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November 15, 2016

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Senate Bill 74, signed into law in June 2016, established the Medical Assistance Reform Program under AS 47.05.270. This new program requires the Department of Health & Social Services to submit an annual report to the legislature on the status and results of Medical Assistance reforms by November 15 of each year. This is the first annual report submitted in compliance with AS 47.05.270.

For questions regarding this report, please contact Tony Newman, DHSS Legislative Liaison, via email at anthony.newman@alaska.gov or 465-1611.

Sincerely,

Valerie "Nurr'araaluk" Davidson
Commissioner
Department of Health & Social Services

cc: Darwin Peterson

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AK DHSS Annual Medicaid Reform Report

FY2016

Senate Bill 74, signed into law in June 2016, reforms Alaska's Medicaid program. SB 74, under AS 47.05.270, requires the Department of Health & Social Services to submit an Annual Report to the legislature by November 15 of each year on the status of reforms enacted by that statutory section. This is the first annual report submitted in compliance with AS 47.05.270.

In compliance with AS 47.05.270

Valerie "Nurr'araaluk" Davidson
Commissioner
Department of Health & Social Services

FY 2016 Annual Medicaid Reform Report

INTRODUCTION

Senate Bill 74 (SB74), signed into law in June 2016, established the Medical Assistance Reform Program under AS 47.05.270. This new program requires the Department of Health & Social Services (the department) to submit an annual report to the legislature on the status and results of Medical Assistance reforms by November 15 of each year.

This report is organized in two parts. The first part is a progress report on the department's efforts to implement the reform program elements mandated by AS 47.05.270. It also includes a progress report on other Medicaid reforms included in SB 74 but not addressed by the provisions of AS 47.05.270.

The second part of the report provides answers to the specific questions that must be addressed in the Annual Report as mandated under AS 47.05.270(d). Fraud, waste and abuse activities and savings are not included in this report, as SB 74 mandated a separate annual report on that topic. That report, produced jointly with the Department of Law, is also due to the legislature on November 15.

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I. PROGRESS REPORT: IMPLEMENTING MEDICAID REFORM

A. Medical Assistance Reform Program Requirements under AS 47.05.270

Following is a brief description of the status of implementation of Medicaid program reforms authorized under the Medical Assistance Reform Program newly established by SB 74 under AS 47.05.270. The subsection headings below correspond to the AS 47.05.270 sections.

(a)(1) Referrals 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.

The Division of Public Assistance (DPA) currently provides case management services and access to supports that promote employment and self-sufficiency for families in the Alaska Temporary Assistance Program (ATAP). Similar services are under development for Alaskans receiving Supplemental Nutrition Assistance Program (SNAP) benefits. ATAP recipients complete a Family Self-Sufficiency plan that includes specific goals, tasks, and deadlines. Tasks and supports may include, but are not limited to: identifying child care, help with job search, short term training leading to employment, and removal of medical or psychological barriers.

DPA is currently working with a contractor to identify agencies that can provide employment support services to Supplemental Nutrition Assistance Program (SNAP) recipients. Agreements with service providers are scheduled to be in place by December 2016. Services will include job search, GED completion, English as a second language, and job training.

Currently, these services are not available to all Medicaid enrollees. However, Medicaid enrollees who are also ATAP and/or SNAP recipients receive these services. The department is coordinating with the Department of Labor and Workforce Development to identify opportunities for referring public assistance recipients to apprenticeship job training opportunities.

(a)(2) Electronic distribution of an explanation of medical assistance benefits to recipients for health care services received under the program.

The department initially planned to use the "MyAlaska" state service portal as a mechanism for providing electronic explanation of benefits (EOBs) to Medicaid recipients. However, it has been determined that MyAlaska does not meet Health Insurance Portability and Accountability Act (HIPAA) security standards for Protected Health Information and therefore is not a viable option. The only other alternative is to establish a recipient portal in the Medicaid Management Information System (MMIS).

The MMIS vendor, Xerox, estimates it will require 8,000 to 10,000 hours and hardware and software upgrades to establish a recipient portal. Xerox will submit a formal plan to the department by December 31, 2016 for development of the portal. Xerox is in the in the process of investigating the use of recipient portals in MMIS systems they operated in other states. The department requested that Xerox's plan assume a start-date for development of the portal no later than February 1, 2017.

(a)(3) Expanding the use of telehealth for primary care, behavioral health, and urgent care.

The Alaska Legislature, through SB 74, addressed a significant barrier to expanded use of telehealth by prohibiting state licensure boards for a variety of health professions from imposing disciplinary sanctions on licensees for evaluation, diagnosis, or treatment of a person through audio, video, or data communications when physically separated from the person, with certain limitations.

The Alaska Medicaid program currently pays for covered medical services through telemedicine applications if the service is covered under traditional, non-telemedicine methods; is provided by a treating, consulting, presenting, or referring provider; and is appropriate for provision via telemedicine. The Medicaid program pays for telemedicine services delivered by a variety of methods, including interactive, store-and-forward, and patient self-monitoring. Paid Medicaid claims for telemedicine services was $4,901,955 in FY 2016, up from $2,419,305 paid for telemedicine services in FY 2015.

In August of this year the department solicited stakeholder representatives to serve on a workgroup to identify opportunities, barriers and solutions for expanding the use of telehealth for delivering Medicaid services. The workgroup held its first meeting on November 2, and will meet several more times over the coming months. They will deliver their report to the department, including findings and recommendations, by July 1, 2017.

Telehealth Workgroup members:

• Brooke Allen	Behavior Analyst
• Connie Beemer	Alaska State Hospital & Nursing Home Association
• Denise Daniello	Alaska Commission on Aging
• Mark Erickson, MD	Alaska Psychiatric Institute
• Brent Fisher	Alaska Sleep Clinic
• Matthew Hirschfeld, MD	Alaska Native Medical Center
• Philip Hofstetter	Norton Sound Health Corporation
• Laura Hudson	Alaska Regional Hospital
• Laura Johnston	Southcentral Foundation
• Richard Kiefer-O'Donnell	University of Alaska
• Ken McCarty	Discovery Cove Recovery & Wellness Center
• Monique Marquis	Fairbanks Memorial Hospital
• Trina McCandless	Emergency medical services
• Robert Onders, MD	Alaska Native Tribal Health Consortium
• Georgiana Page	Alaska eHealth Network
• Patti Paris, MD	Alaska Chapter of American College of Emergency Physicians
• Christopher Simon	Tanana Chiefs Conference
• Mark Williams	Providence Health & Services Alaska
• Thad Woodard, MD	Private Practice Pediatrician

(a)(4) Enhancing fraud prevention, detection, and enforcement.

