
HMA

HEALTH MANAGEMENT ASSOCIATES

Healthy Alaska Plan:

*Preliminary Draft
Medicaid Redesign and Expansion
Environmental Assessment*

PREPARED FOR
ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES

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*Research and Consulting in the Fields of Health and Human Services Policy, Health Economics
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Introduction

The Patient Protection and Affordable Care Act (ACA) of 2010 implemented an array of health insurance reforms aimed at providing more Americans with accessible, affordable and high-quality health care. Integral to the ACA are provisions empowering state efforts to reform finance and delivery systems, with the goal of transforming and expanding the reach of the country's largest publicly financed health insurance program, Medicaid.¹

Alaska has embarked on a series of health reform initiatives to enhance access to care, improve population health and moderate cost growth.² Statewide reform initiatives currently underway or under development are designed to: improve care management through the use of a patient-centered medical homes (PCMHs); reduce unnecessary utilization through an emergency department (ED) diversion pilot for high-cost patients or "super-utilizers;" enhance access for the State's sizable American Indian/Alaska Native (AI/AN) population; develop initiatives to better manage the growing costs of medically necessary transportation, prescription drugs and durable medical equipment (DME); and, seek an 1115 waiver to implement innovative care management initiatives for AI/AN populations (see Appendix D for more detail). Statewide efforts are complimented by various ongoing regional efforts, such as the Southcentral Foundation's Nuka System of Care that utilizes a coordinated approach to wellness for participants.³

Yet Alaska's Medicaid program, and the health care system more generally, still have opportunities to further achieve the State's goals. To that end, Governor Walker announced plans to accept additional federal funding to reform and expand Alaska's Medicaid program, beginning September 1, 2015. Such an expansion is expected to extend health care coverage to more than 20,000 Alaskans and generate approximately \$146 million in revenue in its first year.⁴

To better understand the various reform and expansion options available, the Alaska Department of Health and Social Services (DHSS), in partnership with the Alaska Mental Health Trust Authority (AMHTA), engaged Agnew::Beck Consulting and its subcontractors, Health Management Associates (HMA) and Milliman Associates (collectively referred to as "the Contractor") to engage stakeholders and DHSS/AMHTA leadership to develop strategies and make recommendations for Medicaid redesign and expansion for Alaska. As part of this effort, the Contractor was tasked with developing a Healthy Alaska Medicaid Redesign and Expansion Environmental Assessment, which outlines a spectrum of potential and feasible health reform and Medicaid expansion options available to Alaska. This is the preliminary draft of the Environmental Assessment, and is intended to facilitate discussions on possible delivery system reforms and financing mechanism options. A final Environmental Assessment will be included in the complete full report of all Medicaid redesign and expansion analysis, to be delivered in January 2016.

This Environmental Assessment draws on numerous sources, including DHSS's *The Healthy Alaska Plan: A Catalyst for Reform*, and analyses of estimated enrollment and cost impacts of Medicaid expansion, including: *Projected Population, Enrollment, Service Costs and*

Demographics of Medicaid Expansion Beginning in FY2016 (Evergreen Economics, February 2015); *An Analysis of the Impact of Medicaid Expansion in Alaska* (the Lewin Group, 2013); and *Medicaid in Alaska Under the ACA* (the Urban Institute, February 2013). Findings and recommendations from the Alaska Health Care Commission, the Alaska Medicaid Reform Advisory Group, and legislation introduced in the 2015 Alaska state legislative session (Alaska House Bill 148 and Senate Bills 78 and 74) are also incorporated in this report.

This Environmental Assessment is organized as follows:

- Section I: Key Factors Shaping the US Health System and Health Care in Alaska
- Section II: Financing Authorities Available for Reform and Expansion
- Section III: State Approaches to Coordinated Care and Value-Based Purchasing
- Section IV: State Medicaid Experiences

Section I: Key Factors Shaping the US Health System and Health Care in Alaska

The Alaska health care system is a product of both the State's unique health care landscape and cost drivers affecting health care nationally, including:^{5,6}

- Reliance on a primarily fee-for-service (FFS) reimbursement system
- Fragmented care delivery
- An aging population
- Rising rates of chronic disease and co-morbidities
- The impact of social determinants such as poverty, lack of education, and limited access to healthy foods, on overall health
- Lack of cost and quality transparency and limited data to inform consumer choice
- Health care market consolidation and evolving provider and insurer competition trends
- High unit prices of medical services
- A complex health care legal and regulatory environment
- The structure and supply of the clinician workforce

Publicly financed health care is playing an increasingly important role in helping Americans access health care. The ACA authorized states to expand Medicaid to adults ages 19 to 64 with incomes up to 138 percent of the poverty line (i.e., 133 percent of the Federal Poverty Level (FPL) with a 5 percent disregard). To minimize states' financial burden, the federal government assumed 100 percent of the costs of covering newly eligible adults through 2016, phasing down to 90 percent in 2020. As of August 2015, 30 states and the District of Columbia have expanded Medicaid and several other states were considering expansion.⁷

