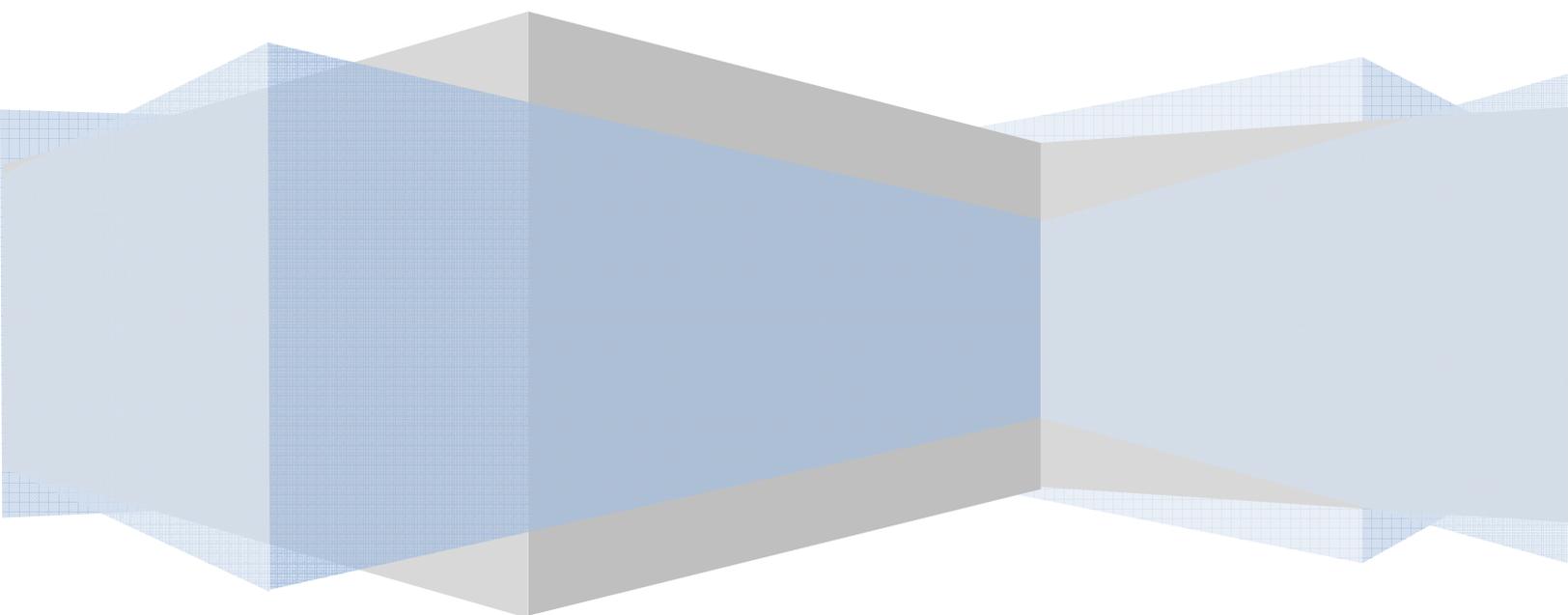


Report of the Alabama Medicaid Advisory Commission

January 2013

Donald E. Williamson, M.D.

Chair, Alabama Medicaid Advisory Commission



INTRODUCTION

The Alabama Medicaid program is an essential source of care for almost 940,000 citizens. Despite its pivotal role in the health care delivery system, it is beset by ongoing challenges characterized by a growing General Fund demand, growing enrollment, and a fragmented delivery system. To address the problems, Governor Robert Bentley established the Alabama Medicaid Advisory Commission on October 25, 2012, and defined its membership (Appendix 1).

The Commission is charged with presenting recommendations on reforming Medicaid to the Governor by January 31, 2013. The recommendations shall address the following: (i) an analysis of the financial needs of Medicaid; (ii) a long-term sustainable financing model; (iii) new delivery models that support quality care and cost control; and (iv) an analysis of methods of increasing transparency and fairness in the system. A reformed Medicaid delivery system will improve patient outcomes through integration and coordination of care. Unnecessary hospitalization and emergency room use will be reduced with care shifted to the primary care setting. Financing for the system will preserve provider assessments, while controlling cost. Payment reform will shift payment from a volume basis to an outcome and quality of care basis. In order to understand the Commission's recommendations, it is necessary to understand the current status of Medicaid.

CURRENT MEDICAID PROGRAM

Eligibility and Coverage

In 2011, 22 percent of Alabamians qualified for services from Medicaid for at least a portion of the year. Medicaid in Alabama covers 53 percent of births, 47 percent of children, and almost two-thirds of nursing home residents. In 2009, Medicaid accounted for 16.3 percent

of all Alabama healthcare expenditures. Given the significant financial impact of Medicaid on the economy, understanding the population served and the services available are essential to structuring Medicaid reform.

As shown in Table 1, Alabama has among the most restrictive Medicaid income limits of any state in the nation. Childless adults are not eligible for Medicaid in Alabama irrespective of income. Parents of children on Medicaid are eligible only if their income is 11 percent of the federal poverty level or less (\$194 per month for a family of four); all other groups identified in Table 1 (with the exception of nursing home and home and community-based waiver clients) are eligible only at the federally-mandated minimum level. While nursing home and home and community-based waiver clients are eligible at levels above the federal minimum income threshold, the ability to create a qualified income trust allows them to transfer income into the trust and become eligible within 30 days, even at the federal minimum income level. In summary, Alabama’s Medicaid program essentially limits coverage to only those populations that are federally-mandated.

TABLE 1

Who Qualifies for Medicaid:

Alabama’s income limits among the most restrictive in the country

- Low-income families (Family of 4 must have < \$194/mo. income)
 - Children ages 6-19 (100% FPL)
 - Pregnant women / children ages 0-5 (133% FPL)
 - SSI for Aged, Blind and Disabled (certified by SSA) (\$730/mth)
 - Medicare-related programs (QMB, SLMB, QI-1) (\$951-\$1,277/mth)
 - Nursing Home Medicaid (\$2130/mth)
 - Home and Community-Based Waivers
 - Same limits as nursing home

Much like the restrictive nature of eligibility, Alabama provides very few services which are not federally required. Table 2 identifies those services which must be provided to all Medicaid eligibles. Table 3 identifies services which are mandatory for children but optional for adults.

TABLE 2

Mandatory Medicaid Services

- Hospital Services – Inpatient and outpatient (except mental disease institutions)
- Services at Rural and Federally Qualified Health Clinics (FQHCs)
- Nursing Home care for people over age 21 (not in a facility for mental disease)
- Laboratory and X-ray services
- Family Planning Services and Supplies
- Services of Physicians, Nurse Midwives and Nurse Practitioners
- Checkups and health services for children (EPSDT)
- Home Health Services
- Transportation
- Pregnancy Related Services
- Dental Services (considered to be the same as physician services)

TABLE 3

Optional Services Covered by Alabama Medicaid

Mandatory services for children, optional for adults.

- Prescribed Drugs*
- End-Stage Renal Disease*
- Eyeglasses*
- Home and Community-Based Services*
- Hospice Services*
- Organ Transplants*
- Prosthetic Devices*
- Clinic services furnished in a facility that is not part of a hospital*

*Indicates the optional services covered by Alabama Medicaid for adults under the State Plan or an approved waiver. QMBs receive additional coverage if Medicare makes payment.

A review of these programs identifies some services, such as dialysis, hospice, or pharmacy that the state could eliminate for adults. However, their elimination would, in the case of dialysis and adult pharmaceuticals, not save money but would likely lead to higher inpatient utilization, avoidable injury, and even death. The elimination of adult hospice for clients with terminal illnesses would increase inpatient hospital or nursing home use.

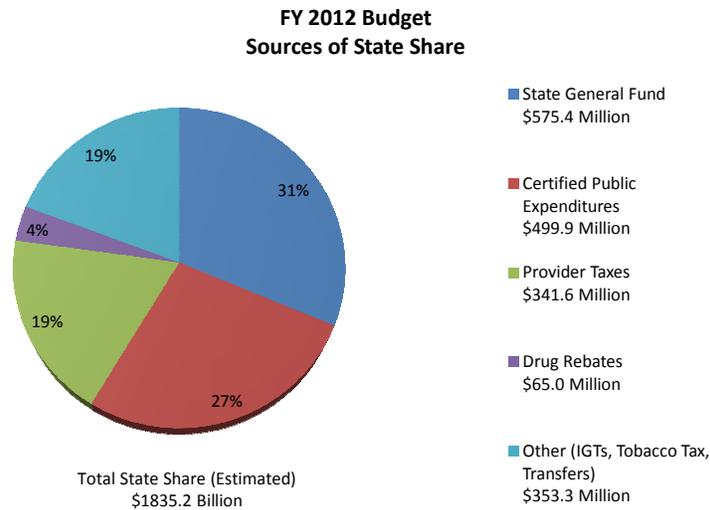
In reviewing Alabama's eligibility standards and available services, there are very few examples where those standards or services exceed the federal minimums. Likewise, even if those few exceptions were rolled back to the federal minimums, it is unlikely that any significant savings could be realized.

Medicaid Financing

In order to contemplate a reform of Medicaid, it is necessary to understand how the system is currently funded and where those funds are spent. In Fiscal Year (FY) 2012, total Medicaid expenditures were \$5.63 billion. The federal matching rate (the percentage of total funds provided by the federal government) was 67.4 percent with a corresponding state matching rate of 32.6 percent. To fund the \$5.63 billion program, a state match of approximately \$1.835 billion was required.

If all state match was derived from the General Fund, very few, if any, dollars would be left for other essential functions of state government. Over time, with the approval of the federal government, Medicaid has diversified its state match base (Table 4).

TABLE 4



In FY 2012, \$575 million was provided by the General Fund. An additional \$353 million was transferred to Medicaid from the tobacco tax and other state agencies to provide match for services delivered to their clients by Medicaid. In addition, \$65 million is returned to Medicaid as a rebate by drug manufacturers.

A very significant portion of the state match comes from the provider community in the form of provider assessments (taxes) and as a credit for unreimbursed cost for care provided to Medicaid patients at public hospitals.

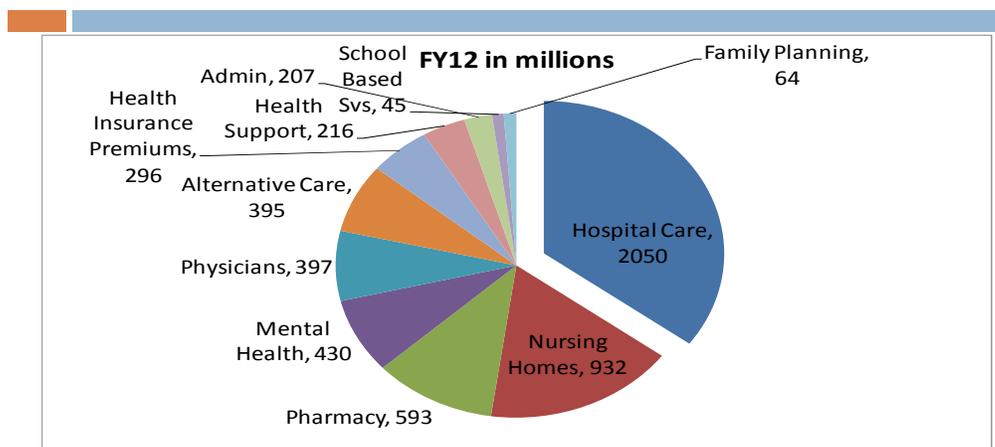
In 2012, Alabama's private hospitals paid a tax equivalent to 5.14 percent of net patient revenue. In FY 2013, that tax is estimated to yield \$243 million to be used as state share. The nursing home tax represents 6 percent of net patient revenue and is expected to yield \$105 million. Pharmacies pay a tax of \$0.10 per prescription, which provides approximately \$9 million available for match. In FY 2013, provider assessments are expected to yield over \$350 million available for state share, which, when combined with federal share, will fund over \$1.0 billion of care for Medicaid recipients.

