ALASKA MEDICAID REDESIGN + EXPANSION TECHNICAL ASSISTANCE

QUESTIONS + ANSWERS

FROM FINAL REPORT OVERVIEW WEBINAR | JANUARY 26, 2016

The questions below have been raised by stakeholders during the course of the project. Answers and other relevant information are provided by the project consultants below.

1. Report Phasing and Analysis

- *Are you saying that those logistical considerations have not been considered? Or perhaps that such considerations were outside of your contract deliverables?*

  DHSS will be reviewing our recommendations and will conduct that assessment internally.

2. Questions about Taxation and Financing Changes

- *Please detail all health or other taxes that are projected and (or) proposed.*

  There are no proposed new taxes included in any of the initiatives. The full risk managed care model includes two current taxes that managed care organizations would be required to pay. These taxes are:

  ACA Health Insurer Assessment Fee: The Affordable Care Act (ACA) placed an annual fee on the health insurance industry starting in CY 2014. The fee will be allocated to qualifying health insurers based on their respective market share of premium revenue in the previous year (e.g., the 2016 health insurer fee will be based on 2015 premium revenue). Market share is based on commercial, Medicare, and Medicaid revenue. CMS regulations require Medicaid managed care rates to include allowances for taxes like the ACA insurer fee because they are an unavoidable cost of doing business for Medicaid MCOs. We have assumed a health insurer assessment fee of 2.4% in the full risk managed care model. This is an estimate and actual taxes can range from 1.7% - 3.5% depending on market share and other factors.

  State of Alaska Health Insurance Premium Tax: The projected capitation rates include an allowance for the 2.7% premium tax collected by the Alaska Division of Insurance.

- *Please show or direct me to the section of the ACA that requires any taxes? I do not think so - ACA only outlines the rule if you want the Federal match for the tax.*

  Section 9010 of the Affordable Care Act outlines the Health Insurers Providers Fee and how this tax will be calculated and collected. This tax applies to Medicaid managed care organizations. More

information from CMS on this tax can be found at https://www.medicaid.gov/federal-policy-guidance/downloads/faq-10-06-2014.pdf.

- *In your calculation of savings/costs associated with managed care, why did you exclude the net gain to the state from the premium tax in your projection of managed care costs?*

  For each of the initiatives, we included only the savings/costs of medical care that would be paid for by the State Medicaid program. There may be other savings/costs related to the initiatives such as DHSS administrative costs and other state-funded programs. The net gain to the State from premium tax would be classified as an item that was not quantified because it is not a Medicaid budget expense or savings. The report does note that there would be a gain to the State from the premium tax.

- *With oil prices low and decreasing federal dollars how are we paying for this? Can we change rule so you will pay for Medicaid Rxs written for those of us opted out?*

  The method for paying to implement proposed reforms will be decided by DHSS and the Alaska legislature.

3. Questions about 1. Primary Care Improvement Initiative

- *Do Health Risk - High Risk include Severe Risk with Addiction (e.g. opioid / heroin)?*

  Yes, it would include drug use and individuals at risk for severe addictions.

- *Best practice for treatment include medication and psychotherapy treatment. Current paradigm does not recognize the psychotherapy. What is the change to address this problem?*

  The Behavioral Health Access initiative outlines strategies to increase access to needed behavioral health services, including:

  - Establishing new standards of care to support expanded delivery of substance use and mental health services;
  - Removing the requirement that only grantees can bill Medicaid;
  - Allowing a broader range of licensed and credentialed behavioral health providers to bill Medicaid.

- *Is the $5 pmpm for all Medicaid participants assigned to primary care providers or just those in health homes?*

  The $5 per member per month (pmpm) is for all Medicaid participants in the primary care case management program, with the exception of those in health homes. The actuarial analysis provided a $15 pmpm for individuals enrolled in Section 2703 Health Homes.

4. Questions about 2. Behavioral Health Access Initiative

- *Will non-grantees be required to be accredited?*

This will be determined by DHSS when and if they decide to move ahead with the reforms recommended in the Behavioral Health Access initiative.

- *Isn't (Sen. Ron) Wyden in Oregon looking into crafting a federal rule change to IMD?*

  This is not in the State's purview, but last summer CMS released proposed rules that included a partial lifting of the IMD (Institute for Mental Diseases) restriction, specifically for stays of 15 or fewer days. The rule has not been finalized as of January 2016.

5. Questions about 3. Health IT Infrastructure Initiative

- *The AKAIMS system is not effective, as I have seen and heard from professional Alaskans throughout the State. Is the analysis of data focused on the use of AKAIMS or are considering other options and integration of effective systems to supply data analysis for the State without imposing an ineffective system.*

  This is addressed on page 61 of the report.

6. Questions about 4. Emergency Care Access Initiative

- *The change in charges is from the shift from ER visits to Primary care visits?*

  We assumed that 50% of the avoided emergency room visits were replaced with an office visit. The resulting office visits were assumed to be distributed as follows: 50% to a primary care physician, 25% to a specialist, and 25% to outpatient psychiatric visits.

7. Questions about 5. Accountable Care Organizations

- *What type of payment mechanism would be used in year 1 for ACOs? Would it be capitated or a FFS payment?*

  See key features E and G, page 77 of the report. This would be a pilot; providers would continue to bill fee for service, but the ACO would negotiate with DHSS to develop an estimated total cost of care for the population served. If the ACO was able to provide the services within that estimate, they would receive a percentage of the shared savings as a payment from the State.

- *Would the ACO as the fiscal intermediary receive the shared savings payment?*

  The ACO would receive the payment from DHSS and would share that among its providers according to the contracts it had negotiated with the participating providers.

8. Questions about Full Risk Managed Care (Explored Not Recommended)

- *How did the committee decide on the potential managed care model by which the assumptions were made?*

  This initiative was developed through the same process as the other initiatives: through an iterative process that involved the consultant team, DHSS and stakeholders. The goal was to develop an initiative that was realistic for Alaska that could be analyzed by Milliman.

9. Questions about Current Expansion Plan (Traditional Plan) (Option 1)

- *Was the Cost Per Enrollee derived from Alaska-specific data? As an example, the Menges report applied a 1.15 factor to 7-state data to arrive at the Alaska cost with no mention of where the 1.15 came from.*

  Yes, the data set used by Milliman for the actuarial analysis is described on page iii of the Executive Summary of the report as follows, "The baseline data used for the actuarial analysis were paid Medicaid claims from Calendar Year 2014, adjusted for anomalies resulting in the conversion to the new Medicaid Management Information System (MMIS)."

10. Miscellaneous Questions

- *How many enrolled in Medicaid, all ages now?*

  On December 31, 2015 there were 129,366 Alaskans, all ages, enrolled in Medicaid. Of those, 7,957 had been enrolled under Medicaid Expansion.