RECOMMENDED MEDICAID REDESIGN + EXPANSION STRATEGIES FOR ALASKA

FINAL REPORT

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By
Agnew::Beck Consulting, LLC
Health Management Associates
Milliman, Inc.




GOALS FOR MEDICAID REDESIGN + EXPANSION

IMPROVE HEALTH

OPTIMIZE ACCESS

INCREASE VALUE

CONTAIN COSTS

EXECUTIVE SUMMARY

Alaska is facing a serious fiscal challenge. This rising cost of health care, including care provided through Alaska's Medicaid program, compounds this challenge. The Alaska Medicaid program must do its part to reduce costs while improving the health of Alaskans enrolled in Medicaid. The consultant team engaged by the Alaska Department of Health and Social Services (DHSS), in partnership with the Alaska Mental Health Trust Authority, developed and analyzed Medicaid reform options based on the following goals:

A range of stakeholders provided input to design, refine, and prioritize the recommended reforms. Stakeholders resoundingly supported strategies to deliver whole person, coordinated care, strengthen the role of primary care, and improve access to behavioral health services.

Many factors influence Alaska's health care system today. Currently, Alaska is one of only two states whose Medicaid program relies exclusively on a fee-for-service payment model. Stakeholders concluded that the current payment model does not encourage providers to coordinate care or reward providers for providing care earlier and in lower care settings. In addition, some services, such as behavioral health, are not accessible and available to those who need them. Vulnerable Alaskans often access care at the highest level of service intensity, at the greatest expense to the program, because lower-level services that could address the underlying health issues are not available. As other states have demonstrated, changing utilization patterns by improving enrollee access to primary and preventive care and ensuring that care is coordinated and effective is the key to reducing costs for Medicaid while improving care and enrollee health. This fundamental understanding shaped the proposed initiatives, as the consultant team and stakeholders sought to develop a package of reforms that could move the Medicaid program from paying for volume to paying for value.

RECOMMENDED PACKAGE OF REFORMS

This report recommends a package of five interconnected reform initiatives aimed at improving the health and well-being of Alaskans while reducing overall costs to the State of Alaska.

- Initiatives 1 through 3 propose foundational reforms that together would create the incentives, services, management structures and controls, data analytics capacity, and technology infrastructure necessary for a well-functioning, sustainable Medicaid program.
- Initiatives 4 and 5 are pilots that would allow DHSS to test value-based payment mechanisms.

The first three initiatives propose engaging third-party entities (two Administrative Services Organizations[1] and an advanced data analytics firm) to enable DHSS to more quickly implement the needed systems changes to improve performance.

[1] An Administrative Services Organization is an entity that provides administrative functions for a client.

INITIATIVE 1. PRIMARY CARE IMPROVEMENT INITIATIVE

The Primary Care Improvement Initiative proposes activities to improve enrollee health status and reduce overall costs by supporting Primary Care Providers and engaging enrollees in improving their health. The initiative introduces Primary Care Case Management, a form of care management, in which every enrollee selects or is assigned to a Primary Care Provider who coordinates his or her care. An annual Health Risk Assessment identifies enrollees with higher health needs and risks. Health Homes and other care management programs would ensure that enrollee needs are addressed as early and appropriately as possible. Under this initiative, DHSS would contract with an Administrative Services Organization to conduct enrollee outreach and education, perform the Health Risk Assessment, manage the stratification and assignment of enrollees, develop and manage the primary care provider network.

INITIATIVE 2. BEHAVIORAL HEALTH ACCESS INITIATIVE

The Behavioral Health Access Initiative identifies key strategies for integrating behavioral health and primary care services, improving access to needed Substance Use Disorder treatment and mental health services, and addressing gaps in the behavioral health continuum of care to strengthen the crisis response system. The initiative includes a recommendation that DHSS contract with an Administrative Services Organization to increase capacity within DHSS to manage a coordinated behavioral health system of care that improves health outcomes for Medicaid enrollees and controls costs.