In addition to the direct payment of provider taxes, hospitals contribute another essential component of state share, Certified Public Expenditures (CPEs). CPEs represent the unreimbursed cost of providing care to a Medicaid patient at a public hospital. The Centers for Medicare and Medicaid Services (CMS) allows the state to count and report that unreimbursed cost as a state expense. The federal government then reimburses the state the federal share (approximately 68 percent) of that unreimbursed cost. These funds are available to Medicaid to fund additional care. In FY 2012, CPEs provided just under \$500 million in state share. Because of this financing model (private hospital provider tax and public hospital CPE), Alabama funds its entire \$2.0 billion hospital program with no state General Fund dollars. The absence of money from the state General Fund in the hospital program has a significant impact on Medicaid reform options.

As noted above, Alabama used multiple sources to generate the \$1.835 billion needed for its state match to support a total Medicaid program of \$5.63 billion. The Alabama Medicaid Agency spends the majority of those funds in six program areas: hospitals, nursing homes, pharmacy, mental health, physician services, and alternative care (Table 5).

TABLE 5

Cost of Medicaid programs



Alternative care includes services such as home health, case management, maternity, and waiver services, such as home-based care instead of nursing home care. When analyzing those six major sites of expenditures, limitations on their restructuring become apparent.

Medicaid pays hospitals on a per diem basis for inpatient care and per encounter for outpatient care. As a result, as utilization increases at a public hospital, unreimbursed cost (CPEs) also increases. This creates additional funding opportunities for the hospital. The combination of CPE funding with episode-based payment discourages decreased hospitalization or improved coordination of care. Likewise, the Alabama Medicaid Agency has no financial incentive to drive change, since no money from the state General Fund is invested in hospital payments. Thus, no state General Fund money is saved if utilization is decreased.

The impact of provider assessments is not limited to the hospital program. While nursing homes receive in excess of \$900 million in annual Medicaid payments, through a provider tax of \$105 million they provide more than one-third of the Medicaid state share to fund the program. Likewise, more than one-third of the state share of pharmacy cost is covered by the pharmacy tax and drug rebates. In addition, many of the other services, such as mental health, home health, home and community-based waiver, etc., are supported at least in part by transfers from other state agencies. As a result, savings in those programs may have little or no direct effect on the Medicaid budget. Lastly, changes in federal law have limited flexibility in the physician program. Beginning January 1, 2013, all primary care physician payments are required by federal law to be increased to the Medicare rate. Fortunately, for the next two years, that increase is funded 100 percent by federal dollars.

While the Medicaid budget is heavily dependent on provider assessments and CPEs, each presents unique challenges. CPEs represent an estimate of unreimbursed cost for Medicaid patients at public hospitals. The estimate is based upon 2009 data adjusted for inflation. When the estimated CPE is reconciled to actual cost 2 to 3 years later, the opportunity for a significant state liability exists. If CPEs were overestimated and the federal funds drawn

down were overstated, then the state will be subject to a repayment demand. Alternatively, if the CPEs were understated and too little federal funds were drawn, then the state unnecessarily spent state funds. While the state may be able to recover the additional federal funds, their absence 2 years earlier may have created an avoidable funding challenge. In FY 2013, all of the hospital assessment (\$243 million) and a portion of the nursing home assessment (\$55 million) expire. If these assessments are not renewed, to maintain the existing Medicaid program an additional \$298 million from the General Fund will be required. To replace the funds provided directly or indirectly (CPEs) from the providers, over \$600 million in additional General Fund money would be required. Based upon the current Medicaid funding system, cooperation with the provider community is essential.

Cost Drivers

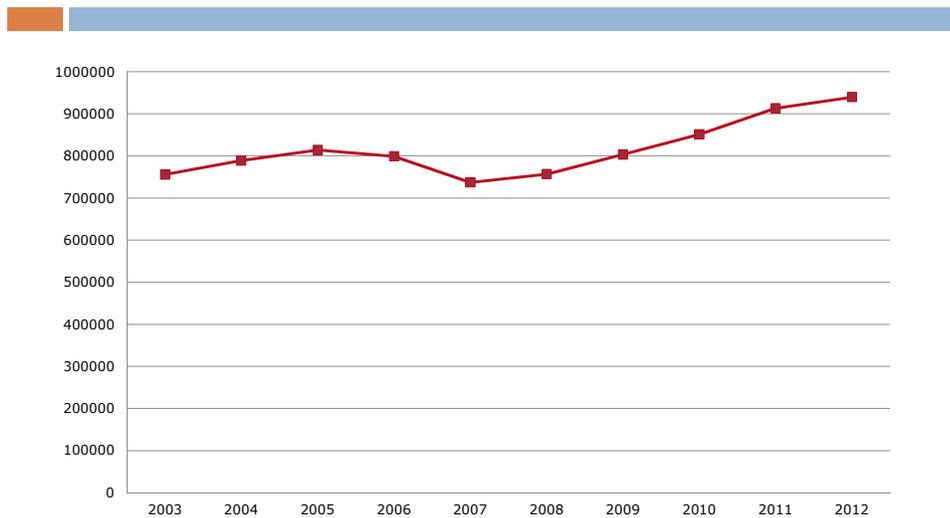
Over the last several years, Alabama has faced a growing demand by Medicaid on the General Fund budget. It has grown from 25 percent of General Fund in 2008 to 35 percent in 2013. There are five major cost drivers for Medicaid. They include enrollment growth, medical inflation, benefit changes, federal match rate changes, and utilization.

Table 6 shows Medicaid enrollment over the past decade. From 2003 to 2007, enrollment ranged from approximately 750,000 to 800,000. However, from 2008 to 2012, enrollment grew by almost 200,000, from 750,000 to 938,000. This increase in enrollment corresponded with the economic downturn experienced in both the national and state economies. This increase largely represented individuals who were previously not eligible for Medicaid but became eligible because of job loss or insurance loss. Most of this increase occurred among pregnant women and children, as evidenced by the growth in the proportion of births paid by Medicaid from 46 percent in 2003 to 53 percent in 2011. Clearly, the economy and its impact on enrollment has been a significant cost driver. Since Alabama must cover the federally-mandated populations, this driver is one over which the state has little direct control. However, as the economy

improves, the number of individuals eligible will decline with a potential lessening of demand on the General Fund. However, since the population that constitutes the greatest driver to the enrollment increase is among the least expensive, the savings may not be as great as might be expected solely based on the decline in enrollment.

TABLE 6

Enrollment Growth, 2003 -2012



Another potential cost driver is medical inflation. As shown in Table 7, national medical inflation from 2008 to 2012 has never been less than 2.5 percent.

TABLE 7

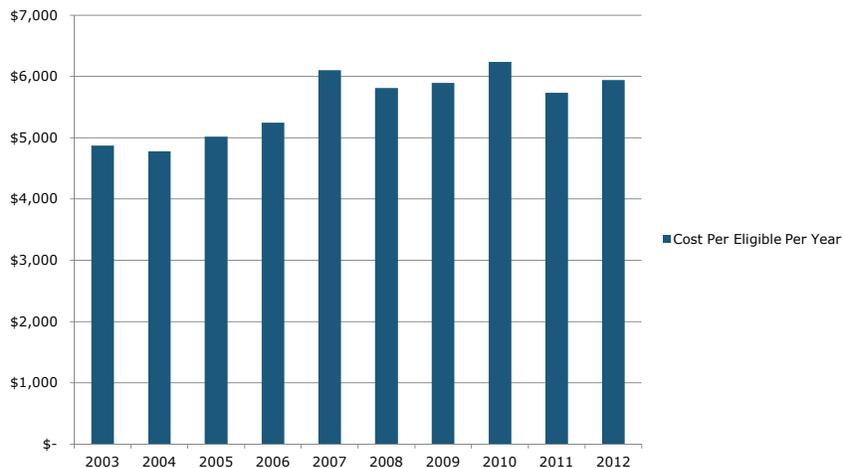
US Health Care Inflation



On the state level, Table 8 demonstrates per member per year (PMPY) Medicaid cost from 2003 to 2012.

TABLE 8

Alabama Medicaid PMPY, 2003 -2012

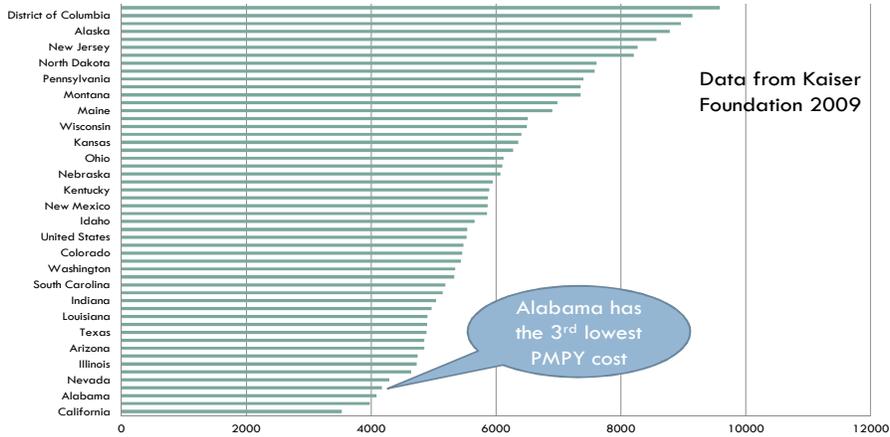


In 2003, the PMPY cost was \$4,872 and in 2012, it was \$5,941. This translates to an average annual inflation rate of 2.4 percent. When the cost increase for the period 2008 to 2012 is analyzed, the annual inflation rate for those 4 years is less than 1 percent per year. Thus, while monitoring medical inflation in Medicaid is always important, it appears that Alabama's Medicaid medical inflation rate has been less than the national medical inflation rate over the past 4 years.

A third potential cost driver would be a change in the benefits provided to Medicaid recipients. Over the past decade, Medicaid has not made significant changes to the benefits it provides. Therefore, it is unlikely that benefit design is a cause of the increasing demand on the General Fund. Table 9 demonstrates the lean financial structure of the current Medicaid program. This data was released by The Kaiser Family Foundation in 2012 and is based on a state-by-state comparison derived from 2009 data. In the analysis, Alabama had the third lowest spending per eligible per year. Only California and Georgia had lower costs. This should not be interpreted to suggest that Alabama has low cost due to efficiency, though that may be a partial answer. Alabama's low cost is also based on limited eligibility and more restricted services compared to other states that have more generous eligibility limits and richer benefit packages.

TABLE 9

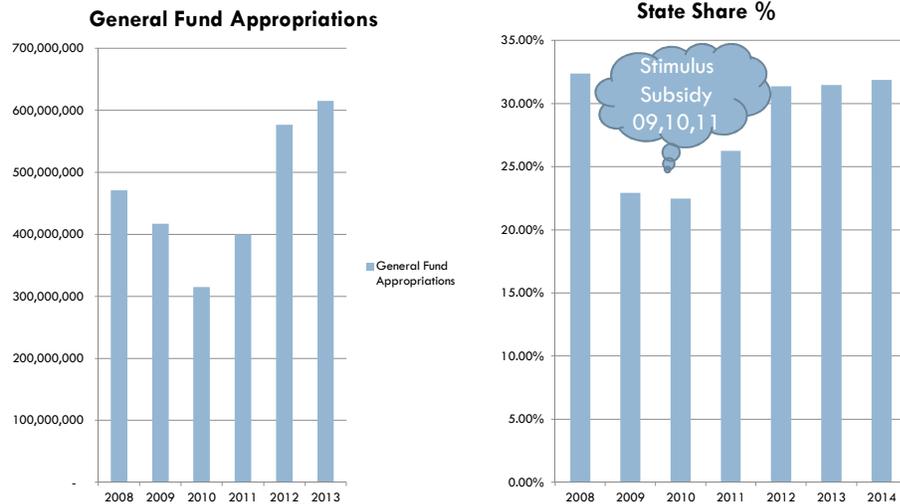
Alabama Has Third Lowest Cost Per Eligible



The fourth possible cost driver is a change in the Federal Medical Assistance Percentage (FMAP) (Table 10). FMAP is the percentage of total Medicaid spending in Alabama paid by the federal government.

