PHPG

THE PACIFIC HEALTH POLICY GROUP

STATE OF ALASKA

Department of Health & Social Services

REQUEST FOR INFORMATION

MEDICAID COORDINATED CARE DEMONSTRATION PROJECT

SUMMARY OF RESPONSES FOR PUBLIC RELEASE

Prepared by the Pacific Health Policy Group

Funding Provided by the State Health and Value Strategies Program of the Robert Wood Johnson Foundation

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INTRODUCTION

The Alaska Legislature in 2016 undertook comprehensive Medicaid reform through enactment of Senate Bill 74 (SB 74), which Governor Walker signed into law on June 21, 2016. Among other provisions, SB 74 directs the Department of Health and Social Services (the Department, or DHSS) to contract with one or more third parties to implement Medicaid coordinated care demonstration projects for the purpose of improving quality, increasing value, and controlling spending. SB 74 requires that a Request for Proposals (RFP) for the first coordinated care demonstration project(s) be released by December 31, 2016.

Request for Information

DHSS issued a Request for Information (RFI) on September 15, 2016, seeking public input to inform the process for development of the RFP and the coordinated care demonstration projects. The RFI summarized the relevant provisions of SB 74, including other reform initiatives having the potential to affect, or be affected by, the coordinated care demonstration(s).

The RFI invited respondents to outline potential demonstration models that would advance SB 74's broad reform objectives and, in accordance with statutory language, include three or more of the following elements:

1. Comprehensive primary-care-based management for medical assistance services, including behavioral health services and coordination of long-term services and support;
2. Care coordination, including the assignment of a primary care provider located in the local geographic area of the recipient, to the extent practical;
3. Health promotion;
4. Comprehensive transitional care and follow-up care after inpatient treatment;
5. Referral to community and social support services, including career and education training services available through the Department of Labor and Workforce Development under AS 23.15, the University of Alaska, or other sources;
6. Sustainability and the ability to achieve similar results in other regions of the State;
7. Integration and coordination of benefits, services, and utilization management;
8. Local accountability for health and resource allocation; and/or
9. An innovative payment process, including bundled payments or global payments.

Pursuant to SB 74, proposals for demonstration projects must also include information demonstrating how the project will implement cost-saving measures, including innovations to reduce the cost of care for Medicaid beneficiaries through expanded use of telehealth for primary care, urgent care, and behavioral health services.

The RFI included a series of questions intended to elicit details on the potential demonstration models outlined by respondents. The questions covered the following topics:

- Organizational structure of the proposed model;
- Service area;
- Covered populations;
- Covered services;
- Payment methodology;
- Model opportunities for delivering accessible, high quality and cost effective care (e.g., through innovative approaches, person-centered/directed care, promotion of quality and improved outcomes);
- Alignment with other State initiatives (e.g., SB 74 behavioral health demonstration, tribal health delivery system and FMAP policy reforms, and the State's health information infrastructure/Health Information Exchange); and
- Implementation considerations, including major tasks, timelines and any state/federal actions necessary to support the model.

Respondents were cautioned that there will be no State funds available to support planning and development of proposed demonstration projects. The contracts established between DHSS and successful demonstration project organizations will be agreements to make policy, programmatic and system changes, including reimbursement changes, required by both parties to implement the proposed model.

The RFI submission instructions and questions are included in an appendix to this document. The full RFI is available at: http://dhss.alaska.gov/HealthyAlaska/Documents/redesign/CCDP-RFI-9-15-16-FINAL.pdf.

Review of RFI Responses

The Pacific Health Policy Group (PHPG) has been retained by DHSS, through a grant from the State Health and Value Strategies program of the Robert Wood Johnson Foundation, to assist in development of an RFP. As a first step in the process, PHPG prepared a summary of responses to the RFI. The information contained in the summary will be used to inform the content of the RFP.

