MEDICAID REDESIGN + EXPANSION TECHNICAL ASSISTANCE PROJECT

Note to reader: As part of the Medicaid Redesign + Expansion Technical Assistance Project, the contractor team has been asked to analyze two to three Alternative Medicaid Expansion Coverage Models and five to ten Medicaid Reform Initiatives. During Round 1 of our analysis, we have identified four potential Alternative Medicaid Expansion Coverage Models and eleven potential Medicaid Reform Initiatives based on stakeholder feedback, other states' experiences, and our understanding of Alaska's current Medicaid system. We need your help during the work session on Friday, October 9th to refine and select models and initiatives for further policy and actuarial analysis in Round 2 and, ultimately, for inclusion and possible recommendation in our final report due January 15, 2016.

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POTENTIAL ALTERNATIVE EXPANSION COVERAGE MODELS

Potential Alternative Medicaid Expansion Models

MODEL NAME	Wellness Benefit Package
DESCRIPTION	This model continues to provide expansion enrollees the same benefits as the current Medicaid benefit package and increases the focus on prevention. It encourages healthy behaviors, chronic disease management, and the use of primary care through wellness incentives, enrollee orientation, and ongoing engagement.
KEY FEATURES	a) Enrollees continue to receive the same benefits as with the current Medicaid plan b) All enrollees receive orientation and education to encourage appropriate use of health care services and settings c) Every enrollee selects a Primary Care Provider or behavioral health provider at enrollment ; if none is selected one will be assigned; enrollee will be required to use this provider; enrollees can opt out of assignment o Primary Care Providers are licensed primary care physicians, advanced nurse practitioners, and physician assistants who are active in the practice of family medicine, primary care internal medicine, or pediatric medicine. *[Input needed: Is this is the right definition?]* A behavioral health provider may be assigned as the Primary Care Provider if the enrollee's primary diagnosis is a behavioral health condition. *[What should the definition of a behavioral health provider be?]* d) Enrollees eligible for wellness incentives related to key health maintenance measures such as A1C levels, Body Mass Index (BMI), blood pressure and tobacco use *[Input needed: which wellness incentives are most promising for Alaska?]* e) Enrollees with chronic conditions receive training in Chronic Disease Self-Management f) Enrollees are offered additional engagement, such as coordination support and coaching, to promote adherence to schedule of recommended preventive screenings, tobacco cessation, physical activity and nutrition, and lifestyle changes g) A health risk assessment may be used to identify high risk/high need enrollees h) Investigate removing co-pays for primary care and prevention services i) Inappropriate use of emergency room services may be disincentivized through a higher co-pay requirement. *[What other disincentives could be included?]* Note: Wellness incentives are also included in the Shared Responsibility

	Benefit Package and Minimum Essential Benefit Package. The full set of wellness and engagement strategies in this model are also included in the Wellness and Prevention Medicaid Reform Initiative for all enrollees.
RECOMMENDED FEDERAL FINANCING AUTHORITY	• Requires a Medicaid State Plan Amendment to implement incentives
BENEFITS AND DOWNSIDES	• All Medicaid enrollees would be on same benefit plan, which is easier for providers and the State to administer and enrollees to manage than multiple Medicaid benefit plans. • Selecting a Primary Care Provider at enrollment will support follow up after Emergency Department and inpatient visits and encourage more appropriate use of health care services, including referrals to behavioral health services if needed. • Wellness Incentives and Enrollee Orientation programs engage enrollees, encourage active participation and reduce inappropriate service use • Assigning enrollees to primary care providers and adding incentives, orientation and engagement will require additional administrative effort for the State
ACTUARIAL ASSUMPTIONS/ QUESTIONS	• Are all expansion enrollees eligible for wellness incentives + orientation (any exclusions?) • Those with chronic conditions receive training in Chronic Disease Self-Management[1]. Chronic conditions include: hypertension, hyperlipidemia, diabetes, ischemic heart disease, heart failure, atrial fibrillation, COPD, asthma, osteoporosis, arthritis. *[Input needed: which chronic conditions should be included?]* • Define specifically what the wellness incentives are and how they will be earned • Potential Implementation Date: January 1, 2017

[1] http://patienteducation.stanford.edu/programs/cdsmp.html

POTENTIAL ALTERNATIVE EXPANSION COVERAGE MODELS

MODEL NAME	Shared Responsibility Benefit Package
DESCRIPTION	This model moves the expansion population to an Alternative Benefit Plan based on an Alaska State Employee Health Plan and incorporates strategies to promote shared responsibility.
KEY FEATURES	a) Alternative Benefit Plan based on an Alaska State Employee Health Plan (specific plan for modeling to be determined) b) Increased cost sharing (copays and premiums) for non-primary care services c) Cost-sharing for enrollees with incomes above 100% FPL would be required and providers could withhold services if co-pay is not paid at time of service. (Note: Cost-sharing requirements for enrollees under 100% FPL are prohibited by the federal government). d) Health Savings Accounts (HSA) would be established for enrollees e) Wellness incentives would allow the enrollee to buy down cost sharing or the State would reward healthy behaviors by putting funds into the enrollee's HSA f) Could also include disincentives such as high copays for receiving non-emergency care at the Emergency Department g) Work Supports (not including work requirements, which are prohibited by federal law)
RECOMMENDED FEDERAL FINANCING AUTHORITY	• Requires Social Security Act Section 1115 waiver to test policy innovations likely to further the objectives of Medicaid, such as: o Health Savings Accounts o Any other elements more restrictive than those in current Medicaid plan • 1916(f) authority is required to: o Impose higher cost sharing than otherwise allowed under federal law o Must test a unique use of copayments o Limited to a two-year period or less • 1115 waivers require the State to demonstrate federal budget cost neutrality.
BENEFITS AND DOWNSIDES	• This approach could engage enrollees to take a more active role in their healthcare o Premiums and cost-sharing, wellness incentives, Health Savings Accounts, and enrollee orientation and education are intended to help enrollees understand the costs of and take responsibility for the health care resources they use and to reduce inappropriate service use • Cost sharing may deter use of needed services for low income persons

	• Enrollees and advocates may oppose changes to and/or reductions in the benefits that enrollees are receiving • Providers have expressed that co-pays are frequently not collected, often do not have the intended effect, and instead increase the difficulty for providers to serve Medicaid • Multiple Medicaid benefit plans would increase administrative complexity for the State and providers, and may cause confusion for enrollees who may have household members on different plans. • Managing Health Savings Accounts will be a new, complex, and costly administrative responsibility for the State
ACTUARIAL ASSUMPTIONS/ QUESTIONS	• Certain populations are exempt from cost-sharing measures, such as American Indian/Alaska Native enrollees • Define Alternate Benefit Plan benefits/cost-sharing • Define wellness incentives • Define HSA • Potential Implementation Date: January 1, 2018

