Helen Phillips

From: Newman, Anthony (HSS) <anthony.newman@alaska.gov>
Sent: Sunday, April 03, 2016 10:05 PM
To: Heather Shadduck; Jane Pierson; Helen Phillips
Cc: Davidson, Valerie J (HSS); Sherwood, Jon (HSS); Forrest, Karen L (HSS); Brodie, Margaret C (HSS); Butler, Jay C (HSS); Erickson, Deborah L (HSS); Martin, Monique R (HSS); Burns, Randall P (HSS)
Subject: FW: Responses to 3/29/16 question on SB 74 in House Finance
Attachments: JPH Contracting Out Discussion 1988.docx; 1988 Senior Voices AKPH Privatization.pdf

Heather, Jane, and Helen: Here are the responses to questions #5 and #9 from the list in my previous email (below). My thanks to Deb Erickson for her assistance in pulling this information together. Tony

5. Please provide additional information on how the 1115 Waiver would work for the behavioral health system reform? (Rep. Neuman)

Section 1115 of the Social Security Act gives the U.S. Department of Health & Human Services Secretary the authority to approve State demonstration projects to test the use of innovative service delivery models in Medicaid. The purpose of the 1115 waiver is to provide States with flexibility and relief from federal Medicaid rules in order to improve care, increase efficiency, and reduce costs. Examples of federal requirements that can be waived through the 1115 process include freedom of provider choice, statewide-ness, and comparability of benefits.

One purpose for which States have used 1115 waivers is to utilize managed care for high-need populations, such as those with behavioral health needs. Another example is to obtain a waiver of the Institutes for Mental Disease (IMD) exclusion rule. The IMD exclusion prohibits the use of federal Medicaid funds for care provided to adults 21 to 64 years old in mental health or substance abuse residential treatment facilities with more than 16 beds.

Section 30 of SB 74 requires the department to apply for an 1115 waiver for a demonstration project focused on improving Alaska's behavioral health system. The department's approach to the demonstration project will be to contract with an Administrative Services Organization (ASO) to manage utilization; provide quality and outcomes reporting; and audit for fraud, waste, and abuse. Once the waiver is approved and the ASO contract is implemented, the department would apply for an amendment to add a waiver of the IMD exclusion rule. This approach was recommended by the Medicaid Redesign technical assistance consultants, Agnew::Beck and Health Management Associates, and the Mental Health Trust Authorities' consultants, the Curie Group. It also aligns with LB&A's consultant, the Menges Group, recommendation to contract for ASO services to provide utilization management.

The department's 1115 demonstration project will include:

- A plan for providing a continuum of community-based services to address housing, employment, criminal justice, and other relevant issues;
- Services from a wide array of providers and disciplines, including licensed or certified mental health and primary care professionals; and,
- Strategies to
    - Reduce operational barriers that fragment services,

- Minimize administrative burdens for providers, and
- Increase the effectiveness and efficiency of the program.

The department will hire consultants to help develop the 1115 waiver application. The federal application process for 1115 waivers is very involved and there are numerous requirements the department will have to meet in order to be successful. Examples of criteria on which the application will be evaluated include whether the waiver will:

- Strengthen coverage for low-income individuals;
- Increase access to, stabilize, and strengthen providers and provider networks;
- Increase efficiency and quality of care through initiatives to transform service delivery networks; and,
- Be budget neutral for the federal budget.

Demonstration projects implemented through an 1115 waiver are approved for five years, with an opportunity to request three-year extensions, in order to provide sufficient time to test innovative practice models.

9. ***Could you clarify the projected annual costs and savings, and identify where there is overlap between the Senate and House versions of FY 17 Budget? (Unknown member)***

There is only one area of overlap between the fiscal notes, the House and Senate versions of the FY 17 budget, and the Governor's FY 17 Budget Request, and that is for costs and savings associated with implementing the federal Tribal FMAP policy.

- The increased funding both the House and Senate have approved to increase staff capacity to implement the policy is included in the fiscal note for component #317 (though at a slightly different amount).
- The GF cuts that both the Governor's Budget and the House and Senate made to the Medicaid budget attributed to implementation of this policy are included in the Fiscal Notes.
  - The portion of the savings attributed to the Governor's Budget reduction is reflected in the 2nd column of the fiscal notes ("Included in Governor's FY 17 Request"), and
  - The portion of savings attributed to the House and Senate cuts are in the 1st column of the fiscal notes ("FY 17 Appropriation Requested")

The comparison is reflected in the table below. Note that the cuts made by both the Governor and the House/Senate total the amount of cuts reflected in the Fiscal Notes.

