STATE OF ALASKA
REQUEST FOR INFORMATION

REQUEST FOR INFORMATION (RFI) #170000007

ALASKA MEDICAID ADMINISTRATIVE SERVICES ORGANIZATION (ASO)

ISSUED February 27, 2017

The Alaska Department of Health and Social Services is seeking public input with regard to options for creating and instituting an Alaska Administrative Services Organization (ASO), as part of Medicaid Reform and Redesign.

ISSUED BY:

DEPARTMENT OF HEALTH & SOCIAL SERVICES
DIVISION OF FINANCE & MANAGEMENT SERVICES

PRIMARY CONTACT:

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SECTION 1. INTRODUCTION AND INSTRUCTIONS

SEC. 1.01 PURPOSE OF THE REQUEST FOR INFORMATION

As part of Senate Bill 74 (2016) the Department of Health and Social Services (the Department, or DHSS) is required to develop and implement a comprehensive redesign and reform of the state's behavioral health system of care. The behavioral health system redesign includes a review of staff and provider readiness to implement a new system of behavioral health services; the development and application to the Centers for Medicare and Medicaid Services (CMS) for a Medicaid 1115 Behavioral Health Waiver Demonstration Project; and a contract with an Administrative Services Organization (ASO) to manage the Medicaid-supported behavioral health system of care in Alaska.

The purpose of this Request for Information (RFI) is to solicit input and information to support preparation of the ASO Request for Proposals (RFP). Final decisions regarding the specific functions and services to be provided by an Alaska ASO are undecided at this time. Following the RFI the Department will analyze all responses to inform and guide the development of a RFP soliciting proposals to provide ASO services for Alaska. It is intended that the RFP will be released by July 31, 2017.

SEC. 1.02 NON-BINDING PROCESS

The sole purpose for this Request for Information is to collect information that may be used for development of a Request for Proposals to identify and contract with a third-party Administrative Services Organization (ASO). No contracts will be issued as a result of the RFI process, and failure to respond to the RFI will not preclude any entity from participation in formal procurements. However, the information and ideas provided in the RFI responses are critical to supporting the Department's planning process. Those who respond to the RFI will not be bound during the RFP process by what is included in or excluded from their RFI response.

SEC. 1.03 DEADLINE FOR RECEIPT OF RESPONSES

Please provide responses no later than 4:00 PM prevailing Alaska Time on March 30, 2017. Responses may be sent via mail or email.

SEC. 1.04 RESPONSE INSTRUCTIONS

Responses may be submitted in paper or electronic format. Please send one copy of your paper response to the following address:

Department of Health and Social Services
Division of Finance and Management Services
Attention: Jon Geselle
RFI Response: Administrative Services Organization

If using U.S. mail, please use the following address:

PO BOX 110650
Juneau, AK 99811-0650

If using a delivery service, please use the following address:

333 Willoughby Ave., Room 760
Juneau, AK 99801

If a paper response is submitted, please also send an electronic copy via email to Jon.Geselle@alaska.gov. Please submit electronic copies in Microsoft Word or Adobe PDF format.

SEC. 1.05 COST OF PREPARING RESPONSES

All costs incurred for response preparation and participation are the sole responsibility of the respondent. The State will not reimburse any respondent for any such costs.

SEC. 1.06 RETENTION OF RESPONSES

Documents and information a respondent submits are public records and subject to disclosure. A competitive bid process will follow this RFI. While DHSS may elect to not make RFI responses available to the public until contract award via the subsequent formal proposal request and review process, it is the intent of the Department to disclose a summary of RFI responses to Behavioral Health Redesign partners and stakeholders, working with the Department to create a system of care that is responsive to the needs of Alaskans.

Respondents claiming any portion of their response as proprietary or confidential must specifically identify what documents or portions of documents they consider confidential and submit an additional copy of the response with this information redacted. DHSS shall make the final decision as to whether the documentation or information is confidential.

SEC. 1.07 ACCEPTANCE OF RESPONSES

DHSS will accept all responses submitted according to the requirements and deadlines specified in this RFI. DHSS may ask for written clarification of any response. The Department is looking for responses from a broad spectrum of organizations with an understanding, expertise and/or experience in providing a care management system like an ASO. As stated, this RFI is soliciting information only, not proposals to provide ASO-types of services.

SECTION 2. BACKGROUND INFORMATION

SEC. 2.01 BACKGROUND INFORMATION

Introduction

The mission of the State of Alaska Department of Health and Social Services (DHSS) is to promote and protect the health and well-being of Alaskans. In pursuit of its mission, the department has three service priorities:

1. Health and wellness across the lifespan;
2. Health care access, delivery and value; and
3. Safe and responsible individuals, families and communities.