TABLE 10

General Fund Appropriations Have Grown With Loss of Stimulus Subsidy



In 2008, the FMAP rate was about 68 percent and the General Fund appropriation was \$472 million. At that time, there were 750,000 eligibles in Medicaid. With the onset of the recession, federal stimulus funds were provided to Alabama from 2009 to 2011. As a result, the federal matching rate went from 68 percent in 2008 to 78 percent in 2010 and 74 percent in 2011. Despite growing enrollment, General Fund spending on Medicaid declined in 2009 and 2010. By 2010, with 850,000 enrolled, the General Fund requirement had fallen to \$310 million caused by the increase in FMAP. However, as the stimulus funds ended and the FMAP declined, the General Fund requirement for Medicaid increased. By 2012, with FMAP returning to 68 percent, Medicaid's General Fund need was at \$575 million. The increased need for General Fund is exacerbated by the lack of a decline in enrollment. With an FMAP relatively stable at 68 percent and enrollment stable at 938,000, it is not surprising that Medicaid's General Fund need will remain elevated. The significance of the role of FMAP on General Fund requirements is highlighted by the situation projected for 2014. The FMAP is adjusted annually based upon the state's per capita income relative to the national average. In Alabama, because of an improvement in our per capita income, FMAP will decline in 2014 by 0.41 percent. While small, that change will require an additional \$22 million state dollars to obtain the same amount of federal dollars as was available in 2013.

Clearly, a significant driver for increased Medicaid costs is the interplay between a change in the FMAP and a change in enrollment. While the increase in FMAP is initially helpful to the state, the return of the FMAP rate to normal levels (68 percent) coupled with a sustained increase in enrollment has created a tidal wave of demand on the General Fund. Unfortunately, neither of these factors are ones over which the state has control. Likewise, two other factors will have a negative impact on the General Fund in FY 2014. A Medicare Part B premium increase mandated by the federal government will cost about \$6 million more in state funds. In addition, the implementation of the health insurance exchange mandated by the Affordable Care Act will result in enrollment of an estimated 35,000 individuals already eligible but currently

unenrolled. This woodwork effect will cost an estimated additional \$7 million state dollars. Like FMAP and enrollment, these represent two additional factors over which the state has little control.

Fortunately, the last driver, healthcare utilization and coordination of care, may represent a cost savings opportunity over which the state can exact some control. As previously noted, the current hospital funding and payment system provides no incentives to decrease utilization, reduce length of stay, minimize emergency room use, or coordinate care. This is demonstrated in recent data reported by The Kaiser Family Foundation (Table 11).

TABLE 11

Total Hospital Utilization

Indicators per 1,000 Population	Alabama	United States	Percent Differential
Admissions	134	114	17.5%
Emergency Room Visits	482	411	17.3%
Inpatient Days	697	613	13.7%
Outpatient Visits	1,839	2,106	-12.6%

Source: Kaiser State Health Facts, 2010 data

Kaiser reported that in 2010, Alabama hospital admissions were 17.5 percent higher than the U.S. average and inpatient days were 13.7 percent greater. Likewise, emergency room visits were 17.3 percent higher and outpatient visits were 12.6 percent lower than U.S. averages. While decreasing hospital and emergency room utilization will not result in cost

savings in the current funding structure, as the hospital reimbursement system is modified and high-risk patients are case managed, decreased utilization will result in state savings.

WORK OF THE COMMISSION (Appendix 2)

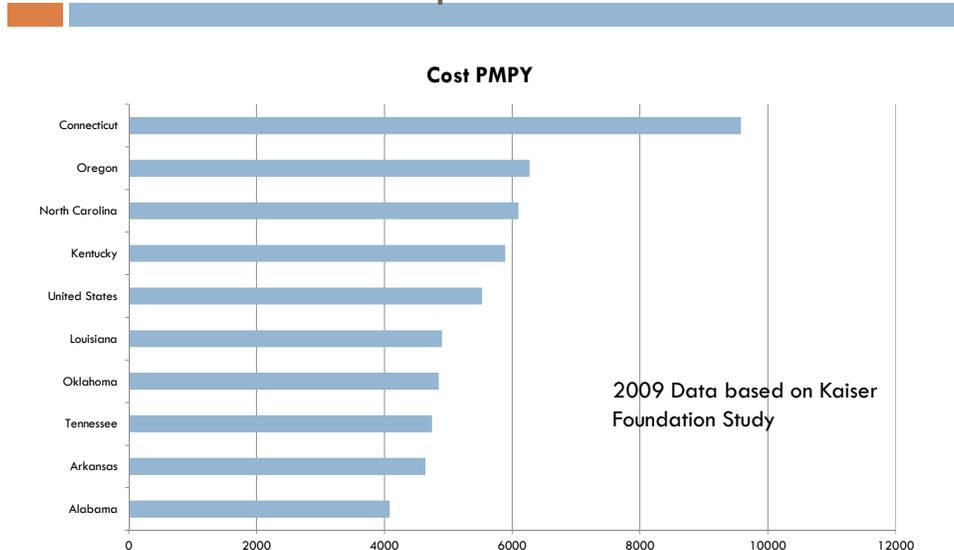
The Alabama Medicaid Advisory Commission met for the first time on November 1, 2012. That meeting provided an opportunity for an overview of the challenges facing the current program. During that meeting, the Executive Committee was selected and began the process of collecting input from interested parties and other states. The Executive Committee met four times by phone and in person before the next Commission meeting on December 12, 2012. During the first Executive Committee meeting on November 14, 2012, the Committee was presented information on two possible delivery system redesigns.

United Health Care, on behalf of commercial managed care companies, presented a vision for how that delivery system could save Alabama money and improve outcomes by improving the quality and coordination of care. Manatt Consulting presented an alternative model, which was developed for the Alabama Hospital Association. Rather than use a commercial managed care firm, Manatt proposed the development of regional care organizations that would be developed locally and governed by the local community and the community providers. This proposal was based on an expansion of Medicaid's existing patient care networks both in geographic scope and administrative responsibility. Current patient care networks exist in four areas around Mobile, Opelika, Tuscaloosa, and Huntsville. Currently, these systems reimburse providers using the existing fee-for-service model. Patients at high risk are case managed to reduce hospitalization and emergency room visits. Currently, patient care networks cover children and the aged, blind, and disabled populations. They do not currently cover maternity patients, Medicare/Medicaid dual eligibles, pharmacy benefits, or long-term care benefits.

Over its next three meetings (November 28, December 6, and December 7, 2012), the Executive Committee heard presentations from officials in Louisiana, Kentucky, Tennessee, Oklahoma, Arkansas, Oregon, and Connecticut. A comparison of PMPY costs demonstrates that Alabama has lower costs than any of the states that made presentations (Table 12). During those presentations, information was provided by Kentucky identifying the problems associated with the very rapid implementation of a new delivery system. Both Tennessee and Louisiana shared their success with commercial managed care. Louisiana has a unique system where both managed care organizations and patient care networks were operating and competing with each other. Conversely, Oklahoma and Connecticut explained why they had chosen to abandon commercial managed care. Arkansas provided information on their new delivery system which does not use a managed care organization but relies on a very robust data analytics system to drive payment incentives and disincentives to improve outcomes. Oregon described their new delivery model based on community care organizations.

TABLE 12

Cost PMPY of States Commission Has Interviewed Compared to Alabama



At the next full Commission meeting on December 12, 2012, a representative of an existing Alabama patient care network made a presentation. After hearing this presentation and reviewing the work of the Executive Committee, the Commission asked Medicaid to use its actuary, Optumas, to develop financial scenarios for presentation at the next Commission meeting. Optumas was asked to present a comparison of the savings achievable by expanding the patient care networks statewide versus moving Alabama into statewide commercial managed care. For the purpose of the exercise, the covered populations were the same (both excluded the long-term care [LTC] and the waiver populations). Likewise, both models were expected to manage pharmacy costs through a pharmacy benefit manager (PBM). Since decreased hospital use does not reduce costs in the current system, and it is impossible to predict the design of a reformed hospital system, hospital savings due to decreased use were eliminated from the model. The Alabama Medicaid Agency worked with the actuary and the commercial managed care organizations over the intervening weeks to ensure consistency of data analysis.

On January 16, 2013, the Commission heard the results of the analysis conducted by Optumas (Appendix 3). Optumas presented 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 patient care network and the managed care organization analysis were compared. It should be noted that removing the LTC and waiver population reduces total baseline cost by almost 50 percent. This highlights the need for a future examination of those services.

The expanded patient care network, including the same populations in the baseline and with the implementation of a PBM, was 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 (Table 13).

TABLE 13

Savings Comparison between Baseline and Optumas PCCM and MCO Scenarios				
	PCCM Total Savings (FFS)	PCCM State Share Savings (FFS)	MCO Total Savings	MCO State Share Savings
SFY14	\$83m - \$151m	\$27m - \$49m	\$142m - \$165m	\$46m - \$53m
SFY15	\$88m - \$180m	\$28m - \$58m	\$143m - \$181m	\$46m - \$59m
SFY16	\$88m - \$207m	\$29m - \$67m	\$174m - \$220m	\$56m - \$71m
SFY17	\$95m - \$218m	\$31m - \$71m	\$182m - \$259m	\$59m - \$84m
SFY18	\$102m - \$230m	\$33m - \$75m	\$189m - \$299m	\$61m - \$97m
State Savings with Current Funding		\$148m - \$320m		\$268m - \$364m

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While these models represent potential savings, there were other revenue concerns raised during the discussion (Table 14).

TABLE 14

Potential Funding Issues		
	PCCM State Share Savings (FFS)	MCO State Share Savings
Total Savings	\$148m - \$320m	\$268m - \$364m
Impact of Pharmacy Assessment	<i>\$(49)m</i>	<i>\$(49)m</i>
Impact of Hospital Assessment		<i>\$(1,343)m</i>
Adjustment for Hospital Savings	<i>\$(15)m - \$(84)m</i>	
One Time IBNP Cash Flow Impact*		<i>\$(78)m</i>
45 Day Capitation Delay**		<i>\$107m</i>
MCO Premium Tax		<i>\$563m</i>
1115 Waiver	??	??
Expenditure Cap	??	??

* Per Mercer's Analyses
** Will be a savings in SFY14-SFY18 but a cost in SFY19

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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 requires 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 (Appendix 4). 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.

The meeting included robust discussion on the Optumas analysis and a brief presentation from a commercial managed care organization representative. Following discussion, the Commission approved by voice vote, with only one dissent, a recommendation that the state be divided into regions; that the patient care networks 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.

The Commission also 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 adequate flexibility to impose adjustments 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 or catastrophic health events that could dramatically increase the Medicaid rolls or budget.

Another issue briefly discussed at the Commission meeting 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. 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.