RFI RESPONSES – OVERVIEW OF RECOMMENDED MODELS

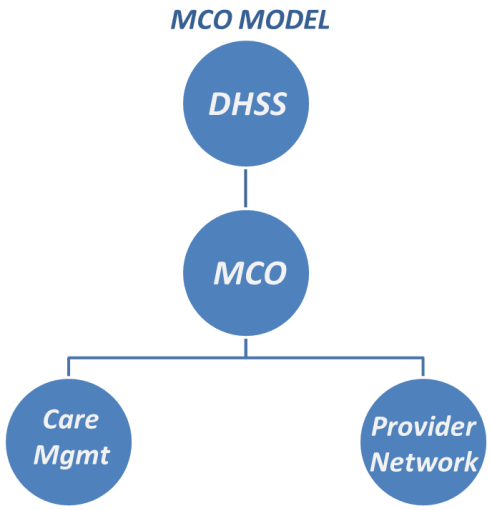
DHSS received twelve responses to the RFI. Ten of the respondents recommended specific demonstration models while two provided higher-level recommendations for DHSS to consider when developing the Request for Proposals.[1]

The responses were thoughtfully constructed and, in many instances, reflected development activities that were well underway at the time of the RFI's release. Respondents generally made a good-faith effort to address the specific questions in the RFI, which facilitated PHPG's review and documentation of similarities and differences in the recommended approaches.

The recommended models each had unique characteristics, as outlined in the next section. However, the responses outlining recommended approaches fell into three broad categories, any of which could constitute a care coordination model for the purpose of RFP development.

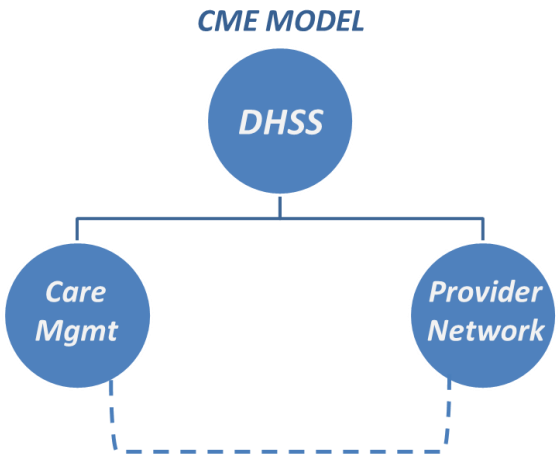
The categories[2] are:

1. **Managed Care Organization (MCO)** – Under this model, DHSS would contract with a licensed health insurer to enroll Medicaid beneficiaries and provide most or all Medicaid-covered services under a "capitated" arrangement whereby the MCO would receive a monthly per enrollee payment and assume financial risk for covered services.



2. **Care Management Entity (CME)** – Under this model, DHSS would contract with an administrative entity to perform care and disease management for Medicaid beneficiaries, either the total population or targeted segments, such as persons with complex/chronic conditions. The contractor would interact with Medicaid providers, particularly primary care providers, but would not develop provider networks.

[1] Responses to the RFI are confidential and not available to the public until after the State's procurement process is complete and the coordinated care demonstration project contract or contracts have been awarded.
[2] Category labels and descriptions are PHPG's and do not necessarily reflect the precise terminology used by particular respondents within the categories.



The contractor's payment would be tied to its ability to reduce expenditures versus what would have occurred absent its intervention. Under this model, financial risk could technically be borne by the contractor, if it assumed downside risk and only received payment in the event of demonstrated savings. Under this methodology, it would be incumbent on DHSS and its actuaries to ensure the "without intervention" expenditure projections are realistic and do not overstate what the Department would project to spend on the target population(s).

3. **Provider-Based Reform (PBR)** – Under this model DHSS would contract with one or more provider-sponsored organizations to perform care and disease management for Medicaid beneficiaries served through the organization's network. At a minimum, the network would include primary care (e.g., patient centered medical homes) but also could include specialty physicians, hospitals, behavioral health providers and ancillary services.

The contractor's payment could include a monthly per member fee intended to compensate providers for care management activities. It also could include financial risk arrangements similar to those described for the CME model. As with the CME model, DHSS and its actuaries would have to ensure the "without intervention" expenditure projections are realistic and do not overstate what the Department would be projected to spend on the target population(s).

RFI RESPONSES – KEY MODEL COMPONENTS

This section compares and contrasts the ten responses that offered specific model recommendations. A summary is provided for each of the following key components of the proposed care coordination models:

- SB 74 Elements Addressed
- Service Areas
- Covered Populations
- Covered Services
- Payment Methodology

SB 74 Elements Addressed

All of the recommended models identified themselves as addressing at least three of the program improvement elements outlined in SB 74; many suggested their approach would address all of the elements, including telehealth. While the relationship between the models and elements was more direct in some instances than others (e.g., the provider-based models clearly address the first element, which is "comprehensive primary care-based management"), it is reasonable to conclude that any of the models would meet the SB 74 "three element" threshold.