The department and Department of Law submitted a separate, joint annual report to the legislature on November 15, 2016 on fraud, waste and abuse activities and savings as required by AS 47.07.076.

(a)(5) Reducing the cost of behavioral health, senior, and disabilities services provided to recipients of medical assistance under the state's home and community-based services waiver under AS 47.07.045.

Home & Community-Based Services (HCBS) Utilization Control

Regulations implemented in 2010 and 2012 clarified eligibility and allocation of Personal Care Services and Waiver Services, and the department continues efforts to improve utilization controls and address fraud and abuse in this area. Spending for Waiver and Personal Care Services declined 7.3% overall in FY 2016 compared to FY 2015. See Section II.2 of this report on page 16 for more information on savings.

Personal Care Assistant and HCBS Prescreening Tool and Options Counselling

The department worked with Aging and Disabilities Resource Centers (ADRC) to pilot test from FY 2014 to FY 2016 a new prescreening tool for Personal Care Assistant and Home & Community-Based Services in seven communities. The pilot project resulted in reduction of inappropriate assessments, and referral of individuals to other community-based supports rather than Medicaid. The pilot resulted in a 62.4% reduction in requests for waiver assessments. The department has been working with the ADRCs and the Alaska Mental Health Trust Authority to implement the Prescreening & Options Counseling services statewide, and is scheduled to implement this new service for all individuals seeking Adults Living Independently and Adults with Physical and Developmental Disabilities Waiver services on January 1, 2017.

1915(i) and 1915(k) Home & Community Based Service State Plan Options

The department contracted with Health Management Associates, Inc. (HMA) in FY 2016 with support from the Alaska Mental Health Trust Authority to conduct an in-depth study of 1915(i) and 1915(k) Medicaid Home and Community Based Services (HCBS) state plan options for four targeted populations, including individuals with:

1) intellectual and developmental disabilities (I/DD),
2) Alzheimer's Disease and related dementia (ADRD),
3) traumatic or acquired brain injury (TABI), and
4) serious mental illness (SMI).

This study included stakeholder input through a series of forums and public meetings in nine communities across the State. HMA's final report includes recommendations for department programs and services that will most cost-effectively and efficiently support the target populations. These recommendations have been presented to the project's stakeholder group, the Inclusive Community Choices Council (ICC Council). The department is reviewing the recommendations and will develop a timeline for implementation.

(a)(6) Pharmacy Initiatives.

The Alaska Medicaid Program is continually exploring and developing strategies for containing the cost of pharmaceuticals. Following is a description of four initiatives that are in the scoping and implementation phase.

Alternate Payment Models

The department has been working with the Oregon Health & Science University's Center for Evidence-Based Policy (Center), through a grant from the Laura and John Arnold Foundation, to discern the feasibility and department readiness to employ alternate payment models within the Medicaid Pharmacy Program, particularly for newer high cost specialty medications. Phase One of the program

included research into the landscape of pharmaceutical pricing and reimbursement in Medicaid programs in various states.

In preparation for Phase Two, the department is currently participating in a readiness assessment for the possible implementation of an alternate payment model pilot. To support the department in this pilot the Center will provide technical assistance, including schedule preparation, measure development, stakeholder engagement guidance, and analytical support.

Pharmacy Professional Dispensing Fee Study

The department is preparing to release an RFP to conduct a professional dispensing fee survey consistent with 42 CFR 447.500-599. The Medicaid professional dispensing fee schedule will be updated based on the results of the study.

Opioid Utilization Initiatives

The department continually researches evolving clinical guidelines and strategies to address the opioid abuse epidemic. Ensuring medically appropriate use of opioids and preventing non-medical use of opioids minimizes opioid overdose and overdose death, opioid dependence, and neonatal abstinence syndrome.

The department co-chaired the Alaska Opioid Policy Taskforce which identified local, regional, and statewide challenges and opportunities. Recommendations from the Taskforce are currently out for public comment. The department will present strategic opioid utilization initiatives at the November meeting of the Alaska Medicaid Drug Utilization Review (DUR) Committee. These strategic initiatives were prepared utilizing evidence-based clinical literature and feedback obtained through public forums with pharmacists. The department will work with the DUR Committee to further refine, frame, and prioritize the initiative work over the next year.

Ambulatory Infusion Center (AIC) Enrollment and Reimbursement

The department is researching the viability of Medicaid reimbursement of infused medications in an Ambulatory Infusion Center setting. An increasing number of specialty medications, particularly biological agents, are available for a number of conditions, including Multiple Sclerosis, Psoriasis, Inflammatory Bowel Disease, and Immunodeficiencies. Many of these products have the potential of being administered in the home, which is reimbursed under the current Home Infusion Therapy program. However, many of these drugs require initial doses to be administered in a health care setting for patient safety purposes, to gauge tolerability.

Under the current structure, these medications are administered and reimbursed through the following provider types:

- Health Professional Groups
    - Hospital-based infusion clinics
    - Physician offices
- Home Infusion Therapy (when drug is safe to infuse in the home setting)

Continuity of care, regimen complexity, patient choice, and a number of other factors warranted research into this care delivery option. The department has researched other state Medicaid programs, clinical literature, and regulatory/accrediting body standards to inform the drafting of regulations for AIC enrollment and payment, and will host a regulation scoping meeting in late November 2016 to invite stakeholders to share their perspectives regarding how the addition of a new provider type in the Medicaid system would aid clinical and economic outcomes.

(a)(7) Enhanced care management.

The Alaska Medicaid Program includes a number of care management and care coordination programs and initiatives. Current programs are expanding, and two new initiatives under SB 74 are in development to enhance care coordination and care management.