INITIATIVE 3. DATA ANALYTICS AND INFORMATION TECHNOLOGY INFRASTRUCTURE INITIATIVE

Through this initiative, DHSS would increase its capacity to appropriately collect and share health information among providers and analyze health data to improve outcomes and decrease costs. This initiative would increase the utility of Alaska's existing Health Information Exchange by connecting Alaska's hospitals, Emergency Departments and community based providers, and integrating the Prescription Drug Monitoring Program database. This initiative also proposes contracting with an advanced data analytics contractor to provide program-level data analysis to DHSS and providers to drive quality improvement and cost containment. These improvements are foundational to support health reform efforts: to connect and coordinate care and to increase capacity to analyze program-level data to improve outcomes and contain costs for Alaska Medicaid.

INITIATIVE 4. EMERGENCY CARE INITIATIVE

This initiative is a private-public partnership between DHSS, the Alaska State Hospital and Nursing Home Association and the Alaska Chapter of the American College of Emergency Physicians. This initiative proposes that Emergency Departments would use Alaska's Health Information Exchange, or a commercially available software package, to share necessary Medicaid enrollee patient data to improve patient care, reduce preventable Emergency Department use, and facilitate follow up with primary care and behavioral health providers. This initiative would increase appropriate service utilization, reduce costs for the Medicaid program, improve care for enrollees, and improve prescription monitoring to reduce opioid misuse.

The Emergency Care Initiative relies on the Information Technology infrastructure investments described in Initiative 3 and additionally proposes that DHSS pursue the authority to offer shared savings to support hospital efforts to drive down Emergency Department costs.

INITIATIVE 5. ACCOUNTABLE CARE ORGANIZATIONS INITIATIVE: SHARED SAVINGS/SHARED LOSSES MODEL

The Accountable Care Organizations Initiative proposes that DHSS pilot value-based payments for quality health care in regions by contracting with groups of providers who come together to form Accountable Care Organizations (ACO). An ACO is a group of health care providers that agrees to share responsibility for the cost and quality of health care for a defined patient population. In this model, a projection is established for the total cost of care and the ACO is eligible for a portion of the savings that results from improvements in health care delivery, if it also meets quality measures. If the total cost of care were exceeded, the ACO would be responsible for a portion of the overrun.

Additionally, the contract team recommends establishing structures, including workgroups, to support ongoing partner engagement and to develop recommendations for telemedicine and Medicaid business process improvements. These workgroups would guide Medicaid Redesign efforts, promote a culture of collaboration, and ensure limited resources are used strategically.

ACTUARIAL RESULTS FOR RECOMMENDED PACKAGE OF REFORMS

Actuarial analysis uses data analysis and statistical models based on national health care experience to make educated estimates about the impacts to health care costs that would result from program changes. The actuarial analysis for this report focuses on costs and savings associated with health care costs that would result from the proposed initiatives, and does not include technology, personnel, or other DHSS administrative costs that would be associated with planning, implementing, or administering the initiatives on an ongoing basis. Similarly, the analysis does not estimate related savings that may accrue from the initiatives to other areas of the State budget or benefits to the economy as a whole.

The baseline data used for the actuarial analysis were paid Medicaid claims from Calendar Year 2014, adjusted for anomalies resulting in the conversion to the new Medicaid Management Information System (MMIS). Note that the baseline projection is not representative of total state and federal expenditures for the Alaska Medicaid program because the populations modeled reflect a subset of Alaska Medicaid enrollees. The populations modeled include the Expansion population and exclude enrollees covered by Home and Community-based Services waivers, the Chronic and Acute Medical Assistance program, those in institutions, those eligible for long term care and nursing home services, those who are Medicare-Mediciad dual eligible, and those enrolled in Medicare Part B only. Additionally, prescription drug rebates and DHSS administrative expenses are excluded from the projections of the reform initiatives. Given these items, the total estimated DHSS expenditures will differ from these projections (see Appendices H and I for the details of Milliman's analysis).

