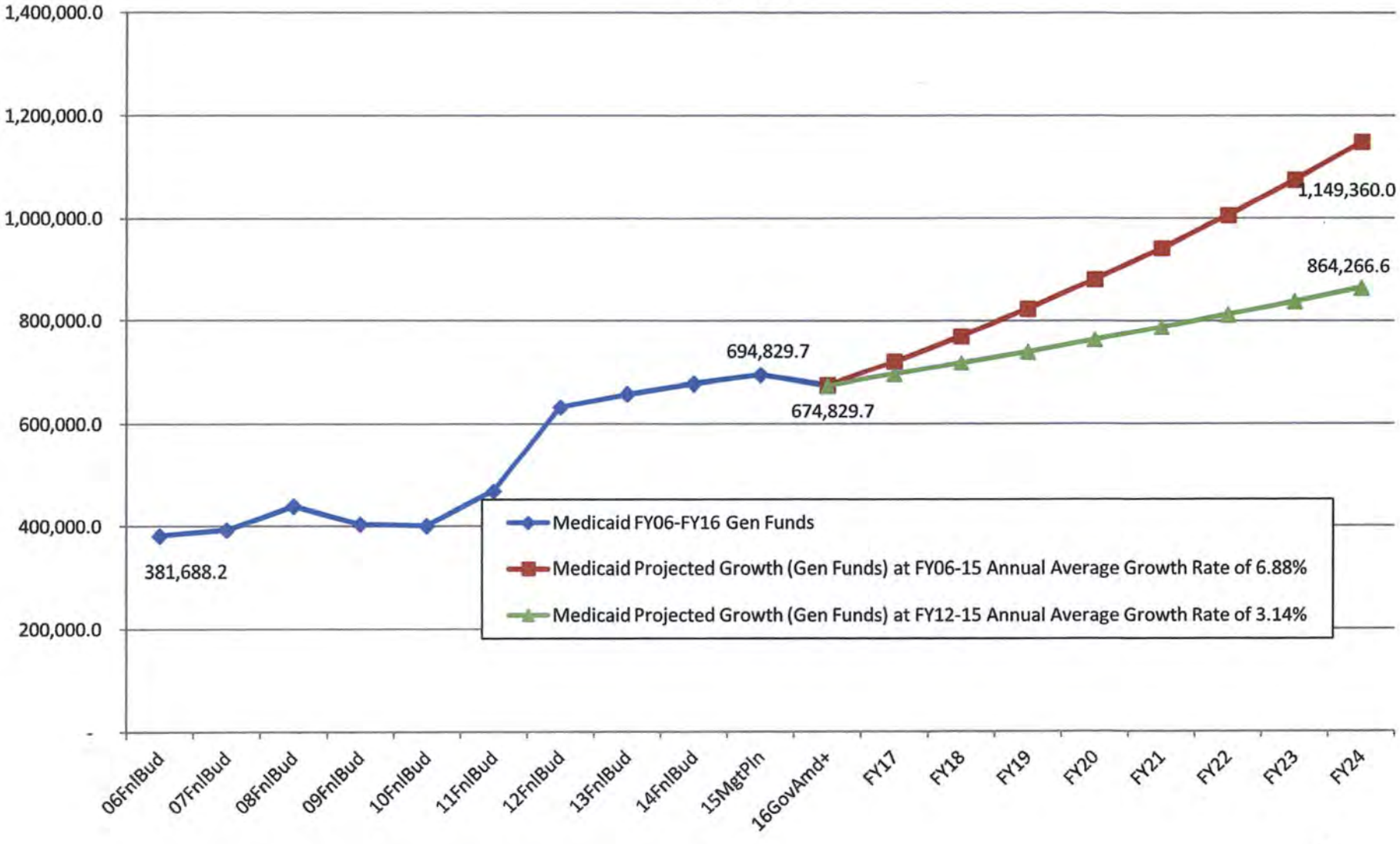
Anchorage Health Care CPI Inflation Adjusted (2014 $)

(GF Only)