Case Management

The Alaska Medicaid Program, though a contract with Qualis Health, provides case management services. Participation in this program is voluntary. Medicaid recipients may self-refer or may be referred by a health care provider or agency staff. These recipients typically have medically complex and costly or long-term conditions. Services include patient assessment, education and referral; care coordination; and collaboration with hospital discharge planners. These services were first implemented in 1997 as an Anchorage-based pilot project, and were expanded to all Medicaid recipients in 1998.

Care Management Program

The Care Management Program (CMP) is an existing program established to address inappropriate use of Medicaid-covered services. Participation in this program is not voluntary. Medicaid recipients who would benefit from CMP enrollment are referred to the department by medical providers or the Medicaid fiscal agent. On referral, a utilization review of medical and pharmacy records determines if the individual meets program criteria. Enrollment in the program generally lasts 12 months, during which time the recipient is limited to services for non-emergent care rendered or referred by an assigned primary care provider and an assigned pharmacy.

The CMP program saved more than $3.2 million in FY 2016 (all funding sources; approximately 50% GF) through improved continuity of care that eliminated payments for inappropriate services, such as using hospital emergency departments for non-emergent care, visiting multiple providers for the same issue, and duplicative prescriptions. The department is in the process of expanding participation in this program from 260 enrollees to 1,000 enrollees by the end of FY 2017. Expanding enrollment in this program is expected to reduce expenditures by $8 million over the fiscal year.

Alaska Medicaid Coordinated Care Initiative/SB 74 Primary Care Case Management

The Alaska Medicaid Coordinated Care Initiative (AMCCI), also known as the “Super-Utilizer” initiative, was launched in December 2014 to enhance care coordination for Medicaid recipients with excessive hospital emergency department (ED) utilization. It was subsequently expanded to include overutilization of other medical services. Participation in this program is voluntary. Enrollees are provided individualized case management services including care coordination and referrals to specialists and social service supports. The department currently contracts with MedExpert to provide these services telephonically. In addition, Qualis Health provides more intensive in-person case management services for 60 very high utilizers of ED services.

The AMCCI saved more than $2.5 million in FY 2016 (all funding sources; approximately 50% GF). More than 16,000 Medicaid recipients were eligible to receive services through this program. 5,500 Medicaid recipients volunteered to enroll. Participants had a 25% reduction in ED use and a 20% reduction in costs.

SB 74, under AS 47.07.030(d), requires the department to establish a primary care case management system and enroll Medicaid recipients with multiple hospitalizations. As an interim strategy for implementing this new requirement, the department is expanding the AMCCI to more than 80,000 Medicaid recipients during FY 2017. This will allow for more immediate statewide access to episodic care management services while new care models are tested through the Coordinated Care Demonstration Project described below.

Coordinated Care Demonstration Project

SB 74 adds AS 47.07.039, which establishes the Coordinated Care Demonstration Project (CCDP). The purpose of the CCDP is to assess the efficacy of various health care delivery models with respect to cost, access, and quality of care. The department is permitted to contract with provider-led entities, Accountable Care Organizations, managed care organizations, primary care case managers, and prepaid ambulatory health plans. The fee structures may include global payments, bundled payments, capitated payments, shared savings and risk, or other payment structures.

The statute requires the department to release the Request for Proposals (RFP) to solicit coordinated care demonstration proposals by December 31, 2016. The department released a Request for Information (RFI) on September 15 to solicit information from entities potentially interested in proposing a CCDP. The department is currently analyzing the responses and will use the information provided to develop the RFP.

The statute also requires the department to use a third-party actuary to evaluate the projects. The department established a contract with Milliman, Inc., an international health care actuarial consulting company, to provide input in the RFP drafting process, publish a Medicaid data book to support development of CCDP proposals, provide the independent analysis of the proposals, and help craft the CCDP payment models once the projects are awarded.

(a)(8) Redesigning the payment process by implementing fee agreements that include one or more of the following: (A) premium payments for centers of excellence; (B) penalties for hospital-acquired infections, readmissions, and outcome failures; (C) bundled payments for specific episodes of care; or (D) global payments for contracted payers, primary care managers, and case managers for recipient or for care related to specific diagnosis.

The department sought actuarial and payment model consulting services for several SB 74 reform initiatives via a single contract, which was awarded through a competitive solicitation to Milliman, Inc. This contract will support actuarial and payment analysis for: 1) the Coordinated Care Demonstration Projects, 2) the 1115 behavioral health reform waiver, 3) the shared savings model for the Emergency Department improvement initiative, 4) the Primary Care Case Management initiative, and 5) other innovative payment models, such as those described in A-D of subsection (a)(8) of AS 47.05.270.

Milliman is currently in the data collection process, and is working with the department to finalize a detailed work plan outlining action steps and timelines to support the various Medicaid reform initiatives. One of the first major deliverables under the contract is the production of a Medicaid data book to support Coordinated Care Demonstration Project proposal development and to inform the development of the 1115 behavioral health reform waiver application.

In 2012, the department implemented regulations for non-payment of claims related to a select list of hospital acquired conditions.

(a)(9) Stakeholder involvement in setting annual targets for quality and cost-effectiveness.

In August, the department solicited stakeholder representatives to serve on a workgroup to help identify annual quality and cost effectiveness targets.

The Quality and Cost Effectiveness Workgroup will meet multiple times over the next several months to discuss meaningful quality and cost effectiveness targets and the best means to measure progress

against the targets. When formulating the targets, the workgroup will consider whether a specified target reflects a reasonable expectation of what the Medicaid program can accomplish; whether data necessary to demonstrate progress toward the target can be gathered without excessive provider reporting; and whether the target can demonstrate the cost effectiveness of program expenditures. Targets will be finalized by June 30, 2017.

A baseline will be created from FY 2016 claims data for all targets that can be measured using Medicaid claims. This baseline will then be used to measure progress on relevant targets in FY 2017 and beyond. Appropriate data sets or data gathering activities will be identified for targets that cannot be measured using claims data.