Findings of the actuarial analysis led by Milliman, Inc. indicate that each of recommended reform initiatives has the potential to produce net annual savings within the projected period, with one exception. The Behavioral Health Access Initiative is expected to produce net costs to the Medicaid

program as enrollees are better able to access needed services. However, these additional costs could potentially be offset by general fund savings elsewhere, such as to behavioral health grant funds or Department of Corrections spending. An initiative that invests in telemedicine could also offset these costs. The Primary Care Improvement Initiative is projected to produce net costs for the first three years as care management practices are initiated and begins to produce net savings in State Fiscal Year (SFY) 2020 as providers gain experience managing care and become more effective and as Section 2703 Health Homes are implemented. Table S-1 below compares the fiscal impact by year of each initiative analyzed.[2]

Table S-1. Summary of Actuarial Analysis for Reform Initatives: Net Costs and Savings

MEDICAID REDESIGN INITIATIVES: NET PROGRAM INITIATIVE COSTS (SAVINGS) TO ALASKA * *VALUES IN $MILLIONS*					
INITIATIVE	**FY17**	**FY18**	**FY19**	**FY20**	**FY21**
Baseline	$490.2	$521.2	$549.3	$589.6	$626.3
Initiative 1: Primary Care Improvement	$2.4	$5.0	$0.5	($0.8)	($2.4)
Initiative 2: Behavioral Health Access	$0.0	$1.7	$3.6	$5.3	$7.2
Initiative 4: Emergency Care	($1.3)	($2.7)	($3.4)	($4.1)	($4.8)
Initiative 5: Accountable Care Organization	$0.0	$0.0	($1.0)	($2.0)	($4.2)
Workgroup 1: Telemedicine	$0.0	($2.6)	($5.8)	($9.4)	($13.2)
Initiative 6: Full-Risk Managed Care Organization	$0.0	$0.0	$0.0	$7.2	$7.6

** Excludes pharmacy rebates and DHSS administrative expenses. Excludes savings from cost reductions in other state programs. Initiatives are not mutually exclusive; therefore, the fiscal implementation of all, or a subset, of the initiatives will not equal the sum of these estimates.*

INITIATIVES CONSIDERED AND NOT RECOMMENDED

Recommendations were developed through an iterative process of analysis, discussion, and refinement that led to decisions about which options to explore and which to recommend. The contract team weighed a variety of factors ranging from potential for significant cost savings to feasibility of implementation in Alaska's particular health care market. Table S-2 provides an overview of and rationale for the initiatives considered but not recommended.

[2] Actuarial analysis was not completed on Initiative 3, the Data Analysis and IT Infrastructure Initiative.

Table S-2. Reform Initiatives Considered and Not Recommended

INITIATIVE[3]	STATUS	RATIONALE
Full-Risk Managed Care Initiative	*Analyzed but not recommended at this time*	• Alaska, with large rural areas and sparse population, presents significant difficulties for Managed Care Organizations (MCO) to achieve typical economies of scale and adequate provider networks. Anchorage and Fairbanks have sizeable populations, but high provider costs even in these areas would likely mean that MCOs would want robust rates to ensure they could make at least a small margin. • Current research is mixed on the extent to which full-risk managed care improves quality and saves money for Medicaid enrollees, particularly in rural areas where limited plan competition and provider participation present challenges. • Lack of experience among Alaska providers with alternative reimbursement methodologies, limited data sharing capabilities, and the quality and performance monitoring typically required of providers in managed care plan networks may reduce participation, which would make it difficult for an MCO to meet network adequacy standards and result in high out-of-network costs. • Lack of full-risk managed care in the commercial health care market in Alaska makes the learning curve steeper for providers and DHSS. • Other similarly situated Medicaid programs have struggled to implement full-risk managed care by MCOs, and DHSS does not currently have the operational infrastructure and capacity to support full-risk managed care, which comes with extensive federal requirements. • Actuarial analysis does not project cost savings.
Dementia Care Access Initiative	*Explored during Round 2; moved to another project for analysis*	• This initiative is now being considered as part of the parallel reform effort to assess the feasibility of the 1915(i) and (k) Medicaid authority options for Alaska.
Bundled Payment Demonstration	*Explored in Round 1 but not prioritized for Round 2 analysis*	• While bundled payments may be a promising approach for Alaska in the future, this payment model requires significant actuarial modeling for a limited number of services. Once DHSS has increased its data analytics capacity, this payment model could be explored.
Pre-paid Ambulatory and Inpatient Health Plans	*Explored in Round 1 but not prioritized for Round 2 analysis*	• These payment models have not been tested widely by other states. The consultant team advised DHSS to explore reforms with substantial experience elsewhere.
Health Savings Accounts	*Explored in Round 1 but not prioritized for Round 2 analysis*	• Health Savings Accounts are typically established as a tax benefit to allow individuals to contribute pre-tax income to their health spending. This same incentive does not exist for low-income individuals. • DHSS's cost of administering Health Savings Accounts would likely outweigh the potential gains in enrollee cost-sharing.