Exhibit 1 on the following page presents the elements addressed within each response. Respondents are identified as "Response 1" through "Response 10".

Exhibit 1 – SB 74 Elements Addressed by Recommended Models (Self-Reported)

SB 74 Elements[3]	Total (out of 10 Responses)	Response 1	Response 2	Response 3	Response 4	Response 5	Response 6	Response 7	Response 8	Response 9	Response 10
1. Comprehensive primary-care based management	9	●	●		●	●	●	●	●	●	●
2. Care coordination, including assignment of a primary care provider	10	●	●	●	●	●	●	●	●	●	●
3. Health promotion	9	●	●	●	●	●	●	●	●		●
4. Comprehensive transitional care and follow-up after inpatient treatment	8	●	●	●	●		●	●	●		●
5. Referral to community and social support services	8	●	●	●	●		●	●	●		●
6. Sustainability and the ability to achieve similar results in other regions of State	8	●	●	●	●		●	●	●		●
7. Integration and coordination of benefits, services and utilization management	9	●	●	●	●	●	●	●	●	●	
8. Local accountability for health and resource allocation	8	●	●	●	●	●	●	●	●		
9. Innovative payment process, including bundled or global payments	7	●	●		●	●	●	●	●		
10. Utilization of telehealth	8	●	●	●	●	●	●	●	●		
Total by Respondent		10	10	8	10	7	10	10	10	3	6

[3] Some elements have been abbreviated for spacing purposes. See report appendix for the unabridged listing.

Service Areas

Only one respondent, an MCO, recommended a statewide care coordination model. The challenge in implementing such a model was illustrated by the MCO's discussion of access standards for contractors. Consistent with standards in MCO programs in the lower 48 states, the respondent recommended adopting a 60 minute drive time to all provider types (physicians, hospitals, pharmacies, etc.) throughout rural Alaska.

CME respondents generally recommended that the program be initiated on a regional basis, with the focus on more populous portions of the State. One CME respondent stated that it could begin statewide, but it did not recommend such a course. All of the CMEs declared that the model could be expanded statewide over time.

The PBR respondents limited their proposals to the communities or regions in which their providers are based. The regional service areas appeared consistent with the concept of a "demonstration", or "pilot" project, as contemplated by the legislation.

Exhibit 2 presents a count of responses by service area for the start of the contract, as well as a count of potential service area expansions over time.

Exhibit 2 – Service Areas

Proposed Service Area	Total (out of 10 Responses)
Initial	
Anchorage only	4
Central Kenai Peninsula only	1
Ketchikan (and surrounding areas) only	1
Mat-Su only	1
Statewide or multi-community/region	3
Potential Expansion	
Statewide	3
Other (e.g., additional communities/regions)	3

Covered Populations

The RFI responses included a mix of covered populations, with several respondents proposing to serve all beneficiaries and others proposing to serve targeted groups, consistent with their care management systems. Respondents proposing to serve all beneficiaries were more likely also to recommend mandatory enrollment and to specify minimum enrollment thresholds, consistent with assuming financial risk. Specified minimum enrollment thresholds ranged from 500 to 50,000+.

Exhibit 3 presents a summary of the Medicaid populations each respondent proposed to serve.

Exhibit 3 – Covered Populations

Covered Population Components	Total (out of 10 Responses)	Response 1	Response 2	Response 3	Response 4	Response 5	Response 6	Response 7	Response 8	Response 9[4]	Response 10
Enrolled Populations (Initial Groups)[5]											
Universal within enrolled categories ● or targeted (e.g., high risk/cost) ❍	9	●	❍	❍	●	❍	●	❍	●		●
Medicaid adults (non-dual eligibles)	9	●	●	●	●	●	●	●	●		●
Medicaid/KidCare children/adolescents (non-dual)	8	●	●	●	●	●	●		●		●
Dual eligibles	7	●	●	●	●			●	●		●
Long term care – HCBS	7	●	●	●	●		●		●		●
Long term care – institutional[6]	4	●	●	●	●						
Enrollment Preference											
Mandatory enrollment	2	●					●				TBD
Voluntary enrollment (including passive enrollment with "opt out")	3			●	●	●					TBD
Either acceptable	3		●					●	●		TBD
Minimum Enrollment Requirement											
Minimum requirement specified	3	Yes	No	No	No	No	Yes	No	Yes		TBD

[4] Respondent did not specifically address covered populations.
[5] All categories are marked in the case of respondents who stated they would serve all populations, with no exclusions.
[6] Shown as included if long term care is identified and residents of institutions are not explicitly excluded.