The ACA offers states many additional tools to reform the way they pay for and deliver health care to their publicly insured residents, including implementing alternative benefit packages and redesigning delivery systems to create patient-centered medical homes (PCMHs) and accountable care organizations (ACOs), among other models. More recently, many state reform efforts have hinged on expanding the reach of managed care, including to populations previously carved out of full-risk contracts, such as the aged, blind and disabled (ABD) or those with severe behavioral health needs. To date, 39 states contract with managed care

organizations (MCOs) to provide comprehensive Medicaid services to enrollees, and more than half of all Medicaid enrollees are covered through some type of managed care.⁸

Finally, the ACA offers an opportunity to expand the reach of Medicaid. Prior to the passage of the ACA, six states expanded Medicaid eligibility to non-mandatory populations, such as non-disabled adults.⁹ Under Medicaid expansion, children and adults enrolled in Medicaid have better access to care and improved health outcomes, and Medicaid enrollees are more likely to have a regular source of care and receive primary care.¹⁰ Medicaid enrollees report higher self-reported health and are less likely to report declines in health.¹¹ Finally, studies have shown that Medicaid improves adults' mental health and significantly reduces catastrophic medical expenses among enrollees.¹²

Health Care in Alaska

With 16 percent of the United States' land mass and 0.2 percent of its population, Alaska's size and terrain play a role in the State's unique health care delivery environment.¹³ Alaska has higher than average per-capita health care costs,¹⁴ due in part to sparsely populated rural areas with relatively few providers. One quarter of the state's population lives in communities of fewer than 2,500 people.¹⁵ Physician specialty costs average 60 percent higher than those of other highly rural/frontier Western states, in part due to the incentives for volume in a FFS delivery system.¹⁶ Average hospital costs are 38 percent higher than those of comparison states.¹⁷ Health care costs are also impacted by State regulations such as those requiring providers to be reimbursed at 80 percent of usual and customary charges for out-of-network services.¹⁸ Finally, three insurers recently exited Alaska's individual insurance market due to poor financial performance, indicating evolving and acute market pressures faced by payers.

Currently, Alaska operates a relatively traditional Medicaid program, serving low income children, pregnant women, families, the elderly, blind and the permanently disabled. Alaska is one of only two states in the country that do not use a managed care delivery system for any Medicaid enrollees. Alaska does currently operate a number of 1915(c) waivers to provide home and community based services (HCBS) for ABD individuals with complex health needs,¹⁹ in addition to the various reform efforts noted in the introduction.

Section II: Financing Authorities Available for Reform and Expansion

This section discusses the financing authorities used to support Medicaid redesign and expansion efforts being implemented by states across the country. We provide a special focus on 1115 waivers; these waivers figure prominently in state efforts to develop comprehensive care coordination programs with non-traditional features, such as enrollee premiums and cost sharing requirements, private option or premium assistance models, alternative benefit packages, health savings accounts, and wellness incentives to increase enrollees' participation in their health care. We also describe the 1915 and 1916(f) waivers, and the Delivery System Reform Incentive Pool (DSRIP) and Alternative Benefit Plans in this section. In Appendix A, we provide a broader range of information about financing authorities, including 1115, 1915, 1916, and 1945 waiver authorities as well as summaries of ACA Section 1332 ("Wyden") waivers, State Plan Amendments (SPA), the DSRIP program and Alternative Benefit Plans.

Section 1115 Demonstration Waivers

Section 1115 of the Social Security Act allows states to test innovative policy solutions aimed at delivering more cost efficient and higher quality care to Medicaid populations. Section 1115 waivers have been used to expand Medicaid eligibility, redesign benefit packages, and test delivery system models that improve care, increase efficiency and reduce costs.²⁰ States are granted 1115 waiver authority for up to five years, with the possibility of three year renewal periods. 1115 waiver demonstrations must further the aims of the Medicaid program and demonstrate budget neutrality.

The 1115 waiver offers states significant flexibility, including the ability to gain exemption from Medicaid requirements for statewideness, comparability of benefits, and freedom of provider choice.²¹ Moreover, the 1115 waiver provides states the authority to simplify enrollment and renewal processes; use Medicaid dollars to subsidize enrollment in Qualified Health Plans for certain population; utilize managed care for high-need populations, such as the elderly and people with intellectual and developmental disabilities; address dual eligible populations in delivery and payment reform efforts; and, provide family planning services.²² The Centers for Medicare and Medicaid Services (CMS) has recently provided states with the opportunity to use 1115 waiver authority to conduct demonstration projects for individuals with Substance Use Disorder and introduced a Medicaid Innovator Accelerator Program to support this work.²³ Finally, 1115 waiver authority has been used to implement Medicaid expansions. To date, five states—Arkansas, Iowa, Indiana, Michigan and Pennsylvania—have used 1115 demonstration waivers to expand their Medicaid programs while testing innovative models of care delivery and financing for expansion populations. (It should be noted that Pennsylvania is currently moving towards a traditional expansion through a SPA.) Montana (MT) is in the design stages of the 1115 waiver for their expansion program.²⁴