[3] Bundled payment models link payments for multiple services patients receive during an episode of care to treat a given condition or provide treatment, providing a single payment for those services. Pre-paid Ambulatory (PAHP) and Pre-paid Inpatient Health Plans (PIHP) are capitated non-comprehensive health plans paid a monthly per member fee for a discrete set of ambulatory or inpatient services.

ANALYSIS AND RECOMMENDATION OF ALTERNATIVE EXPANSION COVERAGE MODELS

In addition to reform initiatives, this project analyzed potential changes to the benefit package for the population covered through Medicaid Expansion implemented in Alaska on September 1, 2015 (referred to as the "Expansion population"). DHSS is currently providing this population with the same benefits as those provided under the traditional Medicaid program. However, federal law allows DHSS to provide a different set of benefits, within the Centers for Medicare and Medicaid Services (CMS) guidelines, to meet the needs of this population. Table S-3 gives a brief overview of the contract team's recommendations and rationale for coverage of the Expansion population.

Table S-3. Recommendations and Rationale for Coverage of the Expansion Population

OPTION	DESCRIPTION	RECOMMENDATION AND RATIONALE
Expansion Option 1. Current Benefit Package	Expansion enrollees continue to receive Medicaid using the benefits, co-payments and delivery system structure offered under the current Medicaid benefit package.	***Recommended*** The current benefit package offers a comprehensive benefit package that includes dental benefits for relatively little additional expense. A single benefit package is simpler and less costly to administer for DHSS and providers.
Expansion Option 2. Alternative Benefit Plan Based on a Qualified Health Plan	DHSS would provide a similar benefit package to that provided by the commercial plan with the largest insured, non-Medicaid enrollment. In Alaska, this plan is the Premera Blue Cross Blue Shield Alaska Heritage Select Envoy plan. The primary difference between Expansion Option 1 and Expansion Option 2 is that Option 1 includes dental benefits and Option 2 does not.	***Not Recommended*** Providing dental benefits for vulnerable populations is a less costly alternative to providing higher level care for dental emergencies and for health conditions that are worsened by lack of routine dental care.[4] Providers expressed significant concern about the additional administrative burden that would be associated with implementing a separate Medicaid benefit plan. Projected minimal cost savings from this option do not outweigh potential negative health impacts and the increased administrative resources required to manage separate benefit plans for Medicaid enrollees.
Expansion Option 3. Private Coverage Option	DHSS would use Medicaid funds to pay for Expansion enrollee coverage through the Federally Facilitated Marketplace. Medicaid would pay premiums and co-payments directly to the private insurer and would continue to fund directly the required Medicaid services not provided through Qualified Health Plans.	***Not Recommended*** The cost of pursuing the private coverage option is significantly higher than administering the program through DHSS and was deemed prohibitive.

[4] Oral Health in America: A Report of the Surgeon General. The National Institute of Dental and Craniofacial Research, September 2000.

