AK DHSS Annual Medicaid Reform Report

FY2017

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 statute.

In compliance with AS 47.05.270

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Commissioner
Department of Health & Social Services

FY 2017 Annual Medicaid Reform Report

Introduction

The Medical Assistance Reform Program was established under AS 47.05.270 by Senate Bill 74 (SB 74) in 2016. Under this new statute the Department of Health & Social Services (the department) is required to submit an annual report to the legislature by November 15 of each year on the status and results of Medicaid reform activities. SB 74 (2016) also mandated a separate annual report on Medicaid fraud, waste and abuse activities and savings, also due on November 15. Those issues are not included in this report but are addressed separately in the report on fraud waste and abuse, which is produced jointly with the Department of Law.

This report is organized in accordance with AS 47.05.270(d), which specifies the questions the department is to address in the annual Medicaid reform report. The department recommends caution in drawing any conclusions from single year comparisons of financial data presented in this report because of the many variables that can impact the timing of claims payment.

I. Realized cost savings related to reform efforts

Sections 1 - 11 of Part I of this report provide information on the reforms implemented under AS 47.05.270(a). Sections 12 through 16 of Part I address additional Medicaid reform projects implemented under other statutory provisions enacted by SB 74 (2016). Information on project status is provided, in addition to realized cost savings for those projects for which that data is available.

(1) Referrals to Community and Social Support Services

AS 47.05.270(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). 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.

Similar services were recently developed for Alaskans receiving Supplemental Nutrition Assistance Program (SNAP) benefits. DPA has entered into agreements with four non-profit agencies in the Anchorage area. These agencies assist SNAP recipients with job search, GED completion, English as a second language, barrier removal, and job training. The agreements are funded through the SNAP Employment & Training Program. Related expenses are met at no cost to the state. Each agency agrees to provide the services to SNAP recipients and receive a reimbursement of 50 percent from the Food & Nutrition Service of the U.S. Department of Agriculture.

These services are currently available only to those Medicaid enrollees who are also ATAP and/or SNAP recipients. The department is also coordinating with the Alaska Department of Labor and Workforce Development to identify opportunities for referring public assistance recipients to apprenticeship job training opportunities.

(2) Explanation of Benefits

AS 47.05.270(a)(2): Electronic distribution of an explanation of medical assistance benefits to recipients for health care services received under the program.

Use of the *MyAlaska* state service portal was originally planned as the mode of distribution of electronic explanations of benefits (EOB) to Medicaid recipients; however, *MyAlaska* was discovered to not meet Health Insurance Portability and Accountability Act (HIPAA) security standards for Protected Health Information (PHI). In lieu of the inability to implement the original plan, the department developed an alternate approach that will use the Medicaid Management Information System (MMIS) to distribute the EOBs.

The MMIS currently includes user portals for enrolled Medicaid providers and department staff, but a recipient portal must be created to allow EOB distribution. During the latter half of FY 2017 the department worked with the MMIS vendor and fiscal agent, Conduent State Healthcare (formerly known as Xerox State Healthcare), to develop the recipient portal project. Hardware requirements were defined and the project scope negotiated and approved in a Statement of Understanding finalized in September 2017. The department and Conduent are currently working on the operational aspects of this project. Implementation is scheduled for calendar year 2018.

(3) Telehealth

AS 47.05.270(a)(3): expanding the use of telehealth for primary care, behavioral health, and urgent care.

Telehealth is a mode of providing a covered service and is not reimbursed as a separate and distinct service by the Alaska Medicaid program; however, the program does pay enrolled providers for medical services delivered through telehealth methods if the service is: 1) covered under traditional, non-telehealth modes; 2) provided by a Medicaid-enrolled treating, consulting, presenting, or referring provider; and, 3) appropriate for provision via telehealth. In FY 2017 the Medicaid program paid $6,765,556 in claims for services delivered via telehealth methods, an increase of 38 percent over the amount paid for services delivered via telehealth in FY 2016, and 180 percent over the FY 2015 amount.

A service delivered via a telehealth delivery application is reimbursed at the same rate as the same service delivered through a traditional, non-telehealth method. Alaska Medicaid currently restricts telehealth coverage to services provided through one of these three modes:

- Interactive method: Provider and patient interact in “real time” using video/camera and/or dedicated audio conference equipment.
- Store-and-forward method: The provider sends digital images, sounds, or previously recorded video to a consulting provider at a different location. The consulting provider reviews the information and reports back his or her analysis.
- Self-monitoring method: The patient is monitored in his or her home via a telehealth application, with the provider indirectly involved from another location.

In response AS 47.05.270, telehealth requirements the department convened a Telehealth Stakeholder Workgroup comprised of tribal and non-tribal health care providers, representatives from tribal health organizations and professional associations, Medicaid recipients, and state staff members. The workgroup met throughout FY 2017, and focused on solutions to the barriers to expanding the use of telehealth to improve access to care and contain costs. The workgroup delivered its report to the department in August 2017. Please see Part VIII of this report starting on page 20 for additional information about the workgroup and for a link to the workgroup’s report.

(4) Fraud Prevention, Detection, and Enforcement

AS 47.05.270(a)(4): Enhancing fraud prevention, detection, and enforcement.

The Division of Health Care Services conducts both provider and recipient fraud prevention, detection, and enforcement through its Surveillance and Utilization Review System (SURS). Provider claims are analyzed and outliers are identified based on state and federal regulations and guidelines, and medical records are used to support or refute claims analysis. Provider SURS is also responsible for the review and evaluation of complaints lodged against Medical providers. Some complaints can be handled through desk audits and provider training, while other, more egregious accusations are referred to Program Integrity and/or the Medicaid Fraud Control Unit. Member SURS efforts include resolution of complaints submitted to the fraud and abuse hotline concerning member misuse of Medicaid. Potential outcomes from member SURS inquiries include placement in the Care Management Program, Case Management, or other Coordinated Care programs.

During FY 2017, 96 Provider Surveillance and Utilization Review (SURS) desk audits were completed resulting in the collection of overpayments in the amount of $80,222.71. Additionally during FY 2017, provider SURS efforts resulted in the discontinuation of coverage for CPT codes for services that provide no substantive results or impact (e.g., dental facial photography) and the issuance of policy clarifications for overused or misused services. Most members for whom a complaint is received are placed in the Care Management Program, Case Management, or other Coordinated Care program. Thus, cost savings from those programs, such as the $3 million in FY 2017 savings from the Care Management Program noted on page 7 of this report, are in part reflective of recipient SURS efforts.

For additional information about other Department of Health and Social Services and Department of Law efforts and results please see the separate FY 2017 *Fraud, Abuse, and Waste, Payment and Eligibility Errors* report submitted to the legislature as required by AS 47.07.076.

(5) Home and Community-Based Waivers

AS 47.05.270(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

The department continues efforts to improve utilization controls and address fraud and abuse in the provision of personal care and waiver services. The personal care services regulations were amended during FY 2017 and took effect in July 2017. The proposed revised application for Personal Care Services contains statements by both the applicant and personal care services agency that the contents of the application are accurate, under penalty of perjury.

Spending for Personal Care Services declined 1.6% overall in FY 2017 compared to FY 2016, while waiver spending increased by 8.3% for the same period, resulting in a net increase of 6.8%, as follows.