However, not all proposed provisions in 1115 waivers have been permitted by CMS. While the federal government is supporting state innovation, CMS has denied state proposals that charge premiums for individuals with incomes below 100 percent FPL; require drug testing or work requirements as a condition of program participation; seek exemption of traditionally eligible children from ESPDT services; or, limit freedom of choice of provider options for family planning services.²⁵ Notably, over the past few months, CMS has also grown increasingly wary of cost sharing requirements.²⁶

Delivery System Reform Incentive Pool

The Delivery System Reform Incentive Pool (DSRIP) initiative is an option under the broader Section 1115 waiver and provides funding for states to develop provider-focused delivery system reforms. DSRIP was initially used to support safety net hospitals as they underwent system transformation. More recently, some states have received CMS approval to conduct DSRIP demonstrations to implement more far-reaching payment and delivery system reforms. DSRIP programs generally focus on four main program areas: infrastructure development; system redesign; clinical outcome improvements; and population-focused improvements.²⁷ Like other 1115 demonstrations, DSRIP must also be factored into a state's overall 1115 budget neutrality. As of August 2015, California, Kansas, Massachusetts, New Jersey, New York and

Texas have been granted approval to run DSRIP programs as part of their overall 1115 demonstrations.²⁸

Section 1915 Waivers & State Plan Options

Many states have used various 1915 waivers to reform Medicaid and transition Medicaid enrollees into managed care arrangements. Broadly speaking, 1915(b) managed care waivers enable states to provide services through managed care systems. The 1915(b) waiver options allow states to implement managed care delivery systems that restrict the number and type of providers enrollees can see; allow county and local governments to act as a choice counselor or enrollment broker to help enrollees select managed care plans; and, permit states to use savings to provide additional services.²⁹ 1915(c) waivers have been used by most states to provide long-term care services in home and community-based settings instead of institutional settings. The 1915(c) waiver provides exemptions for comparability, statewide, and income and resource limits for medically need enrollees. Both 1915(b) and 1915(c) waivers require budget neutrality.³⁰

The 1915(i) HCBS and 1915(k) Community First Choice authorities are State Plan options for HCBS and home and community-based attendant services. The 1915(i) option allows states to provide HCBS for specific populations under a State Plan. The 1915(i) option also enables states to establish separate needs-based criteria and allow HCBS services to be self-directed. For example, since the state can establish need-based eligibility criteria, it can enroll individuals with psychiatric disabilities under 1915(i) coverage who would otherwise be ineligible for HCBS.³¹ 1915(i) programs must be statewide. The 1915(k) Community First Choice option established under the ACA authorizes states to provide home and community-based attendant services and supports to eligible Medicaid enrollees under the authority of an existing State Plan. Under the 1915(k), states receive a six percent increase in federal Medicaid matching ratio for community-based attendant and other services to assist people with ADLs and IADLs, to help them acquire and maintain the necessary skills to live independently.³²

Section 1916 Waivers

The 1916(f) waiver establishes circumstances under which a state may impose cost-sharing above otherwise allowable amounts. Participating states must meet requirements such as testing a unique and previously untested use of copayments and limiting the demonstration to two years or less.³³ Indiana was approved for a two-year 1916(f) waiver to implement graduated co-payments for non-emergency ED use. Of particular note for states with significant AI/AN populations, AI/AN enrollees who have received a service directly from IHS, a tribally-operated facility, an urban Indian health program, or through a referral from IHS under its Contract Health Services (CHS) program, are exempt from all cost sharing requirements. AI/AN enrollees also may not be charged premiums for enrolling in Medicaid.³⁴

Section 1332 (Wyden) Waivers

ACA Section 1332 allows states to waive certain provisions of the ACA to develop State Innovation Waiver programs. While these waivers are not available until 2017, they offer unprecedented flexibility to meet the goals of the ACA while making significant programmatic

changes. States may request waivers of most major ACA coverage requirements, including exchanges, benefit packages and the individual and employer mandates. A participating state would receive the aggregate amount of subsidies—including cost-sharing reductions, premium tax credits and small business tax credits—that would have otherwise gone to the state’s residents and would be responsible to ensure that coverage for residents remains affordable and reaches a comparable number of people.³⁵ Budget neutrality will be required for 1332 waivers.

To date, CMS has only issued general guidance on 1332 waivers; however, several states have indicated interest in pursuing these waivers. Vermont proposed using a 1332 waiver to implement a single-payer health system.³⁶ Hawaii and Minnesota are discussing ways to use the 1332 to expand coverage and enact meaningful payment reform. Iowa and Arkansas have proposed using a combination of 1115 and 1332 waivers to streamline coverage options across insurance markets and further align the public and private insurance markets.³⁷

Alternative Benefit Plan

The Alternative Benefit Plan (ABP), first introduced in the 2005 Deficit Reduction Act and modified by the ACA, is a state plan option that offers flexibility to states in establishing alternative benefit packages. States can use ABPs to provide Medicaid enrollees with coverage based on specified commercial insurance products or a federal Department of Health and Human Services (DHHS)-approved coverage option. The coverage must either be equal to a specified benchmark plan or include certain specified services, and as a package, it must be actuarially equivalent to a specified benchmark.³⁸ The ACA requires that the newly eligible receive benefits through an ABP, which need to include the 10 Essential Health Benefits (EHBs). States may also implement an ABP for children ages six and over. See Appendices A and C for more information about ABP requirements, options and state-specific programs.