DHSS is an umbrella agency that administers or provides most of the state's health and social services, including Medicaid, public health, senior and disability services, behavioral health services, public assistance, juvenile justice, and child protection services. DHSS also administers a number of residential facilities, including the Pioneer Homes (state-owned assisted living facilities), the state psychiatric institute, and secure juvenile detention and institutional treatment facilities.

Medicaid Reform

Senate Bill (SB) 74, passed by the Alaska legislature in April 2016 and signed into law by Governor Walker in June, directs DHSS to undertake a series of Medicaid reforms intended to improve quality of patient care, increase service value over volume, and control spending. SB 74 includes initiatives related to fraud and abuse prevention and detection, primary care case management, and reform of the behavioral health system. The law also directs DHSS to implement coordinated care demonstration projects, participate in a hospital emergency department improvement initiative, and implement other payment reform measures. SB 74 includes authorization for the Department to apply to the federal government for Section 1115 Medicaid waivers, and to add new Medicaid state plan services such as Section 1915(i) and (k) home and community based services and Section 1945 health home services.

Responders to this RFI are highly encouraged to review SB 74 closely to understand the scope of the reforms and consider how they might interrelate. A summary of each of the major delivery system reforms and a note about the status of implementation of each follows. A link to SB 74 is provided in Section 2.02.

- **Behavioral Health System of Care Redesign and Reform**
  SB 74 adds AS 47.05.270(b) requiring DHSS 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 increase 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 Behavioral Health 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 1115 Behavioral Health Waiver Demonstration Project will focus on five identified goals:

1. Expansion of treatment capacity and improved access to services;
2. Integration of care;
3. Cost and outcomes reform;
4. Provider payment and accountability reform; and
5. Delivery system reform.

The Department submitted the 1115 Behavioral Health Waiver Demonstration Project Concept Paper to the Centers for Medicare & Medicaid Services (CMS) on January 5, 2017. A copy of the Concept Paper is available at: http://dhss.alaska.gov/HealthyAlaska/Pages/Initiatives/Initiative-2.aspx.

DHSS anticipates contracting with an Administrative Services Organization (ASO) to implement management of the behavioral health system of care recommended under the legislation. The ASO will be a third-party organization with specialized expertise in integrated behavioral health systems management—the lynchpin of behavioral health reform. The Department will contract with the ASO through a competitive bidding process to provide certain specified administrative services necessary to manage Alaska's behavioral health system of care on the Department's behalf. Potential functions of an ASO (not fully determined or defined at this time) may include:

- Utilization management
- Provider management
- Quality management
- Data management
- Claims processing
- Member Enrollment services

Implementation Status:

- To assess the current capacity of the staff of the Division of Behavioral Health and the Community Behavioral Health provider system, two readiness assessments were conducted in August-September, 2016. Through these assessments the Department is able to develop a training and technical assistance plan to support, expand and increase the behavioral health workforce capacity to initiate, develop and carry-out significant system redesign and reform. A staff and provider training plan/strategy is currently being developed with training opportunities beginning in March 2017;

- The Department has convened six public-private workgroups to support the design and development of the 1115 waiver application for Behavioral Health Reform. These teams are: Policy, Benefit Design, Quality, Cost, Data, and Writing;

- Current Behavioral Health System Redesign and Reform Timeline *(subject to revision)*:

- January 5 2017: Submission of 1115 Waiver Concept Paper to CMS
- February 2017: Release of RFI for ASO Services
- May – June 2017: 1115 Waiver application public comment and tribal consultation process
- July 31, 2017: Submission of 1115 Waiver application to CMS
- July 2017: Release of Request for Proposals to provide ASO services to Alaska
- January 2018: Award of ASO Contract

Other Medicaid Reform Initiatives

Other reform initiatives established by SB 74 Include:

- **Coordinated Care Demonstration Project**
  SB 74 adds AS 47.07.039, which directs DHSS to contract with one or more third parties to implement one or more coordinated care demonstration projects for Medicaid beneficiaries identified by the Department. The purpose of the demonstration(s) will be to assess the efficacy of various health care delivery models with respect to cost, access, and quality of care.

  SB 74 requires that proposals for demonstration projects 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.

  DHSS is permitted by SB 74 to contract with entities situated to improve care coordination for Medicaid recipients and meet the goals of this project, including provider-led entities, Accountable Care Organizations, managed care organizations, primary care case managers, and prepaid ambulatory health plans, to implement a demonstration project. The demonstrations' fee structures may include global payments, bundled payments, capitated payments, shared savings and risk, or other payment structures.

  There are 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.

Implementation Status:

- The State Health & Value Strategies initiative of the Robert Wood Johnson Foundation has contracted with the Pacific Health Policy Group (PHPG) on behalf of the Department to provide consultation on the development of the solicitation for the Coordinated Care Demonstration Projects (CCDP).