Medicaid Services	FY 2016 Spending	FY 2017 Spending	$ Change	% Change
Waiver	$258,364,146	$279,840,764	$21,476,618	8.3%
Personal Care	$72,301,430	$71175652	($1,125,778)	-1.6%
TOTALS	**$330,665,576**	**$351,016,416**	**$20,350,839**	**6.8%**

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 percent reduction in requests for waiver assessments. The department worked with the ADRCs and the Alaska Mental Health Trust Authority to implement the Prescreening & Options Counseling services statewide for all individuals seeking Adults Living Independently and Adults with Physical and Developmental Disabilities waiver services beginning January 1, 2017. The department plans to add the Prescreening and Options Counseling service in FY 2018 for those interested in accessing the Children with Complex Medical Conditions waiver.

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 included recommendations for department programs and services that will most cost-effectively and efficiently support the target populations. These recommendations were presented to the project's stakeholder group, the Inclusive Community Choices Council (ICC Council) in FY2017.

HMA's analysis found that adding new 1915(i) programs would not be cost-effective for Alaska. Instead, HMA recommended that the department focus on creation of a new waiver for people with intellectual and developmental disabilities. HMA also recommended the department pursue a Community First Choice (CFC) State Plan Option (also known as 1915(k)) to capture the additional 6 percent federal match for CFC services. The department spent FY2017 crafting the regulations, analyzing the changes necessary for payment systems and internal operations, and developing the related waiver amendments and new waiver documents. These new programs are expected to be implemented early in 2018.

(6) Pharmacy Initiatives.

AS 47.05.270(a)(6): Pharmacy initiatives.

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

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 2017 from this reform was $23,000,000, approximately 50 percent of which was state general fund dollars.

Alternate Payment Models (APM)

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

During the second phase of this program the department completed a readiness assessment and identified key directions in scalable areas, such as hemophilia, for the development of standards of care to address cross-sectional impacts of high impact drug classes. To support the department in this pilot the Center has provided technical assistance, including schedule preparation, measure development, stakeholder engagement guidance, and analytical support. Work done under this program is under review by the Alaska Medicaid Drug Utilization Review (DUR) Committee.

Additionally, the department has researched APM approaches put forward by other states and is participating in initiatives through the Centers for Medicare and Medicaid Services (CMS) and the National Association of Medicaid Directors (NAMD) on value-based purchasing models (VBP) in the Medicaid pharmacy benefit.

Pharmacy Professional Dispensing Fee Study

The department released a request for information (RFI) on the professional dispensing fee survey to garner insight into stakeholder perspectives on professional dispensing by pharmacists and health-systems. The request for proposal (RFP), informed by the RFI and other project work, is scheduled for release prior to the end of CY2017. In addition to providing evidence to support fees paid for professional dispensing of pharmaceuticals in the outpatient setting, the dispensing fee survey will further aid in providing scoping costs of services not defined specifically under 42 CFR 447.500-599 but which support transitions of care and chronic care management and wellness programs. The Medicaid professional dispensing fee schedule will be updated based on the results of the study. A new dispensing fee survey should be completed within the next year.

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 presented strategic opioid utilization initiatives at the November 2016 meeting of the Alaska Medicaid Drug Utilization Review (DUR) Committee. Such initiatives include, but are not limited to, requiring ICD-10 diagnosis codes on opioid prescriptions; waiving prior authorization requirements for medication-assisted treatment (MAT) during the first 30-days of treatment while promoting the connection of patients to on-going supportive services; limiting opioid-naïve individuals to no more than a seven-day supply of opioids on their initial fill; and restricting access to codeine and tramadol for children as per the Food & Drug Administration's safety guidance. These strategic initiatives were prepared utilizing evidence-based clinical literature and feedback obtained through public forums with pharmacists.

The department is continuing to work with the DUR Committee to further refine, frame, and prioritize the initiative work over the next year as well as track success of the various initiatives utilizing process and outcomes measures.

Hepatitis C

The department has continually worked to identify opportunities to transition to a public health model in the treatment of chronic hepatitis C virus (HCV) infection following the Food & Drug Administration's (FDA) approval of newer direct-acting antiviral drugs starting in 2014. The pharmacy reimbursement costs of these medications challenged the financial integrity of the Medicaid Pharmacy program with potential upfront treatment costs to the state exceeding $300 million dollars in one year to treat approximately 3,500 individuals. This far exceeds the appropriations for the entire Medicaid pharmacy program for over three years.

During FY 2017 the department continued to utilize evidence-based clinical criteria to prioritize the medically necessary treatment of individuals at most risk of progressing to poor clinical outcomes. During the late summer of 2017, new medications were approved by the FDA which allowed more significant competition and decreased upfront pricing in addition to further negotiated rates. This significant development allowed the department to transition to a public health model for treating chronic HCV infection in early FY 2018.

Ambulatory Infusion Center (AIC) Enrollment and Reimbursement

The department is researching the viability of Medicaid reimbursement of infused medications in an Ambulatory Infusion Center (AIC) 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, to gauge tolerability, many of these drugs require initial doses to be administered in a health care setting for patient safety purposes.

Under the current structure, these medications are administered and reimbursed through physician offices and clinics, hospital-based infusion clinics, and home infusion therapy. Continuity of care, regimen complexity, patient choice, safety, and a number of other factors warranted research into care delivery options. 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, in conjunction with providers and a representative of the Alaska State Hospital and Nursing Home Association (ASHNHA). The Alaska Medicaid Drug Utilization Review (DUR) Committee is scheduled to review a list of pharmaceutical products clinically appropriate for administration outside the direct supervision of a physician at its upcoming meeting to evaluate feasibility.

(7) Enhanced care management.

AS 47.05.270(a)(7): Enhanced care management.

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

Case Management

The Medicaid program contracts with a health management firm, Qualis Health, to provide evidence-based case management services for recipients with the most medically complex and costly conditions. Medicaid recipients may self-refer or may be referred by a health care provider or agency staff. Case management services include patient assessment, education and referral; medication reconciliation; care coordination; and facilitation of collaborative efforts of the recipient's entire healthcare team. Case management services were provided to an average of 150 Medicaid recipients per month during FY 2017 and yielded net Medicaid program savings of $2,454,220 and a return on investment average of $3.52 of every $1.00 spent through avoided inpatient stays and duplication of services.

Care Management Program

Established during the mid-1990s, the department's Care Management Program (CMP) addresses inappropriate use of Medicaid-covered services. Medicaid recipients who overuse or misuse Medicaid covered services or who would otherwise benefit from CMP enrollment are identified through post-payment review and are assigned to the program. The department also accepts CMP referrals from medical providers. For recipients who are enrolled, participation is mandatory. An initial CMP placement typically lasts 12 months, during which time the recipient is assigned a primary care provider and limited to one pharmacy. All non-emergent care must be delivered by the assigned primary care provider; all drugs must be dispensed by the selected pharmacy.

The CMP program saved approximately $3 million during FY 2017 (all funding sources; approximately 50 percent 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. CMP enrollment and savings remained relatively stable compared to FY 2016, at 248 recipients and $3 million, respectively.

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. The project was subsequently expanded to include recipients who over-utilize other medical services. Recipient 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 50 of the highest utilizers of ED services.

Based on an average ED cost per visit, AMCCI's reduction in ED utilization saved the Alaska Medicaid program more than $8.5 million in FY 2017, approximately 50 percent of which was state general fund dollars. This represents a savings increase of 340 percent over FY 2016. Of the more than 130,000 Medicaid recipients who were eligible to participate in AMCCI, 58,033 Medicaid enrollees received AMCCI services. AMCCI savings increased in FY 2017, and the reduction of ED use per individual decreased because of the inclusion of those with moderate-use of EDs. During FY 2017, utilization decreased 9 percent, yielding a 6 percent reduction in overall healthcare costs for AMCCI participants.