	Fiscal Note Component #	House & Senate FY 17 Budgets (GF)	Gov's FY 17 Budget (GF)	FY 17 Fiscal Note Request (GF)
COSTS: Staff Capacity to implement the Policy	317	275.9	0	289.7
SAVINGS: Health Care Services Medicaid Claims	2077	<20,000.0>	<6,700.0>	**<26,700.0>**
SAVINGS: Behavioral Health Services Medicaid Claims	2660	0	<2,750.0>	**<2,750.0>**
SAVINGS: Senior & Disability Services Medicaid Claims	2662	0	<2,900.0>	**<2,900.0>**

TOTAL SAVINGS *(w/o costs added)*		<20,000.0>	<12,350.0>	**<32,350.0>**

From: Newman, Anthony (HSS)
Sent: Thursday, March 31, 2016 6:17 PM
To: Shadduck, Heather R (LAA); Pierson, Jane (LAA); Phillips, Helen (LAA)
Cc: Davidson, Valerie J (HSS); Sherwood, Jon (HSS); Forrest, Karen L (HSS); Brodie, Margaret C (HSS); Butler, Jay C (HSS); Erickson, Deborah L (HSS); Martin, Monique R (HSS)
Subject: Responses to 3/29/16 question on SB 74 in House Finance

Heather, Jane, and Helen: Please find the below responses to questions asked of the Department of Health and Social Services during the Tuesday 3/29/16 hearing on SB 74 in House Finance. We intend to follow up with answers to those questions below marked as "In Progress." Please distribute these responses to committee members.

Menges Group Presentation

1. ***How would the "shared savings" provisions in the bill work? (Rep. Neuman)***

   There are two provisions in SB 74, both in Section 31, that reference "shared savings":

   - Page 30, beginning on line 19, adds AS 47.07.038 to require the department to collaborate with hospitals to reduce usage of emergency department services by Medicaid recipients. This provision allows (but doesn't require) the department to include shared savings for participating hospitals.
   - Page 31, beginning on line 16, adds AS 47.07.039 to require the department to implement a Coordinated Care Demonstration project. Subsection (c) (page 33, beginning on line 1) provides a series of options for the payment model the department may use for this demonstration project, including global payment, bundled payment, capitated payment, shared savings and risk, or other payment structures.

   "Shared savings" is a payment model designed to incentivize providers to reduce health care costs for a defined patient population by offering the providers a percentage of net savings realized as a result of their efforts. It recognizes the cost to the provider organization for developing and implementing new approaches to reduce costs, and also compensates them for a share of lost revenue they might incur in a fee-for-service system from more efficient utilization. There is no one methodology for a shared savings payment model — health care payer organizations that have implemented this model elsewhere have used a variety of approaches.

   To implement the shared savings payment model option, the department would negotiate the methodology for determining shared savings with the hospitals and document that methodology in shared savings contracts. The methodology would include a process for setting a baseline projected spending level from which to determine the level of future savings, as well as the services and population to be included in the calculations. Implementation of the methodology may require the services of a health care actuary.

2. ***Will any provisions of the bill cause a delay or prevent Medicaid recipients from being able to get the prescription drugs their provider wants them to have, whether generic or brand-name?***

   No, there are no provisions in SB 74 that specifically limit access to prescribed drugs. The Menges Group recommends the legislature allow the department to more quickly adjust the Preferred Drug List (by moving it outside the regulatory process), and also recommends the department investigate lowering dispensing fees paid to

chain drug stores, but these are very recent recommendations transmitted in the Menges Group report just released on March 24, and are not included in SB 74.

Fiscal Notes Presentation

3. ***How long do parents of OCS-involved youth have to wait to receive treatment? (Rep. Wilson)***

Data on access to behavioral health services specific to parents of OCS-involved youth is not available; however, data from the Division of Behavioral Health's (DBH) information system shows that the average wait time from date of screening to initial treatment for all DBH-supported clients in FY 15 was:

- 13 days for behavioral health services
- 45 days for substance use treatment

One goal of the behavioral health system reform provisions in SB 74 is to improve access to services. Wait times will continue to be monitored as an indicator of access to care under the reform initiative.

4. ***Please provide a summary comparing the consultants' recommendations for care coordination/care management models with the related provisions of the bill. (Rep. Neuman)***