POTENTIAL ALTERNATIVE EXPANSION COVERAGE MODELS

MODEL NAME	Minimum Essential Benefit Package
DESCRIPTION	This model moves the expansion population to an Alternative Benefit Plan based on a Qualified Health Plan (QHP) on the Federally Facilitated Marketplace, and encourages the use of primary care and chronic disease management through wellness incentives and enrollee orientation and engagement.
KEY FEATURES	a) Alternative Benefit Plan based on a QHP b) Maintain current cost-sharing requirements and exemptions c) Wellness incentives would reward healthy behaviors d) Alternative Benefit Plan to include 10 Essential Health Benefits (EHBs) and include Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for children under 21 years of age
RECOMMENDED FEDERAL FINANCING AUTHORITY	• Depending on what the Alternative Benefit Plan includes, it may be authorized by a Medicaid State Plan Amendment or may require a Section 1115 waiver • CMS requires that the Alternative Benefit Plan: o Benchmark to one of the four allowed options o Include the 10 Essential Health Benefits o Comply with Mental Health Parity & Addiction Equity Act o Provide EPSDT benefits for children under 21 o Offer family planning services and supplies o Assure non-emergency medical transportation o Offer federally qualified and rural health center services • States are not required to offer as part of this package all the benefits that it offers in traditional Medicaid. For example, a state that has extended optional benefits, e.g. adult dental care, to its traditional Medicaid enrollees is not required to extend those benefits to the new adult group.
BENEFITS AND DOWNSIDES	• Can reduce the effects of churn for enrollees moving between Medicaid and marketplace plans • Can be a bridge between the traditional Medicaid plan benefits and commercial plans • Can be used to tailor, expand, or restrict benefits to meet the needs of the newly eligible population • Can allow the State to substitute benefits or add benefits • Multiple Medicaid benefit plans would increase administrative complexity and cost for the State and providers, and confusion for enrollees who may have household members on different plans.

	• Could take 1-2 years to implement, including 3 months for design and 6 months for waiver approval
ACTUARIAL ASSUMPTIONS/ QUESTIONS	• Certain populations are exempt from cost-sharing measures, such as American Indian/Alaska Native enrollees • Define wellness incentives • Specify Alternate Benefit Plan benefits/cost sharing • Potential Implementation date: January 1, 2018

POTENTIAL ALTERNATIVE EXPANSION COVERAGE MODELS

MODEL NAME	Private Insurance Option
DESCRIPTION	This model uses Medicaid funds for expansion enrollees to purchase a Qualified Health Plans through the Federally Facilitated Marketplace. Medicaid pays premiums and cost sharing fees to the private insurer.
KEY FEATURES	a) Medicaid funds cover member premiums and cost sharing that exceeds the federally allowable limit of 5% of income (Medicaid costs are eligible for federal match as in any expansion option) b) This model is sometimes called the "Arkansas model"; it was also implemented in Iowa and New Hampshire. Eligibility in each state: o AR: parents with income 17-138% FPL, childless adults 0-138% FPL o IA: all Expansion eligible, income 101-138% FPL o NH: parents as low as 38% FPL - 138% FPL, childless adults 0-138% FPL c) State would be required to add certain required benefits if not provided through the private plan.
RECOMMENDED FEDERAL FINANCING AUTHORITY	• Requires Social Security Act Section 1115 waiver; State would be required to demonstrate cost neutrality for the federal budget
BENEFITS AND DOWNSIDES	• Can reduce the effects of churn for enrollees moving between Medicaid and marketplace plans • Although the private insurance option can expand access for enrollees to more providers, this may not be true in Alaska where Medicaid provider participation may in fact be greater • Increases enrollment in the health insurance marketplace in Alaska. Increased enrollment may bring more healthy lives into the covered-lives pool and stabilize premium prices. • If one of the two issuers on the Federally Facilitated Marketplace (FFM) pulls out, the State would be required to offer enrollees another choice. • Reduces the State's ability to influence care models and provider behavior due to lower proportion of Medicaid enrollees in the State-administered plan. • Cost neutrality may be difficult to achieve. Private insurance coverage may be more costly than Medicaid-administered benefits. State is required by CMS to add required benefits if not provided by private plan. • Could take 2 to 3 years to implement – Federal waiver approval process requires time for drafting the request, CMS review and

	negotiations. Implementation: RFP for issuer participation, contracting, enrollment and follow up/evaluation.
ACTUARIAL ASSUMPTIONS/ QUESTIONS	• Should we use the silver benchmark plan? • Specify Eligibility criteria • Potential Implementation Date: January 1, 2019

POTENTIAL MEDICAID REFORM INITIATIVE OPTIONS

Potential Medicaid Reform Initiative Options: Delivery System Reforms

INITIATIVE NAME	Wellness and Prevention Initiative for All Enrollees
DESCRIPTION	This initiative strengthens the role of primary care as the foundation for enrollee health and well-being, and emphasizes prevention, education and wellness for all enrollees.
KEY FEATURES	a) At enrollment, all enrollees receive education and an orientation to Medicaid, with a goal of promoting appropriate use of health care services and settings b) Every enrollee selects a Primary Care Provider or behavioral health provider at enrollment; if none is selected one will be assigned; enrollee will be required to use this provider; enrollees can opt out of assignment o Primary Care Providers are licensed primary care physicians, advanced nurse practitioners, and physician assistants who are active in the practice of family medicine, primary care internal medicine, or pediatric medicine. A behavioral health provider may be assigned as the Primary Care Provider if the enrollee's primary diagnosis is a behavioral health condition. *[Input needed!]* c) Enrollees eligible for wellness incentives related to key health maintenance measures such as A1C levels, Body Mass Index (BMI), blood pressure and tobacco use *[Input needed: which wellness incentives are most promising for Alaska?]* d) Enrollees with chronic conditions receive training in Chronic Disease Self-management e) Enrollees are offered additional engagement, such as coordination support and coaching, to promote adherence to schedule of recommended preventive screenings, tobacco cessation, physical activity and nutrition lifestyle changes f) Investigate current co-pays for primary care and prevention services (if found, consider removing) g) A health risk assessment may be used to identify high risk/high need enrollees h) Investigate removing co-pays for primary care and prevention services i) Inappropriate use of emergency room services may be disincentivized through a higher co-pay requirement. *[What other disincentives could be included?]*
HOW IT MEETS MEDICAID REFORM GOALS	• Encouraging and providing incentives for enrollees to participate in healthy behaviors and seek prevention and primary care services can positively impact overall health outcomes. Increased physical activity and self-management of chronic conditions, decreased use of tobacco and improved

	nutrition are associated with reduced burden of illness. As overall health improves, the per-member cost of care goes down.
FEDERAL REQUIREMENTS FOR IMPLEMENTATION	• Flexibility under the Deficit Reduction Act (DRA) has allowed states to identify and shape programs for specific populations and expand innovative strategies for engaging enrollees • May be part of an alternative benefit package authorized under a Medicaid State Plan Amendment (SPA) or 1115 waiver • Wellness incentives require a Medicaid State Plan Amendment (SPA) • Participatory incentives (where the incentive is associated with doing the activity rather than success, such as signing up for tobacco cessation rather than the successful outcome of the activity) are not limited by federal law or regulation • Health contingent programs (where the reward is associated with meeting a health goal) may be more restricted in implementation and may require a waiver
RATE STRUCTURE AND/OR PAYMENT MECHANISM	• May include one or any combination of the following payment changes: o increased reimbursement for certain primary care services o pay for performance incentives o a per member per month payment o decrease reimbursement or increase prior authorization for certain non-emergent higher-level services prone to inappropriate use
INFORMATION TECHNOLOGY NEEDS	• Ability to track enrollment with Primary Care Providers • Ability to track quality and outcome measures
QUALITY METRICS	• Number of primary care visits • Number of preventive care services and screenings • Number of emergency department visits and hospitalizations (overall or “avoidable” visits) • Key health status measures among all or subset of enrollees, e.g., diabetes prevalence. • Performance indicators for control of identified chronic conditions, e.g., A1c and blood pressure.
CMS MONITORING + REPORTING REQUIREMENTS	• A Medicaid State Plan Amendment (SPA) would not require additional monitoring, but under an 1115 waiver CMS will require tracking of identified quality measures
EXPERIENCE OF OTHER STATE(S)	• Very dependent on program structure • A high level of enrollee awareness about the program, a clear incentive structure and well-designed program evaluation are elements that have supported improvements sought by wellness programs; programs without these elements have not shown significant health or financial improvements