COMMISSION RECOMMENDATIONS

1. Alabama be divided into regions and that a community led network in each region coordinate the health care services of the Medicaid patients in that region. Regional care networks will formally engage consumer input and oversight at all levels of governance and operation.
2. The expanded regional patient care networks become risk-bearing organizations.
3. Regions may choose to contract with a commercial managed care organization to provide care, risk management, or other services in the region.
4. The Legislature where appropriate, and Medicaid where administratively possible, shall authorize regional care networks throughout the state and establish an implementation timeline. Specific benchmarks shall be set that must be met by the networks. Failure to meet the benchmarks shall authorize state intervention.
5. The Alabama Medicaid Agency should seek an 1115 waiver from CMS to implement the transformation to managed care.
6. Legislation should be developed to create a Medicaid cap, provided that the legislation ensures adequate flexibility for the Alabama Medicaid Agency to address federal mandates, rules, and regulations; economic uncertainty; catastrophic health events; and provider rates.

7. Because of the essential role of provider assessments in funding the state share of the Medicaid program, the Commission encourages the renewal of the hospital and nursing home provider assessments.
8. Because of the complexity of the CPE, the lack of transparency in its calculation, and the potential future liability created by its use, the Commission recommends the Alabama Medicaid Agency work with CMS to convert some or all CPEs to intergovernmental transfers (IGTs) to provide funding for the hospital program.
9. Because the current hospital system, by paying per diem and per encounter, encourages utilization rather than coordination of care, the Commission encourages the Alabama Medicaid Agency to explore changing the current hospital payment methodology to a system that pays for outcome, such as the All Patient Refined Diagnosis Related Group (APR-DRG). Any such change should consider the uniqueness of maternal and child health patients who are high users of outpatient services.

In addition:

1. The Commission strongly supports efforts to identify and punish fraud and abuse in the Medicaid program.
2. Because of the significant portion of Medicaid expenditures excluded from consideration when LTC and waiver populations are excluded, the Commission strongly supports the efforts of provider organizations that will in the near future develop programs for coordination of LTC and waivers.

Appendices

EXECUTIVE ORDER NUMBER 35

WHEREAS, a financially sustainable Alabama Medicaid Agency is a paramount priority of this administration;

WHEREAS, the Alabama Medicaid Agency is the largest recipient of General Fund dollars;

WHEREAS, the Alabama Medicaid Agency provides the aged, the blind, disabled and low income children and families in Alabama access to critical health care services;

WHEREAS, the current financing structure of the Alabama Medicaid Agency is unsustainable due to high and rising health care costs;

WHEREAS, a solvent Alabama Medicaid Agency is necessary for maintaining access to essential services; and,

WHEREAS, the State has an opportunity to more efficiently support quality health care services while helping ensure the long-term sustainability of the Alabama Medicaid Agency for those who need it.

NOW, THEREFORE, based upon these considerations, and for other good and valid reasons related thereto, I Robert Bentley, Governor of the State of Alabama, by virtue of the authority vested in me by the Constitution and laws of the State of Alabama, do hereby establish the Alabama Medicaid Advisory Commission (the "Commission"). The Commission is created to make recommendations to the Governor prior to the 2013 Regular Session of the Alabama Legislature.

The Commission shall consist of:

1. The State Health Officer shall serve as Chair for the Commission;
2. The Chairman of the Permanent Joint Legislative Committee on Medicaid Policy;
3. The Vice-Chairman of the Permanent Joint Legislative Committee on Medicaid Policy;
4. The Commissioner of Mental Health, or his or her designee;
5. The Finance Director, or his or her designee;
6. The Speaker of the House of Representatives, or his designee;
7. The Senate President Pro Tempore, or his designee;
8. The Commissioner of the Alabama Department of Senior Services, or his designee;
9. Three members representing physicians including the appointment of two practicing physicians by the Medical Association of the State of Alabama, and the appointment of one practicing pediatrician by the Alabama Chapter - American Academy of Pediatrics;
10. One member representing dentists appointed by the Governor;
11. One member representing for-profit insurers appointed by the Governor;
12. One member representing not-for-profit insurers appointed by the Governor;
13. One member representing the business community appointed by the Governor;

14. One member representing consumers appointed by the Governor;
15. One member who shall be a registered pharmacist and engaged in active retail pharmacy appointed by the Governor;
16. One member who shall be a Certified Registered Nurse Practitioner appointed by the Governor;
17. Two members appointed by the Alabama Nursing Home Association;
18. Three members appointed by the Alabama Hospital Association, of which one shall represent a for-profit facility, one shall represent a non-profit facility, and one shall represent a rural facility;
19. One member to represent both the Alabama Primary Health Care Association and the Alabama Rural Health Association;
20. One member representing the hospice community appointed by the Governor;
21. One member representing the dialysis care community appointed by the Governor;
- and
22. Additional members as the Governor deems necessary.

All appointments by the Governor shall serve at the pleasure of the Governor.

BE IT ORDERED that the Chairman of the Commission may create an executive committee of no more than 10 members, including no more than one member from each chamber of Alabama Legislature, and any advisory committees that may be needed consisting of stakeholders related to the development of options for reforming the Alabama Medicaid Agency.

BE IT FURTHER ORDERED that the Commission shall adopt rules governing times and places for meetings and the manner of conducting its business. The Commission shall not meet less frequently than twice prior to rendering the recommendation to the Governor. The Commission, and any committee of the Commission, may meet via teleconference. All Commission members shall serve without compensation.

BE IT FURTHER ORDERED that the Commission shall study the options for reforming the Alabama Medicaid Agency and shall make written recommendations to the Governor. The recommendations shall address, at a minimum, the following: (i) an analysis of the financial needs of the Alabama Medicaid Agency; (ii) a long-term, sustainable financing model that meets budget limits on Medicaid spending; (iii) new care delivery models that support quality care and cost control ; and (iv) an analysis of any potential methods of increasing transparency and fairness in the system. These recommendations shall be presented to the Governor by January 31, 2013, in order that any required legislation is prepared for consideration during the 2013 Regular Session of the Alabama Legislature.

BE IT FURTHER ORDERED that this Executive Order become effective immediately upon signing and shall remain in force until such time as it is modified or rescinded by the Governor.

DONE AND ORDERED this 25 day of October, 2012.



Robert Bentley

Robert Bentley
Governor

Attested

Beth Chapman

Beth Chapman
Secretary of State

Alabama Medicaid Advisory Commission

State:

Dr. Don Williamson - State Health Officer, Commission Chair *

Representative Greg Wren *

Chairman of the Permanent Joint Legislative Committee
on Medicaid Policy

Senator Greg Reed *

Vice-Chairman of the Permanent Joint Legislative Committee
on Medicaid Policy

Jim Reddoch – Commissioner, Alabama Department of Mental Health

Dr. Marquita Davis – State Finance Director *

Representative Ed Henry - Speaker of the House or designee

Senator Arthur Orr – President Pro Tempore or designee

Neal Morrison, Commissioner, Alabama Department of Senior Services

Medical Association of the State of Alabama (MASA):

Dr. George Smith - (Family Practice) *

Dr. Ted Catranis - (OB-GYN)

Dr. Michael Ramsey- (Pediatrician)

For-Profit Insurers:

Kyle Godfrey - United Healthcare Gulf States

Not-For-Profit Insurers:

Tim Vines - BlueCross/BlueShield

Consumer:

Jim Carnes - Alabama Arise *

Pharmacy:

Danny Cottrell - Retail Pharmacist *

Alabama Nursing Home Association:

Frank Brown - USA Healthcare *

Richard Brockman - Johnston Barton

Alabama Hospital Association:

Stan Hammack (non profit) USA Health System *

Jeff Brannon (for profit) Community Health System

Barry Cochran (rural) Fayette Medical Center

Alabama Primary Health and Rural Association:

Mary Finch

Alabama State Nurses Association:

Charlotte Wynn

Hospice Care:

Linda Segrest - President, Alabama Hospice Association

Dialysis Care:

Dr. Melanie Halvorson – Vice Chair, Chronic Kidney Disease Task Force

Dental:

Dr. Hiram Johnson

Other:

Jeff Parker - Sarrell Dental

Mike Warren - Children's Hospital *

Jessica Monroe – Johnson & Johnson

Representative Laura Hall

Graham L. Sisson, Jr. – Governor's Office on Disabilities

Brigadier General Edward F. Crowell

Carl T. Jamison, Jamison Money Farmer, PC

Representative Jim McClendon

** Denotes Executive Committee Members*

MINUTES OF THE ALABAMA MEDICAID ADVISORY COMMISSION
NOVEMBER 1, 2012
ALABAMA STATE CAPITOL, OLD ARCHIVES ROOM

Members Present

Donald E. Williamson, M.D., Chair
Mr. Jeff Brannon
Mr. Richard Brockman
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 Hammock
Representative Ed Henry
Mr. Hiram Johnson

Mr. Neil Morrison
Senator Arthur Orr
Mr. Jeff Parker
Mike Ramsey, M.D.
Mr. Jim Reddoch
Senator Greg Reed
Ms. Suzanne Respass for
 Mr. Mike Warren
Ms. Linda Segrest
George "Buddy" Smith, Jr., M.D.
Mr. Tim Vines
Representative Greg Wren
Ms. Charlotte Wynn

Members Absent

Mr. Frank Brown
Ms. Jessica Monroe

Welcome by Governor Robert Bentley

Governor Robert Bentley welcomed the group and expressed his appreciation to those willing to assist with the important issue of Medicaid and expressed his appreciation to Dr. Williamson for his work over the last few months and his work on the 2012 and 2013 budgets.

On October 25, 2012, Governor Bentley signed the Executive Order to bring all stakeholders, participants, and those involved in Medicaid together to provide him with recommendations that would address an analysis of the financial needs of the Alabama Medicaid Agency; a long-term, sustainable financing model that would meet budget limits on Medicaid spending; new care delivery models that would support quality care and cost control; and an analysis of potential methods to increase transparency and fairness in the system. Recommendations are to be provided to Governor Bentley by January 31, 2013, in advance of the 2013 Legislative Session.

Introduction of Commission Members

Commission members and the organizations represented were introduced.

Presentation of the Issue

Dr. Williamson stated that an inordinate amount of time had been spent determining how to fund Medicaid and generating the common set of identifiable problems, identifiable facts about growth, and identifiable facts about enrollment. Dr. Williamson stated that the transition of Medicaid would be a multi-year process and the Commission would assist in drafting the

roadmap for the transition. Discussions need to occur regarding changes in funding, payments, and the delivery system.

Dr. Williamson presented information on Medicaid expenditures, sources and uses of funding, a summary of the current financing system, reasons for change, enrollment, issues with the delivery system, hospital utilization, barriers in access to care, a project by the Alabama Hospital Association, the mission of reform, the goals of a reformed system, options for reform, financing reform, issues in payment and financing reform, issues in delivery system reform, the dual eligible population, and the charge to the Commission.

Dr. Williamson noted that a web page had been established on the Medicaid Agency's Web site so that minutes, handouts, work papers, and other documents could be posted. Additionally, an e-mail address was created for ideas, thoughts, concerns, and issues to be shared. The e-mail address is medicaidcommission@medicaid.alabama.gov.

Representative Wren commented on the unique opportunity of working in partnership with the Governor's Office, Dr. Williamson, and the Legislature. Representative Wren stated that while the state appropriation of \$613 million comes from the General Fund, Medicaid represents one-third of the state's share costs and represents 35 percent of all General Fund dollars collected by the state. Of the 4.8 million people in Alabama, 940,000 are on Medicaid. The population of Alabamians not on Medicaid, 3.7 or 3.8 million, depends on the Legislature to be accountable for the entire state's budget. The budget has increased from \$278 million to \$613 million over a 12- to 13-year period. The system must be rebuilt with a financing and delivery system that is sustainable.

Dr. Williamson stated that if Medicaid was matched as intended by the federal government, all of the General Fund would be appropriated to Medicaid, with no appropriations for Corrections, Public Health, or Mental Health.