Covered Services

While many of the respondents identified a broad array of both health and social services that would be addressed within their proposed models, only half proposed to assume responsibility for coverage or direct delivery of health services. Some of the respondents proposed to phase-in the coverage of services over time.

Several of the respondents anticipated that DHSS would share savings with the contractor, providers or both. The calculation of savings would be based on expenditures for a defined set of services, but DHSS would generally retain responsibility for provider reimbursement.

In addition to either supporting or providing care coordination services, most respondents included case management, health promotion and administrative supports within their covered "services".

Exhibit 4 presents a summary of the covered services each respondent proposed to furnish.

Exhibit 4 – Covered Services

Covered Services	Total (out of 10 Responses)	Response 1	Response 2	Response 3	Response 4	Response 5	Response 6	Response 7	Response 8	Response 9	Response 10
Direct Service Provision											
Comprehensive health services ● or targeted (e.g., acute care, primary care) ❍	5	●					❍	❍	❍		●
Care Coordination	9	●		●	●	●	●	●	●	●	●
Case Management/Transitional Care	7	●	●	●	●		●	●			●
Health Education/Promotion	10	●	●	●	●	●	●	●	●	●	●
Support Services											
Provider Payment Rate Development	5	●	●				●	●		●	
Network Development/Provider Education	9	●	●	●	●	●	●	●		●	●
Data/Analytics	8	●	●	●	●	●	●	●		●	

Payment Methodology

Payment approaches ranged from full risk under a capitated (MCO) model to administrative fees-only in support of developing and implementing care management (coordination) activities.

Most respondents anticipated monthly payment for care coordination services and supports, often coupled with the opportunity to earn additional revenue through performance-based incentives. Several respondents identified shared savings approaches that would be implemented at the start of the project or phased in over time. However, only the MCO model contemplated the assumption of downside risk during the initial phases of the project.

Some of the respondents supported alternative payment approaches for providers, including payments based on outcomes, case rates or episodes of care. Except for the MCO model, fee-for-service reimbursement for most Medicaid-covered services would be retained.

Exhibit 5 provides a summary of the proposed payment approaches.

Exhibit 5 – Payment Approaches

Payment Approach	Total (out of 10 Responses)	Response 1	Response 2	Response 3	Response 4	Response 5	Response 6	Response 7	Response 8	Response 9	Response 10
Start-Up Funding	2					●	●				
Administrative/Care Coordination Payments	9		●	●	●	●	●	●	●	●	●
Performance Incentives	7			●	●	●	●	●	●	●	
Shared Savings: RFI Respondent	6		●		●			●	●	●	●
Shared Savings: Providers	9	●	●		●	●	●	●	●	●	●
Shared Losses	4						●	●	●		●
Capitation or Case Rates	4	●	●				●	●			

RFI RESPONSES – OPPORTUNITIES AND ALIGNMENT WITH STATE INITIATIVES

The respondents addressed at a high level the potential for recommended models to advance State objectives related to expanding access to care, achieving improved quality/outcomes and demonstrating cost containment. The relationship between the three objectives also often was captured within responses. For example:

- Access was often defined broadly, to include linking beneficiaries with community-based/social services, in recognition of the importance of addressing non-clinical needs when seeking to improve health outcomes;
- Quality was described in terms of encouraging beneficiaries to seek preventive care and adopt healthier behaviors, while rewarding providers for actively participating in care management through payment incentives and value-based purchasing models; and
- Cost containment in many responses included proposals for investing in primary/preventive services to reduce costlier acute episodes, as well as shared savings to be earned through improvement in quality/outcomes, as well as reductions in expenditures versus what otherwise would have been spent.

Respondents as a group also discussed potential alignments between proposed models and existing reform initiatives. These included:

- Health Homes (proposed by two respondents);
- PCCM (both traditional, physician based PCCM and data analytics/targeting of members with complex needs);
- Innovative payment methodologies based on quality/outcomes, rather than volume;
- Behavioral health integration, both through primary care screening and integrated health homes;
- Tribal health, by offering the opportunity for tribal providers to participate in the proposed models;
- Health Information Exchange (HIE), through software/systems that would integrate with and support the State's HIE;
- Telehealth, both to extend access to clinical services and to extend care management to remote areas; and
- Corrections, with one respondent proposing to target persons leaving the correctional system for enrollment in care management.