POTENTIAL MEDICAID REFORM INITIATIVE OPTIONS

POTENTIAL CHALLENGES + UNINTENDED CONSEQUENCES	• Workload and/or lack of compensation may pose challenges to provider implementation efforts if changes are seen as requiring additional work • Tracking quality measures and evaluating the impact of wellness incentives may be challenging • Some States have found it difficult to identify eligible participants due to lack of target population data • Where incentives involve debit cards or cash/cash equivalent, it can be difficult to manage this side of the program • Increased administrative burden and cost to state to develop and maintain the new program.
ROLES OF MEDICAL + BEHAVIORAL HEALTH PROVIDERS	• Federally Qualified Health Centers • Tribal health outpatient clinics • Primary care physicians and practices • Advanced Nurse Practitioners and Physician Assistants • Behavioral health providers
COLLABORATION	• Primary Care Providers conduct Health Risk Assessment • Women, Infants, and Children (WIC) program, Supplemental Nutrition Assistance Program (SNAP) • Quit Line, weight reduction organizations
TIMELINE + STATE RESOURCE REQUIREMENTS	• State program changes include project planning, staffing and management; beneficiary recruitment, enrollment, communication and incentives; provider training; and evaluation design and implementation • Resource requirements are partially dependent on incentives • May require staggered implementation (based on other state experiences) • One year to develop and implement, with several years to fine-tune administration and conduct evaluation
ADDITIONAL CONSIDERATIONS	• Targeted versus general population program? • Information and support for states is available through CMS's Medicaid Incentives for the Prevention of Chronic Diseases (MIPCD) – established by ACA Section 4108 http://innovation.cms.gov/initiatives/MIPCD/index.html
ACTUARIAL ASSUMPTIONS/ QUESTIONS	• Identify the services that will increase and decrease as a result of this model • Need specifics on wellness supports and incentives • Will all populations be covered (long-term care?) • Chronic conditions include: hypertension, hyperlipidemia, diabetes, ischemic heart disease, heart failure, atrial fibrillation, COPD, asthma, osteoporosis, arthritis. *[Input needed: which chronic conditions should be included?]* • Potential Implementation Date: January 1, 2018

POTENTIAL MEDICAID REFORM INITIATIVE OPTIONS

INITIATIVE NAME	Primary Care Improvement Initiative
DESCRIPTION	This initiative leverages two models of care, Primary Care Case Management (PCCM) for all enrollees and Health Homes for people with behavioral health and chronic conditions. Additionally, Targeted Case Management is available to provide additional services for specific high-risk/high-cost groups that do not meet Health Home criteria.
KEY FEATURES	a) Primary care case management (PCCM) is available for all enrollees: o Primary Care Providers are licensed primary care physicians, advanced nurse practitioners, and physician assistants who are active in the practice of family medicine, primary care internal medicine, or pediatric medicine. A behavioral health provider may be assigned as the Primary Care Provider if the enrollee's primary diagnosis is a behavioral health condition. *[Input needed!]* o Every enrollee selects a Primary Care Provider or behavioral health provider at enrollment; if none is selected one will be assigned; enrollees can opt out of assignment o Enrollees must see the primary care provider, or that provider's practice, with whom they are enrolled for primary care services o Primary care provider must be available for follow-up from emergency department visits within a defined period o Both primary care and behavioral health providers must demonstrate ability to manage patients and refer to one another o Primary Care Provider provides care coordination, and must provide referral for enrollees to access non-emergent specialty and inpatient care o Telemedicine consultation is allowed b) Health Homes are defined under Section 2703 of the Affordable Care Act, and provide care coordination for individuals with multiple chronic conditions, a team-based approach to clinical care, linkage to community supports and resources, and integration of primary and behavioral health care. The following populations will be identified and enrolled in Health Homes where available: o Multiple chronic conditions o One chronic condition and at risk for another o One serious and persistent mental health condition c) Specific high-risk/high-cost groups (that do not meet Health Home criteria or potentially that meet Health Home criteria but do not live in a region where a Health Home is available) may be identified through data analysis to receive Targeted Case Management services to alter utilization and reduce health risks

POTENTIAL MEDICAID REFORM INITIATIVE OPTIONS

HOW IT MEETS MEDICAID REFORM GOALS	• Enrollee engagement with a primary care provider from initial enrollment on is intended to encourage activities associated with improved outcomes (timely access to appropriate provider, seeking care at lower level of need vs delaying care, having provider/team who is aware of enrollee need
FEDERAL REQUIREMENTS FOR IMPLEMENTATION	• Requires a Medicaid State Plan Amendment to implement incentives • Requires CMS approval of Section 2703 Health Home State Plan Option to establish Health Homes; states receive a 90% enhanced Federal Medical Assistance Percentage (FMAP) for specific health home services for the first eight quarters the program is in place o Health Homes implemented by Medicaid State Plan Amendment (SPA) may not be limited to a subgroup of chronically ill (adults v. children, for example) although state may target certain conditions/diseases, and may target specific geographic regions • Requires a Medicaid State Plan Amendment to authorize Targeted Case Management for specific high-risk/high-cost groups
STATUTORY AND REGULATORY CHANGES NEEDED	• Regulatory changes to support implementation of provider participation requirements and incentives
RATE STRUCTURE AND/OR PAYMENT MECHANISM	• Primary Care Case Management Providers receive the usual Fee-For-Service payment plus a Per Member Per Month payment for care coordination • Health Homes receive the usual Fee-For-Service payment plus an enhanced Per Member Per Month fee; enhanced fee could be tiered based on acuity • Targeted Case Management would use existing payment methodology
INFORMATION TECHNOLOGY NEEDS	• Data systems to track providers designated as Primary Care Providers, Health Homes (including tracking certification required for Health Home designation), track enrollee Primary Care Provider designation, support communication with providers and enrollees • Providers seeking to become Health Homes may be required to adopt Electronic Health Records and be able to upload patient data
QUALITY METRICS	• Number of primary care visits • Number of preventive care services and screenings • Number of emergency department visits and hospitalizations (overall or "avoidable" visits) • Key health status measures among all or subset of enrollees, e.g., diabetes prevalence. • Performance indicators for control of identified chronic conditions, e.g., A1c and blood pressure. Access to supportive services such as Home and Community-based Services, housing and other community supports