Key Findings: Waiver Provision Decisions by CMS³⁹

Private Coverage Option

CMS has indicated that it will permit a limited number of states to use Medicaid funds to pay premiums on behalf of enrollees and purchase coverage in what is called the private option. To date, Arkansas and Iowa have implemented private option models, which are being used to study the impact of enrolling Medicaid enrollees in private insurance on provider access and churn, as well as related care discontinuities.⁴⁰ Arkansas is enrolling parents with incomes between 17-138% FPL and childless adults with incomes between 0-138% FPL; Iowa and Pennsylvania enroll newly eligible individuals with income 101-138% FPL in Marketplace Qualified Health Plans.⁴¹

1115 Waiver proposals in New Hampshire and Utah also move toward private option approaches. New Hampshire would require newly eligible adults to enroll in QHPs in 2016. Governor Herbert’s Utah proposal contains a slight variation: while most newly eligible adults would be required to enroll in Marketplace QHPs, adults with access to employer sponsored insurance (ESI) would receive premium assistance to purchase ESI. This is similar to Indiana’s program, which includes ESI support for those with access to employer coverage.⁴² Tennessee

also allows individuals with access to employer coverage to receive premium subsidies for their employer plan.⁴³

Monthly Contributions and Premiums

Historically, Medicaid enrollees with incomes below 150 percent FPL could not be assessed premiums by state Medicaid programs. The ACA, however, does provide flexibility by allowing states to charge premiums and institute nominal cost-sharing requirements. Typically, CMS has allowed premiums only for those individuals with incomes above 150 percent FPL, limiting the total premium amount to approximately two percent of income.⁴⁴ These premiums vary by state and are commensurate with the premiums allowed through the Marketplaces.

CMS has approved waivers allowing Arkansas, Iowa, Indiana and Michigan to charge premiums to individuals with incomes below 100 percent FPL, but failure to pay premiums cannot lead to permanent disenrollment. While CMS rejected Indiana's proposal to make non-payment of premiums a reason to revoke eligibility, CMS did approve a six-month lockout for unpaid premiums after a 60-day grace period, after which the individual can re-enroll.⁴⁵ Both Iowa and Pennsylvania impose a 90-day grace period before disenrollment, but individuals can reenroll immediately.

Cost sharing requirements are typically limited to certain services and eligible populations. States can require co-pays on non-preferred drugs and non-emergency use of the ED or non-emergency medical transportation (NEMT), for example, but may not charge for emergency, pregnancy or family planning services. Children and pregnant women are exempt from most out-of-pocket costs. Iowa and Arkansas require monthly cost-sharing contributions for enrollees with income above 100 percent FPL.⁴⁶ AI/AN enrollees who have received services from the IHS or tribal health organization are exempt from all cost-sharing requirements.

To implement cost-sharing amounts greater than those allowed under traditional Medicaid, states must seek waiver authority outside of an 1115 waiver. Indiana received authority under Section 1916(f) to implement cost-sharing that exceeds the \$8 maximum for non-emergency services.⁴⁷ Arkansas and Michigan have 1115 waivers in which the participant cost sharing is paid into a medical savings account that is used for health expenditures, but the amounts are consistent with what would have been allowed under traditional Medicaid rules.

The Alaska Medicaid program has a number of cost sharing requirements, detailed in Appendix E. Providers are required to collect the cost-sharing payments from recipients and cannot exceed the set amount; the State then reduces provider reimbursement by that amount.

Waivers of Required Benefits

While states must cover the ten EHBs and other mandatory Medicaid services, as well as meet mental health parity requirements, the law offers flexibility to select a benchmark plan or to waive specific services. Waivers approved in Iowa and Pennsylvania allow the states to waive NEMT, with conditions.⁴⁸ Iowa's waiver approval was accompanied by a CMS comment that allows CMS to request additional data measuring the waiver's impact to continue the waiver, and the state is still required to provide NEMT to medically frail individuals.⁴⁹ Arkansas was

granted the flexibility to establish a prior authorization process for NEMT.⁵⁰ In Indiana, individuals with incomes below 100 percent FPL who fail to pay their premium contribution may receive a limited benefit package that covers EHBs but fewer otherwise covered services (e.g., no dental coverage).⁵¹

Wellness and Healthy Behavior Incentives

CMS has approved wellness incentives that benefit participants. Waivers in Iowa, Indiana, Michigan and Pennsylvania include provisions that waive or reduce member premiums for enrollees who complete certain documented healthy activities. To implement a wellness program, the state must: specify healthy behaviors; identify a strategy to measure the behaviors; conduct stakeholder outreach to develop healthy behavior standards; indicate how healthy behaviors will be tracked; conduct provider and member education; and, explain how incentives triggered by healthy behavior activities will impact cost sharing.