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 continues to expand AMCCI participation, with the ultimate goal of including all who are eligible to participate. 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 established under AS 47.07.039.

(8) Redesigning the payment process

AS 47.05.270(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.

In 2012 the department implemented fee conditions that penalize providers for episodes of care that result in hospital-acquired infections and other hospital-acquired conditions, such as those caused by medical errors. The department is also in the process of implementing demonstration projects authorized under the Coordinated Care Demonstration program (AS 47.07.030) and behavioral health reforms (AS 47.05.270(b) and AS 47.07.036(f)) that have the potential to test other payment redesign models, such as bundled payments and global payments.

To assist with these payment model reform efforts the department contracted with Milliman, Inc., a health care actuarial consulting firm, and is in the second year of a four-year contract. One important tool Milliman has provided under this contract is the Medicaid Data Book, which utilizes FY 2015 and 2016 Medicaid claims data to provide information on spending and utilization by region, eligibility group, and other factors. An on-line pdf version of the data book is available at: http://dhss.alaska.gov/HealthyAlaska/Pages/Redesign/Milliman.aspx.

(9) Quality and cost-effectiveness targets

AS 47.05.270(a)(9): Stakeholder involvement in setting annual targets for quality and cost-effectiveness.

Last year the department established the Medicaid Redesign Quality and Cost Effectiveness Targets Stakeholder Workgroup to make recommendations on Medicaid program performance measures and develop corresponding performance targets. This 16-member group representing providers, provider organizations, tribal health organizations and members of the public, met numerous times throughout the year to identify program measures and performance targets to help monitor Medicaid program quality throughout the redesign process. A list of the workgroup members is provided in Appendix A of this report.

The workgroup submitted their report to the department in August 2017, which recommends 18 quality and cost effectiveness measures and corresponding performance goals. A copy of the Workgroup's report is available on-line at: http://dhss.alaska.gov/HealthyAlaska/Documents/redesign/MCD_Quality_Cost_Target_Report.pdf

Medicaid Redesign Quality and Cost Effectiveness Targets Workgroup Recommended Measures

CATEGORY	MEASURES
Access	A.1 Child and Adolescents' Access to Primary Care
	A.2 Ability to Get Appointment With Provider As Needed
Behavioral Health	B.1 Follow-up After Hospitalization for Mental Illness
	B.2 Medical Assistance with Smoking and Tobacco Cessation

	B.3 Alcohol and Other Drug Dependence Treatment
Chronic Health	CH.1 Emergency Department Utilization
	CH.2 Diabetic A1C Testing
	CH.3 Hospital Readmission Within 30 days - All Diagnoses
Cost	C.1 Medicaid Spending Per Enrollee
	C.2 Number of Hospitalizations for Chronic Obstructive Pulmonary Disease
	C.3 Number of Hospitalizations Attributed to a Diabetic Condition
	C.4 Number of Hospitalizations Attributed to Congestive Heart Failure
Maternal Health	M.1 Live Births Weighing Less Than 2,500 Grams
	M.2 Follow-up After Delivery
	M.3 Prenatal Care During First Trimester
Preventive Health	P.1 Childhood Immunization Status
	P.2 Well-Child Visits for Children 0-6 by Age
	P.3 Developmental Screening in the First Three Years of Life

In their report the workgroup identifies the methodology used to select the measures and some of the challenges they encountered during the process. Of the 18 measures recommended, 13 are currently used to support various national quality initiatives. Examples include measures from the National Committee for Quality Assurance (NCQA) and the Healthcare Effectiveness Data and Information Set (HEDIS). These same measures are included in the Centers for Medicare and Medicaid Services (CMS) Core Set of Medicaid Adult Health Care Quality Measures and the Core Set of Medicaid Children's Health Care Quality Measures. Calculations for these common measures can be based on the corresponding CMS Core criteria as it has been developed specifically for Medicaid programs.

The measure recommendations also include five measures representing either the workgroup's desire to follow a specific issue, such as Medicaid spending per enrollee, or a specific interest to the workgroup. In some cases the workgroup modified a national measure to fulfill a more specific purpose. Measure P.2, Well-Child Visits for Children 0-6 by Age, is an example. The related CMS measure requests a tally of visits by age, e.g., the number of children age 0-1 who had one well-child visit during the year). The workgroup felt it was more important to note the average number of well-child visits (ex. 15 percent of children age 0-1 had a well-child exam during the year) rather than the number of children receiving a set number of services in order to more readily identify gaps. Due to variations in workgroup recommendations from national norms such as this, the department will need time to verify the validity of calculated results from the modified measures, and then determine whether the results provide a reliable picture of program performance. The workgroup also recommended the department explore methods to calculate two measures for which a Medicaid-specific dataset has not yet been identified. Milliman supported the workgroup on behalf of the department, calculating preliminary program performance results for each measure. These calculations, which were derived from a subset of Medicaid claims information provided by the department, provided the workgroup with information necessary to recommend corresponding five-year performance improvement goals. For each measure, the workgroup recommends performance meet or exceed 10 percent improvement by the end of the five-year period. Annual performance targets were then calculated based on an even distribution of growth each year toward the five-year goal.

The department has reviewed both the measures and performance targets brought forward by the workgroup, as well as the preliminary calculations on current performance prepared by Milliman. Although Milliman was able to calculate results for the majority of measures, it is unclear whether the Medicaid claims data can be used as the sole source for the information necessary to identify program performance on some of the recommended measures. The department will further explore this issue.

The department accepted the measures as recommended by the workgroup and will be working throughout the year to test the logic necessary to calculate each measure and identified data sources where necessary. Once the logic has been tested, a baseline of program performance will be calculated. Appendix A provides both the preliminary results developed by Milliman with the modified dataset, and a calculation for annual performance if the preliminary results are used as the baseline. Should the department identify a measure that cannot reliably be calculated through either Medicaid claims data or other reliable source the workgroup will be asked to reconsider the measure.

It is the department's intent to develop baseline performance calculations for all measures that can be calculated using State Fiscal Year 2017 Medicaid claims data, and report baseline results next year, and FY 2018 will be the first year for which performance relative to the baseline will be reported.

The workgroup also presented the department with five additional recommendations, including a list of potential future measures for adoption as redesign initiatives move forward. The additional recommendations are as follows:

- Commit to focusing on Medicaid quality
- Dedicate staff to calculate program performance and support data needs to inform quality initiatives
- Remove barriers prohibiting adoption and tracking of measures that could lead to better health outcomes
- Develop a collaborative process to connect Medicaid performance goals with other Department efforts to improve population health
- Monitor the performance of other states on similar program performance measures

The department will continue to engage the Medicaid Redesign Quality and Cost Effectiveness Targets Stakeholder Workgroup. The workgroup will be asked to monitor measure performance results and develop recommendations for revising or adding measures aligning with redesign efforts.

(10) Travel Costs

AS 47.05.270(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.

The Alaska Medicaid program only covers travel costs for travel required for the recipient to receive medically necessary services not otherwise available in the recipient's home community. This restriction is authorized under a federally approved Medicaid State Plan Amendment that stipulates emergency medical transportation is only covered to the nearest facility offering emergency medical care, and that all non-emergency medical transportation must be authorized by the Medicaid Program in advance. In addition travel segments are arranged to utilize the least costly, appropriate mode of transportation, and the fewest number of overnight accommodation services.