POTENTIAL MEDICAID REFORM INITIATIVE OPTIONS

CMS MONITORING + REPORTING REQUIREMENTS	• Health Home service providers must report quality measures to the State. • The State must report utilization, expenditure and quality data for an interim survey and conduct an independent evaluation o Includes eight health home core quality measures, additional measures identified by the state • States generally monitor cost impact by comparing costs of health home enrollees before and after enrollment; or by comparing costs of health home enrollees to a control group
EXPERIENCE OF OTHER STATE(S)	• States leverage existing programs where possible • States report increased enrollee empowerment, improved care coordination • Some states say the process of identifying, conducting outreach to, and enrolling beneficiaries into their Health Home programs is challenging
POTENTIAL CHALLENGES + UNINTENDED CONSEQUENCES	• Where providers lack resources to adopt required IT infrastructure, participation may be impacted
ROLES OF MEDICAL + BEHAVIORAL HEALTH PROVIDERS	• Expectation of coordination and collaboration among providers • Successful programs focus on integrating behavioral health and physical health care delivery, state requirements can formalize (co-location, annual screenings, etc.)
COLLABORATION	• Section 1945 requires state to consult with the Substance Abuse and Mental Health Services Administration (SAMHSA) during program design, prior to submitting a Medicaid State Plan Amendment (SPA) to CMS
TIMELINE + STATE RESOURCE REQUIREMENTS	• Resources for incentives, technical support for provider implementation and operations • Significant resources required for program design, implementation and maintenance • Two year design, application, federal approval and implementation process
ADDITIONAL CONSIDERATIONS	• To encourage participation, adopt opt-out rather than opt-in participation • CMS requires state to develop methodology for measuring savings and provide estimate of savings
ACTUARIAL ASSUMPTIONS/ QUESTIONS	• Will all enrollees be in either PCCM or Health Home? What exclusions will there be? • Should we include Targeted Case Management in the actuarial analysis? If so, target populations will need to be specifically defined. • Potential Implementation Date: January 2017 for PCCM; January 2018 for Health Homes

POTENTIAL MEDICAID REFORM INITIATIVE OPTIONS

INITIATIVE NAME	Behavioral Health and Primary Care Integration Initiative
DESCRIPTION	This initiative seeks to increase integration of behavioral health and primary care by removing key statutory and regulatory barriers and improve access to a comprehensive continuum of care for behavioral health services.
KEY FEATURES	a) Make regulatory changes to allow Psychologists and Licensed Clinical Social Workers (LCSWs) to bill Medicaid for clinical behavioral health services regardless of the setting in which they work. b) Make statutory changes to allow Licensed Professional Counselors (LPCs) and Licensed Marital and Family Therapists (LMFTs) to bill Medicaid for clinical behavioral health services regardless of setting in which they work and develop supporting regulations c) Make statutory and regulatory changes to support the development of urgent behavioral health care centers. As implemented in places like South Los Angeles, the urgent BH care center provides access to enrollees in urgent situations. This is an effort to assist enrollees in appropriate settings and to ensure access. d) Make statutory and regulatory changes to remove the requirement to be a Division of Behavioral Health grantee in order to bill Medicaid e) Explore an 1115 waiver to implement Substance Use Disorders (SUD) systems and practice changes, address gaps in the continue of care, and increase use of evidence-based practices outcomes[2] f) Pursue waiver of the Institutions for Mental Diseases (IMD) exclusion to allow Medicaid to pay for BH services provided at institutional psychiatric facilities with more than 16 beds in order to increase access to residential treatment services in Alaska o *IMD Exclusion: Institutions for Mental Disease (IMDs) are inpatient facilities of more than 16 beds whose patient roster is more than 51% people with severe mental illness. Federal Medicaid matching payments are prohibited for IMDs with a population between the ages of 22 and 64. IMDs for persons under age 22 or over age 64 are permitted, at state option, to draw federal Medicaid matching funds.* o *The goal of a waiver is to improve access to behavioral health services that in some areas are only available in IMDs.*
HOW IT MEETS MEDICAID REFORM	• Increasing provider types and filling key gaps in the continuum with increase enrollee access to services

[2] http://www.medicaid.gov/federal-policy-guidance/downloads/SMD15003.pdf

POTENTIAL MEDICAID REFORM INITIATIVE OPTIONS

GOALS	• Properly addressing behavioral health care needs of enrollees will reduce per enrollee costs over time • Lower level behavioral health services can prevent the need for intensive and costly behavioral health services
FEDERAL REQUIREMENTS FOR IMPLEMENTATION	• Changes such as removing the IMD exclusion requires a waiver of Section 1905(a)(B) of the Social Security Act. • Other changes that are allowed by Medicaid regulations but not by state statute or regulation can be changed by altering the statute/regulation and including in the Medicaid State Plan.
STATUTORY AND REGULATORY CHANGES NEEDED	• Which statutory and regulatory changes should be pursued?
RATE STRUCTURE AND/OR PAYMENT MECHANISM	• Could include pay for performance incentives or other innovative payment mechanisms
INFORMATION TECHNOLOGY NEEDS	
QUALITY METRICS	
CMS MONITORING + REPORTING REQUIREMENTS	
EXPERIENCE OF OTHER STATE(S)	As cited in the July 27, 2015 CMS letter on 1115 waivers for new service delivery opportunities for individuals with a substance use disorder:[3] • Massachusetts found that monthly Medicaid expenditures were significantly less for beneficiaries receiving SUD treatment compared to diagnosed but untreated beneficiaries. Treatment included ambulatory detoxification and medication-assisted treatment services. • Washington found that Screening, Brief Intervention and Referral to Treatment (SBIRT) services significantly reduced healthcare costs among Medicaid beneficiaries, resulting in savings of $250 per member per month associated with inpatient hospitalization from emergency department admissions. • For individuals in managed care with alcohol dependence, total healthcare costs were 30 percent less for individuals receiving medication-assisted treatment than for individuals not receiving medication-assisted treatment. • Medical costs for Medicaid patients in California decreased by one-third over three years following engagement in medication-assisted treatment.

[3] Please see: http://www.medicaid.gov/federal-policy-guidance/downloads/SMD15003.pdf

POTENTIAL MEDICAID REFORM INITIATIVE OPTIONS

POTENTIAL CHALLENGES + UNINTENDED CONSEQUENCES	
ROLES OF MEDICAL + BEHAVIORAL HEALTH PROVIDERS	
COLLABORATION	
TIMELINE + STATE RESOURCE REQUIREMENTS	
ADDITIONAL CONSIDERATIONS	• Other initiatives that might contribute to behavioral health system improvements: o Behavioral health rate review project o 1915(i) and 1915(k) options for home and community-based services o PCCM and Health Homes model of care implementation (if pursued) o Potentially: Bundled payments, pre-paid ambulatory or inpatient health plans (PAHPs or PIHPs), or managed care (if pursued) o Certified Behavioral Health Clinic Demonstration Project (if SAMHSA grant is approved)
ACTUARIAL ASSUMPTIONS/ QUESTIONS	• Which elements will this initiative include?