Waiver Provisions Denied by CMS⁵²

CMS has denied the following proposed waiver provisions:

- Premiums for individuals with incomes below 100 percent FPL when payment is required to maintain eligibility.
- Elimination of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for newly eligible 19 and 20 year olds.
- Elimination of family planning provider free choice for newly eligible adults.
- Imposition of penalties for non-emergency ED visits after the first visit that are higher than those approved in Indiana.⁵³
- Work requirements as a condition of eligibility.

Section III: State Approaches to Coordinated Care and Value-Based Purchasing

The largest percentage of states' Medicaid costs are attributable to the benefits and services that enrollees use. States are developing ways to manage care for Medicaid enrollees that improve quality while driving value, fundamentally realigning provider and patient incentives. These state efforts to design and implement care management models can be broadly categorized into the following value-based payment models:

Payment Incentives

- Primary Care Case Management
- Patient Centered Medical Homes and Health Homes

Partial Risk/Partial Capitation

- Accountable Care Organizations and Bundled Payments
- Pre-Paid Inpatient Health Plans and Pre-Paid Ambulatory Health Plans

Full Risk/Managed Care

- Full-Risk Managed Care

The majority of states pair care management efforts with payment reforms, exploring ways to move providers along the continuum from volume-based FFS payments to value-based

payment models in which payers or providers assume some or all of the financial risk to better align financial incentives and constrain cost growth.

Simultaneously, states are implementing innovative practice strategies in efforts to provide more cost efficient care to remote and underserved areas, including enhanced patient communication platforms (e.g., physician messaging), telemedicine, and remote tele-diagnostics. The feasibility of implementing some of these care modules is affected in part by existing state laws and regulations. For example, some Alaska providers are limited in their ability to develop telemedicine programs due to state statute that causes providers to risk sanction when they prescribe controlled substances via telehealth modules, and requires prescribing physicians to be physically located in Alaska.⁵⁴ Consequently, some providers are impeded from effectively providing telemedicine services (e.g., behavioral health providers such as child psychiatrists). Tribal health systems, however, are not confined by these regulations and operate various telemedicine programs that have expanded access for AI/AN populations.⁵⁵ Many tribal health telemedicine programs have been aided in part by federal funds that are not available to all Alaskan providers.

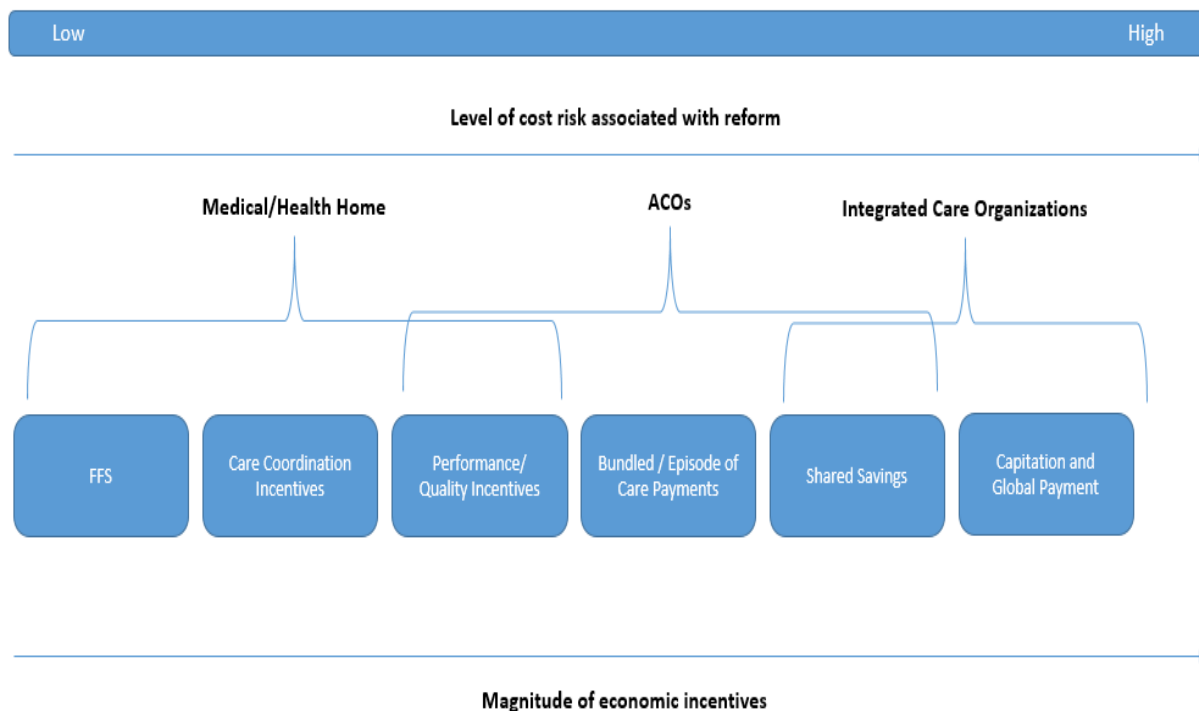
For each of the models described below, some states “carve out” certain Medicaid populations or benefits. In the past, the carved-out groups have tended to be those with the most complex needs and highest costs, such as individuals with disabilities, those receiving long term services and supports (LTSS), and those with severe mental illness (SMI- adults) or severe emotional disturbances (SED – children). States often also carve out certain kinds of services or benefits, most notably pharmacy benefits, dental care, behavioral health and NEMT.⁵⁶