- The Department contracted with Milliman, Inc. in October to provide Medicaid payment reform and actuarial consulting services to support, in part, the CCDP. Milliman will produce a Medicaid Data Book to provide information on Alaska's Medicaid spending for CCDP RFP respondents. The Data Book, which is expected to be released March 7, 2017, will provide two years of information (FY 2015 and FY 2016) on Medicaid service utilization and spending. Milliman will also conduct a financial review and actuarial analysis of CCDP proposals, and evaluate selected CCDP projects two years following implementation. In addition to CCDP support, Milliman will analyze potential costs and savings of other reform initiatives, identify and analyze potential innovative payment models, and provide the cost analysis required for the 1115 waiver application for behavioral health reform.

- The Department issued a Request for Information from September 15 to October 17 to solicit public input on options for Medicaid coordinated care demonstration projects, and to gather information to help inform the development of this RFP. A summary of the RFI responses was released to the public in November. A link to the summary is provided in Section 2.02.

- On December 30, 2016 the Department released a CCDP Request for Proposals—completed proposals are due to the Department by April 17, 2017. A link to the RFP is provided in Section 2.02.

- **Primary Care Case Management**

SB 74 amends AS 47.07.030(d), requiring the Department to establish a primary care case management system (PCCM) or a managed care organization (MCO) contract to increase the use of appropriate primary and preventive care by Medicaid beneficiaries and decrease the unnecessary use of specialty care and hospital emergency department services. DHSS is directed to require Medicaid beneficiaries with multiple hospitalizations to enroll in the program, subject to some exceptions defined in the law. DHSS is required to integrate the PCCM system or MCO contract with the Coordinated Care Demonstration Projects established under AS 47.07.039.

Implementation Status:

- Because SB 74 requires DHSS to integrate the PCCM system with the Coordinated Care Demonstration Projects established under AS 47.07.039, and because of the potential scope of the behavioral health system reforms, the Department is implementing a temporary program to serve as a bridge to system-wide primary care case management. This approach will allow Coordinated Care Demonstration Projects and the behavioral health system reform initiative to develop and test new models of primary care case management and to be analyzed by the third-party actuary.

- The temporary program involves expanding the current Alaska Medicaid Coordinated Care Initiative (AMCCI) contracts to include as many as 90,000 Medicaid recipients. The Department anticipates transitioning the AMCCI recipients to the new Coordinated Care

Demonstration project(s) and behavioral health reform program when those are implemented. For more information on the AMCCI see the link provided in Section 2.02.

- Current DHSS Primary Care Case Management Timeline *(subject to revision)*:
  - By January 2017: Expand AMCCI contracts
  - Beginning in January 2018: Transition affected Medicaid recipients from AMCCI to new demonstration projects.

- **Health Homes**

  SB 74 adds AS 47.07.036(d), authorizing the Department to implement Health Home state Medicaid plan option services established under Section 1945 of the Social Security Act (SSA)(sometimes referred to as Section 2703 Health Homes for the section of the Affordable Care Act that added Section 1945 to the SSA).

  Implementation Status:
  - The Department does not intend to begin planning for Health Home services until SFY 2018; however, Coordinated Care Project Demonstration projects may propose to develop and pilot test a Health Home model, and other reform initiatives may choose to implement a Health Home model, earlier than that for specific populations.

  - Current DHSS Health Homes Timeline *(subject to revision)*:
    - July 2017: Begin planning and development process for Health Homes.
    - July 2019: Implement Health Homes state Medicaid plan amendment(s).

- **Emergency Department (ED) Improvement Project**

  SB 74 adds AS 47.07.038, which requires the Department to collaborate with the state hospital association to establish a hospital-based project to reduce the use of emergency department services by Medicaid beneficiaries. The statute stipulates that the hospital association will administer the project, and outlines a series of best practices for emergency departments that this project must address. DHSS is authorized by SB 74 to establish a shared savings mechanism with participating hospitals as part of this project, subject to federal approval.

  Implementation Status:
  - The Department is currently participating in meetings organized by the Alaska State Hospital & Nursing Home Association and the state chapter of the American College of Emergency Physicians.

  - Current DHSS ED Improvement Project Timeline *(subject to revision)*:
    - August – December 2016: Collaborate with hospitals and ED physicians on development of required data systems.
    - January – June 2017: Collaborate with participating hospitals on the development of shared savings payment models.

- **Section 1915(i) and 1915(k) Home & Community Based Services**

  SB 74 adds AS 47.07.036(d), authorizing the Department to implement home and community-based services authorized under sections 1915(i) and 1915(k) of the Social Security Act. These two service options may provide an opportunity for increasing federal reimbursement for services currently

funded with state general fund dollars, and for filling gaps in services for certain populations.