Senator Reed advised that Medicaid, and the decisions that would be made, would have an effect on every Alabamian due to Medicaid's support of the health delivery network. The research and work that would be done by the Commission would be essential to decisions that would be made in the future.

Comments from Committee Members

Mr. Carnes stated that those who did not have Medicaid coverage were seeking and obtaining care, with the expense falling across the system. The Commission would need to review the savings that would come from offsetting uncompensated care. Dr. Williamson made reference to disproportionate share hospital payments, which is a part of uncompensated care, and agreed that this needed to be reviewed.

Appointment of the Executive Committee

As allowed by the Executive Order, Dr. Williamson appointed ten members to the Executive Committee. The following members were appointed: Mr. Frank Brown, Dr. Buddy Smith, Mr. Stan Hammock, Mr. Danny Cottrell, Dr. Marquita F. Davis, Representative Greg Wren, Senator Greg Reed, Mr. Jim Carnes, and Mr. Mike Warren.

Dr. Nancy Dunlap, who is with the School of Public Health in the new Alabama Health Policy Initiative, was assigned by the Governor's Office as staff and advisor to the Commission.

Dr. Dunlap is a Robert Woods Johnson Health Policy Fellow and will bring a lot of expertise to the Commission. She will be available to the Commission full-time in January.

Closing Comments

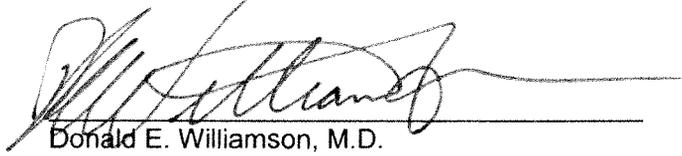
The Executive Committee must decide between commercial managed care and patient care networks. In order for the Executive Committee to understand the advantages of each one, the Alabama Hospital Association's consultant will make a presentation at the first meeting of the Executive Committee, as will a group of commercial managed care plans. In the interim, actuaries will work with the Alabama Hospital Association on the transition from per diem to diagnosis related groups and whether this would be possible. Additionally, conversations will continue regarding intergovernmental transfers versus certified public expenditures.

Next Meeting Date

The Commission will meet again in December and once or twice in January.

The Executive Committee will meet on Wednesday, November 14, from 2 to 4 p.m., in the Board Room of the Alabama Department of Public Health. The Executive Committee meetings will be public and will be in person or via conference call every other week until the end of December, then weekly during the month of January.

There being no further business, the meeting was adjourned.



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

**MINUTES OF THE ALABAMA MEDICAID ADVISORY COMMISSION
DECEMBER 12, 2012
MONTGOMERY CITY HALL AUDITORIUM**

Members Present

Donald E. Williamson, M.D., Chair	Ms. Jessica Monroe
Mr. Richard Brockman	Mr. Jeff Parker
Mr. Frank Brown	Mike Ramsey, M.D.
Mr. Jim Carnes	Senator Greg Reed
Ted Catranis, M.D.	George "Buddy" Smith, Jr., M.D.
Mr. Barry Cochran	Mr. Courtney Tarver representing
Mr. Danny Cottrell	Mr. Jim Reddoch
Dr. Marquita F. Davis	Mr. Tim Vines
Ms. Mary Finch	Mr. Mike Warren
Mr. Stan Hammack	Representative Greg Wren
Ms. Nancy Herndon representing	Ms. Charlotte Wynn
Mr. Kyle Godfrey	

Members Absent

Mr. Jeff Brannon	Mr. Carl Jamison
Brigadier General Edward F. Crowell	Hiram Johnson, D.M.D.
Representative Laura Hall	Mr. Neil Morrison
Melanie Halvorson, M.D.	Senator Arthur Orr
Representative Ed Henry	Ms. Linda Segrest
	Mr. Graham L. Sisson, Jr.

Consideration of Minutes

The minutes of November 1, 2012, were approved as distributed.

Discussion

The following information was provided to the Commission: a letter from Mercy Medical encouraging the Commission to continue to keep the Program for All-Inclusive Care for the Elderly in mind as a redesign of Medicaid was considered, a document from Alabama ARISE detailing core principles of consumer centered Medicaid reform, and the one-page summary document with the accompanying detailed document of the work of the Executive Committee regarding other states' managed care experiences.

Dr. Williamson noted that, as compared to other states, Alabama had the third lowest per member per year (PMPY) cost and among the most restrictive Medicaid programs in the nation. Additionally, all Medicaid programs were different and while there could be savings in Medicaid, he did not know the amount of state savings Alabama could

expect, but did not anticipate it being \$100 million. He further noted that Alabama had 940,000 Medicaid eligibles and spent just under \$5.6 billion. Alabama saw less than 1 percent annual inflation of PMPY during the last 4 to 5 years and had a significant growth in enrollment, which was driven by the economic downturn.

If Alabama's economy were to continue to improve, the Commission would need to determine the effect a decrease in unemployment would have on Medicaid. If Alabama's economy improved more rapidly than the national average, the federal medical assistance percentage, or FMAP, rate would decrease. As a result, Alabama would pay a higher match to receive the same funds.

Dr. Williamson suggested that an estimate of cost savings be requested from one or more commercial managed care companies and from Medicaid's actuary, if the existing patient care networks were to be expanded statewide. The net figures would be non-binding, would include the source of the savings, would be built upon the existing funding structure, would be based on the assumption that the Legislature would renew the provider taxes, would include whether or not the savings would be continual, would include the carve ins and carve outs of the population groups, would include qualitative goals, and would not include long term care in the core benefits.

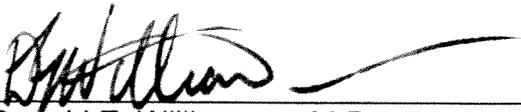
A motion was made and passed for Dr. Williamson to obtain the best comparisons allowed between the commercial managed care option and the community-based managed care option so that the Commission could have some level of fiscal comparison.

The Medicaid staff was charged with inviting no more than three commercial managed care companies to provide an estimate of cost savings. Additionally, the Medicaid actuary would provide an estimate of cost savings for expansion of the patient care networks.

The cost savings estimates would be provided to the Commission at its next meeting and if the Commission were in a position to make the decision regarding the state moving to commercial managed care, community-based managed care, or a hybrid of both, a discussion regarding the benefits of one model versus the other would occur and a vote would be taken. The next series of meetings would revolve around inclusions, exclusions, indicators to rate the plans, and risk transfer.

Adjournment

There being no further business, the meeting was adjourned.



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

**MINUTES OF THE EXECUTIVE COMMITTEE OF THE
ALABAMA MEDICAID ADVISORY COMMISSION
NOVEMBER 14, 2012
GORDON PERSONS AUDITORIUM**

Members Present

Donald E. Williamson, M.D., Chair
Mr. Frank Brown
Mr. Jim Carnes
Mr. Danny Cottrell
Dr. Marquita F. Davis

Mr. Stan Hammock
Senator Greg Reed
George "Buddy" Smith, Jr., M.D.
Mr. Mike Warren
Representative Greg Wren

Welcome by Dr. Williamson

Dr. Williamson welcomed the group and stated it was highly likely that Alabama would move to managed care in 2014, whether commercial managed care or community managed care. The change is necessary due to Alabama's current system being fragmented, there being too much hospital and emergency room utilization, and Alabama not having the appropriate incentives to ensure coordination of care. There were fundamental issues around the payment system, which was focused on paying for utilization, with the result being incentivized utilization. There were discussions regarding moving from a per diem to a diagnosis related group (DRG) model and ultimately looking at capitation. The revenue system would also require a fundamental revision. Alabama built a hospital funding system on certified public expenditures (CPEs), which were neither transparent nor simple and created an opportunity for future significant liability. Alabama would need to move from CPEs to something that would be understandable and transparent.

The Governor stated yesterday that he would not expand Medicaid under the current program; it would not be rational to add thousands more new people to a broken system.

Presentation by Manatt

Manatt, a consulting firm hired by the Alabama Hospital Association to work on health system reform from the hospitals' perspective, presented their perspective on how Alabama could begin transforming its healthcare system.

In summary, Manatt proposed putting all existing Medicaid beneficiaries into one single system, providing the existing three or four primary care networks with new tools and better data to manage care, and changing them from fee for service payment to capitated payment. Over time, the networks would evolve from non risk bearing entities to risk bearing entities so that they became community-based managed care entities

coordinating care for individuals. A new payment model, followed by a global cap, would be imposed.

To obtain the maximum benefit of this design, physicians, hospitals, pharmacy services, nursing home services, home health services, and the entire spectrum of Medicaid services would be coordinated by the community-based entities.

Manatt's proposal would be done in phases and would take two years for implementation.

Presentation of Commercial Managed Care Plans

United Healthcare presented information on commercial managed care plans. The presentation was a collaborative effort with feedback provided by Amerigroup, Amerihealth Mercy, Centene Corporation, HealthSpring, Meridian Health Plan, Viva Health, and Wellcare.

This proposal recommended restructuring the provider financing/payment model to allow Alabama to benefit from managed care savings by implementing a managed care organization-based capitated Medicaid program. The system should cover all populations and all services. At least three plans should be selected in a competitive process to provide member choice and create a competitive environment to drive health plan performance and reduce complexity for providers and state agencies. In addition, managed care organizations recommended that preference be given to entities that bid on a statewide basis with extra points in the scoring process.

The model could be built to Alabama's specifications and would take 12 to 24 months for implementation.

Tennessee, Texas, Kansas, New Mexico, New York, and New Jersey are implementing the model that was recommended for Alabama.

Discussion

In response to questions posed by Committee members, the managed care representatives provided the following additional observations:

Given Alabama's history of no real deep base of managed care, it may be reasonable to begin with a less ambitious integration as a first step, realizing less money would be saved, with an ultimate step being the addition of other populations at a later date - - if Alabama contemplated going in this direction.

The managed care approach, which would not be implemented overnight and would be implemented in phases, would be a paradigm shift not only for providers but also for the Medicaid Agency. The role of the Medicaid Agency would change fundamentally whether commercial managed care or community-based managed care was selected.

If Alabama shifted risk and capitulated an entity, the Medicaid Agency would move from paying bills to managing data and from performing the work to managing the companies that performed the work.

Either type of transformation of the Medicaid system would likely require an 1115 waiver; however, the waiver would be structured and written differently depending upon the type of managed care chosen.

The managed care companies proposed a commercial managed care plan that would be a turnkey operation built to Alabama's specifications rather than a community-based managed care plan that Alabama would have to grow and develop. The trade off would be that the commercial managed care organization would be paid the return investment whereas if Alabama developed the community-based managed care plan, those dollars would be saved by the state.

The commercial managed care organizations asserted that they would not restrict access and would offer the benefits that the state required as part of Medicaid, and therefore, they would not be allowed to eliminate certain benefits. They also could not pay providers less than Medicaid required them to pay providers and often times would pay providers more. Commercial managed care organizations would do profit sharing either by pay for performance or a shared savings model.

A key difference between patient care networks and managed care organizations is that patient care networks would not bear the risk that a managed care organization would bear. If patient care networks had a loss, the state would be responsible. Additionally, managed care organizations would provide more holistic case management whereas patient care networks would be more siloed to what would be of most interest to a particular group of providers.

The managed care companies assumed this model would be actuarially sound if Alabama changed the way it paid hospitals.

In response to questions posed by Committee members, Manatt provided the following additional observations:

Community-based managed care and commercial managed care increasingly demonstrated the kind of results important to Alabama. Commercial managed care is present around the country and succeeded in producing budgetary savings for states. In a number of states, it also significantly disenfranchised the provider communities creating, in certain situations, pockets of access vacuums as well as significant excessive or incremental costs to providers. The fundamental economics of the program would have to be addressed. The principles of managed care organizations have merit but the approach to implementing them would be challenging.