Actuarial analysis indicates that Expansion Option 2 would result in a cost reduction of approximately four percent in SFY 2020 and beyond compared to the projected expenditures for Expansion Option 1. The cost savings are primarily driven by the removal of dental benefits. Removal of dental benefits produces savings, as well as costs. Milliman assumed a two percent increase in utilization of Emergency Department services due to removing dental benefits, but did not project anticipated costs from conditions that can be worsened by lack of dental preventive and treatment services or contribute to higher risks of dental disease. Expansion Option 3 would result in increased State and federal expenditures of between 30 percent and 40 percent, depending on year, over Expansion Option 1. However, the federal government will not fund expenditures greater than those projected in the baseline. Therefore, the cost to the State would increase substantially with Expansion Option 3. Table S-4 below shows the actuarial results for the options analyzed. Estimates do not consider the anticipated general fund savings associated with current and ongoing DHSS reform efforts, many of which are made possible by increased health care coverage made available through Medicaid Expansion (see Appendix H for additional details).

Table S-4. Actuarial Analysis and Comparison of Alternative Expansion Coverage Models

COMPARISON OF ALTERNATIVE EXPANSION COVERAGE OPTIONS*	FY17	FY18	FY19	FY20	FY21
EXPANSION OPTION 1: CURRENT ALTERNATIVE BENEFIT PACKAGE					
Total Cost	$184,161,000	$219,234,000	$229,743,000	$240,876,000	$252,634,000
Federal Cost	$179,294,000	$207,471,000	$215,331,000	$221,394,000	$228,761,000
State Cost	$4,867,000	$11,763,000	$14,412,000	$19,482,000	$23,873,000
EXPANSION OPTION 2: ALTERNATIVE BENEFIT PLAN BASED ON A QUALIFIED HEALTH PLAN					
Change in Total Cost	($11,513,000)	($13,403,000)	($13,722,000)	($14,045,000)	($14,368,000)
Change in Federal Cost	($11,595,000)	($13,077,000)	($13,255,000)	($13,279,000)	($13,365,000)
Change in State Cost	$82,000	($326,000)	($467,000)	($766,000)	($1,003,000)
EXPANSION OPTION 3: PRIVATE OPTION BASED ON A QUALIFIED HEALTH PLAN					
Change in Total Cost	$57,586,000	$72,434,000	$79,998,000	$88,186,000	$97,037,000
Change in Federal Cost	$0	$0	$0	$0	$0
Change in State Cost	$57,586,000	$72,434,000	$79,998,000	$88,186,000	$97,037,000

** Excludes impact of pharmacy rebates and third party recoveries. Excludes savings from Medicaid Reform Initiatives. Excludes savings from cost reductions in other state programs.*

By leveraging federal Expansion dollars, which currently cover 100 percent of costs and will not fall below 90 percent, DHSS can create new opportunities for coordination, early intervention, and prevention, and increase access to needed services. In this way, Medicaid Expansion can be a major catalyst for system transformation. Maintaining the current approach to Medicaid Expansion will allow DHSS to focus on the reform initiatives recommended in this report, as well as other important reform initiatives planned or underway. Creating a high functioning, well-managed system with the right incentives presents the best opportunity for cost savings and is most likely to produce the desired results over the long term.

INITIATIVE 2. BEHAVIORAL HEALTH ACCESS INITIATIVE

This initiative identifies key strategies for integrating behavioral health and primary care services, improving access to needed Substance Use Disorder treatment and mental health services, and addressing gaps in the behavioral health continuum of care to strengthen the crisis response system. This initiative includes a recommendation to contract with an Administrative Services Organization to increase capacity within the Department of Health and Social Services (DHSS) to manage a coordinated behavioral health system of care that improves health outcomes for Medicaid enrollees and controls costs.

