

**MINUTES OF THE ALABAMA MEDICAID ADVISORY COMMISSION
JANUARY 16, 2013
MONTGOMERY COUNTY HEALTH DEPARTMENT AUDITORIUM**

Members Present

Donald E. Williamson, M.D., Chair
Mr. Richard Brockman
Mr. Frank Brown
Mr. Jim Carnes
Ted Catranis, M.D.
Mr. Barry Cochran
Mr. Danny Cottrell
Dr. Marquita F. Davis
Ms. Mary Finch
Mr. Kyle Godfrey
Melanie Halvorson, M.D.
Mr. Stan Hammack
Representative Ed Henry

Mr. Carl Jamison
Hiram Johnson, D.M.D.
Representative Jim McClendon
Ms. Jessica Monroe
Senator Arthur Orr
Mr. Jeff Parker
Mr. Jim Reddoch
Senator Greg Reed
Mr. Graham L. Sisson, Jr.
Mr. Tim Vines
Mr. Mike Warren
Representative Greg Wren
Ms. Charlotte Wynn

Members Absent

Mr. Jeff Brannon
Brigadier General Edward F. Crowell
Representative Laura Hall
Mr. Neil Morrison

Mike Ramsey, M.D.
Ms. Linda Segrest
George "Buddy" Smith, Jr., M.D.

Consideration of Minutes

The minutes of the Executive Committee Meetings held on November 28, December 6, December 7, and December 12, 2012, were approved as distributed.

The minutes of the Advisory Commission Meeting held on December 12, 2012, were approved as distributed.

Discussion

Following the December 12, 2012, meeting of the Medicaid Advisory Commission, Medicaid's actuary, Optumas, reviewed the patient care networks (PCNs), modeled the baseline estimates of cost over the next 5 years if no changes were made to the Medicaid program, modeled a major expansion of the PCNs over 5 years and, by working with four commercial managed care companies, generated a range of potential savings that have been modeled for the state over 5 years if commercial managed care

is used. Estimates provided by the commercial managed care companies were not binding.

Mr. Steve Schramm, Managing Director of Optumas, presented information on Alabama's Medicaid managed care options and the results of three different scenarios.

The first assumed that no changes were made to the Medicaid program. That analysis projected a total 5-year expenditure for the Medicaid population, excluding the LTC and waiver populations, of \$15 billion, including a required state match of \$4.89 billion for FY 2014 to FY 2018. This served as the baseline against which the expanded PCN and the managed care organization analysis were compared.

The expanded PCNs, including the same populations in the baseline and with the implementation of a pharmacy benefit manager (PBM), were projected over 5 years to reduce state spending from the baseline by \$148 to \$320 million. A similarly designed managed care option, using data provided by four commercial managed care companies, was projected for the same population to yield savings over 5 years of \$268 to \$364 million.

While these models represent potential savings, there were other revenue concerns raised during the discussion.

Alabama's pharmacy tax is based on minimum payments to pharmacies. The pharmacy representative on the Commission felt that the industry would oppose continuation of the tax if there were a significant reduction in payments to pharmacies through a PBM. This was projected to result in a loss of \$49 million over 5 years. Likewise, the Alabama Hospital Association expressed skepticism that the hospitals would support the renewal of the hospital provider tax set to expire on September 30, 2013, if the state were placed into commercial managed care. Given the size of this revenue source (\$243 million in FY 2013 and \$1.343 billion over 5 years), its loss would significantly impact the Medicaid program.

Another fiscal issue which required consideration is the unfunded Medicaid Incurred But Not Paid (IBNP). The IBNP represents payments due for services already performed but for which no bill has yet been received by Medicaid. Medicaid's IBNP has been estimated at \$379 million (\$125 million state share) for all populations. The state share of IBNP for the populations included in the analysis is estimated at \$78 million. To address this potential issue, which could result in paying the unfunded IBNP and the capitation payments to a risk-bearing entity at the same time, Optumas proposed avoiding this cash flow problem by delaying initial capitation by 45 days. While this addresses the problem at inception, it shifts the problem to the end of the period, when the capitation would have to be paid for 45 days after the end of a contract.