Alabama's Medicaid system is bare bones and the notion of shifting risk would be attractive on one hand and yet if it were simply a game of squeezing providers in a

relatively low cost per beneficiary world, it would be a no win proposition after a short period of time.

If the decision to change to commercial managed care was made in January 2013, implementation would not occur until June 2014. If community-based managed care were selected, it would be 2014 before the networks could be set up and functioning and it would be 2016 and 2017 before Alabama would be sharing risk.

Closing Comments and Next Meeting Date

The Executive Committee was not prepared to make a recommendation to the Commission at the conclusion of the meeting.

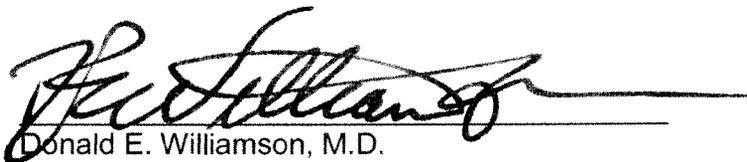
The next meeting of the Executive Committee will be held on Wednesday, November 28, at 2 p.m.

Dr. Williamson stated that he and Dr. Nancy Dunlap would obtain more information regarding the 1115 waiver since the waiver would be required, regardless of the direction that would be taken. Dr. Williamson indicated he would also follow-up with the actuary on information regarding how Wyoming's 1115 waiver was received by the Centers for Medicare and Medicaid Services.

At the next meeting, the Executive Committee will hear from state Medicaid programs that are in both models so the Executive Committee can make a recommendation to the Commission at the next meeting on December 7.

Information regarding DRG transformation may also be available for discussion at the next meeting.

There being no further business, the meeting was adjourned.



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

**MINUTES OF THE EXECUTIVE COMMITTEE OF THE
ALABAMA MEDICAID ADVISORY COMMISSION
NOVEMBER 28, 2012**

**VIA VIDEO CONFERENCE AND CONFERENCE CALL
MONTGOMERY, ALABAMA**

Members Present

Donald E. Williamson, M.D., Chair	Mr. Stan Hammack
Mr. Frank Brown	Senator Greg Reed
Mr. Danny Cottrell	George "Buddy" Smith, Jr., M.D.
Dr. Marquita F. Davis	Mr. Mike Warren
Ms. M.J. Ellington (representing Mr. Jim Carnes)	

Member Absent

Representative Greg Wren

Opening Comments

Since the last meeting of the Executive Committee, work was done on the 2014 Medicaid budget. Dr. Williamson indicated the federal medical assistance percentage (FMAP) rate for 2014 would decrease by .41 percent, which would translate to 22 million state dollars. Medicare Part B premiums would increase by approximately 6 million state dollars. Additionally, there would be issues regarding the impact of a woodwork effect, even without Medicaid expansion.

Dr. Williamson called attention to the recently released *Kaiser Commission Report on Medicaid and the Uninsured*, which contained information for years 2013-2022 and indicated the report would be made available on the Medicaid Agency's website.

Consideration of the Minutes of November 14, 2012

The draft minutes from the November 14 Executive Committee Meeting were made available to the Committee; however, a vote was not taken to accept the minutes. The minutes will be reviewed and discussed at the next meeting.

Experiences of Other States

Mr. Lawrence Kissner, Commissioner, Kentucky Department for Medicaid Services; and Ms. Ruth Kennedy, Medicaid Director, Louisiana Department of Health and Hospitals, shared their states experience with managed care and the lessons learned by their organizations.

Discussion of the Executive Committee

Regardless of whether Alabama selected a community-based managed care system or a commercial managed care system, it is likely someone would be asked to bear risk and would be capitated.

If commercial managed care was selected, implementation could occur a year earlier than with a community-based system; the network could potentially be less durable due to less buy in from the provider community; and funds would be moved out of state. If community-based systems were selected, implementation would take longer and would likely occur in 2016 or 2017; the network might be more durable because the providers would own the product; and funds would remain in state.

Dr. Williamson indicated he would schedule a conference call with Cindy Mann of the Centers for Medicare and Medicaid Services to determine if Alabama could apply for or obtain an 1115 waiver without a commitment to expand Medicaid under the current system. Alabama could consider moving a small portion of its population to managed care, but would not likely consider moving the dual eligible population or the nursing home population first.

Regardless of which method of managed care was selected, Alabama would first need to change its hospital reimbursement method from per diem to a diagnosis related group model, realizing that dual payment systems would exist for a period of time so there would be an incentive for hospitals to code correctly. Second, Alabama would need to change from certified public expenditures to intergovernmental transfers (IGTs). In the meantime, work could be done on the 1115 waiver. Changing the hospital reimbursement method and changing to IGTs would likely be Medicaid policy changes and State Plan Amendment changes.

The Medicaid Advisory Commission's report is due to Governor Bentley on January 31, 2013. Assuming the Executive Committee could make a recommendation regarding the managed care system before January 31, Dr. Williamson would like to provide the recommendation to Governor Bentley so the 1115 waiver process could begin. Dr. Williamson would also like to inform the Legislature during the 2014 budget discussion that Alabama had applied for a waiver that would help with the 2015 budget.

It was suggested that periodic updates on the work of the Commission be provided to the Legislature by Dr. Williamson.

Dr. Williamson reminded the Executive Committee that Dr. Nancy Dunlap would be available beginning January 1, 2013, and that her assistance on the 1115 waiver would be critically important.

The Committee indicated it was helpful to hear other states' experiences and indicated it would also be helpful if a summary or comparison could be done on each state that

presented, to include the positives and negatives, and the views of the provider communities. An inquiry could be made of each sister organization or provider community regarding the positives and negatives, actions they would do differently, access issues, savings (both real and aspirational), and the match. The responses could be sent to Dr. Williamson.

Next Meeting Date

In an effort to use the Executive Committee's time wisely, and to allow the Executive Committee to have as much information as necessary to make a decision, conference calls were scheduled for December 6 at 8:30 a.m., and for December 7 at 10:00 a.m., for the Committee to hear from Tennessee, Oklahoma, Arkansas, Connecticut, and Oregon.

There being no further business, the meeting was adjourned.



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

**MINUTES OF THE EXECUTIVE COMMITTEE OF THE
ALABAMA MEDICAID ADVISORY COMMISSION
DECEMBER 6, 2012
VIA CONFERENCE CALL**

Members Present

Donald E. Williamson, M.D., Chair
Mr. Richard Brockman (representing
Mr. Frank Brown)
Mr. Jim Carnes
Mr. Danny Cottrell

Dr. Marquita F. Davis
Senator Greg Reed
George "Buddy" Smith, Jr., M.D.
Mr. Mike Warren
Representative Greg Wren

Member Absent

Mr. Stan Hammack

Consideration of Minutes

The Executive Committee approved the Minutes of November 14, 2012, as distributed; the motion carried unanimously.

Experiences of Other States

Dr. Garth Splinter, Medicaid Director, Oklahoma Health Care Authority; and Mr. Darin Gordon, Medicaid Director, Tennessee Department of Human Services and Dr. Wendy Long, Chief Health Officer, Tennessee Department of Human Services shared their states experience with managed care and the lessons learned by their organizations.

Closing Comments and Next Meeting

The Executive Committee will meet by conference call on December 7, 2012, at 10 a.m., to hear from the states of Arkansas, Connecticut, and Oregon.

The Executive Committee will also meet on December 12, 2012, at 2 p.m. at the Montgomery City Hall Auditorium, prior to the full Commission meeting at 3 p.m., at the same location.

There being no further business, the meeting was adjourned.



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

**MINUTES OF THE EXECUTIVE COMMITTEE OF THE
ALABAMA MEDICAID ADVISORY COMMISSION
DECEMBER 7, 2012
VIA CONFERENCE CALL**

Members Present

Donald E. Williamson, M.D., Chair
Mr. Frank Brown
Mr. Jim Carnes
Mr. Danny Cottrell
Dr. Marquita F. Davis

Senator Greg Reed
George "Buddy" Smith, Jr., M.D.
Mr. Mike Warren
Representative Greg Wren

Member Absent

Mr. Stan Hammack

Experiences of Other States

Dr. Andy Allison, Director, Arkansas Medicaid; Commissioner Judy Mohr-Peterson, Division of Medical Assistance, Oregon Health Authority; and Ms. Kate McEvoy, Interim Director of Health Services, Connecticut Department of Social Services shared their states experience with managed care and the lessons learned by their organizations.

Discussion

As a result of a discussion with Ms. Cindy Mann of the Centers for Medicare and Medicaid Services (CMS), it was determined that expansion of the Medicaid population would not be an absolute requirement for contemplation of an 1115 waiver. There would be a number of reforms that CMS would support and there would be strong support to move away from certified public expenditures to intergovernmental transfers and for moving away from fee for service to diagnosis related group payment. Dr. Williamson indicated that when a decision was made regarding reform, staff could meet with CMS to determine the steps for implementation.

In order for an 1115 waiver to be granted, a massive transformation of the Medicaid system must take place and state match must be met. Alabama would need to research the funds that are spent on health services that are similar to Medicaid and to a Medicaid similar population.

If the Commission decided to apply for an 1115 waiver, it would require presentation to and approval by the Governor, submission to CMS, and negotiations with CMS. The waiver could be approved in June or July 2013, or it could take more than one year. Dr. Williamson stated he was concerned about securing the state match for the waiver.

Dr. Williamson stated that he would like for the Executive Committee to make a recommendation to the Commission on how to proceed, before the end of the year, recognizing that it may be necessary for some of the Executive Committee members to visit other states to talk with representatives of the hospitals, physicians, nursing homes, and the Medicaid program.

It was noted that Alabama had the second lowest per member per year expenditure in the country, based on 2009 data from the Kaiser Foundation. Changing the way funds are pulled down, changing the hospital payment mechanism, and changing the delivery model to improve care coordination and improve outcomes would not necessarily produce the savings hoped for, in the short term. Long term, improving care coordination would save money.

It was stated that part of Medicaid's growth was due to the change in the federal match rate. In the past, the match rate was artificially suppressed due to Hurricane Katrina and stimulus funds. When Alabama received stimulus funds, the match rate was 25 percent. The rate is currently 32 percent, which is more of a reality. Additionally, the cost of Medicaid increased 27 percent from 2008 to 2012 and this growth was driven by a corresponding 24 percent increase in enrollment. This increase was due primarily to the economy. If the economy were to improve, eligibility would slowly decrease and the demand on the General Fund would decrease. If Alabama's economy were to improve better than other states relative to the national average, the federal match rate would decrease and more state dollars would be demanded for the same federal dollars. In 2014, the federal match rate decreasing from 68.53 to 68.12 (.41 percent) will cost an additional \$22 million state dollars.

It was stated that Medicaid expansion could occur at any time; however, there is a deadline to receive the 100 percent match. Realistically, Alabama could consider transformation beginning in 2014, with the major implementations occurring between 2015 and 2016. The Commission will receive two independent economic analyses on expansion, upon completion.

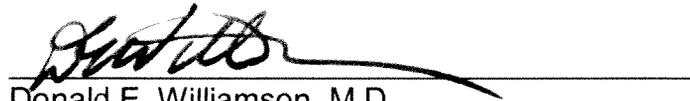
Even without expansion, the non elderly and non disabled working parents, pregnant women, and children will impact the federally facilitated health insurance exchange, Medicaid, and the Children's Health Insurance Program (CHIP). Effective January 1, 2014, all children between 100 percent and 133 percent of the Federal Poverty Level and currently covered by CHIP, will be transferred to Medicaid. The match rate will remain the same with the number of CHIP enrollees decreasing from 86,000 to 66,000.

The Kaiser report estimated that if Alabama did not expand Medicaid, Medicaid enrollment would increase by 58,000 by the year 2022 and the cost would be approximately \$199 million from 2014 to 2022.