DESCRIPTION

The need for behavioral health services in Alaska is great. Alaska grapples with the highest rates of suicide in the nation. [69,70] Heroin use has increased sharply in recent years, along with its corresponding impacts and costs.[71] Alaska's correctional system has experienced a steady increase in the prisoner population.[72] An analysis completed in 2014 estimated that Alaska Mental Health Trust beneficiaries[73] account for more than 40 percent of incarcerations each year.[74] When compared to five other states (Arkansas, Louisiana, New Mexico, Tennessee, and Washington), Alaska adults reported rates of Adverse Childhood Experiences in three categories that were higher by a statistically significant margin than the five-state cohort: incarcerated family member, household substance abuse, and separation and divorce.[75] The Alaska Behavioral Health Systems Assessment estimated that 145,790 Alaskan adults (more than a quarter of the adult population) needed treatment for illicit drug or alcohol use and/or experienced a mental illness in 2013.[76]

To improve health outcomes and decrease costs to the State that result from untreated behavioral health issues, Alaska needs a well-managed, coordinated behavioral health system of care. Limited access to behavioral health providers and services has led to a fragmented and crisis-driven system of care that frequently misses opportunities to engage children and adults with behavioral health needs that present in the health care, child protection, public safety, judicial, and correctional systems. Statutory and regulatory barriers, insufficient provider network development, stagnant reimbursement rates, siloed funding streams, and a lack of health care coverage for a significant portion of the

[69] Suicide Prevention Council http://dhss.alaska.gov/SuicidePrevention/Pages/Statistics/aksuiciderate_nativenonnative96-05.aspx

[70] Alaska Scorecard http://dhss.alaska.gov/dph/HealthPlanning/Documents/scorecard/assets/Scorecard2013.pdf

[71] Health Impacts of Heroin Use in Alaska. State of Alaska Epidemiology Bulletin. July 14, 2015. http://www.epi.alaska.gov/bulletins/docs/rr2015_01.pdf

[72] In 2011, Alaska's incarcerated population totaled 4,734 with 3,663 prisoners in in-state facilities and 1,071 in out-of-state facilities. From 2010 to 2011, the in-state prisoner population increased one percent and the out-of-state population increased by eight percent http://justice.uaa.alaska.edu/forum/29/3-4fall2012winter2013/b_ak_corrections.html

[73] Beneficiaries include individuals with mental illness, developmental disabilities, chronic alcoholism and other substance related disorders, Alzheimer's disease and related dementia, and traumatic brain injury. http://mhtrust.org/about/beneficiaries/

[74] Trust Beneficiaries in the Alaska Department of Corrections, May2014. Completed for the Alaska Mental Health Trust Authority by Hornby Associates, Inc. http://mhtrust.org/mhtawp/wp-content/uploads/2014/10/ADOC-Trust-Beneficiaries-May-2014-FINAL-PRINT.pdf

[75] Adverse Childhood Experiences (ACEs) are stressful or traumatic childhood experiences including abuse, neglect, and household dysfunction such as growing up with substance abuse, mental illness, an incarcerated parent, separation or divorce, and witnessing domestic violence. The more ACEs an individual experiences, the more likely he or she is to experience negative physical and behavioral health outcomes later in life. Adverse Childhood Experiences: Overcoming ACEs in Alaska. Advisory Board on Alcoholism and Drug Abuse. State of Alaska Department of Health and Social Services. January 2015. http://dhss.alaska.gov/abada/ace-ak/Documents/ACEsReportAlaska.pdf. Page 7.

[76] Alaska Behavioral Health Systems Assessment. Completed in 2015 by Agnew::Beck Consulting and Hornby Zeller, Inc. for the Alaska Mental Health Trust Authority. http://mhtrust.org/impact/behavioral-health-systems-assessment/

population experiencing behavioral health needs, have limited access to services and impeded efforts to integrate behavioral health into the broader health care system. The result is that the system often pays for behavioral health services at the highest level and cost of care, and individuals and families go without needed treatment and recovery services.

An effective behavioral health system must have many doors where individuals receive appropriate screening and service referrals. Behavioral health services that are well-integrated with each other and with primary care can increase access to needed services for individuals, particularly those with mild and moderate mental health issues and Substance Use Disorders, who might not otherwise seek care due to the stigma frequently associated with accessing care through behavioral health-specific service settings.