Implementation Status:

- The Department contracted with Health Management Associates (HMA) to analyze potential opportunities, costs, and savings associated with implementing these two service categories. A link to HMA's final report is provided in Section 2.02
- Current DHSS 1915(i) & 1915(k) Timeline *(subject to revision)*:
  - 1st Quarter of 2017: Develop plan for implementing new home and community-based service options.

- **Federal Policy on Tribal Medicaid Reimbursement**

  SB 74 adds a new Section to the uncodified law of the State of Alaska requiring the Department to collaborate with Alaska tribal health organizations and the U.S. Department of Health & Human Services to fully implement changes in federal policy on Tribal Medicaid Reimbursement that authorizes 100 percent federal funding for services provided to American Indian and Alaska Native (AI/AN) individuals eligible for Medicaid. The new federal policy allows the state to claim 100 percent federal reimbursement for Medicaid services provided to AI/AN Medicaid recipients in non-tribal facilities if the recipients' tribal health organization has a care coordination agreement established with the non-tribal facility.

  Implementation Status:

  - The Department is currently claiming 100 percent under the new policy for some services, and is working with CMS to ensure care coordination agreements between tribal and non-tribal providers required for claiming 100 percent federal match for Medicaid services provided to tribal beneficiaries enrolled in Medicaid meet their standards.
  - Current DHSS Federal Policy on Tribal Medicaid Reimbursement Timeline *(subject to revision)*:
    - July 2016 – June 2017: Implement tribal claiming systems for air and ground ambulance, transportation management, nursing facility, Residential Psychiatric Treatment Facility, and NICU/PICU services.
    - July 2017 – June 2019: Implement tribal claiming systems for home and community based services; and for in-patient, specialty, and other medical services.

- **Innovative Payment Models**

  SB 74 adds AS 47.05.270(a), requiring the Department to implement a program for reforming the state Medicaid program and outlining a series of elements the program must include. One provision directs DHSS to redesign the payment process by implementing fee agreements that include: 1) premium payments for centers of excellence; 2) penalties for hospital-acquired infections, readmissions, and outcome failures; 3) bundled payments for specific episodes of care; and/or 4) global payments for contracted payers, primary care managers, and case managers for a recipient or for care related to a specific diagnosis.

Implementation Status:

- The Department has contracted with Milliman, Inc. to provide Medicaid payments reform and actuarial consulting services to, in part, identify and analyze potential innovative payment models.
- Current DHSS Innovative Payment Model Timeline *(subject to revision)*:
  - January 2017 – June 2017: Identify and analyze potential innovative payment models, including those proposed through other reform initiatives.

- **General 1115 Waiver Authority**
  SB 74 adds AS 47.07.036(e), 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 innovative payment models for one or more groups of Medicaid beneficiaries in one or more specific geographic areas. The demonstration projects may include managed care organizations, community care organizations, patient-centered medical homes, or other innovative payment models that ensure access to health care without reducing the quality of care.

  Implementation Status:
  - The Department may use this general waiver authority to implement a Coordinated Care Demonstration Project if necessary, but has no current plans to develop additional 1115 Waiver projects beyond the waiver planned for the behavioral health reform initiative.

- **Stakeholder Engagement in Medicaid Redesign Implementation**
  The Department, with the support of the Alaska Mental Health Trust Authority, currently has a contract with Agnew::Beck, LLC, to support a number of stakeholder engagement efforts, including:
  - Meetings with the Medicaid Redesign Key Partners group, which includes representatives of major stakeholder groups and associations;
  - Meetings of the six behavioral health 1115 waiver design teams;
  - Meetings of the Telehealth Workgroup;
  - Meetings of the Quality & Cost-Effectiveness Targets Workgroup; and,
  - Public webinars to provide periodic updates on implementation (the first two were held in September and November, and are available on-line on the Department's Medicaid Redesign web site).

  The public may also submit comments and questions to Medicaid.Redesign@alaska.gov.

SEC. 2.02 LINKS TO ADDITIONAL INFORMATION

Additional background information may be accessed via the following links.