POTENTIAL MEDICAID REFORM INITIATIVE OPTIONS

INITIATIVE NAME	"Emergency Room is for Emergencies" Initiative
DESCRIPTION	Based on collaborative efforts in Washington[4] (and later Oregon) to reduce emergency visits and coordinate patient care, this initiative is designed to address opioid misuse and prescription monitoring, and improve the healthcare of homeless individuals and people with chronic behavioral health issues who are high utilizers of the Emergency Departments. Some elements, such as patient education and implementation of narcotic guidelines, can be implemented without significant technology upgrades. Full implementation of this effort requires adoption of health information exchange (HIE) technology by providers (including hospitals), health plans and the state.
KEY FEATURES	a) The seven best practice features of Washington's program are: o Tracking frequent Emergency Room users o Patient education about appropriate care settings o Designate personnel to receive and disseminate information on Medicaid clients o Contact primary care provider for follow-up visits o Implementing narcotics guidelines to direct patients to Primary Care Providers or pain management services o Physician participation in Prescription Drug Monitoring Program o Emergency physician provides review and feedback b) Full implementation requires interoperable health information exchange (HIE) technology [through an Emergency Department Information Exchange (EDIE) and/or Alaska eHealth Exchange?], as well as: o On-call primary care and behavioral health staff for Emergency Department o Emergency Department provider access to a real time, easy to

[4] For additional information on Washington's experience, please see: http://www.wsha.org/quality-safety/projects/er-is-for-emergencies/ and https://www.wsma.org/wcm/For_Patients/ER_is_for_Emergencies/wcm/Patients/Know_Your_Choices/ER_is_for_Emergencies_Home.aspx?hkey=30298295-d65b-4804-b8a1-8a79d40e3207

	use prescription drug monitoring database o Connection of Emergency Departments with Health Homes and Healthcare for the Homeless[5] to manage high utilizers and engage with primary care and behavioral health
HOW IT MEETS MEDICAID REFORM GOALS	• The program is intended to improve access to appropriate care while reducing use of high cost care and drug-seeking behaviors. This positively impacts patient outcomes and reduces Medicaid program costs.
FEDERAL REQUIREMENTS FOR IMPLEMENTATION	• This work will require collaboration with providers and associations, and can be done without federal approval. State spending on implementation can be supported with federal Medicaid funds.
STATUTORY AND REGULATORY CHANGES NEEDED	• TBD
RATE STRUCTURE AND/OR PAYMENT MECHANISM	• Increased reimbursement or performance incentives to primary care providers and behavioral health providers to provide follow up for ED visits?
INFORMATION TECHNOLOGY NEEDS	• Ensure consistent funding for Prescription Drug Monitoring Program database and IT infrastructure[6] • What do providers think is the best way to share data between hospitals and with primary care providers and behavioral health providers?
QUALITY METRICS	• Utilization of Emergency Department Services • Utilization of Emergency Department Services by high utilizers (5+ ED or hospital uses in a calendar year) • Utilization of primary care and behavioral health services • Number of prescriptions for opioids
CMS MONITORING + REPORTING REQUIREMENTS	• Federal monitoring is not a condition of adoption
EXPERIENCE OF OTHER STATE(S)	• In the first year of implementation in Washington, Medicaid Emergency Department costs dropped by $34 million. Medicaid enrollee ED visits were reduced by nearly 10%, with visit rates by high utilizers (5+ visits/year) declining by approximately 11%. For less serious conditions, the rate went down by more than 14% over the year.

[5] http://www.nhchc.org/wp-content/uploads/2011/09/HCHFactSheetMay2011.pdf

[6] See p10 of Alaska Health Care Commission's Recommendations regarding Opioid Abuse Prevention + Control http://dhss.alaska.gov/ahcc/Documents/2014%20FINAL-Commission-Strategies-Recommendations.pdf

	• Oregon began implementation this summer, and has already had almost universal adoption by hospitals across the state, and strong participation by Medicaid managed care plans.
POTENTIAL CHALLENGES + UNINTENDED CONSEQUENCES	
ROLES OF MEDICAL + BEHAVIORAL HEALTH PROVIDERS	• Emergency departments and physicians • Primary Care (on call) • Behavioral Health (on call) • Primary Care Provider
COLLABORATION	• In Washington, the initiative was led by the Washington State American College of Emergency Physicians, the Washington State Medical Association, and the Washington State Hospital Association. • Pilot with Providence, Alaska Regional, Mat-Su Regional, Alaska Native Medical Center? • Collaborate with Healthcare for the Homeless
TIMELINE + STATE RESOURCE REQUIREMENTS	• Private-public collaboration requires leadership by state and association partners. Implementation of technology can take a year or more once participation is planned.
ADDITIONAL CONSIDERATIONS	• Some elements of the program (education) can be done without technology adoption. Implementation should be considered on a phased basis.
ACTUARIAL ASSUMPTIONS/ QUESTIONS	

POTENTIAL MEDICAID REFORM INITIATIVE OPTIONS

INITIATIVE NAME	Accountable Care Organization (ACO) Demonstration
DESCRIPTION	This initiative aims to conduct a demonstration of accountable care organizations (ACOs) in Alaska. ACOs are healthcare organizations designed to align care delivery and provider payments to meet health outcome criteria and quality metrics while reducing the total cost of care for assigned enrollees. ACOs can be regional and include all providers, or may be groups of providers in an area who come together. Providers typically have shared savings agreements and may also have shared losses agreements.
KEY FEATURES	• Potential demonstration sites for actuarial modeling: o Anchorage (urban) o Fairbanks (urban) o Mat-Su (rural) o Kenai Peninsula (rural) • Model would be regional (all providers and all enrollees) in the rural areas and provider-based (a subset of providers and enrollees) in the urban areas • Includes primary and acute physical care, behavioral health care, and long-term supports and service
HOW IT MEETS MEDICAID REFORM GOALS	• ACOs can align providers to focus on managing their enrollees on a population basis, as well as ensuring care coordination and management for complex, high-needs enrollees. Shared savings creates the incentive for the ACO providers to work together to meet quality and cost goals.
FEDERAL REQUIREMENTS FOR IMPLEMENTATION	• Could be done with a Medicaid state plan amendment (SPA), although depending on design, payment mechanism and savings/loss structure, may require an 1115 demonstration waiver
STATUTORY AND REGULATORY CHANGES NEEDED	• Could possibly require exemptions under Alaska State laws that govern antitrust issues.
RATE STRUCTURE AND/OR PAYMENT MECHANISM	• Fee-for-service reimbursement to providers, with shared savings as incentive to coordinate care • Shared savings for first two years, then includes shared losses; savings/losses calculated from total cost of care from baseline year (with appropriate adjustments)
INFORMATION TECHNOLOGY NEEDS	• ACOs require that all participating providers are able to share information in a timely manner about enrollees so care can be coordinated across systems. • The State must be able to manage enrollment in ACOs, as well as track claims associated with ACO enrollees and any quality or performance

	metrics assigned to the ACOs
QUALITY METRICS	• Could include standard HEDIS[7] quality measures, specific metrics that track with DHSS's overall Medicaid quality goals (e.g., inpatient readmissions, ED utilization, medication management, etc.)
CMS MONITORING + REPORTING REQUIREMENTS	
EXPERIENCE OF OTHER STATE(S)	
POTENTIAL CHALLENGES + UNINTENDED CONSEQUENCES	• Participating providers may not be sufficiently prepared to collaborate and coordinate to the level required to achieve savings
ROLES OF MEDICAL + BEHAVIORAL HEALTH PROVIDERS	• Participating providers must be bought in to the model and the requirements to achieve savings, and be willing to accept the risk of shared losses within a certain timeframe
COLLABORATION	
TIMELINE + STATE RESOURCE REQUIREMENTS	• Will require significant work with and among participating providers to ensure the appropriate/optimal legal structures, data and analytics infrastructure for both the State and ACOs, and agreement on the shared savings/losses calculation methodology
ADDITIONAL CONSIDERATIONS	• Provider responses varied, many expressed uncertainty about Alaska's readiness to implement this model (from both the State and provider perspectives)
ACTUARIAL ASSUMPTIONS/ QUESTIONS	• What percentage of savings/losses will be shared? When will shared losses begin? How will savings/losses be measured? • Will ACO's include all populations, including long-term care? Are there eligibility exclusions? How should the urban populations be selected? • How should we treat Tribal health providers in this model? Should we exclude Tribal beneficiaries in this analysis?