However, with costs of care rising exponentially over the past decade, states have sought ways to manage care more effectively for the most expensive enrollees. States are increasingly moving complex and high-cost enrollees into their overall care management programs, or designing care management structures specifically for them. For example, the portion of LTSS provided through MCOs went from four percent in FY 2008 to 10 percent in FY 2013.⁵⁷ There has been significant growth in the following types of state programs:⁵⁸

- Expanding capitated managed care to all populations, including individuals with behavioral health needs and ABD enrollees.
- Expanding capitated managed care to new geographic regions.
- Including additional services such as long-term care or behavioral health services, either through separate programs or by integrating them into a capitated model.
- Exploring ways to integrate services by including the services in the capitation payment and making managed care plans responsible, or by requiring establishment of MOUs or contracts between providers.

Health Reform and Financial Risk

As states pursue health system redesign that includes payment reforms, risk may be transferred from the state to managed care entities, providers and patients. Figure 1 (below) illustrates the continuum of carrier and provider financial risk associated with various reform efforts.

Figure 1: Trade-off between magnitude of economic incentives and transition of risk

Risk-based contracting offers the state an opportunity to utilize value-based purchasing, align incentives with program goals and potentially capture savings. The FFS payment system encourages volume over value, which has helped to increase costs for medical care.⁵⁹ However, the evidence on incremental care coordination and pay-for-performance (P4P) programs is mixed, showing modest reductions in utilization of inpatient and specialty care and costs.^{60, 61}

Alaska and other states considering more integrated models of care or fuller risk models also face challenges related to existing state insurance regulations. State regulations that impede adoption of provider risk affect the viability of accountable care, bundled payment, and global capitation models. Existing Alaska statutes also have the potential to enhance provider pricing power in certain markets, specifically by requiring the calculation of usual and customary rates using a methodology that grants providers pricing leverage.⁶² The statute also aims to ensure providers receive equitable payments for services provided when no contract rate exists, and to shield patients from excessive charges caused by balance billing. (Alaska is the only state with no prohibitions on network providers balance billing Medicaid managed care patients.)⁶³ While these legislative and regulatory debates are beyond the scope of this report, they do impact Alaska's ability to implement new models of care without preceding regulatory changes.

Models of Care Overview

Primary Care Case Management (PCCM)

In a PCCM model primary care providers (PCPs) are responsible for approving and monitoring the care of enrollees based on the criteria established by the state. Enrollees choose a PCP who

“manages” their care by ensuring appropriate access to specialists, high-cost imaging, expensive medications, and inpatient hospitalizations. PCCM can be implemented without a waiver from CMS or extensive changes to the Medicaid State Plan. Many states, such as Colorado, use PCCMs in rural areas where full-risk managed care is not practical.⁶⁴ The model works well in rural areas because most providers can meet requirements without needing to significantly alter infrastructure or staff investments. States typically pay PCPs who participate in PCCMs a FFS rate plus a monthly care management fee (typically between \$2 and \$5 per member per month).⁶⁵ Some states include pay-for-performance incentives (e.g., Pennsylvania's ACCESS Plus program).⁶⁶

Patient Centered Medical Homes (PCMHs)

PCMHs have existed since 1967 but broadly recognized standards and principles for what constitutes a PCMH were not fully developed until the American Academy of Family Practice and the National Committee for Quality Assurance (NCQA) created standards for providers seeking to be recognized as a PCMH.⁶⁷ Over the past several years, many states and health plans have formalized programs supporting development of PCMH practices, especially for their Medicaid and Medicare enrollees.

The PCMH focuses on “whole person” care. It differs from a traditional primary care practice or PCCM model in the more team-based approach to integrated care and the inclusion of additional care coordination supports and services. For example, PCMH recognition criteria include standards such as ensuring after-hours access, maintaining electronic health records, tracking quality metrics, conducting comprehensive health assessments for all new patients, and proactively managing and reducing barriers for high-risk patients.⁶⁸

Many Federally Qualified Health Centers (FQHCs), Community Health Centers (CHCs) and other large primary care practices utilize the PCMH model, which can be supported relatively easily in both urban and rural settings. As with PCCMs, most states pay providers a PMPM care management fee, sometimes based on the level of PCMH certification (level 1 – 3). Fees can vary considerably from state to state and include a variety of adjustments for factors such as patient age, patient acuity, and eligibility category. States and providers need to have more sophisticated data systems in place to ensure they are able to capture and report relevant data to support PCMH quality metrics and payment structures. There is evidence that the PCMH model can achieve quality improvement and cost savings. Research indicates that PCMHs are most effective for high-utilizer and high-cost enrollees with complex needs.⁶⁹