- SB 74:
  http://www.legis.state.ak.us/PDF/29/Bills/SB0074Z.PDF

- RFP for Medicaid Payment Reform and Actuarial Consulting Services:
  - Public Notice:
    https://aws.state.ak.us/OnlinePublicNotices/Notices/View.aspx?id=182646
  - To access the solicitation without an IRIS vendor account, click the "Public Access" button on this page and scroll down to the Medicaid Payment Reform solicitation:
    https://iris-adv.alaska.gov/webapp/PRDVSS1X1/AltSelfService

- Alaska Behavioral Health Reform 1115 Waiver Concept Paper:
  http://dhss.alaska.gov/HealthyAlaska/Pages/Initiatives/Initiative-2.aspx

- Coordinated Care Demonstration Project:
  - Summary of Responses to the Request for Information:
    http://dhss.alaska.gov/HealthyAlaska/Documents/DHSS_RFI_Response_Summary_Redacted.pdf
  - Request for Proposals:
    http://dhss.alaska.gov/HealthyAlaska/Documents/RFP%20170007291%20Medicaid%20CCDP%20FINAL.pdf

- Health Management Associates (HMA) report on 1915(i) and 1915(k) options for Alaska:
  http://dhss.alaska.gov/dsds/Documents/MRICC/meetings/20160930/Implementation%20Plan_09292016.pdf

- CMS State Health Official Letter #16-002, dated February 26, 2016, regarding federal funding for services "received through" an IHS/Tribal Facility and furnished to Medicaid-eligible American Indians and Alaska Natives:
  - https://www.medicaid.gov/federal-policy-guidance/downloads/sho022616.pdf

- Alaska Medicaid Program Annual Report:
  http://dhss.alaska.gov/dhcs/Documents/PDF/Alaska-Medicaid-Annual-Report-SFY2015.pdf

- Healthy Alaska Medicaid Redesign, Behavioral Health System Reform Initiative:
  http://dhss.alaska.gov/HealthyAlaska/Pages/Initiatives/Initiative-2.aspx

- Alaska Medicaid Coordinated Care Initiative (AMCCI): *(Note – This initiative is not directly associated with the SB 74 Coordinated Care Demonstration Project. It predates SB 74, and was initially established as the "Super-Utilizer" project intended to reduce overuse of hospital emergency department services)*
  http://dhss.alaska.gov/dhcs/Pages/amcci/default.aspx

- CMCS State Health Officer Letter: Federal Funding for Services "Received Through" an IHS/Tribal Facility and Furnished to Medicaid-Eligible American Indians and Alaska Natives:
  https://www.medicaid.gov/federal-policy-guidance/downloads/SHO022616.pdf

- CMCS Informational Bulletin: Indian Provisions in the Final Medicaid and Children's Health Insurance Program Managed Care Regulations:
  https://www.medicaid.gov/federal-policy-guidance/downloads/cib121416.pdf

SEC. 2.03 DEFINITIONS

Health information infrastructure: Health care specific information technologies, data, and analytic capabilities that support health care delivery, payment, and evaluation.

Telehealth: The practice of health care delivery, evaluation, diagnosis, consultation, or treatment, using the transfer of health care data through audio, visual, or data communications, performed over two or more locations between providers who are physically separated from the recipient or from each other or between a provider and a recipient who are physically separated from each other. (AS 47.05.270(e))

Value-based payment: A payment model intended to promote quality and value of health care services by shifting from pure volume-based payment models such as fee-for-service, to payment based on quality metrics and outcomes.

Healthcare Effectiveness Data and Information Set (HEDIS): HEDIS is one of the most widely used sets of health care performance measure in the United States. HEDIS is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. Because so many plans collect HEDIS data, and because the measures are so specifically defined, HEDIS makes it possible to compare the performance of health plans on an "apples-to-apples" basis. Health plans also use HEDIS results themselves to see where they need to focus their improvement efforts. See more at: http://www.ncqa.org/hedis-quality-measurement/hedismeasures#sthash.ORxbXaXU.dpuf.

National Outcomes Measures (NOM): The Substance Abuse and Mental Health Services Administration (SAMHSA) has identified 10 domains for National Outcome Measures (NOM). The domains embody meaningful, real-life outcomes for people who are striving to attain and sustain recovery, build resilience, and work, learn, live, and participate fully in their communities. The NOMs matrix represents the beginning of a state-level reporting system that, in turn, will create an accurate and current national picture of substance-abuse and mental-health services.

SECTION 3. RESPONSE FORMAT AND CONTENT

SEC. 3.01 RESPONSE FORMAT AND CONTENT

Respondents are encouraged to answer all of the questions listed below, in order to help inform the development of the forthcoming 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 34 pages.

SEC. 3.02 QUESTIONS

Utilization Management (3 pages)

1. Please describe your experience with providing the following utilization management functions. Please be specific and cite States, sub-state regions, or local areas that documents, supports, and validates your experience:
    a. Determination of eligibility for utilization management programs
    b. Service authorizations (prior authorizations, re-authorizations)
    c. Care management for acute care
    d. Care coordination--including primary care, justice-involved systems, child welfare systems, tribal systems, or other appropriate social service systems
    e. Concurrent/retrospective reviews
    f. Wait list elimination—please specify where and how you eliminated wait lists
    g. Reporting utilization trends—e.g. Inpatient hospital admissions and days; Percent of Emergency Department visits resulting in admissions; readmissions per quarter/biennium/year; average visits per provider by major service type; prescriptions dispensed by major drug class; and follow-up Substance Use Disorder (SUD) services post discharge from withdrawal management services.