In many rural communities, non-emergent diagnostic and treatment services are unavailable or are available only periodically. Travel is not approved when non-emergent services are available via

telehealth or are expected to be available locally from a traveling provider within three months. Providers are frequently reminded of these travel requirements through remittance advice messages, flyers, training presentations, provider billing manual updates, and newsletter articles. A memorandum from the division director offers clarification to providers regarding travel policy and provides guidance for frequently occurring and problematic travel situations. 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.

In FY 2017 total travel expenditures grew by $15.5 million over FY 2016, an increase of 18.3 percent. However, total state general funds spending for these services decreased by 69.3 percent, or $24.7 million. The increased overall spending was due in part to increased program enrollment. The decrease in general fund expenditures resulted from implementation of the new CMS tribal Medicaid reimbursement policy described in Section XV of this report on page 25. Since implementation of this new policy two tribal entities now issue transportation authorizations. The department is working with additional tribal entities that have expressed interest in providing transportation authorization services. See Section IX of this report on page 21 for more detailed information on FY 2016 and FY 2017 travel costs.

(11) Disease Prevention and Wellness

AS 47.05.270(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 continues to move toward updating Medicaid coverage policies with the goals of ensuring efficient delivery and availability and of evidence-based wellness and preventive services. The department's internal task force will refine and modernize Alaska Medicaid's wellness benefits to ensure evidence-based coverage for key preventive services based on recommendations from the U.S. Preventive Services Task Force and the Medicaid Evidence-Based Decisions Project, a collaborative of 19 state Medicaid programs and agencies and the Oregon Health & Science University's Center for Evidence-Based Policy.

The coverage benefit proposal is under review by department leadership; regulatory changes will be needed to support any new policies that are adopted. These changes, once fully implemented, will result in the efficient delivery and availability of evidence-based wellness and preventive services.

(12) 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 added 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.

In January of 2017, the department took its first important step towards realizing comprehensive reform by submitting a Concept Paper outlining Alaska's vision for its application to the Centers for Medicare and Medicaid Services (CMS) for an 1115 Behavioral Health Demonstration Waiver. The Concept Paper is available at http://dhss.alaska.gov/HealthyAlaska/Pages/Initiatives/Initiative-2.aspx.

Relying on the initial work of the six public/private workgroups created to support the design and development of the 1115 Waiver application (Policy, Benefit Design, Quality, Cost, Data, and Writing), the Concept Paper has been the basis of the department's ongoing discussions with CMS around the intent of Alaska's 1115 waiver application. Since submission of the Concept Paper, the department has concentrated its efforts with the workgroups, its professional waiver consultants (Colston Consulting Group, LLC, and Harbage Consulting), and its actuarial contractor (Milliman) on determining both the appropriate scope of the waiver's content (new service design and development) and ensuring the waiver meets the required cost neutrality to the federal Medicaid budget.

A major part of these combined efforts has been focused on identifying the Medicaid Eligible Populations (MEGs) to be included in the behavioral health waiver (e.g., Medicaid Child, Medicaid Expansion Adult, Children in State Custody), determining how the new services designed for the waiver will affect the targeted populations, what percent of these Medicaid populations will utilize the new services, and the estimated cost to Medicaid of the proposed behavioral health service/system reforms. Also included in these cost calculations is an estimate of the impact of re-designing or removing some existing Medicaid services and the development of the proposed new service delivery system. Reforming the delivery system entails identification of a formal model for regional service delivery and the cost of implementing Medicaid services across these new regions over the five-year span of the demonstration waiver. It also includes the introduction of an Administrative Services Organization (ASO) to assume responsibility for management of the reformed behavioral health system of care.

As of the end of June, 2017, the waiver application was in draft with an expectation that the completed application will be filed with CMS at the end of January, 2018. As of the date of this report the department expects the draft application for an 1115 Behavioral Health Demonstration Waiver will be released by the end of November, 2017 for at least a minimum of thirty days of public comment and tribal consultation.

A Request for Information (RFI) for an Alaska Medicaid Administrative Services Organization was issued by the department in late February 2017, seeking public input with regard to options for creating and instituting an ASO as part of Alaska's Medicaid reform and redesign efforts. The department received ten (10) responses to the RFI, including six responses from tribal health organizations (THOs) and four responses from national health care management entities. As of the end of June, 2017, the department was moving forward on its plan to develop a Request for Proposals (RFP) for ASO services for release in February, 2018. As of the date of this report, the draft Scope of Work for the RPF is in the final stages of review.

Finally, as part of systems reform, throughout FY17 the department has engaged in behavioral health readiness assessments of 1) the department's Division of Behavioral Health (DBH) staff, with respect to

the ability of DBH staff to both implement and manage oversight of an ASO and an 1115 Behavioral Health Medicaid Waiver; and 2) behavioral health provider organizations, with respect to the capacity and ability of the staff of these entities to work within a more highly managed Medicaid delivery system administered by an ASO for efficiency, cost effectiveness (the 1115 waiver requires cost-neutrality by the end of the five year demonstration), and quality outcomes. Following completion of these assessments by the department's waiver consultant (October 2016 for DBH staff and February 2017 for provider organizations), the department, with the financial assistance of the Alaska Mental Health Trust Authority and the content expertise of its waiver consultant, contracted with the Alaska Training Cooperative to develop training and education focused on those areas identified by the completed assessments as beneficial to the success of Alaska's reform efforts. Trainings were held in late 2016, and as of June 30, 2017, twice more in FY17 for both groups. These trainings were presented in person but also video-taped and are available on line to the staff of all affected agencies. The training efforts are ongoing, however, and will be provided over the anticipated two years before full implementation of the 1115 waiver and the contracting of an ASO. As of the date of this report, separate, intensive two-day training sessions for both DBH and provider staff will be offered in late November, 2017.

(13) 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. As the department makes the incremental transition from EIS to ARIES we will incorporate the new eligibility verification system at the most cost effective point to fit it into the schedule.

Integration of the two computer systems used by the Division of Public Assistance to determine eligibility has been delayed due to a contract dispute with the original contractor. The Division is in the final stages of entering into an agreement with the New England States Consortium Systems Organization to procure an Asset Verification System. Initially, staff will access information about financial accounts on a national level using a web-based portal. As development of the eligibility system advances, an automated interface will be developed.

(14) Emergency Care Improvement

The Emergency Department Coordination Project (EDCP) is a collaborative effort between the Alaska Department of Health and Social Services, the Alaska State Hospital and Nursing Home Association (ASHNHA), the State of Alaska, and the Alaska Chapter of the American College of Emergency Physicians (ACEP). EDCP was developed in response to AS 47.07.038, which requires the department, in collaboration with Alaska's statewide professional hospital association, to establish a hospital-based project to reduce the use of emergency department services by Medicaid recipients.

EDCP includes the development and implementation of a system for real-time electronic exchange of patient information among EDs. During FY 2017 the Emergency Department Information Exchange (EDIE) was implemented in six of fourteen hospitals, and contracts are signed or implementation is underway or scheduled in three hospitals.