Health Homes

Health Homes are a variation of the PCMH model authorized by Section 2703 of the ACA. The statute delineates services Health Homes must provide, and the types of Medicaid enrollees who can participate in Health Homes – including those with mental health and substance abuse issues, as well as those with specific chronic medical conditions. As more states implement Health Homes, CMS has allowed some flexibility to include other chronic medical conditions and modify the definitions of Health Home services, as long as they are included in the SPA.⁷⁰

The Health Home legislation allows states to target geographic areas without needing a waiver. Additionally, CMS will provide states with a 90 percent match for certain Health Home services for the first eight quarters of operations – which includes an additional eight quarters of enhanced match for each new geographic area or for new enrollees with additional conditions program to help states establish them.⁷¹

Health Homes must meet standards that are not part of PCMH recognition standards. They must integrate physical and behavioral health services; target enrollees with specific high-risk behavioral health and chronic conditions; and include social and community supports in their care coordination services. Health Homes may be created by a variety of provider types, including behavioral health providers, as long as they provide integrated care and can meet the required service criteria. While the same kinds of payment models are applied to Health Homes as for many PCMHs, some states are experimenting with shared savings, risk-adjusted payments, bundled payments, and capitated payments for Health Homes. The delivery system and the various possible payment models that can be applied require robust information system and data sharing infrastructure in order to meet CMS reporting requirements and the state's management needs. Health Home providers generally have to make substantial changes in their practice approaches to support integrated care across multiple providers, agencies, services and systems. Early evaluations are showing that these investments are worthwhile. Health Homes can have positive quality and cost outcomes for target populations, primarily through reduced inpatient admissions, ED visits and pharmacy costs.⁷²

Accountable Care Organizations (ACOs) and Bundled Payments

ACOs are a relatively new delivery reform effort comprised of health care providers coming together to share accountability for the care, health outcomes and costs for a defined group of enrolled individuals. Most often ACOs are formed by providers, such as hospitals and affiliated physicians/practice groups, but can also be formed by (or turn into) MCOs. ACOs began with several large Medicare demonstration and have since been established in some commercial markets and Medicaid. Currently, 17 states have or plan to implement Medicaid ACOs.⁷³ Notable examples include Oregon's Coordinated Care Organizations, Alabama's Regional Care Organizations (Alabama), and Colorado's Regional Care Collaborative Organizations.

Medicaid ACOs exhibit a variety of organizational structures, populations served, benefits offered, and the payment structures supporting it. ACOs built on existing delivery system infrastructure such as well-established PCCMs, PCMHs, or MCOs are usually the most successful. Payment structures range from FFS with care coordination payments similar to PCCMs, or "enhanced PCCMs", to shared savings and shared losses, to global budgets similar to full-risk capitation. As ACOs feature increasingly integrated provider networks that include more specialists and post-acute providers, bundled payment financing mechanisms offer a promising path forward to further align provider incentives. Payers are supportive of these efforts because the enhanced integration of ACOs allows provider networks to better manage the full spectrum of an episode of care. Moreover, providers who develop effective care management and evidence-based protocols for the entire episode of care are able to capture additional savings through shared savings contracts with payers.⁷⁴

Timely and accurate patient data is vital for the success of an ACO. Similar to the Health Home model, providers working in ACOs must make substantial changes to their practice to ensure a team-based approach and a focus on common goals and outcomes. ACOs that make the necessary adaptations to the model have shown potential for savings. Many of the Medicare ACO demonstrations now are beginning to demonstrate cost savings, and Colorado and Oregon have shown improvements in care quality and cost reductions for their Medicaid ACOs.⁷⁵

Prepaid Ambulatory Health Plans (PAHPs) and Prepaid Inpatient Health Plans (PIHPs)

PAHPs and PIHPs offer an alternative to ACOs that stops short of full-risk capitated managed care. States pay a PMPM rate to a plan, which then agrees to cover a set of services for enrollees. PAHPs provide medical services to enrollees under contract with a state, do not provide or arrange any inpatient hospital or institutional services for enrollees, and do not have a comprehensive risk contract. PIHPs provide or arrange for inpatient hospital or institutional services for enrollees.⁷⁶

Neither PAHPs nor PIHPs work under comprehensive risk contracts, but rather are components of a full-risk capitated plan that “specialize” in either managing ambulatory or inpatient care. States often use PAHPs to cover outpatient services such as dental or behavioral health care; similarly, they use PIHPs to cover specialized inpatient hospital and/or institutional services, such as for behavioral health. In 2014, 20 states had either or both PAHPs and PIHPs.⁷⁷ PAHPs and PIHPs are accountable to manage the required services and must meet similar quality and reporting requirements as for full-risk MCOs. In fact, recent proposed rules from CMS expand and clarify managed care requirements related to PAHPs and PIHPs.