2. What are the qualifications of personnel (e.g., case managers) who interact with providers to authorize care?

3. Please specify whether your Utilization Management experience has improved access to care.
    a. If so, where?
    b. How was access improved?

4. Please specify whether the Utilization Management experience you have has decreased costs for any state, jurisdiction or region in which you have operated.
    a. If so, where and how much was saved?

5. Has your behavioral health Utilization Management experience ever led your client to increase your Utilization Management responsibilities for other systems, such as the ones listed in Question 1d?
    a. If so, where and what responsibilities were added?

Provider Management (3 pages)

1. Please describe your experience with providing the following provider management functions—be specific and cite states, sub-state regions, or local areas that documents, supports, and validates your experience:
    a. Provider recruitment, including new provider types
    b. Provider contract management
    c. Access management
    d. Provider performance monitoring
    e. Onsite operational audits/reviews
    f. Provider satisfaction surveys and follow-up

2. Access to care management in a state like Alaska creates unique challenges. There are both geographical and cultural issues that must be addressed when approaching Alaska's rural and remote communities. Alaska's population density is 1.3 persons per square mile, by far the least densely populated state in the country.
    a. Based on your experience, what steps would you take to improve access to behavioral health care and to integrate primary and behavioral health care in Alaska?
    b. Please describe how you have improved access in other states, sub-state regions, or local areas with similar challenges.

3. Please describe the efforts used by your company in other jurisdictions to integrate not only new types of service providers into existing provider systems, but also adding providers to increase access to limited but already existing services.

4. What is the average length of time it takes for your organization to credential new providers? Are there additional costs for credentialing providers with an ASO? Would you propose to utilize existing credentialing services your company may already have in place? If so, would you increase staffing to that centralized service to minimize delays when beginning service in Alaska, especially during the first year of operations here?

5. Have state-owned/operated psychiatric hospitals been included in your utilization management programs?
    a. If so, where?
    b. Were both civil and forensic populations included?
    c. Please describe whether any savings were achieved.
    d. Did the role of – or populations served by – any of the state-owned/operated psychiatric
    e. hospital(s) change?
    f. If state-owned/operated psychiatric hospitals were not included in your program, has your company been involved in managing a public psychiatric hospital(s) as a part of a state's system of behavioral health care? If you did have a role in managing a state public psychiatric hospital, how did you ensure continuity and coordination of care between the state-owned psychiatric hospital(s) and community-based providers (including hospitals and clinics)?

Quality Management (3 pages)

1. Please describe your experience in providing the following quality management functions—be specific and cite states, sub-state regions, or local areas that documents, supports, and validates your experience.
    a. Developing a Continuous Quality Improvement (CQI) culture among participating providers
    b. Incident and complaint investigation/resolution
    c. Chart reviews/potential fraud & abuse audits
    d. Population-wide studies
    e. Systematic review of provider and beneficiary satisfaction surveys
    f. Quality of care and outcomes trends across participating providers

2. Please provide example(s) of population-wide studies you have conducted as part of quality surveillance.

3. How often do you conduct chart reviews/audits of your participating providers? Based on your experience in other jurisdictions, on an annual basis what is the average number of referrals your company made to the state's/states' fraud and abuse agency/agencies.

4. Please provide examples of quality improvement initiatives that you have conducted in other jurisdictions.

5. How many of your existing contracts are managed on the basis of performance (e.g., part of payment is withheld as a bonus incentive to providers when they meet specific performance targets)?
    a. Please provide examples of specific performance indicators used in such instances.

Data Management (3 pages)

1. Please describe your experience in providing the following data management functions—be specific and cite states, sub-state regions, or local areas that documents, supports, and validates your experience:
    a. Collection/reporting of required data, including but not limited to NOMS, CMS Core Data Sets for Adults and Children, and selected HEDIS measures
    b. Real time reporting capacity
    c. Ability to generate systematic reports in the following areas:
        (1) enrollment data
        (2) utilization by provider, service recipient, population, & program-wide
        (3) outcomes by provider, service recipient, population, & program-wide
        (4) cost by service, service recipient, population, & program-wide
        (5) utilization/cost/outcomes patterns across program providers
        (6) service rates
    d. Exchange electronic data files
    e. Electronic enrollment interfaces

2. How many jurisdictions require your organization to use BH HEDIS measures?
    a. Were they used to measure provider performance (i.e., pay-for-performance)?
    b. Were they used to measure your company's own performance?

3. What is your experience with establishing performance benchmarks and performance targets tied to objectives such as service access, quality, overall community to IP ratio, overall expenditures?