Hospital	Status	Progress
Providence Alaska Medical Center	Live	Successfully implemented
Providence Kodiak Island Medical Ctr.	Live	Successfully implemented
Providence Seward Medical Center	Live	Successfully implemented
Providence Valdez Medical Center	Live	Successfully implemented
Alaska Regional Hospital	In progress	Contracts signed; kick-off scheduled
Mat-Su Regional Medical Center	In progress	Contracts signed; implementation underway
ANTHC	In progress	Contract under review
Central Peninsula Hospital	Live	Successfully implemented
South Peninsula Hospital	Live	Successfully implemented
Fairbanks Memorial	In progress	Contract under development
Bartlett Regional Hospital	In progress	Contracts signed, kick-off scheduled
North Star Behavioral Hospital	In progress	Contract under review
Alaska Psychiatric Institute	In progress	Program introduction complete
PeaceHealth Ketchikan Medical Center	In progress	Contract under development

(15) Coordinated Care Demonstration Project

SB 74 (2016) established the Coordinated Care Demonstration Project (CCDP) under AS 47.07.039. 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 department was required 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, 2016 to solicit information from entities potentially interested in proposing a CCDP and used the information received to craft the RFP, which was released on December 30, 2016. Based on the responses to the RFI, the department invited proposals for three different health care models: Managed Care Organizations (MCO), Care Management Entities (CME), and Provider-Based Reforms (PBR). Nine proposals were received in response to the RFP, and all three models were represented among those proposals.

Proposals were reviewed and verified for completeness by the department's procurement office; one proposal was determined to be non-responsive. A team of staff members from each division within the department reviewed the remaining eight proposals, assessing each for feasibility, cost savings, integration with other SB74 initiatives, federal and state authority requirements, and information technology requirements. The internal review findings were provided to the Proposal Review Committee, which is comprised of five voting members, for review along with the proposals.

In accordance with SB74, the department has contracted with Milliman, Inc., an international health care actuarial consulting company, to provide the independent financial analysis of the proposals, publish a Medicaid data book to support development of CCDP proposals, and assist with developing CCDP payment models after contracts are awarded.

After a thorough review process, the Proposal Review Committee made a formal recommendation to the Commissioner of Health and Social Services to proceed to the negotiation phase with four of the bidders. The department is currently in negotiations with three of those offerors (the fourth withdrew their proposal during the negotiation period). All three potential health care models are represented among the group of three offerors. The schedule for award of the eventual contracts is contingent on negotiations with the offerors and with CMS.

(16) Health Information Infrastructure Plan

Section 56 of SB 74 (2016) 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 Medicaid reform. 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 contracted with HealthTech Solutions to provide technical assistance. The contractor has facilitated two workgroup meetings for the Health Information Infrastructure Plan, in March and May of FY 2017. The workgroup has identified several measures of success that include:

- Measurable health infrastructure outcomes based on SB 74.
- Alignment of state technology standards and identified critical areas where standards are needed.
- Leverage of existing and emerging technologies with a resulting Health Insurance Portability and Accountability Act (HIPAA) compliant framework.
- Implementation of a streamlined approach to a complex technology environment.
- Development of methods to measure compliance with the plan.
- Implementation of the plan with a phased and scalable approach.

Each workgroup meeting focuses on a functional approach to delivering services that will impact the Health Information Infrastructure Plan.

- Workgroup meeting #1: claims adjudication, pharmacy, and program integrity.
- Workgroup meeting #2: member enrollment, and provider management.
- Workgroup meeting #3 (held in September): care management and registries.
- Workgroup meeting #4 (scheduled for November 2017): data management and system interfaces/connections.
- Two additional workgroup meetings have been added to discuss health information exchange and how the other Medicaid Redesign initiatives will impact the infrastructure plan.

The Health Information Infrastructure Plan will be submitted in calendar year 2018.

II) 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).

Utilization Management

The department contracts with a health management firm to provide utilization management services, also known as service authorization, for all inpatient hospital stays; inpatient stays and outpatient services for selected procedures and diagnoses, regardless of length of stay; and all outpatient magnetic resonance imaging (MRI), positron emission tomography (PET), magnetic resonance angiography (MRA), and single-photon emission computed tomography (SPECT). During FY 2017, these utilization management services yielded net Medicaid program savings of $21,623,677 and a return on investment of $14.91 for every $1.00 spent through the avoidance of unnecessary or untimely medical care.

Healthcare Management Systems

The department contracts with Healthcare Management Systems (HMS) to manage coordination of benefits for Alaska Medicaid recipients with a third party payer. HMS also audits provider claims and associated financial records to identify underpayments and overpayments, and recovers any overpayments made to providers. During FY 2017, HMS recoveries and savings exceeded $30 million.

Tribal Health System Partnerships

The federal government reimburses the state at 100% FMAP (federal medical assistance percentage) for services provided to American Indian/Alaska Native (AI/AN) Medicaid enrollees served at an Indian Health Service facility, including Alaska's tribally operated facilities. Development of tribal health system capacity to meet the needs of the AI/AN population saves state general fund dollars because of this policy. The department has partnered with tribal health organizations over the years to help facilitate capacity development in order to maximize federal reimbursement for Medicaid services, and to improve access to and continuity of care for AI/AN Medicaid recipients.

Examples of new or continued expansion of services in the tribal health system in FY 2017 include expanded dental services in certain rural communities, long term care beds in the northern and western regions, additional newborn intensive care beds, obstetric services, extended hours for orthopedic surgeries in Anchorage, and additional residential capacity in Anchorage to accommodate recipients on the Alaska Native Medical Center campus. Increased service capacity at tribal health facilities resulted in increased claims for those services by approximately $30 million in FY 2017. In lieu of this increased capacity at tribal facilities, these services would have been provided in a non-tribal setting and only reimbursed at 50 percent. The state saved as much as $15 million in FY 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 2017 Medicaid paid claims billed in the amount of $6.24 million for inpatient care for Department of Corrections (DOC) inmates. In the past these fees would have been paid by DOC with 100 percent general fund dollars.

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

As described in Part I (9) on page 8 of this report, AS 47.05.270(a)(9), requires the department to work with stakeholders to set annual targets for quality and cost-effectiveness of the Medicaid program. Over the past year the department engaged the Medicaid Redesign Quality and Cost Effectiveness Targets Stakeholder Workgroup to develop measures for the Medicaid program. The workgroup brought forward 18 performance measures, each with a corresponding annual target and five-year performance goal. The department and workgroup received technical assistance from Milliman, Inc., an actuarial firm contracted with the department, to calculate preliminary performance information for each measure. The preliminary results may be found in Appendix A.

Given that these measures are new and the data analytics systems and expertise necessary to calculate performance must be developed, the department is now in the process of establishing baseline program performance based on FY 2017 Medicaid claims data. The new baseline data and FY 2018 performance relative to the FY 2017 baseline will be reported in the FY 2018 Annual Medicaid Reform Report.

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

At present, 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 as they evolve.

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

The department is unaware of any changes made in SFY 2017 in federal law, regulation or policy that may result in a cost or savings to the state of more than $1 million.

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

The department did not apply to establish a new state plan optional service during FY 2017.
The department did not apply for new waivers during FY 2017, but did submit and received approval from the Centers for Medicare and Medicaid Services for amendments to each of Alaska's four existing Medicaid Home and Community-Based Services (HCBS) 1915(c) waivers. The amendments were for renewal of the waivers, and the renewal period is for FY 2017 through FY 2021. The following waivers have been renewed:

- 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

All four waivers were amended to include a mediation process in advance of Fair Hearings. In addition, AK.0260 was amended to increase the cap on the number of unduplicated recipients allowed on this waiver, and AK.0261 and AK.0262 were amended to remove reference to use of the Truncated Consumer Assessment Tool to determine level of care eligibility. No changes were made to the services covered under these Waivers in the amendment process.