Quality and Cost Effectiveness Workgroup members:

- Kathy Allely — Parent of IDD Medicaid waiver recipient
- Barbara Berner — School of Nursing, University of Alaska Anchorage
- Dave Branding — Juneau Alliance for Mental Health
- Alan Gross, MD — Petersburg Medical Center
- Andrea Gurley — Alaska Regional Hospital
- Amberly Hobbs — Mountain-Pacific Quality Health
- Jerry Jenkins — Anchorage Fairbanks Community Mental Health Services
- Patty Linduska — Alaska Primary Care Association
- Jenny Love, MD — Anchorage Neighborhood Health Center
- Nancy Lovering — Speech-language pathologist, private practice
- Rebecca Madison — Alaska eHealth Network
- Jacqueline Marcus-Ledford — Yukon Kuskokwim Health Corporation
- Jeannie Monk — Alaska State Hospital & Nursing Home Association
- Nick Papacostas, MD — Alaska Chapter of American College of Emergency Physicians
- Jim Roberts — Alaska Native Tribal Health Consortium
- Sharon Skidmore — Physical Therapy for Kids, LLC
- Bill Sorrells — Cornerstone Clinic Medical Center
- Steve Tierney — Southcentral Foundation

(a)(10) To the extent consistent with federal law, reducing travel costs by requiring a recipient to obtain medical services in the recipient's home community, to the extent appropriate services are available in the recipient's home community.

Alaska Medicaid regulations require that all travel be medically necessary (7 AAC 105.100(5)), and also be arranged using the least costly appropriate mode of transportation (7 AAC 120.410(c)). These requirements are reinforced frequently in department communications with the fiscal agent, and by the fiscal agent with each request from a provider. Providers are also reminded of travel requirements through remittance advice messages, newsletter articles, flyers, training presentations, and provider billing manuals.

The Division of Health Care Services (DHCS) carefully monitors fiscal agent travel authorization activity to ensure compliance with these regulations. The DHCS Director issued a policy memorandum to all applicable entities this past spring to clarify existing travel policy and provide guidance for frequently occurring and problematic travel situations. Although the policies have not changed, the memorandum addresses these situations with a level of detail not previously provided. The memorandum includes identification of non-covered services and also reinforces other existing requirements, such as combining multiple appointments into a single travel episode, denial of non-emergent travel when

services are available locally within a reasonable time period, and ensuring that medical necessity exists for all travel referrals.

Through a multi-division approach, the department is continuing past efforts and is developing new initiatives to reduce travel costs. For example, DHCS collaborates with the Division of Public Health and with the Tribal Health Program in the Commissioner's Office to determine when providers are scheduled to visit remote villages so non-emergent travel by resident Medicaid enrollees can be avoided.

The department's response to Annual Report element (9) provided in Part II below on page 19 documents that overall gross travel expenditures decreased slightly from $85.5 million in FY 2015, to $84.7 million in FY 2016, even with an increase in Medicaid enrollees in FY 2016. Different FMAP rates apply for different eligibility populations, but no more than 50% is allocated to GF.

(a)(11) Guidelines for health care providers to develop health care delivery models supported by evidence-based practices that encourage wellness and disease prevention.

The department is in the process of updating Medicaid coverage policies to ensure evidence-based wellness and preventive services are available to program enrollees, and that appropriate service limits for these benefits are in place to assure their delivery is efficient. The update process includes reviews of outcome evidence from two highly respected resources:

- Reports from MED, a collaboration of 12 state Medicaid programs which pools resources to critically review the effectiveness evidence for selected acute medical therapies and preventive services. Reports from the MED partnership—which is facilitated and staffed by Oregon Health & Science University's Center for Evidence Based Policy—have been highly useful in departmental efforts to optimize Medicaid coverage policy for acute medical therapies. Likewise, the department anticipates the Center's evidence reports will be very useful as it develops coverage policy for the delivery of wellness services.

- Evidence based preventive services recommendations developed by the U.S. Preventive Services Task force (USPSTF), a federal task force charged with making recommendations about the optimal utilization of various preventive and wellness services.

Based on reviews and recommendations from these groups, an internal DHSS task force will refine and update Alaska Medicaid's wellness benefit to ensure evidence based coverage for key preventive services. Service limits will be put in place to assure these services are not covered inappropriately. Draft coverage benefit proposals will be ready for review by department leadership by December 2016, and regulatory changes needed to support the new policy will be noticed in the following months.

(b) Behavioral health system reform.

AS 47.05.270(b), added by section 43 of SB 74, requires the department to coordinate with the Alaska Mental Health Trust Authority to develop and manage a comprehensive and integrated behavioral health program that uses evidence-based, data-driven practices to achieve positive outcomes for people with mental health or substance abuse disorders and children with severe emotional disturbances. The program must include a plan for providing a continuum of community-based services to address housing, employment, criminal justice, and other relevant issues. It also must include services from a wide array of providers and disciplines, and efforts to reduce operational barriers that fragment services, minimize administrative burdens, and reduce the effectiveness and efficiency of the program.

SB 74 also adds AS 47.07.036(f) requiring the Department to apply for a section 1115 Waiver under 42 U.S.C. 1315(a) to establish one or more demonstration projects focused on improving the state's behavioral health system for Medicaid beneficiaries. The 1115 Waiver demonstration project must be consistent with the comprehensive and integrated behavioral health program required under AS 47.05.270(b) and include continuing cooperation with the grant-funded community mental health clinics and drug and alcohol treatment centers that have historically provided care to recipients of behavioral health services.

The department plans to contract with an Administrative Services Organization (ASO) to implement the behavioral health managed system of care required under this legislation. An ASO is a third-party organization with special expertise in behavioral health systems management. The department will contract with the ASO through a competitive bidding process to provide certain specified administrative services necessary to manage the behavioral health system of care on the state's behalf.

This fall the department convened six public-private workgroups to support the design and development of the 1115 Waiver application for Behavioral Health System Reform. The six teams are: Policy, Benefit Design, Quality, Cost, Data, and Writing. Currently, each team is meeting approximately twice a month to identify the system parameters that will be addressed in the Waiver. The first milestone in development of the 1115 Waiver is preparation of a Concept Paper, which the department intends to complete and submit to the Centers for Medicare and Medicaid Services (CMS) this winter. Also this winter, the department will release a Request for Letters of Interest (RFLOI) for ASO services. The 1115 Waiver process includes extensive public review, which will occur in the spring of 2017. The target date for submission of the Waiver application to the federal government is June 30, 2017, and award of an ASO contract is anticipated in January 2018.