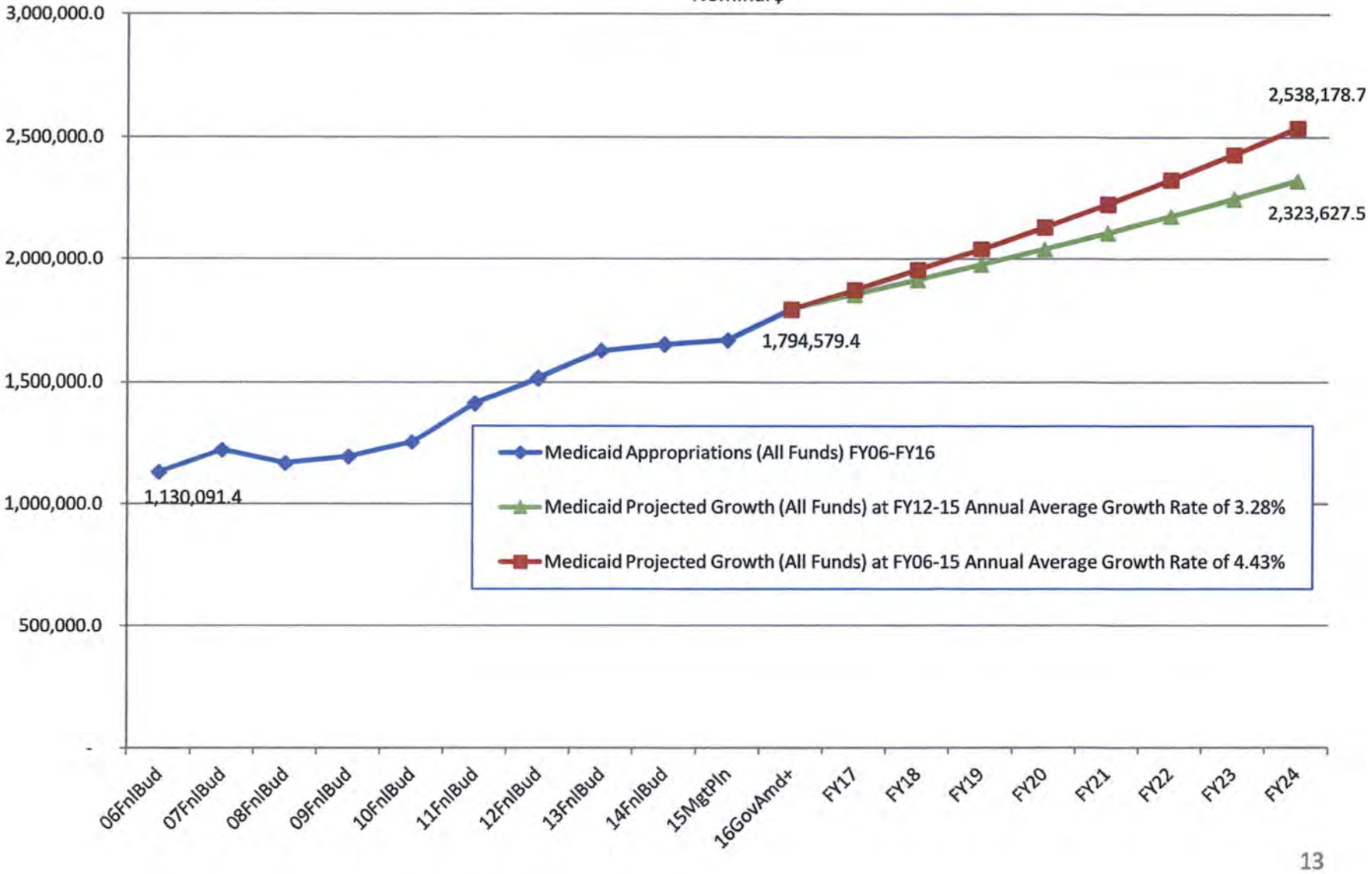
Historical and Projected Medicaid Growth

(GF Only)
($Thousands)
Nominal $



Historical and Projected Medicaid Growth Rates

(All Funds)
$ Thousands
Nominal $



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 P.O. Box 110300, Juneau, AK 99811-0300
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Alaska Dispatch News

Published on *Alaska Dispatch News* (http://www.adn.com)

Zaz Hollander [1]
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

Links:
[1] http://www.adn.com/author/zaz-hollander

April 1, 2015

Dear Senate Health and Social Services Committee Members:

I urge you to support SB 74 by Senator Kelly to reform Alaska's Medicaid program.
I'm a life-long Alaskan, born and raised in Anchorage. This May I'll be graduating from UAA, and seek to continue living in this state that I love.

