
Report to:
State of Alaska
Senate Finance Committee

MEDICAID PROGRAM REVIEW



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EXECUTIVE SUMMARY

Medicaid is a critical component of the Alaska health care system, responsible for providing health coverage to nearly one-in-five of the state's residents, including one-third of Alaska's children. It is also a program confronting major challenges.

In state fiscal year 2005, Medicaid expenditures for the first time exceeded \$1 billion in state and federal funds. Although the rate of spending growth slowed last year, a recent report commissioned by the Department of Health and Social Services (DHSS) concluded that over the next five years, "Medicaid spending by the state is projected to grow at a faster rate than the Alaska economy (GSP) and faster than total personal income in the state." Some of the underlying factors driving this growth – such as Alaska's aging population – will continue into the next decade and beyond.

Scope of Work

The Pacific Health Policy Group (PHPG) was retained by the Alaska Senate Finance Committee to conduct an analysis of Alaska Medicaid and make recommendations for enhancing program accountability and cost containment, while ensuring the state continues to provide necessary services to the Alaska's most vulnerable citizens.

The Senate Finance Committee defined three specific tasks for the engagement:

1. *50-State Ranking:* PHPG compared Alaska's Medicaid eligibility standards and benefit packages to those in the 49 other states. As part of this evaluation, PHPG also researched best practices in other states with respect to service delivery and financing, cost containment strategies and administrative procedures.
2. *Internal Alaska Evaluation:* PHPG reviewed Alaska's Medicaid State Plan, statutes and regulations to identify any unclear or conflicting provisions that could lead to misinterpretations, inappropriate eligibility determinations, or areas of noncompliance with federal law or regulation. PHPG also conducted a high-level review of DHSS's organizational structure and administrative costs and reviewed the state's strategy for procuring a new Medicaid Management Information System (MMIS) vendor.

3. *Reform Options*: PHPG examined opportunities for strengthening the Medicaid program, both incremental and broad-based (structural).

Summary of Findings & Recommendations

The findings and recommendations presented below are discussed in greater detail in Chapters 2 – 6. Medicaid eligibility is addressed first, followed by covered services, tribal health care, program administration and reform options.

Medicaid Eligibility

Medicaid covers five major low-income groups – children, pregnant women, parents, the elderly and the disabled. The federal government has established minimum eligibility standards within each of the five major groups, and states must offer Medicaid at least up to these standards as a condition of receiving federal matching dollars. The populations falling within these minimum standards are commonly referred to as “mandatory” coverage groups and primarily include persons who, prior to welfare reform, often qualified for Medicaid as an adjunct to receiving some type of cash assistance (e.g. AFDC payment or SSI payment).

States are not limited to enrolling the mandatory populations, but have the latitude to extend coverage to other “categorically or medically needy optional coverage groups”. These optional groups consist of persons who would qualify as part of a mandatory group except they live in households with incomes above the mandatory limits.

Alaska ranks in the middle tier of states, in terms of the optional coverage groups the state includes in Medicaid. Alaska’s optional Medicaid population accounts for about 30 percent of all enrollees and 30 percent of all medical costs.

Although Alaska is comparable to other states in its coverage policies, the state did experience faster than average enrollment growth in recent years. Medicaid today is the second largest health insurance payer in the state, while nationally it ranks third.

In sheer numbers, Medicaid is primarily a program for children and pregnant women, and Alaska’s historically younger profile has contributed to the size of the state’s Medicaid program. At the same time, Alaska’s elderly population is growing quickly, and the state is going to confront new challenges in the form of larger numbers of Medicaid-eligible frail

elderly and disabled residents in coming years. This will place pressures on the state's long-term care system, which is already under stress.

Alaska also has a large uninsured population, which contributes to the level of uncompensated care in the state. The Department of Health and Social Services (DHSS) does operate a state-funded program, known as Chronic and Acute Medical Assistance, or CAMA, which serves as a payer of last resort for individuals with chronic or life-threatening conditions who meet program eligibility standards.

Alaska's qualifying conditions for CAMA are consistent with the types of conditions covered in medically needy programs, as well as Section 1115a research and demonstration waiver programs in some other states. Under such demonstrations, states are able to secure federal matching funds while capping enrollment, state expenditures or both.

In state fiscal year 2004, the CAMA program served 1,522 persons. Program expenditures totaled \$2.2 million, of which about three-quarters went for prescription drugs and most of the remainder for hospital and physician services. If this group was enrolled under a research and demonstration waiver – either for a pharmacy-only benefit or for all services – state expenditures could be used to draw down funds to serve additional persons. Alternately, the federal matching funds could be used to reduce state expenditures by about \$1.3 million (at the current federal matching rate).