(c) Telehealth.

AS 47.05.270(c), added by section 43 of SB 74, requires the department to identify the areas where improvement in access to telehealth would be most effective in reducing the costs of medical assistance and improving access to health care services for medical assistance recipients. The recently formed Telehealth Workgroup described in Part I.A.(a)(3) on page 6 above will fulfill this requirement.

B. Additional SB 74 Medicaid Reform Provisions

Updates on implementation of Medicaid Reform Initiatives required under other sections of SB 74 and not addressed either directly or indirectly under the Medical Assistance Reform Program of AS 47.05.270 are provided below.

Eligibility Verification System

AS 47.05.105, added by Section 39 of SB 74, requires the department to establish an enhanced computerized income, asset, and identity eligibility verification system. The purpose of the required system is to verify eligibility, eliminate duplication of public assistance payments, and deter waste and fraud in public assistance programs. The department is currently in the process of transitioning the public assistance programs' Eligibility Information System (EIS) to the new Alaska's Resource for Integrated Eligibility Services (ARIES) system, and will contract with an eligibility verification system vendor upon completion of that transition.

Emergency Care Improvement

AS 47.07.038, added by Section 46 of SB 74, requires the department and the Alaska State Hospital & Nursing Home Association (ASHNHA) to establish a hospital-based project to reduce the use of emergency department services by medical assistance recipients. The project, to be administered by ASHNHA, may include shared savings for participating hospitals. It must include a number of emergency department (ED) best practices, including a system for real-time electronic exchange of patient information among EDs. ASHNHA is currently leading the effort to develop this project in collaboration with the Alaska Chapter of the American College of Emergency Physicians and the department. The department's recently established contract with Milliman, Inc., will support development of the shared savings payment model.

Health Information Infrastructure Plan

Section 56 of SB 74 requires the department to develop a plan to strengthen the health information infrastructure, including health data analytics capability. The purpose of the plan is to transform the health care system by providing data required by providers for care coordination and quality improvement, and by providing information support for development and implementation of the Medicaid reform provisions of SB 74. The Health Information Infrastructure Plan is required to leverage existing resources, such as the statewide health information exchange, to the greatest extent possible.

The department awarded a contract to HealthTech Solutions LLC through a competitive solicitation process to support the first phase of the planning process by assessing the current condition of the health information infrastructure. The department also has a contract in place with the Alaska eHealth Network, the administrator of the statewide health information exchange, to support development of the infrastructure. In the coming months the department will solicit stakeholder representatives to serve on a workgroup to guide development of the plan. The plan will be finalized by January 2018.

II. ANNUAL REPORT ELEMENTS REQUIRED UNDER AS 47.05.270(d)

Following is information provided in response to the 15 elements required to be included in this annual report on Medicaid reform under AS 47.05.270(d). The department recommends caution in drawing any conclusions from single year comparisons because of the many variables that can impact the timing of claims payment.

1) Realized cost savings related to reform efforts under this section (AS 47.05.270).

AS 47.05.270 was not enacted until FY 2017. There are no cost savings to report for FY 2016.

2) Realized cost savings related to medical assistance reform efforts undertaken by the department other than the reform efforts described in this section (AS 47.05.270).

Pharmacy Payment Reform: National Average Drug Acquisition Costs (NADAC) implementation
The department changed the Medicaid program's methodology for pricing drugs from wholesale average cost to the National Average Drug Acquisition Costs methodology in FY 2015. Total savings, all funding sources, in FY 2016 from this reform was $23,600,000, approximately 50% of which was state general fund dollars.

Commercial Insurance and Medicare Recoupment
When a recipient is found to have retroactive insurance or Medicare coverage, the program recovers funds by billing the resource for paid Medicaid services. Total savings, all funding sources, from this initiative in FY 2016 was $5,261,712, approximately 50% of which was state general fund dollars.

Alaska Medicaid Coordinated Care Initiative
The Alaska Medicaid Coordinated Care Initiative (AMCCI) was launched in FY 2015 to provide care coordination for Medicaid enrollees who over-utilize hospital emergency department (ED) services. In FY 2016 5,500 Medicaid enrollees received AMCCI services, reducing their emergency department use by 25%. Based on an average ED cost per visit, the reduction in ED utilization saved the Medicaid program a total of $2,564,412 in FY 2016, approximately 50% of which was state general fund dollars.

Utilization Management
The Medicaid program contracts with a utilization management firm to provide case management services for Medicaid patients when they are discharged from inpatient hospital care. This service saved the Medicaid program a total of $3,511,317 in FY 2016, approximately 50% of which was state general fund dollars.

Care Management Program (CMP)
Medicaid recipients identified as over-utilizing services may be placed in the Care Management Program, which assigns the recipient to a single primary care provider and a single pharmacy, and limits specialty care to services referred by the primary care provider. 260 recipients were enrolled in this program in FY 2016, saving a total of $3,412,631, approximately 50% of which was state general fund dollars.

Health Insurance Premium Payment Program
Families enrolled in Medicaid who have employer-sponsored insurance available but cannot afford the employee premium can request the department pay for their insurance premium if doing so will save

state Medicaid program dollars. Estimated cost avoidance in FY 2016 from this program totaled $1,275,323, approximately 50% of which was state general fund dollars.

Fraud Prevention, Detection and Enforcement

The department and Department of Law has reported savings from fraud, waste and abuse prevention and enforcement in a separate annual report to the legislature submitted November 15, 2016 as required by AS 47.07.076.

Tribal Health System Partnerships

The federal government reimburses the state at 100% FMAP for services provided to American Indian/Alaska Native Medicaid enrollees served at Indian Health Service and tribal health facilities. Therefore, development of tribal health system capacity to meet the needs of the AI/AN population saves state general fund dollars. The department has partnered with tribal health organizations over the years to help facilitate capacity development.