As you all know, oil provides nearly 90% of Alaska's revenues. A precipitous drop in oil prices since last June, along with a combination of other factors, has left our state grappling with a $3 5 billion dollar deficit. At this critical juncture in our state's history, serious efforts to reign in unsustainable programs are desperately needed.

Sen. Kelly's bill takes the right steps to finally begin the process of reforming Alaska's broken and unsustainable Medicaid program. Our Medicaid program costs taxpayers over $1.8 billion annually, is failing current enrollees and providers, and has been plagued with fraud and abuses for years.

According to a 2013 report done by the Medicaid Budget Group of the Department of Health and Social Services, Alaska will be spending $2.8 billion on Medicaid services by 2032. Given the discussion surrounding Medicaid expansion, it is worth noting that $2.8 billion does not include calculations of Obamacare Medicaid expansion. Should Alaska expand Medicaid, the State will likely be spending far more on the program. Even without expansion, total spending on our Medicaid program will quadruple between 2012 and 2032, due in large part to rapid growth in spending on long-term care services. Another worthy piece of data from that report concerns enrollment numbers. By 2032, over 204,000 Alaskans are projected to be enrolled in Medicaid, up from 145,000 in 2012. Again, these numbers do not account for an expansion of Medicaid under Obamacare.

If oil prices remain low, as expected, it's reasonable to ask how the State will pay for essential services like education, infrastructure, and public safety if the majority of our budget is consumed by a non-essential service like Medicaid. In order to contain costs, and protect taxpayers, patients, and providers it is imperative we reform the broken and costly system that is Medicaid. SB 74 does just that. It implements a number of cost containment reforms that have been discussed for years. Some of these reforms include starting a managed care system, greater use of brand-name drugs, creation of health savings accounts, expanded use of tele-medicine,

and enhancement of fraud prevention. SB 74 also kickstarts the dialogue to privatize certain aspects of our Medicaid program

I would like to thank Sen. Kelly for introducing SB 74, as it contains meaningful reforms that do far more than just shift costs to the feds.

Thank you for your service to our great state during these difficult times.

Sincerely,

Hans Rodvik
Field Director, Americans for Prosperity-Alaska
Anchorage, Alaska
Senate District K, House District 22

MAR 2 3 2015

Congregation Sukkat Shalom "Shelter of Peace"

A RESOLUTION URGING THE ALASKA LEGISATURE TO IMPROVE THE HEALTH AND WELL BEING OF ALASKANS, ALLOWING THEM BENEFITS SHARED BY OUR MEMBERSHIP AND THE MEMBERSHIP OF THE ALASKA LEGISLATURE BY EXPANDING MEDICAID

WHEREAS the Jewish virtue of "tikkun olam", repairing our world, calls upon us to fix the injustice of inequality and suffering; and

WHEREAS, the Jewish tradition of "tzedakah", giving to others less fortunate, is not considered charity but "the right thing to do"; and

WHEREAS, the majority of the membership of our congregation and the entire membership of our State Legislature are blessed with the benefit of insurance coverage so that we have access to preventive and healing health care for our families and our children; and

WHEREAS, we have knowledge that tens of thousands of Alaskans do not share our same access to health care; and

WHEREAS, nearly 42,000 other Alaskans would have the opportunity to gain health care coverage under Medicaid expansion; and

WHEREAS, Medicaid expansion will improve health outcomes by reducing the numbers of uninsured Alaskans by half, improving preventive and primary care access, providing substance abuse treatment and mental health counseling, and reducing the mortality rate; and

WHEREAS, Medicaid expansion would help Alaska economically by bringing in over $1 billion in new federal revenue over the first five years; and

WHEREAS, the State would save $6.1 million in 2016 by using federal funds to pay for health services currently paid for with state general funds; and

WHEREAS, federal funds will pay for 100% of services provided to the expansion population through 2016 and will transition to 90% in 2020 and beyond;

THEREFORE BE IT RESOLVED, as an act of "tikkun olam", healing the world, Congregation Sukkat Shalom urges Medicaid expansion in Alaska and deems it imperative that the Alaska Legislature expands Medicaid to take effect in July, 2015.