[7] Healthcare Effectiveness Data and Information Set (HEDIS) - See more at: http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures.aspx#sthash.fzGspgpB.dpuf

POTENTIAL MEDICAID REFORM INITIATIVE OPTIONS

Potential Medicaid Reform Initiative Options: Payment Reforms

INITIATIVE NAME	Bundled Payment Demonstration
DESCRIPTION	This initiative would explore the use of bundled payments for episodes of care .
KEY FEATURES	• Bundled payment models link payments for the multiple services patients receive during an episode of care to treat a given condition or provide a given treatment, and provides a single payment for those services. • Potential care episodes for pilot testing might include: o Labor and delivery o Substance abuse treatment o Cardiac care o Other ideas? • Potential care episodes for actuarial modeling will be identified through a preliminary utilization review conducted by the project actuarial consultants. Identification of care episodes will be for modeling purposes only. The State would collaborate with providers to identify care episodes to be tested in a bundled payment demonstration project.
HOW IT MEETS MEDICAID REFORM GOALS	• Bundled payments can align incentives for providers and promote collaboration across settings and specialties.
FEDERAL REQUIREMENTS FOR IMPLEMENTATION	
STATUTORY AND REGULATORY CHANGES NEEDED	
RATE STRUCTURE AND/OR PAYMENT MECHANISM	
INFORMATION TECHNOLOGY NEEDS	
QUALITY METRICS	
CMS MONITORING + REPORTING	

REQUIREMENTS	
EXPERIENCE OF OTHER STATE(S)	
POTENTIAL CHALLENGES + UNINTENDED CONSEQUENCES	
ROLES OF MEDICAL + BEHAVIORAL HEALTH PROVIDERS	
COLLABORATION	
TIMELINE + STATE RESOURCE REQUIREMENTS	
ADDITIONAL CONSIDERATIONS	
ACTUARIAL ASSUMPTIONS/ QUESTIONS	• Definition of bundles including trigger and end points. What is carved out? • All populations?

POTENTIAL MEDICAID REFORM INITIATIVE OPTIONS

INITIATIVE NAME	Pre-paid Ambulatory Health Plan (PAHP) Demonstration
DESCRIPTION	This initiative uses Pre-paid Ambulatory Health Plans (PAHP), capitated non-comprehensive health plans, to pay for dental and/or Non-Emergency Medical Transportation (NEMT) on a Per Member Per Month basis. This is a partial-risk, managed care option.
KEY FEATURES	• Capitated non-comprehensive health plan, typically used by states as a managed care option for dental and NEMT (both have a discrete set of services on the ambulatory side, making them easier to adjust for risk) • Subject to quality and performance metrics • Must develop adequate networks to provide sufficient options
HOW IT MEETS MEDICAID REFORM GOALS	
FEDERAL REQUIREMENTS FOR IMPLEMENTATION	• States can implement voluntary managed care (MCOs, PAHPs, PIHPs) under 1932(a) state plan authority as long as they have established statewide free choice of providers, one or more MCOs, PIHPs or PAHPs. States can use selective contracting in selection of plans, i.e., they do not have to award a contract to each plan that responds to the RFP. • States can have multiple PAHPs; for instance, California has 16 dental PAHPs in operation while Oklahoma has six. This allows the state to set PMPM rates for different geographical areas of the state. Only South Carolina uses more than one NEMT PAHP. Voluntary managed care means that enrollees must have the choice of Fee-For-Service (FFS) or a Managed Care Organization (MCO).
STATUTORY AND REGULATORY CHANGES NEEDED	• This initiative would require additional administrative requirements and monitoring to oversee the managed care entity.
RATE STRUCTURE AND/OR PAYMENT MECHANISM	• Replace fee for service with Per Member Per Month pre-paid plan for specific set of services
INFORMATION TECHNOLOGY NEEDS	
QUALITY METRICS	
CMS MONITORING + REPORTING REQUIREMENTS	• CMS considers pre-paid health plans as 'managed care' entities and are subject to similar CMS regulations
EXPERIENCE OF OTHER	Dental

STATE(S)	• CA: the dental PAHP for Los Angeles County is voluntary but mandatory elsewhere. In CA, each dental plan receives a negotiated monthly PMPM rate. Medi-Cal Dental Managed Care recipients can only receive services from the plan's provider network. • Covered dental services provided by Medi-Cal dental managed care plans are the same dental services provided under the Denti-Cal Fee-for-Service (FFS) Program. Non-Emergency Medical Transportation (NEMT): • NJ and other states use LogistiCare as their NEMT provider under the PAHP and enrollees must go through this broker in arranging NEMT. • UT, like NJ, uses LogistiCare Services. However, it is limited to people who do not live in an area served by bus, para-transit services or for people who need door-to-door service. If they meet the requirements, they can apply for LogistiCare services by filling out a "Mobility Evaluation." • Maine has a regional NEMT PAHP in which the state selected three brokers from a competitive bid. These brokers are at risk for managing costs for NEMT. The state ties payment to quality benchmarks.
POTENTIAL CHALLENGES + UNINTENDED CONSEQUENCES	• Managed care contracting would be a different line of business for Alaska DHSS that would require additional capacity and new capabilities for actuarial analysis, capitated rate setting, managed care contract development and management
ROLES OF MEDICAL + BEHAVIORAL HEALTH PROVIDERS	
COLLABORATION	
TIMELINE + STATE RESOURCE REQUIREMENTS	
ADDITIONAL CONSIDERATIONS	
ACTUARIAL ASSUMPTIONS/ QUESTIONS	• Define services and regions that are in PAHP

POTENTIAL MEDICAID REFORM INITIATIVE OPTIONS

INITIATIVE NAME	Pre-Paid Inpatient Health Plan (PIHP) for Critical Access Hospitals
DESCRIPTION	This initiative uses a Pre-paid Inpatient Health Plan (PIHP), which is a capitated non-comprehensive health plan, to fund Critical Access Hospital services provided to Medicaid enrollees on a Per Member Per Month basis. A PIHP is a partial-risk, managed care option.
KEY FEATURES	• The State would negotiate a Per Member Per Month rate with each Critical Access Hospital to provide a specific set of inpatient services to Medicaid enrollees in that region. • This initiative intends to make funding more predictable for both Critical Access Hospitals and the State, to stabilize rates and related budget uncertainty.
HOW IT MEETS MEDICAID REFORM GOALS	
FEDERAL REQUIREMENTS FOR IMPLEMENTATION	• States can implement voluntary managed care (MCOs, PAHPs, PIHPs) under 1932(a) state plan authority as long as they have established statewide free choice of providers, one or more MCOs, PIHPs or PAHPs. States can use selective contracting in selection of plans, i.e., they do not have to award a contract to each plan that responds to the RFP
STATUTORY AND REGULATORY CHANGES NEEDED	
RATE STRUCTURE AND/OR PAYMENT MECHANISM	
INFORMATION TECHNOLOGY NEEDS	
QUALITY METRICS	
CMS MONITORING + REPORTING REQUIREMENTS	
EXPERIENCE OF OTHER STATE(S)	
POTENTIAL CHALLENGES + UNINTENDED	• Managed care contracting would be a different line of business for Alaska DHSS that would require additional capacity and new

CONSEQUENCES	capabilities for actuarial analysis, capitated rate setting, managed care contract development and management • Would need to address Medicaid enrollees from other regions, as they would not be covered by PMPM for that geographically-based network.
ROLES OF MEDICAL + BEHAVIORAL HEALTH PROVIDERS	
COLLABORATION	
TIMELINE + STATE RESOURCE REQUIREMENTS	
ADDITIONAL CONSIDERATIONS	
ACTUARIAL ASSUMPTIONS/ QUESTIONS	• Define services in PIHP. Any carve outs? Would long-term care be included?