Examples of new or expanded services in the tribal health system in FY 2016 include dental clinics, long term care beds, newborn intensive care, obstetrics, and orthopedics. Increased service capacity at tribal health facilities resulted in increased claims for those services by approximately $28 million in FY 2016. In lieu of this increased capacity, those services would have been provided in a non-tribal setting and only reimbursed at 50%. The state saved as much as $14 million in FY 2016.

Home & Community-Based Services (HCBS) Utilization Control

Regulations implemented in 2010 and 2012 clarified eligibility and allocation of Personal Care Services and Waiver Services, and the department continues efforts to improve utilization controls and address fraud and abuse in this area. Spending for Waiver and Personal Care Services declined between FY 2015 and FY 2016 as follows.

Medicaid Services	FY 2015 Spending	FY 2016 Spending	$ Change	% Change
Waiver	$270,078,817	$258,364,146	($11,714,671)	-4.3%
Personal Care	$86,644,531	$72,301,430	($14,343,101)	-16.6%
TOTALS	**$356,723,348**	**$330,665,576**	**($26,057,772)**	**-7.3%**

Personal Care Assistant and HCBS Prescreening Tool and Options Counselling

The department worked with Aging and Disabilities Resource Centers (ADRC) to pilot test from FY 2014 to FY 2016 a new prescreening tool for Personal Care Assistant and Home & Community-Based Services in seven communities. The pilot project resulted in a reduction of inappropriate assessments, and referral of individuals to other community-based supports rather than Medicaid. The pilot resulted in a 62.4% reduction in requests for waiver assessments. The department has been working with the ADRCs and the Mental Health Trust to implement the Prescreening & Options Counselling services statewide, and is scheduled to implement this new service for all individuals seeking Adults Living Independently and Adults with Physical and Developmental Disabilities Waiver services on January 1, 2017.

Medicaid Payment for Inpatient Care for Incarcerated Individuals

In FY 2015 the department began providing Medicaid reimbursement for inpatient care provided outside correctional facilities for incarcerated individuals. This state policy change was based on earlier policy clarification from CMS. In FY 2016 Medicaid paid $1,667,000 for inpatient care for Department of Corrections (DOC) inmates. In the past these fees would have been paid by DOC with 100% general fund dollars, and at a higher rate closer to the market payment rate. The Division of Juvenile Justice saved approximately $20,000 in state general fund dollars in FY 2016 for incarcerated youth hospitalization costs due to this Medicaid policy change.

3) A statement of whether the department has met annual targets for quality and cost-effectiveness.

AS 47.05.270(a)(9), added by section 43 of SB 74, requires the department to work with stakeholders to set annual targets for quality and cost-effectiveness. The department launched the target-setting process by publicly recruiting stakeholder representatives to participate on the Medicaid Quality & Cost Targets Workgroup. The workgroup held their first meeting on October 25, and will meet several times over the coming months with the goal of adopting a final set of targets by June 30, 2017.

The indicators, targets, baseline data, and current status of progress toward meeting the identified targets will be included in the November 2017 Annual Medicaid Reform Report to the Legislature. Please see Section I.A.(a)(9) above on page 10 for a more detailed description of the department's efforts in this area.

4) Recommendations for legislative or budgetary changes related to medical assistance reforms during the next fiscal year.

SB 74 was signed by Governor Walker on June 21, 2016. The department's primary objective has been implementation of the many initiatives and changes required by the bill. At this writing the department has no recommendations for additional changes to legislation or budgeting related to medical assistance reforms. The department is continually evaluating the Medicaid program's effectiveness and efficiency and will work closely with the Governor's Office and the Legislature on recommendations.

5) Changes in federal laws that the department expects will result in a cost or savings to the state of more than $1,000,000.

A federal policy clarification announced by the Centers for Medicare and Medicaid Services (CMS) in 2014 regarding services for children under age 21 with Autism Spectrum Disorders (ASDs) is expected to increase state costs by more than $1 million. The policy clarification has the effect of requiring states who serve children with ASDs under a 1915(c) waiver to move those children out from under the waiver if they qualify for Medicaid without the waiver and only receive Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services. Applied Behavior Analysis (ABA) services must be added as a Medicaid-covered service under Behavioral Health Medicaid Services to comply with EPSDT requirements for meeting these children's needs. The new requirement takes effect July 1, 2017.

The department is unaware of any other changes in federal law, regulation or policy that may result in a cost or savings to the state of more than $1 million.

6) A description of any medical assistance grants, options, or waivers the department applied for in the previous fiscal year.

The department submitted seven Medicaid State Plan Amendments during FY 2016, as follows:

- SPA 15-002A: Addition of payment methodologies for certified nurse anesthetists, physician assistants, community health aides III and IV, and community health practitioners.
- SPA 15-0002B: Revision of payment methodology for physician services provided in tribal outpatient hospital settings.
- SPA 15-0004: Annual Rate Adjustment, to update the optional state supplement standards for special income level groups consistent with the published 2015 federal poverty standards.

- SPA 15-0005: Alternative Benefit Plan — eligibility, benchmark plan, essential health benefits, other 1937 covered benefits, EPSDT assurances, prescription drug assurances, other benefit assurances, service delivery designation, general assurances, and payment methodology. (Required for Medicaid Expansion)
- SPA 15-0006-MM1: Election to cover adult eligibility group under the Medicaid State Plan in accordance with section 1902(a)(10)(A)(i)(CIII) of the Social Security Act. (Required for Medicaid Expansion)
- SPA 15-007: Describes the methodology used by the state for determining the appropriate FMAP rates, including the increased FMAP rates, available under the provisions of the Affordable Care Act applicable for the medical assistance expenditures under the Medicaid program associated with enrollees in the new adult group adopted by the state and described in 42 CFR 435.119. (Required for Medicaid Expansion)
- SPA 15-0009: A1-A3 Exchange – Changes the state from accepting Medicaid eligibility assessment to accepting eligibility determination made by the Federally Facilitated Marketplace and describes the single state agency's delegation of appeals and determinations in accordance with the Affordable Care Act.