3/16/15

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Alaska State Medical Association

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April 2, 2015

The Honorable Bert Stedman
Alaska Senate
State Capitol, Room 30
Juneau, AK 99801

RE: Senate Bill 78

Dear Senator Stedman:

The Alaska State Medical Association (ASMA) represents physicians statewide and is primarily concerned with the health of all Alaskans.

As the Legislature debates Medicaid reform and expansion measures this Session we would like to make you aware of our current policy position on access to healthcare in Alaska. ASMA strongly supports access to healthcare for all Alaskans, and in that context supports robust and sustainable payment mechanisms for the Alaska healthcare industry. ASMA supports expansion of coverage of the approximately 30,000 currently uninsured Alaskans.

Improved access to healthcare in Alaska and improving the efficiency and effectiveness of Alaska's current Medicaid health care service system are important to improving the health outcomes of Alaskans.

Please let us know if there is anything we can do to further support passage of this legislation.

Sincerely,

Michael Haugen
Executive Director: The Alaska State Medical Association

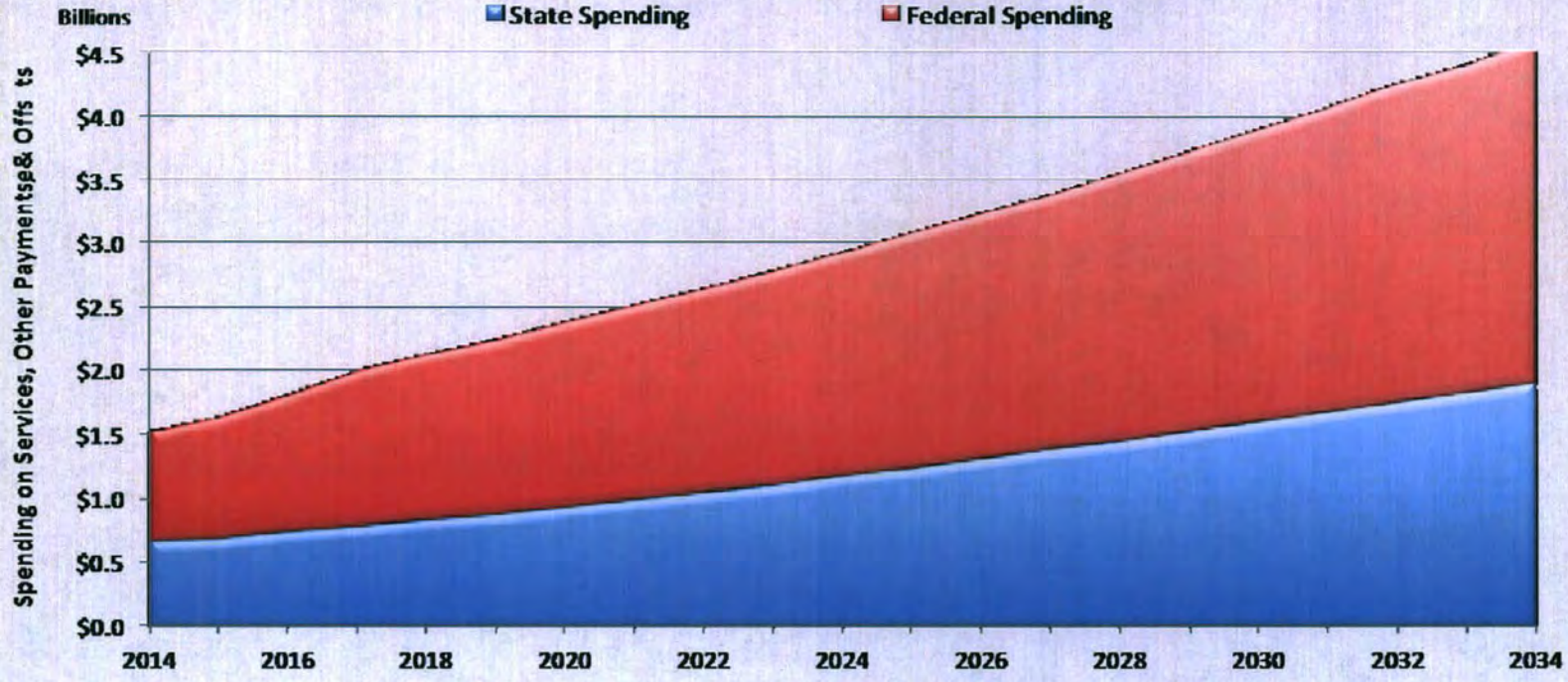
Medicaid Spending and Enrollment in Alaska (MESA) Forecast – from Evergreen Economics
http://dhss.alaska.gov/fms/Pages/home.aspx.