Covered Services

State Medicaid programs must make available a federally-defined package of “mandatory services” to categorically needy beneficiaries (the only type enrolled in Alaska Medicaid) and may, at their choosing, supplement the mandatory services with one or more federally-recognized “optional services”. Alaska is comparable to other states in terms of the optional Medicaid services it offers. Alaska actually spends less on optional services – as a percentage of total care dollars – than most other states.

Alaska's program is expensive, compared to other states. Adjusting for cost of living differences, Alaska spent \$1,200 more per enrollee than the national average in 2003 (the most recent year for which national data is available). Spending within individual service categories – hospital, physician, pharmacy and long-term care – also ranks near the top on a per beneficiary basis.

Program costs grew at double digit rates in the first part of the decade. Although spending growth has slowed of late, DHSS's long-term forecast projects it will return to near double digit levels again before the end of the decade.

DHSS has taken a number of steps to contain costs, consistent with actions in the other 49 states, all of whom also face budget pressures within their Medicaid programs. Opportunities exist for additional cost containment in selected areas – particularly pharmacy and long-term care.

Medicaid's pharmacy program has instituted a preferred drug list and other controls in the past two years intended to curb the upward growth spiral. The program's payment rates to pharmacies, however, are among the highest in the nation. This may be an appropriate payment policy for critical access pharmacies serving as sole community providers, but the state should explore using tiered pricing to secure discounts from larger chain drug stores in urban areas such as Anchorage. The pharmacy program also should move quickly to expand a just-introduced prior authorization process currently in force for only a portion of covered prescriptions.

Medicaid's long-term care program serves two distinct populations – the elderly/physically disabled and the developmentally disabled. The first group is growing in size along with the aging of the state's population. In recent years, enrollees in the two home- and community-based waiver programs for the elderly and physically disabled have driven up costs in the Personal Care Attendant program, which exists outside of the waiver and is not subject to the same controls. This bifurcated system has had the dual effect of driving up costs while impeding good care management.

The state has put in place some controls specifically for Personal Care. However, it would be best served by establishing a strong, up-front screening process that looks at all care components together, and directs services to persons who truly meet the long-term care standard of need. At the same time, new, lower cost community-based service options for persons with mild dementia and manageable physical deficits should be explored. This is a process that will take some time; Medicaid should act now before the elderly population's growth outstrips the state's ability to serve everyone who needs care.

The state's issues with respect to the developmentally disabled are different. A significant number of services are provided with state-only dollars to persons on the DD waiver waiting

lists and persons with developmental disabilities who do not qualify for the waiver. The state should consider extending Medicaid coverage to these persons, thereby securing federal matching dollars. This could be done either by enlarging the current waiver or creating a new waiver with services matching those available today through the state-only program.

Not every program area shows the same potential for additional cost containment. Physician and clinic fees, while high, appear to be supporting the broader ambulatory health care infrastructure.

Behavioral health is being transformed to some extent through the Bring the Kids Home Initiative. However, it lacks significant investments in preventive/early intervention services which, if made, could eventually reduce the need for more expensive institutional services.

Tribal Health Care

Native Alaskans account for nearly four-in-ten Medicaid beneficiaries, by far the largest Native American segment of any state Medicaid program. In fiscal year 2005, the program included 52,000 American Indian/Alaska Native (AI/AN) enrollees, an increase of 3.6 percent from the previous year. The number actually receiving services grew by 5.2 percent.

The great majority of Alaska Natives live in rural areas, many in remote villages with fewer than 300 residents. The health status of the AI/AN is significantly worse than that of the general population, with higher incidences of tuberculosis, diabetes and other serious health conditions. Alaska Natives are reliant for most of their care on a tribal health system that is increasingly under strain.

Alaska tribes govern and operate the tribal health system under a statewide compact. Tribes may operate independently or may designate a single entity to operate the health care delivery system. Federal law (PL93-638) authorized tribal providers to take over facilities of the Indian Health Service (IHS); these “638” providers develop annual funding agreements with IHS. The Indian Health Service provides approximately \$440 million in funding annually, representing about 60 percent of the tribal system’s total annual budget.

Various treaties, judicial opinions, federal statutes, executive orders and other measures establish an obligation on the part of the federal government to provide health care to tribal members. For this reason, Medicaid payments to tribal providers are paid with 100 percent federal funds.

However, IHS, unlike Medicaid or Medicare, is not an entitlement under federal statute, and is therefore subject to the annual federal budget process. IHS funding for the Alaska tribal health system increases one to two percent per year, while the tribal system's expenses have been growing at a rate of approximately eight to nine percent per year.