During FY 2016 the department also submitted five-year renewal applications to renew Alaska's four Medicaid Home and Community-Based Services (HCBS) 1915(c) Waivers for the period FY 2017 through FY 2021, as follows:

- AK.0260.R05.00 – 1915(c) HCBS Waiver for People with Intellectual or Developmental Disabilities
- AK.0261.R05.00 – 1915(c) HCBS Waiver for Alaskans Living Independently
- AK.0262.R05.00 – 1915(c) HCBS Waiver for Adults with Physical and Developmental Disabilities
- AK.0263.R05.00 – 1915(c) HCBS Waiver for Children with Complex Medical Conditions

No changes were made to the services covered under these Waivers in the reapplication process.

The department did not apply for any medical assistance grants in the last fiscal year.

7) The results of demonstration projects the department has implemented.

The department did not implement any demonstration projects in FY 2016. Development of two demonstration projects required under SB 74 began in FY 2017:

- 1115 Demonstration Waiver for Behavioral Health System Reform, required under AS 47.05.270(b) and AS 47.07.036(f). Please see Part I.A.(b) on page 12 of this report for information on implementation of this project.
- The Coordinated Care Demonstration Project, required under AS 47.07.039. Please see Part I.A.(a)(7) on page 10 of this report for information on implementation of this project.

8) Legal and technological barriers to the expanded use of telehealth, improvements in the use of telehealth in the state, and recommendations for changes or investments that would allow cost-effective expansion of telehealth.

This year the Alaska Legislature, through SB 74, addressed a significant barrier to expanded use of telehealth by prohibiting state licensure boards from imposing disciplinary sanctions on a variety of licensees for evaluation, diagnosis, or treatment of a person through audio, video, or data communications when physically separated from the person, with certain limitations.

In August of this year the department solicited stakeholder representatives to serve on a workgroup to identify opportunities, barriers and solutions for expanding the use of telehealth for delivering Medicaid services. The members appointed to the Telehealth workgroup are listed on page 6. This workgroup held its first meeting on November 2, and will meet several more times over the coming months. They will deliver their report, including findings and recommendations, by July 1, 2017.

Barriers to expanded use of telehealth and recommendations for changes to allow cost-effective expansion of telehealth will be included in the November 2017 Annual Medicaid Reform Report to the Legislature. Please see Sections I.A.(a)(3) and (c) on pages 6 and 13 above for a more detailed description of the department's efforts in this area.

9) The percentage decrease in costs of travel for medical assistance recipients compared to the previous fiscal year.

The department was able to hold transportation and accommodation expenses relatively steady from $85,466,731.43 in FY 2015 to $84,716,915.12 in FY 2016, a decrease of 0.9%. Approximately 50% of these totals are state general fund dollars. The department's efforts to contain transportation costs are described in section I.A.(a)(10) of this report on page 11.

10) The percentage decrease in the number of medical assistance recipients identified as frequent users of emergency departments compared to the previous fiscal year.

Number of Medicaid Recipients Identified as Frequent ED Users

Medicaid Population	FY 2015	FY 2016	% Change
Non-Expansion Recipients	2,406	2,451	1.9%
Expansion Recipients	n/a	966	n/a

The threshold for frequent users was five visits within the fiscal year. Medicare crossover claims were excluded from this analysis.

11) The percentage increase or decrease in the number of hospital readmissions within 30 days after a hospital stay for medical assistance recipients compared to the previous fiscal year.

Number of Hospital Readmissions (2 – 30 days following discharge)

Medicaid Population	FY 2015	FY 2016	% Change
Non-Expansion Recipient Readmissions	1,300	1,315	1.2%
Expansion Recipient Readmissions	n/a	480	n/a

Readmissions are counted for the 2 to 30 day period following a hospital stay because 1-day readmissions inappropriately capture medevacs and hospital transfers. For example, a medevac from a Fairbanks hospital to an Anchorage hospital is a facility to facility transfer, not a readmission.

12) The percentage increase or decrease in state general fund spending for the average medical assistance recipient compared to the previous fiscal year.

The percentage in state general fund spending for the average medical assistance recipient decreased 21.2% in FY 2016 compared to FY 2015. In FY 2015 the state general fund spending averaged $4,565 per recipient, and in FY 2016 it averaged $3,598. The decrease in this average may be attributed in part to Medicaid Expansion, which increased the number of recipients covered 100% with federal funds. In FY 2015 there were 147,392 recipients and state general fund spending was $672,867,000; and in FY 2016 there were 176,429 recipients and state general fund spending was $634,959,800.

13) The percentage increase or decrease in uncompensated care costs incurred by medical assistance providers compared to the percentage change in private health insurance premiums for individual and small group health insurance.

Due to differing fiscal years and reporting periods, complete cost report data for CY 2015 is not yet available. Following are the CY 2011 – 2014 uncompensated care costs incurred by hospitals in Alaska that complete standard Medicare cost reports and for which this information is available.

	Uncompensated Care	% Change
2011	$91,791,134	N/A
2012	$96,759,654	5.40%
2013	$101,544,876	4.90%
2014	$93,861,891	-7.60%

Source: Alaska State Hospital & Nursing Home Association, October 2016

The following is information provided by the Alaska Division of Insurance in response to the question regarding the change in health insurance premiums.

	2014	2015	$ change	% change
Individual Market				
Total Premium Payment	$ 117,103,505	$ 200,892,206	---------	---------
Total Member Months	266,002	326,711	---------	---------
Average Monthly Premium Payment	**$ 440**	**$ 615**	**$ 175**	**39.7%**
Small Group Market				
Total Premium Payment	$ 123,538,386	$ 133,752,599	---------	---------
Total Member Months	205,017	208,435	---------	---------
Average Monthly Premium Payment	**$ 603**	**$ 642**	**$ 39**	**6.5%**

Source: The Alaska Division of Insurance, October 2016
https://www.commerce.alaska.gov/web/Portals/7/pub/DOI-AR2015.pdf

14) The cost, in state and federal funds, for providing optional services under AS 47.07.030(b).

SFY 2016 spending for provision of optional services is presented in the tables below with a breakdown by service category and funding source.