In general, the proposed models presented opportunities for supporting/complementing other State initiatives.

RFI RESPONSES - IMPLEMENTATION ACTIVITIES

The respondents outlined implementation activities and requirements at a high level, with most suggesting they could be operational within six to nine months of contract award. Many discussed phased implementation schedules, both in terms of service areas and covered populations.

The timelines did not in most cases take into consideration the need for federal approval of proposed initiatives. Depending on the model, this could include approval of a 1915b or 1115 waiver, and approval of managed care contracts between DHSS and vendors. The time required for federal review and approval would be dependent on the model, but would, at a minimum, be measured in months.

Several of the respondents discussed the need for start-up funding, despite the caution in the RFI that new funding is not available for this initiative. While funding from sources other than DHSS was identified in some instances, and two respondents proposed to repurpose existing State dollars, it is not clear that all of the respondents recognized the limitations facing DHSS in terms of providing funding up-front to support implementation. The challenge this presents extends even to the MCO model, which would require appropriations to address a "claims bubble" during the transition from fee-for-service to capitation, as well as other federally-mandated administrative expenses related to enrollment counseling and oversight of MCO activities.

The implementation discussions also addressed expectations with regard to State activities/support aside from start-up funding. Many of the models would be dependent on State-generated data and/or State rate development to assess the feasibility and magnitude of potential program savings. Most of the models also contemplated continued payment of provider claims by the State, either on a fee-for-service basis or through an "innovative" payment methodology.

Once implemented, the same models that look to the State for establishment of potential savings would likely be dependent on DHSS to calculate whether savings have been achieved and should be distributed in accordance with a pre-defined methodology. At a minimum, the State would need to have the capacity, directly or through its actuaries, to evaluate and verify any claim for shared savings from a contractor.

CONSIDERATIONS FOR DEVELOPMENT OF REQUEST FOR PROPOSALS (RFP)

The RFI process provided the State with valuable information to inform development of the RFP to be released by December 31, 2016. Key findings from the RFI responses include the following:

- Most of the proposed models included essential components of care management in some form, including:
  - Care coordination – clinical and non-clinical;
  - Promotion of person-centered care;
  - Health promotion and wellness;
  - Case management/transitional care; and
  - Use of technology and data analytics to support care delivery.

- Most of the proposed models explicitly require an up-front investment by the State to achieve program objectives, including cost savings.

- The key difference between CME and PBR models is whether providers/local systems assume contractual responsibility for care coordination activities, or are instead either performed or supported by a third party.

- Generally, CMEs offer advanced tools to support care coordination functions, including training protocols, applications and data analytics.

- PBR's are well-positioned to understand the needs of the community, integrate care coordination within their existing service delivery systems and advance local accountability for health and resource allocation.

The State's objective is to create an RFP process that has the necessary flexibility to support development and implementation of innovative models. However, the RFP also must sufficiently define the State's expectations to enable potential vendors to assess whether they are willing and able to meet these expectations.

The proposal submission requirements therefore will need to be designed to achieve the following:

- Allow for unique and creative approaches within the allowable framework defined in the RFP;
- Provide the State with assurances that the potential vendor has the appropriate skills, experience and resources to both meet the State's expectations and successfully implement the model as proposed;
- Select, via the proposal evaluation process, vendor(s) whose model(s) best meet the State's objectives and best demonstrate an ability to implement the proposed model.

APPENDIX – RFI SUBMISSION SECTION

SECTION 3. RESPONSE FORMAT AND CONTENT

SEC. 3.01 RESPONSE FORMAT AND CONTENT

Respondents are encouraged to answer all of the questions listed below if possible to help inform the development of the request for proposals, but are not required to answer every question. It is not necessary to repeat the question in the response, but please clearly indicate the question number for which a response is provided.

Throughout the response, please highlight the information considered to be critical to the proposed model. Respondents who are not prepared to answer these questions are invited to share concepts for improved delivery system models they would like the Department to consider.

A suggested page limit is provided for each question, but respondents are not bound by the page limits if additional space is required. However, the total response should not exceed 25 pages.