POTENTIAL MEDICAID REFORM INITIATIVE OPTIONS

INITIATIVE NAME	Full-Risk Managed Care
DESCRIPTION	This initiative uses managed care organizations (MCOs) to deliver Medicaid health benefits, plus additional benefits to Medicaid enrollees. Contractual arrangement in which the MCO agrees to accept a fixed per member per month payment (capitation) to deliver a broad range of Medicaid services outlined in the contract. If expenditures exceed income, the plan absorbs the loss. Enrollees would receive services through a network of participating providers. Participation can be voluntary or mandatory.
KEY FEATURES	a) Covered populations can vary from all enrollees to subsets of the enrollee population, such as: o women and children o expansion population o Aged, blind, disabled, o those needing long term care o those needing behavioral health care b) Would require development of an adequate network with maximum time and distance c) Leverages expertise and infrastructure of companies who provide Medicaid managed care nationwide d) Allows MCO to assume risk for enrollee care; allows state to have more predictable budget
HOW IT MEETS MEDICAID REFORM GOALS	• Provides budget predictability for the State but does not typically bend the cost curve without necessary system reforms • MCOs can be contracted to assume care coordination/case management duties and serve as gatekeepers for more efficient care • Commercial MCOs may have larger provider pool; access to specialty services, etc.; higher quality care
FEDERAL REQUIREMENTS FOR IMPLEMENTATION	• State must meet federal requirements: provider payment rates, network adequacy, covered services, grievance and appeals, quality of care. • 1915(a) State Plan option (voluntary managed care) • 1915(b) waiver if the state wishes to restrict type of providers an enrollee can use, allow county or local government to provide choice counseling or enrollment brokerage services, use savings incurred to provide additional services to enrollees, restrict the number and type of providers • 1115 Waiver: Can waive statewideness, comparability of services, freedom of choice
STATUTORY AND REGULATORY CHANGES	• Wellness and prevention requirements

POTENTIAL MEDICAID REFORM INITIATIVE OPTIONS

NEEDED	
RATE STRUCTURE AND/OR PAYMENT MECHANISM	• Capitated PMPM rate
INFORMATION TECHNOLOGY NEEDS	• To meet needs of QI efforts (42 C.F.R. §438.200 et seq.) must have ability to identify enrollees with special health care needs, collect data for reporting performance measures and financial performance • Monitor MCO contracts
QUALITY METRICS	• Performance Data • Encounter Data • External Quality Review (EQR)
CMS MONITORING + REPORTING REQUIREMENTS	• 1903(m): Plans must allow federal access to program records, including financial • State must provide encounter data specified by CMS • 42 C.F.R. §438.200 et seq.: State must have a written strategy for assessing and improving the quality of managed care services offered within the state • Plans must conduct External Quality Review (compliance, performance monitoring)
EXPERIENCE OF OTHER STATE(S)	• Approximately 80% of Medicaid enrollees in some form of managed care • In 2009, 47% of Medicaid enrollees in full-risk MCO (56% in Medicaid only MCOs) • Has produced short-term cost savings but has not demonstrated cost-savings over the long-term.
POTENTIAL CHALLENGES + UNINTENDED CONSEQUENCES	• Managed care contracting would be a different line of business for Alaska DHSS that would require additional capacity and new capabilities for actuarial analysis, capitated rate setting, managed care contract development and management • State is one step removed from delivery system, providers, and enrollees • Determining MCO rates / risk adjustment is complex; could drive providers from program • MCO interest in Alaska may vary, but expansion likely makes managed care more feasible to MCOs • There are currently limited full-risk plans in operation in State • Network building could prove challenging

ROLES OF MEDICAL + BEHAVIORAL HEALTH PROVIDERS	• Case management and care coordination
COLLABORATION	
TIMELINE + STATE RESOURCE REQUIREMENTS	• If 1115 Waiver required (likely), plus network development, Request for Proposals (RFP), contracting, etc. – at least 2 years
ADDITIONAL CONSIDERATIONS	• Can be a steep adjustment to managed care particularly in states where little to no managed care has occurred in the past
ACTUARIAL ASSUMPTIONS/ QUESTIONS	• Which populations should be included? At minimum, long-term care is very different and typically managed separately. • Potential Implementation Date: January 1, 2018

Potential Medicaid Reform Initiative Options: Process and Infrastructure Improvements

INITIATIVE NAME	Telemedicine Initiative
DESCRIPTION	This initiative seeks to address barriers and improve supports for use of telemedicine in Alaska. Telemedicine is the remote delivery of health care services using telecommunications equipment, such as wireless and internet, satellite, and telephone. It can be used for a range of purposes, including to monitor and support chronic conditions, provide behavioral health services, and to provide initial and follow up visitations where in person is not necessary.
KEY FEATURES	• The purpose of this initiative would be to facilitate the use of telemedicine for physical and behavioral health: o Consultation between providers o Consultation between patient, specialist and primary care provider o Consultation between specialist and primary care provider to build capacity to address needs where specialist expertise is useful but not locally available o Psychiatric medication management o Use for care coordination of complex cases? o Behavioral health: can cover therapy visits, monitoring, health assessments, medication management, etc. • Could position Alaska to take advantage of new fiber optic line that will connect northern region of state.
HOW IT MEETS MEDICAID REFORM GOALS	• Increasing the use of telemedicine is likely to reduce need for non-emergency travel and to reduce emergency travel due to lack of routine care • Broader access to enrollees located in remote communities • Helps fill provider shortage gaps in rural/remote areas
FEDERAL REQUIREMENTS FOR IMPLEMENTATION	• State Plan Authority: Most Medicaid State plans specifically cover at least some telehealth services; and amendment may be necessary
STATUTORY AND REGULATORY CHANGES NEEDED	• Clarify and protect providers regarding possible litigation related to issues of licensure • Identify and remove statutory and regulatory barriers
RATE STRUCTURE AND/OR PAYMENT MECHANISM	• Identify reimbursement issues related to paying for both ends of the telehealth connection and for consultation
INFORMATION TECHNOLOGY NEEDS	• This initiative could include development of a common platform for scheduling telemedicine visits, sharing IP addresses, and managing