	State Spending	Federal Spending	TOTAL
ADULT DAY CARE	$ 2,166,331.89	$ 2,166,331.89	$ 4,332,663.77
CARE COORDINATION	$ 5,991,636.76	$ 6,574,789.19	$ 12,566,425.95
CHORE SERVICES	$ 1,348,036.17	$ 1,348,036.17	$ 2,696,072.34
DAY HABILITATION	$ 21,850,850.36	$ 22,816,673.32	$ 44,667,523.68
ENVIRONMENTAL MODIFICATIONS	$ 259,941.68	$ 259,941.68	$ 519,883.36
INTENSIVE ACTIVE TREATMENT/THERAPY	$ 1,003,212.43	$ 1,003,212.43	$ 2,006,424.85
MEALS	$ 1,603,357.11	$ 1,604,017.92	$ 3,207,375.03
RESIDENTIAL HABILITATION	$ 58,097,034.19	$ 61,579,745.34	$ 119,676,779.53
RESIDENTIAL SUPPORTED LIVING	$ 22,164,258.69	$ 22,316,102.45	$ 44,480,361.14
RESPITE CARE	$ 6,085,739.34	$ 6,427,043.15	$ 12,512,782.49
SPECIALIZED EQUIPMENT AND SUPPLIES	$ 168,228.99	$ 168,228.99	$ 336,457.98
SPECIALIZED PRIVATE DUTY NURSING	$ 663,820.77	$ 663,820.77	$ 1,327,641.55
SUPPORTED EMPLOYMENT	$ 3,650,954.06	$ 3,654,829.82	$ 7,305,783.89
TRANSPORTATION	$ 1,363,985.43	$ 1,363,985.43	$ 2,727,970.85
TOTAL WAIVERS	**$ 126,417,387.87**	**$ 131,946,758.54**	**$ 258,364,146.41**
CASE MANGEMENT SERVICES	$ 150.00	$ 69,432.23	$ 69,582.23
CHIROPRACTIC SERVICES	$ 42,573.12	$ 130,240.71	$ 172,813.83
DENTAL SERVICES	$ 12,250,812.64	$ 28,246,257.56	$ 40,497,070.20
DME SERVICES	$ 2,616,300.96	$ 3,127,027.62	$ 5,743,328.58
DRUG ABUSE CENTER	$ 1,372,951.72	$ 8,287,619.42	$ 9,660,571.14
ESRD SERVICES	$ 2,494,556.04	$ 2,588,162.33	$ 5,082,718.37
HEARING SERVICES	$ 709,794.62	$ 1,348,263.01	$ 2,058,057.63
HOSPICE CARE	$ 188,429.16	$ 252,194.58	$ 440,623.73
ICF/DD SERVICES	$ 803,601.62	$ 840,633.19	$ 1,644,234.80
INPATIENT PSYCHIATRIC SERVICES	$ 276,799.41	$ 276,799.41	$ 553,598.81
MEDICAL SUPPLIES SERVICES	$ 3,392,494.74	$ 3,518,840.39	$ 6,911,335.13
MENTAL HEALTH SERVICES	$ 11,804,062.05	$ 32,352,591.23	$ 44,156,653.28
NUTRITION SERVICES	$ 963.43	$ 4,600.93	$ 5,564.36
NUTRITION SERVICES UNDER 21	$ 5,925.00	$ 11,562.50	$ 17,487.50
OCCUPATIONAL THERAPY	$ 134,145.21	$ 204,309.15	$ 338,454.36
PERSONAL CARE SERVICES	$ 36,027,260.94	$ 36,274,169.48	$ 72,301,430.41
PODIATRY	$ 35,051.91	$ 47,857.62	$ 82,909.53
PERSCRIBED DRUGS	$ 24,337,616.80	$ 47,826,146.07	$ 72,163,762.87
PRIVATE DUTY NURSING	$ -	$ -	$ -
PROSTHETICS AND ORTHOTICS	$ 311,319.93	$ 432,595.31	$ 743,915.23
PSYCHOLOGY SERVICES	$ 224,463.29	$ 384,645.78	$ 609,109.06
REHABILITATIVE SERVICES	$ 1,615,643.72	$ 2,292,431.49	$ 3,908,075.21
VISION SERVICES	$ 1,874,004.68	$ 2,789,166.27	$ 4,663,170.95
TOTAL MEDICAID OPTIONAL SERVICES	**$ 100,518,920.96**	**$ 171,305,546.25**	**$ 271,824,467.21**
GRAND TOTAL	**$ 226,936,308.83**	**$ 303,252,304.79**	**$ 530,188,613.62**

15) The amount of state funds saved as a result of implementing changes in federal policy authorizing 100 percent federal funding for services provided to American Indian and Alaska Native individuals eligible for Medicaid, and the estimated savings in state funds that could have been achieved if the department had fully implemented the changes in policy.

On February 26, 2016, the Centers for Medicare and Medicaid Services (CMS) released State Health Official (SHO) letter #16-002 which updated its policy regarding circumstances in which 100% federal funding is available for services "received through" facilities of the Indian Health Service (IHS), including Tribal health organizations.

As outlined in the SHO letter, care coordination agreements between tribal and non-tribal providers are required to claim the enhanced federal match. The department is working with Tribal Health organizations (THOS's) to initiate care coordination agreements with non-tribal organizations to achieve the enhanced federal matching. While many tribal and non-tribal providers have existing purchased/referred care agreements in place, the SHO requires additional elements, such as shared electronic health records and referring patients back to the originating Tribal health organization.

Upon review, the department determined existing agreements between Tribal health organizations and medevac service providers met the requirements outlined in the SHO letter. The department saved $1,887,935.76 by retroactively claiming the enhanced federal match for Medevac services from the date of the SHO Letter, February 26, 2016, through June 30, 2016. The State of Alaska was the first state in the nation to move forward with claiming the enhanced federal matching for medevac services based on the SHO Letter.

Alongside this effort, the department's Tribal Programs section is working with the Tribal health organizations that opted to provide service authorization and arrangement of travel services for AI/AN who are also Medicaid recipients. The savings associated with this transition have not yet been quantified as the first organization to provide these services started on July 18, 2016.