Next Meeting

A representative from one of the four primary care networks in Alabama will present at the next meeting of the Executive Committee, which is scheduled for December 12, 2012, at 2 p.m. at the Montgomery City Hall Auditorium. The full Commission Meeting will follow at 3 p.m., at the same location.

There being no further business, the meeting was adjourned.

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

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

**MINUTES OF THE EXECUTIVE COMMITTEE OF THE
ALABAMA MEDICAID ADVISORY COMMISSION
DECEMBER 12, 2012
MONTGOMERY CITY HALL AUDITORIUM**

Members Present

Donald E. Williamson, M.D., Chair
Mr. Frank Brown
Mr. Jim Carnes
Mr. Danny Cottrell
Dr. Marquita F. Davis

Mr. Stan Hammack
Senator Greg Reed
George "Buddy" Smith, Jr., M.D.
Mr. Mike Warren
Representative Greg Wren

Welcome by Mayor Todd Strange

Mayor Todd Strange welcomed the Executive Committee to the newly renovated City Hall.

Consideration of Meeting Minutes

Approval of the minutes of the meetings of November 28, December 6, and December 7, 2012, was deferred to the next meeting of the Executive Committee.

Discussion

The following information was provided to the Executive Committee: a document entitled *All Market Medicaid Managed Care Grid* provided by AmeriGroup that listed each state and its relationship to commercial managed care and the one-page summary document with the accompanying detailed document of the work of the Executive Committee regarding other states' managed care experiences.

Dr. Williamson noted that since 2008, Medicaid's inflation rate had averaged less than 1 percent per year while there were major efforts in Medicaid reform in other parts of the country to reduce inflation from 6 percent to 3 or 4 percent. Alabama's baseline inflation rate of less than 1 percent creates a significant problem in terms of saving money going forward. Alabama's Medicaid per member per year (PMPY) cost is the third lowest in the country, behind only California and Georgia. Additionally, enrollment increased from 750,000 in 2008 to 940,000 in 2012. From 2003 to 2008 and before the economic downturn in 2008, enrollment remained at approximately 750,000 members. Finally, the federal medical assistance percentage (FMAP) rate changed dramatically and paralleled the General Fund appropriation. In 2009 and 2010, the state share was 22 percent; in 2011, it was 26 percent; in 2012, it was 32 percent; and in 2014, it will increase by one-half point.

The growth in enrollment, the relatively stable PMPY cost, and the change in FMAP created the financial crisis faced by the Commission.

Dr. Williamson referenced two reports: *Kaiser Commission on Medicaid and the Uninsured: The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis* and *Kaiser Commission on Medicaid and the Uninsured: Why Does Medicaid Spending Vary Across States: A Chart Book of Factors Driving State Spending*.

Experience of a Patient Care Network

Dr. Williamson noted that Alabama has a managed care like product in its four regional patient care networks, which are private non-profit care management organizations who have contracted with primary care providers and are in partnership with hospitals, social service agencies, and county health departments. The networks are charged with improving the health outcomes and reducing the care costs of the Patient 1st population.

Ms. Sylvia Brown, Executive Director of MedNet West, Inc., the Tuscaloosa region patient care network, provided information on the networks, described the organization of the networks, and answered questions from the Executive Committee.

Adjournment

There being no further business, the meeting was adjourned.



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



Alabama Medicaid Managed Care Options: PCCM and MCO Savings Analysis

Steve Schramm
Optumas, Managing Director

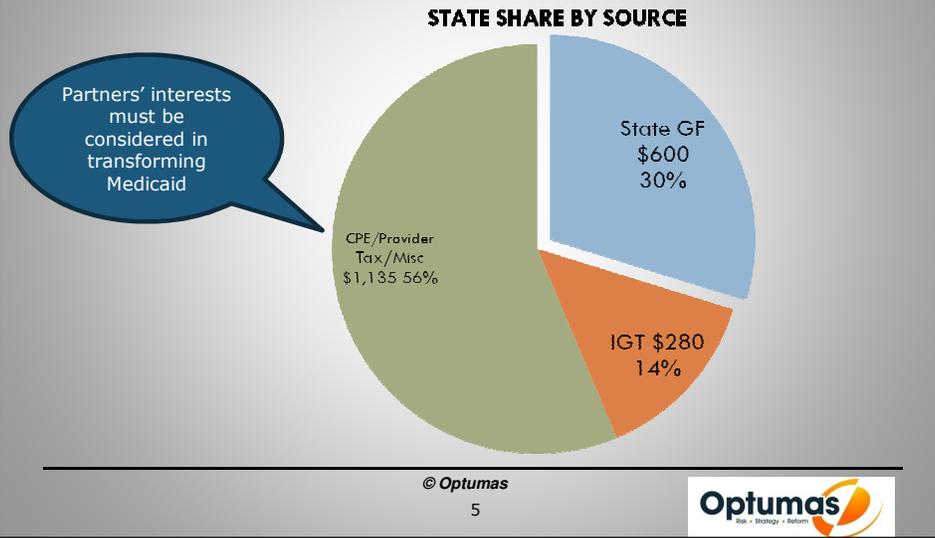
January 16, 2013

Goals of a Reformed System

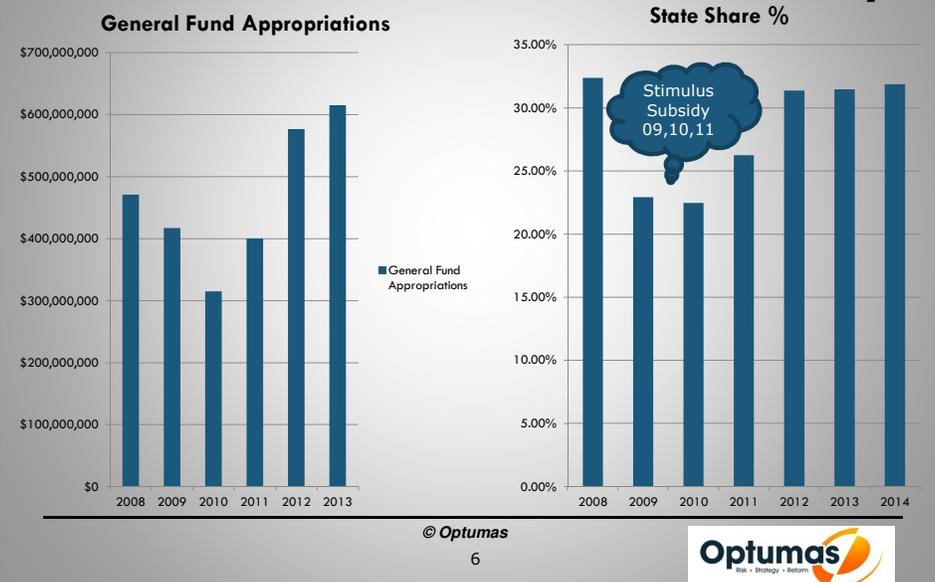
- Health Care System
 - Improve health outcomes through integrated care and better patient compliance
 - Reduce unnecessary hospital and ER visits
- Financial and Operational
 - Preserve and enhance provider contributions
 - Control and/or reduce cost
 - Reduce fraud and abuse of system
 - Shift payments from volume to accountability and outcome basis
 - Improve service and administration through improvement of data systems

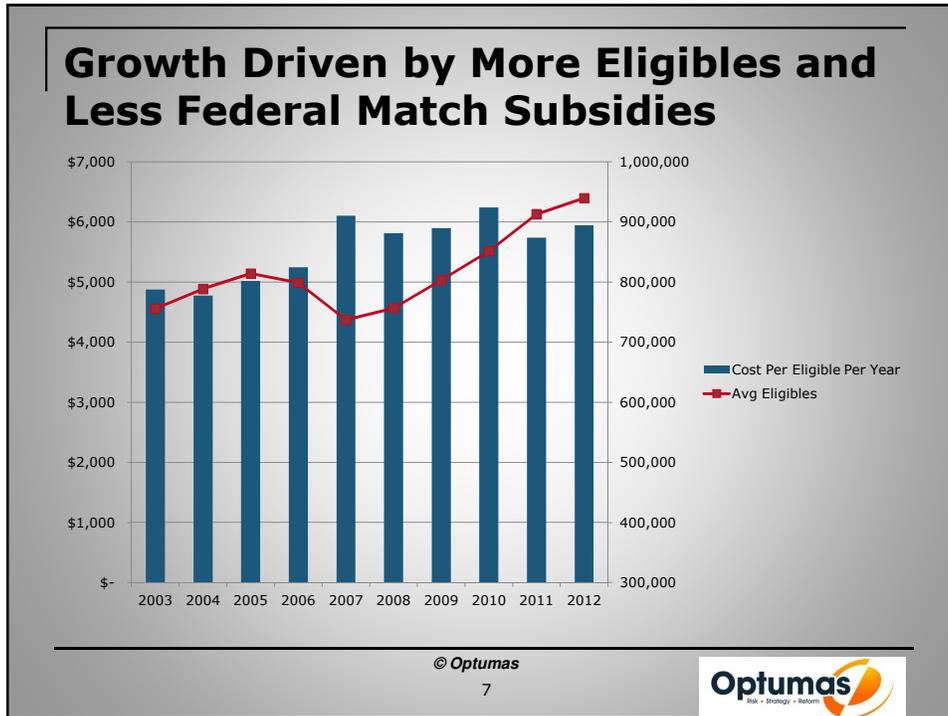


Current State-Share Funding Mechanisms (CMS Approved)



General Fund Appropriations Have Grown With Loss of Stimulus Subsidy





- ### Outline
- Scenario 1 – Fee-For-Service (FFS) is current Delivery System (Baseline)
 - Scenario 2 – Primary Care Case Management (PCCM) Statewide
 - Scenario 3 – Managed Care Organization (MCO) Statewide
 - Savings Comparison between Baseline and Scenarios
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Scenario 1 – Current Delivery System

- Maintains current delivery system and represents baseline scenario
 - PCCM in regions 1-4
 - FFS in regions 5-12
- Identified members eligible for PCCM program
 - \$0.50 PMPM for Non-Chronic members
 - \$8.50 PMPM to physicians for Chronic members and \$9.50 PMPM to network
- Base data was CY10 and CY11
- Accounted for enhancement payments and provider taxes

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Scenario 1 – Current Delivery System

- Incorporated adjustments for Incurred but not Reported (IBNR), maternity program change, trend and PCCM savings
- Includes State Administration of 1.7% of premium so that scenario can be directly compared to PCCM and MCO scenarios
 - Previously State Administration was 3.4% however a portion will remain regardless of the direction the State goes with the program
- Pharmacy rebates accounted for once savings are modeled

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Scenario 2 – PCCM Statewide

- Assumes PCCM expanded to regions 5-12 and to all Medicaid members Statewide

- Used same base data as Scenario 1
 - CY10 and CY11
 - Data adjusted for enhancement payments and provider taxes
 - Incorporated adjustments for IBNR, maternity program change, and trend
 - Pharmacy rebates accounted for once savings are modeled

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Scenario 2 – PCCM Statewide

- Incorporated impacts due to a PBM

- Incorporated impacts due to Statewide PCCM savings

- Includes State Administration of 1.7% of premium so that scenario can be directly compared to Current and MCO scenarios
 - Previously State Administration was 3.4% however a portion will remain regardless of the direction the State goes with the program

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Scenario 3 – MCO Statewide

- Assumes MCO established Statewide
- Used same base data as Scenario 1
 - CY10 and CY11
 - Data adjusted for enhancement payments and provider taxes
 - Incorporated adjustments for IBNR, maternity program change and trend
 - Pharmacy rebates accounted for once savings are modeled