Medicaid Redesign and Expansion paired with Alaska's current fiscal situation present an opportunity and a challenge to meet the behavioral health needs of Alaskans while limiting costs for the State of Alaska. To meet this challenge will require changing current utilization patterns, and shifting from state grant-funded services to federally-matched Medicaid-funded services to reduce overall State expenditures. The Substance Abuse and Mental Health Services Administration's (SAMHSA) "Description of a Good and Modern Addictions and Mental Health Service System"[77] continuum of care provides a model for a comprehensive system.

In order to develop the capacity for a well-managed behavioral health system of care, this initiative includes a recommendation that DHSS contract with a third party Administrative Services Organization, which would provide national expertise and experience to DHSS to help transition from a program management model to a contract and outcomes management model. Under this initiative the Administrative Services Organization would not take over claims processing and payment functions.

A contract with an Administrative Services Organization would include significant performance incentives within the payment structure, with flexibility for the Administrative Services Organization to pass on incentives to providers for achievement of quality and network targets. In some regions, the Administrative Services Organization might elect to subcontract with a capable regional entity that is better equipped to perform provider network development and other regional tasks. The contractual structure could be similar to that of Connecticut's, where a percentage of administrative payments is withheld by the State pending completion of each fiscal year. To earn back these withholds, each Administrative Services Organization must demonstrate that it has achieved identified benchmarks on health outcomes, healthcare quality, and both member and provider satisfaction measures. All savings go back into the program to increase and improve services. Effective utilization management by an experienced vendor is a strategy that can ensure utilization is actively monitored and managed when steps are taken to open access to needed behavioral health services.

KEY FEATURES

a) Increase DHSS capacity to manage the behavioral health system.

    1. Consider proposing a Section 1115 waiver in State Fiscal Year (SFY) 2017 to secure authority and additional resources to broaden the behavioral health services array and to increase management capacity at DHSS. Once the demonstration project is underway, DHSS can

[77] Description of a Good and Modern Addictions and Mental Health Service System. 2011. SAMHSA. http://www.samhsa.gov/sites/default/files/good_and_modern_4_18_2011_508.pdf. See Appendix D.

propose an amendment to undertake Substance Use Disorder treatment delivery system transformation efforts. [78]

2. Contract with an Administrative Services Organization to perform key support functions for the behavioral health system. These functions would include developing and managing a network of behavioral health providers; utilization management; outcomes reporting; and, fraud, waste and abuse auditing.

b) Expand access to behavioral health services, both Substance Use Disorder treatment and mental health services, and integrate with primary care.

1. Establish standards of care to allow DHSS-authorized nationally accredited providers to bill Medicaid for behavioral health services.

2. Allow licensed and credentialed behavioral health providers to bill Medicaid regardless of setting. Medicaid billing limitations for behavioral health services present a barrier to current integration efforts and constrain the available workforce. Psychologists and Licensed Clinical Social Workers are recognized as rendering providers in Alaska statute[79] and can bill Medicaid for clinic services delivered in Federally Qualified Health Centers under federal authority. However, they are not authorized by current Alaska Medicaid regulations to provide clinic services, such as psychotherapy, in other settings unless a psychiatrist is located on-site at least 30 percent of the time. Even if the cost of a part-time psychiatrist were surmountable, the estimated vacancy rate for psychiatrists was 22 percent in 2012.[80] Other qualified behavioral health professionals and paraprofessionals that could provide early intervention and clinic services within their scope of practice either in a primary care setting or independently include Licensed Psychological Associates, Licensed Professional Counselors, Licensed Marriage and Family Therapists, and Tribal health system Behavioral Health Aides,[81] but these professionals and paraprofessionals are not currently recognized as rendering providers within Alaska statute. Given Alaska's workforce challenges, such barriers significantly limit the health care system's capacity to meet the behavioral health needs of Alaskans, including routine behavioral health screening and referral and access to mild and moderate mental health services.