4. Did your company provide reports monthly, quarterly, and annually to the state or other governmental agency for whom you were contracted? How would you / the government agency describe your success in filing your reports on time?

5. Would it be your preference to require providers to utilize Electronic Health Record and data management software that you provide/require them to use, so that performance and outcomes data is uniform from the outset? If not, how will you ensure data comparability and management efficiencies?

Claims Processing (2 pages)

1. Please describe your experience in providing the following claims processing functions—be specific and cite states, sub-state regions, or local areas that documents, supports, and validates your experience:
    (1) Process claims and adjustments from original receipt through determination of disposition
    (2) Receive, verify, and log claims and adjustments received
    (3) Perform internal claims edits
    (4) Perform claim validation edits
    (5) Complete claims development and adjudications
    (6) Maintain pricing and user files
    (7) Transfer claims data to state Medicaid Management Information System or comparable claims processing systems
    (8) Generate reports:
        (1) Routine and ad hoc reporting
        (2) Denial management
        (3) Claims resolution tracking
        (4) Error analysis
        (5) Medical review of claims
        (6) Reporting of claims payments to payers

2. What is your average turnaround time for clean claims?

3. How do you set payment rates for:
    a. Inpatient (IP) Hospital
    b. Inpatient Withdrawal Management
    c. Residential services
    d. Outpatient and Intensive Outpatient
    e. Crisis
    f. Ambulatory detoxification
    g. Community support
    h. Peer support
    i. Day Treatment/Partial Hospitalization

Enrollment and Outreach (2 pages)

1. Please describe your experience in providing the following enrollment and outreach functions—be specific and cite States, sub-state regions, or local areas that documents, supports, and validates your experience:
    a. Member outreach, education, and issue resolution
    b. Create/distribute benefit summary forms
    c. Create/distribute member enrollment materials
    d. Create/distribute member handbooks
    e. Train the Trainer
    f. Onsite enrollment benefit education

2. What methods have you used to reach out to beneficiaries who are resistant to behavioral health care? Please cite specific examples.

3. What incentives have you used to assure providers assertively engage seriously ill individuals who are not receiving regular treatment?

Covered Benefits/Services (2 pages)

1. Please provide examples of the scope of services included in your existing contracts.

2. What types of community support and peer support services have you utilized?
    a. How have you credentialed these services?

3. Please provide examples of how you have "braided" Medicaid funding with other funding streams to ensure a more robust benefit package.

4. If you have not been required to manage behavioral health funds other than Medicaid, how have you supported linkages between Medicaid services and services funded by other funding streams?

Complaints/Grievances (2 pages)

1. Please provide examples of your conflict and grievance resolution policies and procedures that identify, prevent, and resolve conflicts or complaints.

2. What systems have you put in place to facilitate open and transparent two-way communication and feedback mechanisms among your organization, providers, and consumers?

3. What mechanisms have you used to ensure that providers report and appropriately resolve complaints and grievances as part of their CQI programs?

Culturally and Linguistically Appropriate Services (3 pages)

1. What methods have you used to ensure the availability of bilingual providers and trained interpreters in the languages present in at least 5% of Medicaid enrollees?

a. How would you modify those methods to address the needs of Alaska—with its vast size, rural nature, limited road system, arctic climate, diversity of people and languages, and approximately 37 percent of Medicaid enrollees are American Indian/Alaska Native (AI/AN)?
b. How would you recruit, promote, and support a culturally and linguistically diverse leadership and behavioral health workforce within your organization that is responsive to the populations in Alaska?
c. Has your organization ever conducted an assessment of the cultural and linguistic appropriateness of your goals, policies, and management accountability in order to determine the extent your planning and operations reflect cultural appropriateness of services?
d. Has your organization ever conducted an assessment of the cultural and linguistic appropriateness of providers' goals, policies, and management accountability in order to determine the extent their planning and operations reflect cultural responsiveness and appropriateness of services?

5. Can you provide examples of culturally and linguistically appropriate indicators and measures you have used in your CQI or performance improvement activities?

Experience with tribal organizations, including Alaskan Native/American Indian health systems and providers (2 pages)

1. Please describe your experience working with tribal organizations.
    a. Have you worked with or are you familiar with the Alaska Tribal Health System?
    b. Have you worked with other tribal organizations outside of Alaska?
    c. Describe your organization's understanding and level of work related to the federal Medicaid policies regarding American Indian/Alaska Native (AI/AN) populations.
    d. Describe your organization's understanding of and any work to date related to the current Federal Policy on Tribal Medicaid Reimbursement as outlined in the CMS State Health Official Letter #16-002, dated February 26, 2016.
        (1) How would your organization recommend collaborating with the state and tribal health entities to optimize full implementation of the Federal Policy on Tribal Medicaid Reimbursement?
    e. Describe your organization's understanding of and any work to date related to the current Federal Policy on Indian Provisions in the Final Medicaid and Children's Health Insurance Program Managed Care Regulations as outlined in the CMS Informational Bulletin dated December 14, 2016.
        (1) Have you worked in states with managed care where AI/AN enrollment was voluntary? What was successful and what challenges did you encounter?