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Scenario 3 – MCO Statewide

- Incorporated impacts due to a PBM
- Incorporated impacts due to Statewide MCO savings
- Includes MCO administration and profit so that scenario can be directly compared to Current and PCCM scenarios

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Total Baseline and State Costs (Excluding LTC and Waiver Populations)

	Total Baseline Costs	Total Baseline State Share
SFY14	\$2,796m	\$906m
SFY15	\$2,887m	\$935m
SFY16	\$3,004m	\$973m
SFY17	\$3,130m	\$1,014m
SFY18	\$3,261m	\$1,057m
TOTAL	\$15,078m	\$4,885m

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Savings Comparison between Baseline and Optumas PCCM and MCO Scenarios

	PCCM Total Savings (FFS)	PCCM State Share Savings (FFS)	MCO Total Savings	MCO State Share Savings
SFY14	\$83m - \$151m	\$27m - \$49m	\$142m - \$165m	\$46m - \$53m
SFY15	\$88m - \$180m	\$28m - \$58m	\$143m - \$181m	\$46m - \$59m
SFY16	\$88m - \$207m	\$29m - \$67m	\$174m - \$220m	\$56m - \$71m
SFY17	\$95m - \$218m	\$31m - \$71m	\$182m - \$259m	\$59m - \$84m
SFY18	\$102m - \$230m	\$33m - \$75m	\$189m - \$299m	\$61m - \$97m
State Savings with Current Funding		\$148m - \$320m		\$268m - \$364m

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PCCM and MCO Savings Drivers

■ PCCM Savings

- ❑ Mostly through incorporation of a PBM
- ❑ Also PCCM Savings from chronic populations
- ❑ Offset by increased non-medical load for PCCM fees

■ MCO Savings

- ❑ MCO Savings (Hospital, Pharmacy, and Lab/Rad)
- ❑ Offset by increased non-medical load
- ❑ Also offset by slightly higher trends

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Savings Comparison between Baseline and Optumas PCCM and MCO Scenarios

■ PCCM(+) and MCO(++)

- ❑ Inpatient – reduction in admits due to more integrated care management
- ❑ ER – lower intensity visits avoided due to more efficient patient management by physicians
- ❑ Outpatient – shift in utilization due to reduction in inpatient utilization
- ❑ PCP/FQHC/RHC – increase in utilization due to care management and shift in ER utilization; promotion of preventive services
- ❑ Rx – savings achieved through PBM

■ MCO(++)(in addition to above)

- ❑ Lab/Vision – savings achieved through aggressively managing specialty vendor
- ❑ Payment integrity program – to remove fraud/abuse

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Potential Funding Issues

	PCCM State Share Savings (FFS)	MCO State Share Savings
Total Savings	\$148m - \$320m	\$268m - \$364m
Impact of Pharmacy Assessment	\$(49)m	\$(49)m
Impact of Hospital Assessment		\$(1,343)m
Adjustment for Hospital Savings	\$(15)m - \$(84)m	
One Time IBNP Cash Flow Impact*		\$(78)m
45 Day Capitation Delay**		\$107m
MCO Premium Tax		\$563m
1115 Waiver	??	??
Expenditure Cap	??	??

* Per Mercer's Analyses
 ** Will be a savings in SFY14-SFY18 but a cost in SFY19



Sudha Shenoy FSA, CERA, MAAA
Principal

3560 Lenox Road, Suite 2400
Atlanta, GA 30326
+1 404 442 3249
sudha.shenoy@mercer.com
www.mercer.com

Ms. Kathy Hall
Deputy Commissioner
Alabama Medicaid Agency
P.O. Box 5624
Montgomery, AL 36103-5624

August 10, 2012

Dear Kathy:

The Alabama Medicaid Agency (AMA) asked Mercer Government Human Services Consulting (Mercer) to estimate the incurred but not paid (IBNP) claims liability as of September 2012, based upon data provided to Mercer related to particular claims experience. The IBNP reserve represents the outstanding claims the AMA would still have to pay if the program terminated because those claims have already been incurred prior to the termination or valuation date. This letter presents the results of Mercer's actuarial estimate of IBNP claim liability for the specific data provided by AMA as of September 2012. As this valuation was based upon data provided by AMA and not based upon Mercer's review of claims information, this valuation is an estimate based upon the data provided and should be used only for such purposes as appropriate based upon the data provided to Mercer. As the data has not been reviewed for completion or accuracy, it should not be used for financial reporting.

Data

AMA provided Mercer paid claims data from October 2007 through June 2012. In addition, they provided historical and projected eligibility data by month from October 1988 to March 2014. Claims and eligibility data between October 1, 2007 to June 30, 2012, was used to perform the IBNP analysis. We excluded supplemental payments outside of the MMIS system and excluded the certain fund codes in Fund Code Crosswalk.xls provided on July 27, 2012. Mercer grouped claims into different major service categories based on mapping provided by the State. The Hospital Care category was analyzed by separating it into Inpatient and Outpatient Hospital categories since they have different completion factors and to better reflect historical program changes.

Separate IBNP analysis was performed by the following eight major service categories:

- Inpatient Hospital Claims
- Outpatient Hospital Claims
- Physician Claims



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- Institutional Other Claims
- Nursing Home Claims
- Pharmacy Claims
- Family Planning Claims
- Other Claims

AMA has confirmed that all claim amounts shown as paid through June 2012, provided to Mercer, have been validated to match their internal claims systems for all service categories and for all years. While Mercer has not audited the data, Mercer has reviewed the data for reasonableness and consistency.

Mercer confirmed with AMA that the following fund codes were excluded from the analysis in addition to the fund codes excluded in the fund code crosswalk file provided by the state:

- 170-Medicare HMO
- 172-FP1115 WVR ED
- 173-FP1115 WVR DRG
- 215-FAM PLN-INST DYS
- 371-FP1115 WVR DYS
- 372-FP1115 WVR DYS
- 563-TELEMETRY MONITORING
- 956-REHAB EARLY INTERVENTION
- 744-Health Insurance
- 745-Family Planning
- 754-Family Planning
- 210-Other State Agencies



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Please note that the total annual Medicaid expenditures provided by the AMA to be used for this analysis for FY 2012 are approximately \$3,218,346,195. Based upon other information provided by AMA, it appears the total Medicaid budget within AMA is over \$5 billion. Although AMA specifically identified certain amounts to be excluded from this analysis, such as Medicaid programs funded in other agencies, Medicaid Disproportionate Share and supplemental payments, etc., we would like to also point out that other payments may not be included within this analysis, including but not limited to: Medicare Part D clawback payments, Medicare Part A and B premium assistance payments, other non-claims based payments and or amounts not provided to Mercer.

Methodology

In estimating the IBNP reserve for AMA, Mercer used generally accepted actuarial principles and practices. When claims patterns are stable, Mercer primarily used the lag development method. This method uses historical payment patterns to predict future payment amounts. In general, this method divides the amounts paid-to-date by a completion factor calculated using historical development patterns to estimate the incurred amount for a given month. The IBNP reserve for a particular month is the estimated incurred amount less the amount paid-to-date for that month.

Without additional run out, the most recent months' incurred estimates based on the lag development method may be unstable and lack sufficient credibility. Basically, this means that the lag development method is not always the best method to determine IBNP for the most recent months. To overcome the instability and credibility concerns, Mercer used a variety of projection methods to estimate the incurred amounts for the most recent months. These alternative projection methods include using an average PMPM based on the most recent completed months to estimate recent months' incurred PMPMs or adjusting the most recent months' PMPMs for seasonality. Such an adjustment would produce all or a significant portion of the claims incurred in recent months. Because claims incurred in recent months are a significant portion of the estimated IBNP, such adjustments have a material effect on the final resulting IBNP estimates.

Margin for Uncertainty

The estimated IBNP is a current estimate of a liability for which the ultimate amount will be known only after 18, 24, or even more months past the valuation date. We have considered the need for a margin for adverse deviation from the best estimate of IBNP. We have added a margin of 5-6 percent to the estimated unpaid claims for potential adverse deviation.

Drug Manufacturer Rebates

Mercer did not receive drug manufacturer rebates information from AMA. The pharmacy INBP was estimated based on the pharmacy claims data provided. Therefore, Mercer's estimate of INBP does not include a contra-liability for any outstanding pharmacy rebates receivable.

Claim Adjudication Expense for INBP Claims

Mercer did not include the claim adjudication expenses in the INBP estimates. The AMA may have additional liability for the administration of claims incurred but not paid as of the valuation date.

Inpatient and Outpatient Reimbursement Methodology Change

AMA changed the reimbursement methodology for inpatient and outpatient providers during the study period from capitation and encounter-based payments to FFS payments. Mercer made reasonable adjustments to the INBP methodology and estimates to account for and reflect these changes. Specifically, Mercer separated the inpatient triangle into two separate triangles to study completion factors before and after the switch from capitation to an FFS program in October 2010, and combined the INBP estimates from the two triangles. For outpatient claims, Mercer added an additional 1% margin to account for the effect of the transition from encounter payments to an FFS program.

Results

Mercer's calculation determined that the total INBP estimate as of the end of June 30, 2012 is approximately \$369 million, and as of September 30, 2012, it is approximately \$379 million.

The exhibits below provide additional detail on the INBP estimates, average monthly incurred claims, and the number of months that the INBP is equivalent to the average monthly incurred claims for each category of service.

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 Alabama Medicaid Agency

Estimated Alabama Medicaid Agency IBNP

IBNP as of September 30th, 2012

Category of Service	Average Incurred Amounts		Months of IBNP	Rounded IBNP
	Oct 2011 – Sep 2012			
Inpatient	\$65,527,764		2.249	\$147,000,000
Outpatient	\$10,765,843		1.846	\$20,000,000
Physician	\$34,890,380		1.433	\$50,000,000
Institutional Other	\$5,809,869		1.396	\$8,000,000
Nursing Homes	\$77,394,407		1.152	\$89,000,000
Pharmacy	\$45,091,773		0.415	\$19,000,000
Family Planning	\$2,095,882		1.541	\$3,000,000
Other	\$32,708,918		1.306	\$43,000,000
Total	\$274,284,836		1.383	\$379,000,000

IBNP as of June 30th, 2012

Category of Service	Average Incurred Amounts		Months of IBNP	Rounded IBNP
	Jul 2011 – Jun 2012			
Inpatient	\$63,152,830		2.203	\$139,000,000
Outpatient	\$11,887,959		1.504	\$18,000,000
Physician	\$34,530,498		1.453	\$50,000,000
Institutional Other	\$5,781,237		1.413	\$8,000,000
Nursing Homes	\$77,320,690		1.180	\$91,000,000
Pharmacy	\$44,357,783		0.398	\$18,000,000
Family Planning	\$2,055,247		1.447	\$3,000,000
Other	\$32,403,887		1.291	\$42,000,000
Total	\$271,490,131		1.359	\$369,000,000



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Alabama Medicaid Agency

Caveats

The IBNP estimates were prepared using generally accepted actuarial methods and procedures. The information presented in this report is based on actuarial assumptions and reasonable expectations, which represent our best estimate of anticipated experience based on the eligibility, claims and fund code crosswalk files provided by Alabama Medicaid Agency who has confirmed that all the data had been validated to match their internal claims systems.

All estimates are based upon the information available at a point in time, and are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely range of variability from the estimate. Any estimate or projection may not be used or relied upon by any other party or for any other purpose than for which it was issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use.

We are available to answer any questions on this material contained in this letter, or to provide explanations or further details, as may be appropriate.

Sincerely,

A handwritten signature in cursive script that reads 'Sudha Shenoy'.

Sudha Shenoy, FSA, CERA, MAAA
Principal

Copy: Ed Davidson, Alabama Department of Public Health
Chris McInnish, Alabama Medicaid Agency
Dr. Robert Moon, Alabama Medicaid Agency
Robert Butler, Mercer

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