HIV Health Improvement Affinity Group

The Division of Health Care Services and Division of Public Health received a grant to join the HIV Health Improvement Affinity Group. Affinity Groups are programs the Centers for Medicare and Medicaid Services (CMS) established to bring state Medicaid agencies together to share best practices and receive technical assistance related to CMS priority areas. CMS partnered with the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA) to establish the HIV Health Improvement Affinity Group in support of the National HIV/AIDS Strategy five-year plan that identifies priorities and strategic actions related to the HIV epidemic. Participating states are developing and implementing one or more performance improvement projects that address gaps along the HIV care continuum to increase the proportion of Medicaid and CHIP enrollees living with HIV who achieve better outcomes.

The department will benefit as a recipient of this grant from direct assistance provided by CMS to support improved HIV-related outcomes among Medicaid enrollees, and will be provided opportunities to learn from and share best practices with other states. Department efforts are focusing primarily on the prevention of HIV and sexually transmitted disease since Alaska is a low-HIV prevalence and incidence state. The department is also focusing on viral suppression of those infected with HIV, with the goal of 90 percent viral suppression of Alaskans with HIV as a result of active engagement in HIV medical care.

CMS Innovation Grant

The department is participating in the Medicaid Innovation Accelerator Program for State Medicaid-Housing Agency Partnerships. The Medicaid Innovation Accelerator Program (IAP) is a partnership between the Center for Medicaid and CHIP Services (CMCS) and the Center for Medicare and Medicaid Innovation designed to build state capacity and support ongoing innovation in Medicaid. CMCS is also partnering with several other federal agencies, including the U.S. Department of Housing and Urban Development (HUD), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the U.S. Interagency Council on Homelessness, on program planning and coordination. IAP provides targeted technical support to states' ongoing delivery system reform efforts across four priority program areas:

- substance use disorders
- Medicaid beneficiaries with complex care needs and high costs
- community integration through long-term services and supports
- physical/mental health integration.

IAP provides support to states through data analytics, quality measurement, value-based payment and financial simulations, and performance improvement.

Through its participation in the IAP for State Medicaid-Housing Agency Partnerships, the department has identified a set of goals, including:

- develop a policy framework to guide implementation of permanent supportive housing as an essential component of the Medicaid and Behavioral Health service system
- establish a coordinated and consistent approach to housing and housing-related services across all DHSS divisions
- establish a Permanent Supporting Housing (PSH) program, including a PSH clearinghouse to coordinate referrals
- establish a funding source for sustainable and individualized services delivered in supportive housing settings
- expand service delivery in home and community-based settings to promote housing stability and community integration
- strengthen community provider workforce capacity to deliver home and community-based services that promote wellness, recovery, and community integration.

CDC 6|18 Initiative Grant

The Centers for Disease Control and Prevention (CDC) is partnering with health care purchasers, payers, and providers to improve health and control health care costs. CDC provides these partners with rigorous evidence about high-burden health conditions and associated interventions to inform their decisions to have the greatest health and cost impact. The 6|18 initiative targets the six most costly health conditions (tobacco use, hypertension, healthcare-associated infections, asthma, unintended pregnancies, and diabetes) and offers 18 proven interventions that prevent chronic and infectious diseases by increasing their coverage, access, utilization and quality. Additionally, it aligns evidence-based preventive practices with emerging value-based payment and delivery models.

Alaska's participation in the CDC 6|18 Initiative will focus on diabetes prevention, tobacco use cessation, blood pressure control, and the prevention of healthcare associated infections.

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

The department did not implement any demonstration projects in FY 2017, but did work on development of two demonstration projects required under SB 74:

- 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 (12) on page 11 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 (15) on page 14 of this report for information on implementation of this project.

VIII) 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.

The department convened the Medicaid Redesign Telehealth Stakeholder Workgroup to identify barriers and legal issues impeding the expansion of telehealth services throughout the state. The workgroup, comprised of 18 members representing providers, provider associations, tribal health organizations and academia (membership included in Appendix B), met five times during FY 2017 to discuss barriers and develop potential solutions to advance telehealth options throughout the state.

In August the workgroup presented the department with their report detailing 10 recommendations members believe will expand access to telehealth services. The report and recommendations center around two primary issues: the creation of new reimbursable Medicaid services that will allow providers to receive payment for all communications between a patient and the provider (phone call, text, email, etc.) and use of remote monitoring technology; and barriers to expanding currently allowable telehealth services. The workgroup's report is available at: http://dhss.alaska.gov/HealthyAlaska/Documents/redesign/MCDRE_Telehealth_Workgroup_Report.pdf

Medicaid Redesign Telehealth Stakeholder Workgroup Recommendations	
Recommendation 1	Reimburse Care Management and Use of Remote Monitoring Strategies in Home Settings
Recommendation 2	Revise Regulations Regarding Prescriptions for Controlled Substances
Recommendation 3	Monitor Medical Board Licensing Regulations Regarding Delivery of Telehealth Services
Recommendation 4	Require All Payers to Reimburse Telehealth at Parity
Recommendation 5	Improve Coordination Between Schools and Providers to Expand the Use of Telehealth
Recommendation 6	Support Collaborative Efforts to Leverage Federal Funding for Internet Coverage in Rural Areas
Recommendation 7	Work with the Health Information Exchange and Department of Commerce to Develop Telehealth Central Network
Recommendation 8	Help Providers Invest in Equipment and Connectivity to Support Telehealth Strategies
Recommendation 9	Develop Baseline Data of Telehealth Utilization and Analyze Use and Need Patterns
Recommendation 10	Continue Medicaid Redesign Telehealth Stakeholder Workgroup

The department found great value in the information shared by stakeholders during the workgroup process, and greatly appreciates the commitment and dedication of the members to the development of recommendations for inclusion in the report. The department is generally supportive of the recommendations presented, though several do not fall under the department's purview and some may be cost prohibitive or may conflict with federal policy. The department will release a more specific response to the workgroup's recommendations by early CY 2018.

As the department continues discussion of the workgroup's recommendations, several divisions within the department are also evaluating varied telemedicine strategies aimed at improving recipient access to necessary services as they pertain to their specific programs. Efforts within the Division of Senior and Disabilities Services and the Division of Behavioral Health are each exploring ways in which advances in new technology may streamline services and expand access to care. Further development of these strategies is necessary to determine whether the options can reliably provide services long-term and will be cost effective for the program in the long-run.

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

Total transportation and accommodation expenditures increased 18.3 percent in FY 2017 compared to the prior year; however, state general fund spending decreased by 69.3 percent. The overall increase in spending is at least partly attributable to the increase in Medicaid enrollment between FY 2016 and FY 2017. The savings in state general funds is due in large part to implementation of the new Centers for Medicare and Medicaid Services (CMS) tribal Medicaid reimbursement policy described in Part XV of this report on page 25. Since implementation of this new policy, two tribal entities now issue transportation authorizations. The department is working with additional tribal entities that have expressed interest in providing transportation authorization services. See Part I(10) of this report on page 10 for more discussion of department efforts to contain travel costs.

Transportation Expenditures

	FY 2016	FY 2017	Change from Prior Year
Federal Funds	$49,140,478.65	$89,284,131.72	81.7%
State General Funds	$35,576,436.87	$10,915,321.17	-69.3%
Total Expenditures	**$84,716,915.52**	**$100,199,452.89**	**18.3%**

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

The following table depicts the number of frequent users of emergency departments in FY 2016 and FY 2017. The threshold for frequent users was five visits within the fiscal year. Medicare crossover claims were excluded from this analysis. The increased number in frequent users may be attributable in part to the increased enrollment in Medicaid between FY 2016 and FY 2017.