2. If tribal providers possess infrastructure capacities that place them in a better position to transition to a pay-for-performance environment, what methods would you use to facilitate developing those capacities among non-tribal providers?

Rural and Remote Area Service Delivery (2 pages)

Alaska, a frontier state, has virtually no road access in most of the state. Access to health and social services is further challenged by the lack of local providers, a lack of specialty providers, and the need to travel to receive services (most often via plane or boat).

1. Have you ever worked in Alaska?
    a. If so, please specify where, when, and what services you provided
    b. If you worked in any rural and remote communities, what did you learn that you would apply to a statewide ASO role?

2. How would you approach provider recruitment for the rural and remote communities of Alaska?

3. How many States with rural and remote sub-state areas have you worked in?
    a. Which ones are they?
    b. What did you learn from this experience that you could apply to a statewide ASO role here in Alaska?

4. What approaches have you found to be most effective to reduce the impact of behavioral health conditions and promote a good quality of life for those with behavioral health challenges that live in rural and remote communities?

5. How have you used telehealth approaches to provide and/or address service access and workforce gaps for underserved communities and populations?
    a. Please provide examples of how you have facilitated connecting patients to needed services via technology in an underserved community.

6. Please provide examples of how you have addressed any of the following barriers to behavioral health care access in a rural or remote community:
    a. Workforce shortages
    b. Health insurance status
    c. Distance and transportation
    d. Stigma and privacy issues
    e. Poor health literacy
    f. Language access—where English is not the primary language spoken

Use of Technology (2 pages)

1. Please describe your experience with telehealth approaches to care and how you might apply those approaches to management of the Alaska behavioral health system of care in both urban and rural areas of the state.

2. Please describe your experience with use of digital and mobile technologies to care and how you might apply those technologies to meet the needs of the rural and remote areas of Alaska.

3. Does your organization utilize an Electronic Health Record (EHR)? Have you ever provided an EHR for those providers unable to afford one?

4. Do you generally require providers to place patient portals on their websites as a consumer friendly approach to access and general information?

Coordination and Integration of Care across Multiple Systems (2 pages)

1. As with most statewide behavioral health systems of care, Alaska's behavioral health population

intersects with many other public systems, particularly justice systems (juvenile and adult), welfare systems (adult and child), primary care systems, and tribal health systems. These systems are siloed and care is fragmented.

a. Please describe your experience with coordinating and integrating care across any or all of these systems.
b. Please explain what approaches you used to integrate care across multiple systems in order to provide holistic, person-centered care.
c. Has your organization ever been directly responsible for managing behavioral health care within any of the above-listed systems?
   (1) If so, please describe the states, sub-state regions, or local areas involved.
d. Did population health outcomes improve as a result of implementation of integrated care?
   (1) If so, how?

2. What do you think are the most important components that guide integrated care?

3. Please describe your experience with any of the following methods to develop and implement integrated care:
   a. developing common clinical protocols
   b. integrating treatment plans
   c. enhancing care coordination methods
   d. implementing transitions across levels of care
   e. training staff across systems

4. What do you think are the most important workforce competencies for integrated care between behavioral and primary health care?

General Questions (3 pages)

1. The Department may delegate administration of the contract(s) ultimately awarded under the Coordinated Care Demonstration Project RFP to the ASO. A link to the RFP is provided in Section 2.02.
   a. Please describe services your organization provides to states, sub-state regions, or local areas beyond behavioral health care management.
      (1) Have you expanded services provided to states, sub-state regions, or local areas over time?
   b. Please describe additional opportunities for partnership you would recommend to be further explored for the Alaska ASO.

2. Are you accredited by the National Committee on Quality Assurance?
   a. If so, for how long?

3. Do you publicly release all of your HEDIS results?

4. Please describe your experience with transitioning providers from a fee-for-service payment method to a performance/value-based payment method. Please be specific and cite States, sub-state regions, or local areas that document your experience.
   a. How long did the process take?
   b. What kinds of provider infrastructure issues did you encounter?

c. How did you resolve them?

5. In how many jurisdictions does your organization manage Medicaid and non-Medicaid funds (e.g., CMHS and SAPT Block Grants)?
    a. Please specify which jurisdiction(s).

6. In how many jurisdictions have you worked with your contractor to reinvest savings to expand capacity to deliver sustainable BH services? Please be specific and cite states, sub-state regions, or local areas that document your experience.