EVERGREEN ECONOMICS

MESA—Highlights from Current Forecast

The ***2006*** forecast of total Medicaid spending was $4.8 billion in 2025. We now project total Medicaid spending will be about $2.8 billion in 2025.*
Lower projected growth is due to...

- Cost containment actions taken by the Department and Legislature
- Slower growth in healthcare price inflation
- Slower population growth projected by Alaska Department of Labor



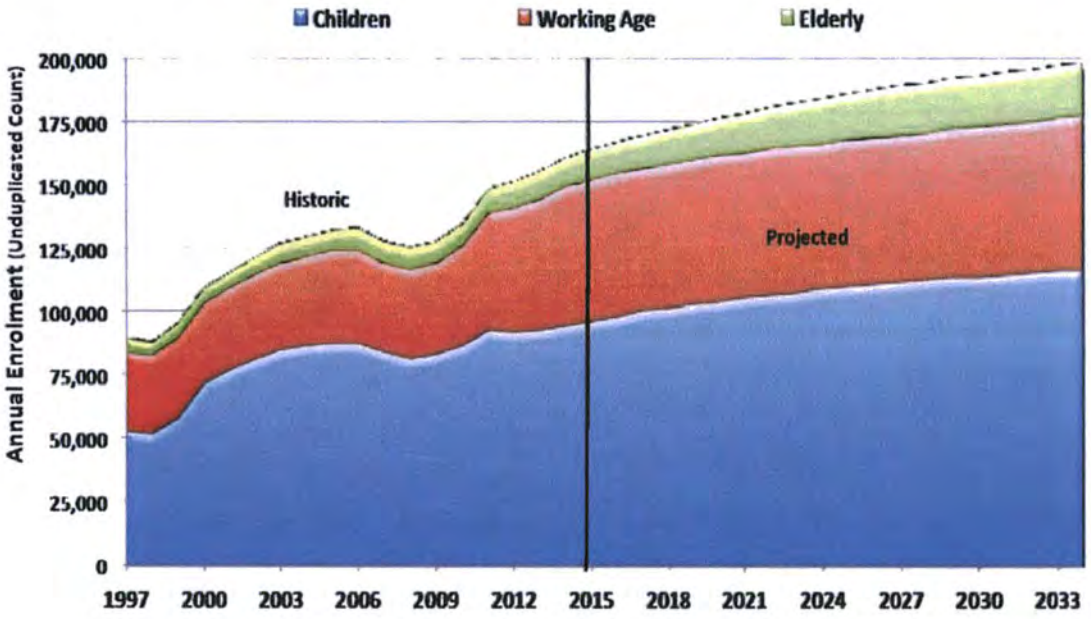
*Total Medicaid spending includes non-claim related costs (including admin), which we estimate to be 5% of spending on services.

Medicaid Enrollment and Spending in Alaska (MESA) forecast – from Evergreen Economics

http://dhss.alaska.gov/fms/Pages/home.aspx.

MESA—Highlights from Current Forecast

We anticipate annual, unduplicated count of enrollment will reach 197,000 by CY2034.



Provided by the Department of Health and Social Services to the Senate State Affairs Committee in response to questions by members on 4-13-2015