	connections[8] • Bandwidth needs: take advantage of new fiber optic network • Requires MMIS to accept modifier on services billable as telemedicine for reimbursement purposes
QUALITY METRICS	• Decreased non-emergency travel • Decreased emergency travel related to lack of specialist care
CMS MONITORING + REPORTING REQUIREMENTS	• CMS: state proposals must "demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate."
EXPERIENCE OF OTHER STATE(S)	• Forty-eight states have telemedicine programs in operations and increasingly used in behavioral health field. • Store and Forward (asynchronous exchange of health information) in South Dakota: physician consultations, follow-up visits, and pharmacological management, without limitation by medical specialty • CA: regulations have no barriers for coverage and reimbursement of services provided via telemedicine, including telebehavioral health IL: use of telepsychiatry
POTENTIAL CHALLENGES + UNINTENDED CONSEQUENCES	• Bandwidth issues/white space in remote communities
ROLES OF MEDICAL + BEHAVIORAL HEALTH PROVIDERS	• Increasingly used to coordinate care; Primary Care Provider may offer Behavioral Health assessment via telehealth in routine office visit; Both types of providers can use telehealth to reach enrollees in remote locations as well as enrollees in area • Initiative would build on Alaska provider successes to date
COLLABORATION	
TIMELINE + STATE RESOURCE REQUIREMENTS	• This could be expanded rapidly; barrier is more provider/enrollee access to resources necessary • HRSA grants to expand telehealth available to Federally Qualified Health Centers and Rural Health Clinics
ADDITIONAL CONSIDERATIONS	• Can leverage Health Home model to cover video conferencing and remote patient monitoring
ACTUARIAL	• Limited information to base projections on?

[8] See p11-12 of Alaska Health Care Commission's Recommendations regarding Health Information Technology and Telemedicine http://dhss.alaska.gov/ahcc/Documents/2014%20FINAL-Commission-Strategies-Recommendations.pdf

POTENTIAL MEDICAID REFORM INITIATIVE OPTIONS

ASSUMPTIONS/ QUESTIONS	• Should we model this? Or do simplified model?
INITIATIVE NAME	Medicaid Business Process Improvement Initiative
DESCRIPTION	This initiative aims to optimize Medicaid business processes and procedures to ensure that DHSS and the Medicaid delivery system are able to operate as efficiently and effectively as possible, as well as build the system's capacity to support new care delivery and other reform models.

KEY FEATURES	• Potential areas of focus include:
	  o Strengthening the utilization management program
	  o Improving transportation policies
	• *Input needed: which other business process improvements are necessary?*

HOW IT MEETS MEDICAID REFORM GOALS	• Supports all the reform goals by ensuring that DHSS has the necessary capability and capacity
FEDERAL REQUIREMENTS FOR IMPLEMENTATION	• Unknown until specific features are defined
STATUTORY AND REGULATORY CHANGES NEEDED	• Unknown until specific features are defined
RATE STRUCTURE AND/OR PAYMENT MECHANISM	•
INFORMATION TECHNOLOGY NEEDS	•
QUALITY METRICS	• processing times • manual inputs • staff hours • customer service (internal and external) indicators
CMS MONITORING + REPORTING REQUIREMENTS	• None
EXPERIENCE OF OTHER STATE(S)	• Most states have had to undertake business process improvements as they have worked through implementing the various aspects of the ACA and their own Medicaid reforms. Major policy and program changes require review and revisions to business processes.
POTENTIAL CHALLENGES	• It is always difficult for states to find both the time and the resources to do

+ UNINTENDED CONSEQUENCES	thorough business process reviews and revisions
ROLES OF MEDICAL + BEHAVIORAL HEALTH PROVIDERS	• Input into process improvements, training
COLLABORATION	• Interagency collaboration and interdivision collaboration is very important
TIMELINE + STATE RESOURCE REQUIREMENTS	• Requires a focused effort and dedicated resources • Generally can be implemented relatively quickly when managed effectively
ADDITIONAL CONSIDERATIONS	•
ACTUARIAL ASSUMPTIONS/ QUESTIONS	• This initiative may not be amenable to actuarial analysis

POTENTIAL MEDICAID REFORM INITIATIVE OPTIONS

INITIATIVE NAME	Data Analytics + IT Infrastructure Initiative
DESCRIPTION	This initiative is intended to support Alaska's ability to implement health care payment and delivery reform initiatives, which will require robust data analytics capabilities and tools to measure performance. The state must build the capacity to use the data it collects. Many states have the ability to collect data but have not sufficiently invested in developing the analytic capabilities necessary to effectively use the data to measure reform, drive program decisions, and lower costs. This initiative is also intended to support the patient data and reporting needs of providers participating in reform initiatives.
KEY FEATURES	• Robust, accurate and timely claims and encounter data are key • IT systems and architecture that supports access to required and desired data and reduces redundancy in reporting, such as o Provider Portals for data reporting; statewide Health Information Exchange to support exchange of patient information and use of Electronic Health Records; interfaces to support exchange of data o Data accessible from a warehouse or repository o Federally required and other reports and advanced analytics • May include an All-Payer Claims Database to support provider access to data to conduct the financial modeling that would be necessary for participating in payment reform initiatives
HOW IT MEETS MEDICAID REFORM GOALS	• The expansion models and reform initiatives Alaska is looking to implement rely on data to support decision making for reimbursement (ACO), monitoring (Health Homes, ER for Emergencies), and for quality improvement efforts. • Allows the State to understand the needs and health of the Medicaid population, as well as measure the success of health reform initiatives • Provides the infrastructure and health data analytic capability to meet CMS reporting requirements
FEDERAL REQUIREMENTS FOR IMPLEMENTATION	• Advanced Planning Document (APD) update for federal funding for IT infrastructure improvements and capacity building
STATUTORY AND REGULATORY CHANGES NEEDED	•
RATE STRUCTURE AND/OR PAYMENT MECHANISM	•
INFORMATION TECHNOLOGY NEEDS	• Data analytic tools for State and providers • data exchange capabilities

	• All payer claims database? • Other?
QUALITY METRICS	• Ability to produce timely, accurate reports for CMS and for DHSS program management • Systems that capture and can report required and desired data • Staff with requisite skills and knowledge for supporting IT systems and performing data analytics
CMS MONITORING + REPORTING REQUIREMENTS	
EXPERIENCE OF OTHER STATE(S)	• National Association of Medicaid Directors (NAMD) named six states with robust data analytics: AZ, CO, NJ, TN, TX, WI (can look at their experience building capacity)
POTENTIAL CHALLENGES + UNINTENDED CONSEQUENCES	• Providers may not have the IT infrastructure to support the State's goals (electronic medical record (EMR), health information exchange (HIE) engagement, etc.) • Staff and resource strain, even if contracted out • Financial strain in time of budget cutbacks
ROLES OF MEDICAL + BEHAVIORAL HEALTH PROVIDERS	• Using data to inform patient care • Collaborating with state in assessing programs
COLLABORATION	• Data interoperability and sharing is key, particularly across state agencies (public health, social services) and across divisions within DHSS • Access to Medicare data • Alaska e-Health Network & Regional Extension Center • Providers
TIMELINE + STATE RESOURCE REQUIREMENTS	• Assessment of State "as-is" and "to-be" to meet program goals, funding requests (State and federal), and approval needed • Can be a large financial investment upfront in infrastructure, software licensing, and costs of maintaining (though federal support could be maximized) •
ADDITIONAL CONSIDERATIONS	• State could contract out for services? Use a blended approach? (build internal + contract ongoing data analytics) – state must manage contract and assure appropriateness of project • Without an All Claims Database in Alaska there is no access to commercial, Medicare or other claims data

ACTUARIAL ASSUMPTIONS/ QUESTIONS	• This initiative may not be amenable to actuarial analysis.