Number of Medicaid Recipients Identified as Frequent ED Users

FY 2016	FY 2017	Percent Change
3,417	4,442	30%

XI) 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.

The following table depicts the number of hospitalized Medicaid recipients who were readmitted to the hospital within 30 days of discharge. Readmissions are counted for the two- to 30-day period following a hospital stay to omit hospital-to-hospital transfers that are captured as one-day readmissions. The increased number of readmissions may be attributable in part to the increased enrollment in Medicaid between FY 2016 and FY 2017.

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

FY 2016	FY 2017	Percent Change
1,795	1,913	6.6%

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

State general fund spending for the average medical assistance recipient decreased 1.7 percent in FY 2017 compared to FY 2016. In FY 2016 the state general fund spending averaged $3,598 per recipient and in FY 2017 it averaged $3,537. The decrease may be attributed in part to Indian Health Services (IHS) care coordination agreements with non-IHS/Tribal providers, which increased the number of claims covered 100 percent with federal funds. In FY 2016 there were 176,429 recipients and state general fund spending was $634,959,800, and in FY 2017 there were 184,956 recipients and state general fund spending was $654,223,953 ($638,296,477 Medicaid component GF and $15,927,476 DHSS GF through Interagency).

State General Fund Spending per Medicaid Recipient on Average

FY 2016	FY 2017	Percent Change
$3,598	$3,537	-1.7%

XIII) 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.

Following are the 2011 – 2015 uncompensated care costs incurred by hospitals in Alaska that complete standard Medicare cost reports and for which this information is available. Due to differences in hospital fiscal years the data may represent different periods. For example, 2015 includes data from July 1, 2015 through June 30, 2016 for hospitals on a July – June fiscal year; and October 1, 2015 through September 30, 2016 for those on an October – September fiscal year.

	Uncompensated Care Amount	% Change from Prior Year
2011	$91,791,134	N/A
2012	$96,759,654	5.4%
2013	$101,544,876	4.9%
2014	$93,861,891	-7.6%
2015	$73,164,170	-24.5%

Source: Alaska State Hospital & Nursing Home Association, October 2017.

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

Year/Market	Member Months	Total Direct Premiums Paid	Premium Per Member Per Month PMPM	PMPM Increase From Previous Year
CY 2014				
Individual Market	266,002	$117,103,505	$440.24	
Small Group Market	205,017	$123,538,386	$602.58	
CY 2015				
Individual Market	326,711	$200,892,206	$614.89	39.67%
Small Group Market	208,435	$133,752,599	$641.70	6.49%
CY 2016				
Individual Market	256,629	$215,793,787	$840.88	36.75%
Small Group Market	202,711	$134,307,229	$662.56	3.25%

Source: The Alaska Division of Insurance, October 2017.

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

SFY 2017 spending for provision of optional services is presented in the tables below with a breakdown by service category and funding source.

	STATE	FEDERAL	TOTAL SPENDING
ADULT DAY CARE	$2,377,002	$2,377,002	$4,754,004
CARE COORDINATION	$6,825,619	$7,402,589	$14,228,208
CHORE SERVICES	$1,106,319	$1,113,318	$2,219,637
DAY HABILITATION	$24,685,642	$25,929,497	$50,615,139
ENVIRONMENTAL MODIFICATIONS	$200,913	$200,913	$401,825
INTENSIVE ACTIVE TREATMENT/THERAPY	$1,073,750	$1,073,750	$2,147,499
MEALS	$1,564,406	$1,564,406	$3,128,812
RESIDENTIAL HABILITATION	$62,108,751	$66,490,129	$128,598,880
RESIDENTIAL SUPPORTED LIVING	$23,947,063	$24,213,479	$48,160,543
RESPITE CARE	$6,487,862	$6,913,542	$13,401,404
SPECIALIZED EQUIPMENT AND SUPPLIES	$140,108	$140,108	$280,215
SPECIALIZED PRIVATE DUTY NURSING	$325,311	$325,311	$650,621
SUPPORTED EMPLOYMENT	$4,314,788	$4,328,781	$8,643,569
TRANSPORTATION	$1,305,203	$1,305,203	$2,610,406
TOTAL WAIVER	**$136,462,736**	**$143,378,028**	**$279,840,764**
CASE MANAGEMENT SERVICES	$152	$8,063	$8,214
CHIROPRACTIC SERVICES	$43,501	$91,080	$134,581
DENTAL SERVICES.	$11,742,737	$38,031,444	$49,774,180
DRUG ABUSE CENTER	$1,541,969	$14,667,675	$16,209,643
DURABLE MEDICAL EQUIPMENT/MEDICAL SUPPLIES	$2,933,013	$4,578,369	$7,511,382
END STAGE RENAL DISEASE SERVICES	$2,811,514	$3,242,778	$6,054,292
HEARING SERVICES	$946,668	$2,116,262	$3,062,930
HOSPICE CARE	$167,762	$322,741	$490,503
INPATIENT PSYCH SERVICE	$279,750	$279,750	$559,500
INTENSIVE CARE FACILITY/INTELLECTUALLY DISABLED SERVICE	$826,369	$1,007,089	$1,833,458
MEDICAL SUPPLIES SERVICE	$3,559,616	$3,998,992	$7,558,608
MENTAL HEALTH SERVICE	$12,965,490	$43,737,476	$56,702,966
NUTRITION SERVICES	$2,036	$2,329	$4,365
NUTRITION SERVICES UNDER 21	$1,663	$5,223	$6,886
OCCUPATIONAL THERAPY	$184,260	$477,982	$662,242
PERSONAL CARE SERVICES	$35,317,625	$35,858,027	$71,175,651
PODIATRY	$38,413	$49,948	$88,361
PRESCRIBED DRUGS	$29,876,435	$88,007,761	$117,884,196
PROSTHETICS & ORTHOTICS	$284,342	$602,170	$886,512
PSYCHOLOGY SERVICES	$283,988	$743,133	$1,027,121
REHABILITATIVE SERVICES	$1,990,894	$4,446,930	$6,437,824
VISION SERVICES	$2,185,514	$4,258,400	$6,443,914
TOTAL MEDICAID OPTIONAL SERVICES	**$107,983,711**	**$246,533,619**	**$354,517,330**
GRAND TOTAL	**$244,446,447**	**$389,911,647**	**$634,358,094**

XV) 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 worked with Tribal Health Organizations (THOs) to initiate care coordination agreements (CCAs) with non-tribal organizations to achieve the enhanced federal match. While many tribal and non-tribal providers had existing purchased/referred care agreements in place, the SHO requires additional elements, such as shared electronic health records and referral of patients back to the originating Tribal health organization. As of this report period for FY 2017 there are now 751 CCAs in place, this includes 64 non-tribal providers and 18 THOs. Some, but not all, THOs have signed with each of the 64 non-tribal sites.

The department's Tribal Section was able to establish that the existing agreements between Tribal Health Organizations and medevac service providers, the 751 CCA's, subsequent referral validations, exchange of health records, and transportation arrangements made by Alaska Native Tribal Health Consortium (ANTHC), the Yukon Kuskokwim Health Corporation and CTM for American Indian/Alaska Native (AI/AN) recipients met the requirements outlined in the SHO letter. Based on this determination, the department saved $35,018,868.53 on refinancing of claims at the enhanced federal match from the date of the SHO Letter, February 26, 2016, through March 31, 2017. Savings are only reflected through the third quarter of FY 17 as there is a quarter lag in claiming to allow time for claim adjustments and referral validation. The State of Alaska is the only state in the nation refinancing claims at this level since the SHO Letter was released.