In federal fiscal year 2005, Medicaid payments to tribal providers amounted to approximately \$180 million. However, Medicaid paid another \$220 million to non-tribal providers at the regular federal matching rate. Most of the non-tribal expenditures went for three services: inpatient hospital, behavioral health and long-term care.

It would be in the state's interest, from both a financial and quality of service perspective, to actively participate in establishing greater capacity among tribal providers, particularly with respect to long-term care. For example, the Alaska Medicaid program spends approximately \$19 million for non-tribal nursing facility services provided to AI/ANs, of which approximately \$8 million is state matching funds. If Alaska were to provide financial support for development of tribal health long-term capacity, the potential state savings could be significant.

Alaska also may want to consider collaborating with tribal providers on a broader re-organization of the tribal health care delivery system that would permit it to be recognized by the federal government as a managed care entity. Under this arrangement, which could continue to resemble the current system from an operational standpoint, Medicaid funding to the tribal health plan would be based on the full range of Medicaid-eligible services for Medicaid-eligible Native Alaskans. Subject to negotiation with the federal government, such payments could potentially be 100 percent federally funded, thereby removing most or all of the state's current expenditures.

In exchange for payment, the tribal health entity would be responsible for ensuring access and delivery of all Medicaid-eligible services, including sub-contracting with non-tribal providers (who could still be permitted to bill and receive payment through the MMIS). The tribal health entity, in return, would have the opportunity to re-invest monies into health promotion, disease prevention and culturally-appropriate community-based care initiatives intended over the long term to improve access to services in rural communities, while lowering costs.

Program Administration

Alaska's Medicaid administrative costs on a per eligible basis are much higher than most states', though this is at least partly due to the program's small enrollment base and geographic challenges.

The federal government monitors state Medicaid agencies with respect to their accuracy rates for eligibility determination and claims payment. Alaska's program appears to meet CMS standards for eligibility determination, but faces challenges in preparing for new federal payment accuracy audits (known as "PERM") scheduled to begin in 2008.

DHSS performed an internal audit to help prepare for the federal audit and identified three priority areas – Dental, DME and therapies. The legislature should seek regular updates on activities in 2007 to prepare in these three areas and program-wide for the federal audits. States that fail the audits could be at risk of losing millions of dollars in federal payments, through disallowances.

Concurrent with its preparation for the PERM audit, DHSS will be overseeing the handover of its MMIS to a new contractor. The RFP lays out an aggressive timetable for the new contractor to design, develop and implement its system, while potentially taking over operation of the current MMIS from First Health. The legislature should seek regular updates of this process as well, and use the contractor deliverable schedule outlined in the RFP as a guide for determining if the process is on schedule.

As part of our scope of work, PHPG also reviewed the department's recently-issued draft regulations for covered services. We found them in compliance with federal law and regulations and identified only a few areas for potential follow-up by DHSS.

Program Reform Options

Over the past five years the federal government has shown a greater willingness to provide states with the flexibility to restructure their programs and adopt new financing and health care delivery methods intended to bring greater control over program budgets. The government has done so in two ways – through the Deficit Reduction Act of 2005 (DRA) and the Section 1115a waiver process.

Alaska has recognized the importance of program planning and evaluation, as evidenced by recent studies to forecast program expenditures and assess the long-term care system. These studies indicate that program change is inevitable; the program as it exists today is not financially sustainable over the long term. The logical next step is to develop a comprehensive approach for program reform.

Chapter 6 of the report reviews a number of private sector-oriented reforms being tested in other states, as part of DRA initiatives or Section 1115a waivers. These include both incremental measures – such as introduction of employer-sponsored coverage initiatives and disease management programs – and broader reforms.

For example, Vermont in 2004 negotiated a global cap on its program, locking in federal financial participation up to a pre-defined level. The state also received federal match for services that previously had been funded with state dollars only and was granted the flexibility to change coverage conditions for optional Medicaid groups without, in most cases, filing state plan amendments or seeking federal approval.

Ultimately, the decision over whether to take incremental steps or pursue a waiver should be made based on what Alaska hopes to achieve through Medicaid reform. The reform planning process should begin at the broadest possible level, working towards a reform plan that best meets Alaska's programmatic and fiscal objectives. Once the reform plan has been developed, an assessment can be made to determine what aspects of the plan may be implemented within the parameters of federal regulations and what aspect would require federal waiver authority. Alaska then would be in a position to determine the best approach for securing federal approval of its plan.