Care Coordination/Care Management Models	SB 74	Agnew::Beck	Menges Group
Managed Care Organizations (MCO) are organizations that manage cost, utilization, and quality of health care services through contracted arrangements with a payer, such as Medicaid, and accept a set per member per month (capitated) payment for their services. MCOs bear full financial risk for incurring costs that exceed their contracted payment amount.	Allows the department to contract with a MCO as one option for primary care case management (Section 29, pages 28-29); and as one option for the Coordinated Care Demonstration Project (Section 31, pages 31-34).	Recommends DHSS NOT contract with a MCO due to lack of experience with full-risk managed care in Alaska's private sector health care industry.	Recommends DHSS NOT contract with a MCO due to Alaska's relatively small and dispersed patient population.
Accountable Care Organizations (ACO) are local or regionally-based and provider-led groups of doctors, hospitals and other health care providers who organize voluntarily to assume some level of financial risk along with responsibility for patient outcomes, and collaborate to provide coordinated care for a defined patient population.	Doesn't specifically address ACOs, but the Coordinated Care Demonstration Project required under Section 31 provides the flexibility to adopt an ACO model.	Recommends DHSS pilot test the ACO model to engage communities and local providers to form collaborative care arrangements and begin accepting some financial risk.	Recommends DHSS NOT use the ACO model due to lack of experience among Alaska providers in playing the role of medical cost reduction facilitator.
Health Homes are a particular service type authorized under Section 1945 of the Social Security Act to serve patients with complex needs such as multiple chronic conditions or behavioral health conditions	Authorizes DHSS to apply to provide the Section 1945 Health Home service (Section 30, page 29, line 17).	Recommends DHSS implement the Health Homes service.	References the benefit of linking enrollees to health homes, but does not specifically recommend DHSS implement the

through team-based integrated care models.			Health Home service.
Primary Care Case Management (PCCM) is model of care where the enrollee is required to choose, or has assigned, a primary care provider who is responsible for coordinating the enrollee's care, typically for an additional fee.	Requires DHSS to implement a PCCM system (Section 29, pages 28-29). DHSS is authorized to contract with an MCO as one option for implementing this system.	Recommends DHSS implement a PCCM program utilizing the services of an ASO (see below).	Recommends DHSS implement a program similar to PCCM by contracting with an MCO (see above) to provide only ASO services (see below).
Administrative Services Organizations (ASO) provide management and administrative services for a fixed fee and do not incur any financial risk for the cost of delivering care. Examples of services provided by ASOs in support of Medicaid programs include care coordination, utilization management, disease management, data reporting, and provider network development.	Does not directly refer to ASOs, but does not preclude their use in implementing care coordination provisions of the bill.	Recommends DHSS contract with ASOs to develop and run the primary care case management system, and the managed behavioral health system of care.	Recommends DHSS contract with an MCO to provide ASO services only, specifically to provide care coordination for high-need/cost beneficiaries, and to manage utilization through a prior authorization system for high-cost services.

5. ***Please provide additional information on how the 1115 Waiver would work for the behavioral health system reform? (Rep. Neuman)***

   IN PROGRESS

6. ***Can't the existing data system provide the eligibility verification service (Section 24 of SB 74)? Why do we need a new data system? (Rep. Wilson)***

   The department's new public assistance eligibility information system (ARIES) includes a module that provides for eligibility verification, but the Senate Finance Committee identified an opportunity for additional state savings through contracting with a separate, independent organization with expertise in matching eligibility data with data from other systems to identify and provide additional information needed for making eligibility determination decisions.

7. ***Please provide a table showing all the MMIS systems changes required by the bill and how they "dovetail" with one another. (Rep. Gattis)***

   Below is a table of the MMIS system changes that would be required to implement all provisions of the bill. The year the system change design process would begin is included in the table below. The changes would be staged so they do not conflict and to allow time for testing, so for example the Emergency Department change may begin in the 2nd quarter of FY 17 and the Coordinated Care project change may begin in the 4th quarter of FY 17. Note that all MMIS design and implementation changes are reimbursed by the federal government at 90%.

Section of SB 74	Program	Implementation Year	1-time MMIS Capital Costs (90% Fed/10% GF)
Sec. 31	Emergency Department Reduction Project	FY 2017	$1,000.0
Sec. 31	Coordinated Care Demonstration Project	FY 2017	$3,125.0
Sec. 29	Primary Care Case Management System	FY 2018	$1,000.0
Sec. 30	Managed System of Behavioral Health Care	FY 2018	$1,000.0
Sec. 30	Health Home Option	FY 2019	$1,000.0
		TOTAL	**$7,125.0**
		Fed Total	**$6,412.5**
		GF Match	**$ 712.5**

8. ***Please provide a list of previous privatization studies of DHSS facilities. (Rep. Gara)***

   There has been discussion regarding potential privatization of the Alaska Psychiatric Institute and the Pioneers' Homes, but to our knowledge an actual feasibility study has never been conducted. There was an attempt to privatize the newly constructed Juneau Pioneers' Home (JPH) when it was set to first open in 1988, but the solicitation process was not successful. A copy of an article describing that plan and the minutes from the LB&A meeting at which legislators subsequently voted to allow the administration to run JPH as a state-operated facility (following the failed solicitation attempt) are attached.

Public Testimony

9. ***Could you clarify the projected annual costs and savings, and identify where there is overlap between the Senate and House versions of FY 17 Budget? (Unknown member)***

IN PROGRESS

Thank you.

Tony

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