Alongside this effort, the department's Tribal Section is working with the Tribal Health Organizations that opted to provide service authorization and arrangement of travel services for AI/AN Medicaid recipients. The savings associated with this transition are included in the total savings figure above, and accounts for between 750-900 travel arrangements per week. In FY 2018, with the addition of one more THO as a travel services provider, the count will increase to well over 1,000 travels per week financed at 100 percent federal match.

APPENDIX A

MEMBERS

Medicaid Redesign
Quality and Cost Effectiveness Targets Stakeholder Workgroup

MEMBER	ORGANIZATION	LOCATION
Kathy Allely	Consumer	Anchorage
Andrea Bernard, RN	Chief Patient Safety Officer, Alaska Regional Hospital	Anchorage
Barbara Berner, EdD	Director School of Nursing, University of Alaska	Anchorage
David Branding	Chief Executive Officer, Juneau Alliance for Mental Health, Inc.	Juneau
Alan Gross, MD	Petersburg Medical Center	Petersburg
Jerry Jenkins	Chief Executive Officer, Anchorage Community Mental Health Services	Anchorage
Patty Linduska, RN	Alaska Primary Care Association	Anchorage
Jenny Love, MD	Anchorage Neighborhood Health Center	Anchorage
Nancy Loverling	Speech-language Pathologist, in private practice	Anchorage
Rebecca Madison	Executive Director, Alaska eHealth Network	Anchorage
Jacqueline Marcus-Ledford	Performance Improvement Administrator, Yukon-Kuskokwim Health Corporation	Bethel
Jeannie Monk	Vice President, Alaska State Hospital and Nursing Home Association	Juneau
Nick Papacostas, MD	U.S. Army, Joint Base Elmendorf Richardson	Anchorage
Jim Roberts	Liaison, Intergovernmental Affairs, Alaska Native Tribal Health Consortium	Anchorage
Sharon Skidmore, PT	Physical Therapy for Kids, LLC	Anchorage
ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES STAFF		
Donna Steward	Project Leader, Office of the Commissioner	Anchorage
CONTRACT SUPPORT STAFF		
Thea Agnew Bemben	Managing Principal, Agnew::Beck Consulting	Anchorage
Anna Brawley	Senior Associate, Agnew::Beck Consulting	Anchorage

RECOMMENDED PERFORMANCE MEASURES AND PRELIMINARY CALCULATIONS

CATEGORY	MEASURES	2016 MILLIMAN CALCULATED RATE	2018 PRELIMINARY TARGET (BASED ON CALCULATED RATE)
Access	A.1 Child and Adolescents' Access to Primary Care	a: Age 12-24 mos = 87.0% b: Age 25ms-6 yr = 77.6% c: Age 7-11 yrs = 82.6% d: Age 12-19 yrs = 83.7%	a: 88.5% b: 78.8% c: 84.0% d: 85.1%
	A.2 Ability to Get Appointment With Provider As Needed	a: Age 0-21 yrs = 67.2% b: Age 21+ yrs = 60.6%	a: 68.1% b: 61.3%
Behavioral Health	B.1 Follow-up After Hospitalization for Mental Illness	a: Child – Acute = 63.3% b: Child – Psych = 67.7% c: Adult – Acute = 78.8% d: Adult – Psych = 74.9%	a: 64.1% b: 68.6% c: 80.1% d: 76.0%
	B.2 Medical Assistance with Smoking and Tobacco Cessation	Recommendation: Identify a measure that can be supported with available data	
	B.3 Alcohol and Other Drug Dependence Treatment	a: Initiation = 57.6% b: Engagement = 11.4%	a: 58.3% b: 11.5%
Chronic Health	CH.1 Emergency Department Utilization	496.9	486.9
	CH.2 Diabetic A1C Testing	a: Age 18-64 yrs =71.9% b: Age 65+ yrs = 52.8%	a: 72.9% b: 53.4%
	CH.3 Hospital Readmission Within 30 days - All Diagnoses	a: MH admits = 40.0% b: Other admits = 15.3%	a: 39.5% b: 15.1%
Cost	C.1 Medicaid Spending Per Enrollee	a: Age 0-21 yrs = $5,828 b: Age 21+ yrs =$10,436	a: $5,711 b: $10,227
	C.2 No. of Hospitalizations for Chronic Obstructive Pulmonary Disease	a: Age 40-64 yrs = 40.8 b: Age 65+ yrs = 46.2	a: 40.0 b: 45.3
	C.3 Number of Hospitalizations Attributed to a Diabetic Condition	a: Age 18-64 yrs = 20.1 b: Age 65+ yrs = 16.8	a: 19.7 b: 16.5
	C.4 Number of Hospitalizations Attributed to Congestive Heart Failure	a: Age 18-64 yrs = 11.3 b: Age 65+ yrs = 42.8	a: 11.1 b: 41.9
Maternal Health	M.1 Live Births Weighing Less 2,500 Grams	6.8%	6.7%
	M.2 Follow-up After Delivery	39.2%	39.5%
	M.3 Prenatal Care During First Trimester	76.4%	77.1%
Preventive Health	P.1 Childhood Immunization Status	Recommendation: Identify reliable data source	
	P.2 Well-Child Visits for Children 0-6 by Age	a: Second yr = 1.98 b: Third yr = 0.90 c: Fourth yr = 0.51 d: Fifth yr = 0.56 e: Sixth yr = 0.52	a: 2.0 b: 0.91 c: 0.52 d: 0.57 e: 0.53
	P.3 Developmental Screening in the First Three Years of Life	a: First yr = 12.9% b: Second yr = 11.8% c: Third yr = 8.8% d: 0-3 combined = 11.3%	a: 13.1% b: 12.0% c: 8.9% d: 11.4%

APPENDIX B

MEMBERS MEDICAID REDESIGN
TELEHEALTH STAKEHOLDERS WORKGROUP

MEMBER	ORGANIZATION	LOCATION
Brooke Allen	Certified Behavior Analyst	Anchorage
Connie Beemer	Alaska State Hospital and Nursing Home Association	Anchorage
Denise Daniello	Alaska Commission on Aging	Juneau
Mark Erickson, MD	Alaska Psychiatric Institute	Anchorage
Brent Fisher	Alaska Sleep Clinic	Anchorage
Matthew Hirschfeld	Alaska Native Medical Center	Anchorage
Philip Hofstetter	Norton Sound Health Corporation	Nome
Laura Hudson	Alaska Regional Hospital	Anchorage
Laura Johnston	SouthCentral Foundation	Anchorage
Richard Kiefer-O'Donnell	University of Alaska, Anchorage	Anchorage
Ken McCarty	Discovery Cove Recovery Center	Eagle River
Trina McCandless	Haines Borough Fire Department EMS	Haines
Robert Onders, MD	Alaska Native Tribal Health Consortium	Anchorage
Georgiana Page	Alaska eHealth Network	Anchorage
Christopher Simon	Tanana Chiefs Conference	Fairbanks
Mark Williams	Providence Health Services	Anchorage
Thad Woodard, MD	Private Practice	Anchorage
ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES STAFF		
Donna Steward	Project Leader, Office of the Commissioner	Anchorage
CONTRACT SUPPORT STAFF		
Thea Agnew Bemben	Managing Principal, Agnew::Beck Consulting	Anchorage
Shanna Zuspan	Senior Associate, Agnew::Beck Consulting	Anchorage