Full-Risk, Capitated Managed Care

To date, 39 states (including the District of Columbia) have full-risk, capitated managed care programs for some or nearly all of their Medicaid enrollees and for some or nearly all benefits and services.⁷⁸ Medicaid MCOs deliver a set of Medicaid benefits to a specific Medicaid population in exchange for a capitated (PMPM) rate. Historically, full-risk contracts were limited to children and pregnant women, but many states now employ full-risk contracts that include or are specifically designed for more complex enrollees such as ABD enrollees and those with severe behavioral health needs.⁷⁹

Full-risk capitation rates must be actuarially-certified, and typically are adjusted for age, sex, existence of Medicare or other third party insurance, or Medicaid eligibility category. The proposed Medicaid MCO rules published in May 2015 substantially change what constitutes “actuarially sound” rates, as well as other requirements that states and MCOs must meet for enrollee experience and choice, program integrity, information standards, quality improvement programs, and provider network adequacy and access. The proposed rules also include requirements related to serving individuals who need LTSS, which is a reflection of the growth in full-risk programs for this population. The regulations propose more stringent requirements regarding timely, accurate encounter data from both MCOs and states, to ensure that MCOs comply with quality assurance and utilization measures, enrollee satisfaction standards, and to improve the accuracy of capitation rates.

Establishing full-risk capitation requires significant communication with providers, including those with little experience with capitated payments and those not prepared to meet more rigorous quality and performance metrics. MCOs face particular challenges in rural and frontier areas which pose significant challenges to achieving economies of scale, developing adequate provider networks, and ensuring the infrastructure necessary to meet all performance and reporting requirements. Whether full-risk models generate true cost-savings is still debated. Some studies have found overall cost savings, while others conclude full-risk is either cost-neutral or even more costly than FFS programs.⁸⁰ When cost savings have been achieved, it is most often a result of reduced inpatient utilization and reductions in other high-cost services.⁸¹

Proposed CMS Managed Care Regulations

Newly proposed federal managed care regulations indicate CMS is continuing to support more robust quality measurement requirements, more closely aligned insurance markets, and stronger incentives to coordinate enrollee care. The proposed regulations also more closely align requirements for Medicaid, the Children's Health Insurance Program (CHIP), Medicare and Medicare Advantage (MA), and qualified health plans, creating administrative efficiencies and lowering costs for providers and payers operating in multiple markets.⁸² The proposed rule calls for more aggressive quality measurement and care coordination activities, while providing flexibility for states to design individualized plans to meet the broadly defined proposed goals.⁸³

Section IV: State Medicaid Experiences

As of July 2015, 30 states (including DC) have expanded or were preparing to expand Medicaid.⁸⁴ Of this group, 26 states expanded Medicaid using SPAs, while 5 states used 1115 waivers. Table 1 highlights key features of alternative Medicaid expansion plans from states that have been approved for or are pursuing 1115 demonstration waivers to expand Medicaid.

Five states (AR, IA, IN, MI and PA) have received approval of 1115 waivers authorizing them to expand Medicaid eligibility with provisions that do not meet traditional Medicaid requirements, and still draw federal matching funds for the newly eligible population. Appendix C details elements of each plan for a subsection of states.

	Premium Contribution	Wellness Incentives	Premium Assistance	Benefits differ from SPA	Copayment	Work Referral
AR	X		X			
IA	X	X	X	X		
IN	X	X	X	X	X	
MI	X	X				
PA	X	X		X		
NH			X			X
TN	X	X	X	X	X	
UT	X	X	X	X	X	

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- ² http://dhss.alaska.gov/HealthyAlaska/Documents/Healthy_Alaska_Plan_FINAL.pdf
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- ⁴ http://dhss.alaska.gov/HealthyAlaska/Documents/Evergreen_Medicaid_Expansion_Analysis-020615.pdf
- ⁵ <http://www.rwjf.org/en/library/research/2012/09/what-is-driving-u-s--health-care-spending.html>
- ⁶ http://www.allhealth.org/publications/Cost_of_health_care/Cost_Drivers_in_Health_Care_109.pdf
- ⁷ <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>
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- ¹³ <http://dhss.alaska.gov/dph/wcfh/Documents/mchepi/pubs/databook/MCHDataBook2014tweb.pdf>
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- ¹⁶ http://dhss.alaska.gov/ahcc/Documents/drivers_healthcare_costs.pdf
- ¹⁷ http://dhss.alaska.gov/ahcc/Documents/drivers_healthcare_costs.pdf
- ¹⁸ <http://www.legis.state.ak.us/basis/aac.asp>
- ¹⁹ <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/Waiver-Descript-Factsheet/AK-Waiver-Factsheet.html#AK0261>
- ²⁰ <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Section-1115-Demonstrations.html>
- ²¹ <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Section-1115-Demonstrations.html>
- ²² <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8318.pdf>
- ²³ <http://medicaid.gov/federal-policy-guidance/downloads/smd15003.pdf>
- ²⁴ <http://www.montanabudget.org/medicaid-expansion-waivers-providing-options-protecting-montanans/>
- ²⁵ Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services are federally-required benefits for children enrolled in Medicaid.
- ²⁶ HMA project and client experience
- ²⁷ <http://files.kff.org/attachment/an-overview-of-dsrip>
- ²⁸ <http://files.kff.org/attachment/an-overview-of-dsrip>
- ²⁹ http://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/waivers_faceted.html
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- ⁴⁷ <http://files.kff.org/attachment/fact-sheet-medicaid-expansion-in-indiana>
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