SEC. 3.02 QUESTIONS

1. Overview (3 pages)

    a. Please identify the entity (or entities if a collaborative effort) submitting the Coordinated Care Demonstration Project (CCDP) RFI response. If a collaborative effort, please identify the lead entity. Please identify the key contact person for this effort.
    b. What is (or would be) the organizational structure for the proposed coordinated care model?
    c. Please provide a high-level description of the model.
    d. Please identify the elements from SB 74 (listed below) the model addresses and how the model addresses each identified element. (Note that SB 74 requires CCDP projects to include a minimum of three of the following nine elements)
        1. Comprehensive primary-care-based management for medical assistance services, including behavioral health services and coordination of long-term services and support;
        2. Care coordination, including the assignment of a primary care provider located in the local geographic area of the recipient, to the extent practical;
        3. Health promotion;
        4. Comprehensive transitional care and follow-up care after inpatient treatment;
        5. Referral to community and social support services, including career and education training services;
        6. Sustainability and the ability to achieve similar results in other regions of the state;
        7. Integration and coordination of benefits, services, and utilization management;
        8. Local accountability for health and resource allocation; and/or
        9. An innovative payment process, including bundled payments or global payments.
    e. Please describe how the model will utilize telehealth.

2. Service Area (1 page)

    a. Please identify the proposed service area for the model. If the service area could potentially change over time, please explain.

3. Covered Populations (2 pages)

    a. Please identify the Medicaid-eligible populations to be served by the model (e.g., families, Denali KidCare, Medicaid Expansion, long-term care participants, individuals dually eligible for Medicare and Medicaid, etc.)
    b. Please identify populations the model will specifically serve, if applicable (e.g., individuals diagnosed with specific conditions or chronic diseases, such as SMI, SUD, diabetes, or asthma; homeless; individuals reentering society from the correctional system; etc.).
    c. Does the model require a minimum or maximum membership threshold? If so, please specify and explain the rationale.
    d. Would voluntary or mandatory participation (subject to regulatory restrictions that prohibit mandatory participation) best support the model?
    e. If the covered population potentially could change over time, please explain.

4. Covered Services (2 pages)

    a. Please describe the services covered within the model.
    b. Please explain the rationale for excluding certain services from the model, if applicable.
    c. Please describe how the model will support coordination across the full array of health services.
    d. If certain services would be excluded at the outset, does the model allow for expansion of covered services over time?

5. Payment Methodology (2 pages)

    a. Please provide a general overview of the payment methodology (e.g., risk-based, shared savings, administrative fee, etc.).
    b. Please describe how the proposed payment methodology promotes value-based payment (i.e., payments to providers based on performance (including positive and/or negative adjustments based on quality and/or efficiency) rather than solely based on volume of provided services).
    c. Please describe how the payment methodology promotes the project's objectives.
    d. Please note if the payment methodology addresses local accountability for health and resource allocation, and if so, how.

6. Model Opportunities (8 pages)

    a. What do you see as the greatest challenges to delivering accessible, high quality and cost effective care to Alaskans statewide (or in your proposed service area) and how does your model address these challenges?
    b. Please describe any innovative approaches within the model for meeting the needs of program participants and promoting health.
    c. Please describe how the service delivery model promotes the project's objectives, including local accountability for health and resource allocation.

d. How does the model promote person-centered and person-directed care?
e. How does the model promote appropriate access to quality care?
f. Please describe how the model promotes high quality care and improved outcomes. Please describe the methodology that you would propose for evaluating the effectiveness of the model.
g. Please describe how the model generates program savings and constrains the rate of expenditure growth for the State Medicaid program. Please describe how the model advances transformation of the delivery system to control overall costs.

7. Alignment with other State Initiatives (2 pages)

To the extent that you are able based on your knowledge and understanding, please:

a. Describe how the model might align or integrate with other health reform initiatives described in SB 74 and in implementation by DHSS (as described in the Background Section), including the behavioral health demonstration and advancement of telehealth?
b. Describe how the model might align with the tribal health delivery system and support the state's ability to fully implement the new federal tribal FMAP policy?
c. Describe how the model might support and utilize Alaska's health information infrastructure?
d. Describe how the state's Health Information Exchange, administered by the Alaska eHealth Network, would be used to support the model?

8. Implementation Considerations (5 pages)

To the extent of your ability based on the current status of model development and your understanding of State and federal operations and requirements, please describe:

a. The major implementation tasks, and provide a high-level timeline for implementation activities.
b. How development and implementation activities will be funded, recognizing that no state funds are available to support project planning, development and implementation.
c. Model components (e.g., services, populations, payment approaches) that could be refined post-implementation and the timeline for these changes.
d. State activities that would be required to implement the model.
e. Federal requirements with which the model would have to comply
f. Statutory or regulatory changes that would be necessary to permit the model to operate.