There was robust discussion on the Optumas analysis and a brief presentation from a commercial managed care organization representative, Dr. Mike McKinney.

Dr. McKinney's organization operated both a PCN and a managed care organization in Texas in two side-by-side regions. The PCN model saved no money and may have actually cost more per member per month. The spend trend remained the same in fee for service and the PCN. When Texas enhanced their PCN, they realized about 2 percent in savings. Dr. McKinney stated there is budget certainty with commercial managed care organizations, managed care organizations have quality measures and provide reports, PCNs do not have data systems for reporting, and PCNs are untenable due to the lack of a credentialed specialty network.

Three options were proposed to the Commission for discussion: 1) Divide the state into regions and move the state into statewide commercial managed care; 2) Divide the state into regions and expand the PCNs statewide with expanded populations while attempting to transition to risk bearing entities; and 3) Divide the state into regions and allow both the PCNs and managed care organizations to operate in separate discrete regions.

The Commission discussed requesting an 1115 waiver from CMS and the need for a Medicaid budget cap. An 1115 waiver could provide federal funds to support the transformation of the system. Funds could be used to acquire the hardware, software, and other tools needed to evaluate outcome and costs in the system. With the shift from a per diem and encounter-based payment to a capitated payment, some hospitals are likely to experience significant financial problems. Funds from the 1115 waiver could be used to ensure the stability of financially vulnerable hospitals. Because there is little experience in the Alabama healthcare system with risk-bearing, there will be a need for the establishment of risk pools to assist newly formed regional networks. A potential source for the funding of these pools would be from an 1115 waiver. While the transition to risk-bearing community networks may be possible without an 1115 waiver, it is more likely with one.

A cap on Medicaid expenditures, coupled with the implementation of a capitated payment system, may help ensure the fiscal certainty that the state is seeking. A cap on expenditures could be applied to total Medicaid expenditures, the state share of Medicaid spending, per member per month cost, or Medicaid as a percent of the General Fund. It is essential the cap be based on actual expenditures not just appropriated funds which may fail to include operating deficits. While any one or a combination of these approaches could stabilize spending, it would be important that legislation to implement the cap allow the state to impose across-the-board cuts in provider payments if it appeared that the cap would be exceeded during a fiscal year. A cap should also have a mechanism to deal with significant unexpected economic events that could dramatically increase the Medicaid rolls.

Another issue briefly discussed was the need for an implementation timeline with specific benchmarks for the creation and development of patient care networks. The Alabama Medicaid Agency should be empowered to intervene if a region is unable to meet specific requirements for organization, care delivery, provider contracting, risk-bearing, etc. The intervention could range from the state combining the failing region

with a nearby region to the state directly accepting proposals for a commercial managed care organization to serve the area. It is essential that a timeline be enforced to ensure that Alabama maximizes the savings available from this model, as well as to ensure high-quality patient care and improved patient outcomes.

Following significant discussion, the Commission approved by voice vote, with only one dissent, a recommendation that the state be divided into regions; that the PCNs be expanded statewide; and that populations served within the networks be expanded. In addition, each region is to move toward becoming a risk-bearing entity capable of contracting with Medicaid to provide care to recipients for a fixed amount. The motion was amended to ensure that a region could have the option of contracting with a commercial managed care organization to provide care, rather than developing a community-based network.

A draft report of the Commission's recommendations to Governor Bentley will be provided to the Commission and a meeting will be held for the Commission to discuss and approve the report.

Adjournment

There being no further business, the meeting was adjourned.

A handwritten signature in black ink, appearing to read "Donald E. Williamson", written over a horizontal line.

Donald E. Williamson, M.D.
State Health Officer
Chair, Alabama Medicaid Advisory Commission