3. Change the definition of rehabilitative service provider to remove the requirement from Alaska Statute that limits Medicaid behavioral health rehabilitative service providers to those who are grantees of the Division of Behavioral Health.[82]

[78] Centers for Medicare + Medicaid Services, letter to State Medicaid Directors # 15-003, July 27, 2015, http://www.medicaid.gov/federal-policy-guidance/downloads/SMD15003.pdf. Charlie Curie of The Curie Group advised DHSS that the current policy at CMS is to offer amendments of approved Section 1115 demonstration projects that focus on behavioral health system transformation, rather than proposing a separate Section 1115 demonstration project solely focused on Substance Use Disorder services (December 2015).

[79] Alaska Statute 47.07.030

[80] Alaska Health Workforce Vacancy Study: 2012 Findings Report. Alaska Center for Rural Health, Alaska's Area Health Education Center, University of Alaska. Prepared by Katherine Branch, 2014. http://www.uaa.alaska.edu/acrh-ahec/projects/vacancy/upload/2012ak-hlth-workforce-vacancy-study_12-23-14_FINAL.pdf

[81] Behavioral Health Aides, within the Tribal health system, work in remote villages and provide a range of services, including Medicaid billable rehabilitation services. Additionally, Behavioral Health Aides could provide early intervention and other clinic services under the supervision of a physician. This approach would be similar to today's Medicaid reimbursement model for Community Health Aides/ Practitioners within Alaska's Tribal health system.

[82] Alaska Statute 47.07.900

4. Seek a federal waiver of Section 1905(a) of the Social Security Act, which prohibits the federal government from reimbursing states under the Medicaid program for services provided in Institutions for Mental Diseases (IMDs), to allow residential Substance Use Disorder treatment providers to bill Medicaid for services. Generally, the IMD exclusion applies to any institution whose primary purpose is diagnosis, treatment or care of individuals with mental health and Substance Use Disorders. The IMD exclusion does not apply to individuals under 21 and over 65 or for institutions with 16 or fewer beds.[83] The IMD exclusion remains a barrier to billing for Medicaid for treatment providers who operate a facility with more than 16 beds or may wish to expand beyond 16 beds.

5. Work with Medicaid behavioral health providers to increase access to Medicaid billable services, which are both evidence-based and lower-cost alternatives to higher-level services, for example, group and family clinic and rehabilitative services; peer support; use of telemedicine in provision of Substance Use Disorder and mental health services; Medication Assisted Treatment; and Intensive Outpatient Substance Use Disorder treatment. [84]

6. Increase the use of Screening, Brief Intervention, and Referral to Treatment (SBIRT) in primary care settings and introduce a new billable service to promote the delivery of mental health screening and assessment using a DHSS-approved tool.

7. Connect enrollees recovering from mental illness with evidence-based supported employment services, such as Individual Placement and Support services.

c) Identify and fill key gaps in the behavioral health system, especially for higher needs individuals who are in crisis, cycling in and out of corrections, and those who are homeless. In hub communities, individuals experiencing psychiatric crises often present at Emergency Departments, which provide crisis stabilization and/or psychiatric boarding and, if necessary, arrange for escort and transport through the Secure Patient Transport Program to the Alaska Psychiatric Institute (API), or the nearest available psychiatric care.[85] When an individual experiences an acute psychiatric crisis in a village or community without a hospital, the individual is frequently held in a jail until s/he can be safely escorted to the nearest hospital.[86] Emergency Departments are often ill-equipped to address psychiatric crises due to lack of appropriate space and staffing. The Centers for Medicare and Medicaid Services (CMS) described psychiatric boarding as follows:

> *Psychiatric boarding occurs when an individual with a mental health condition is kept in a hospital emergency department for several hours because appropriate mental health services are unavailable. There are a number of factors that contribute to the prevalence of psychiatric boarding including a lack of outpatient*

[83] The nuances of this rule are explained in more detail in SAMHSA's Medicaid Handbook: Interface with Behavioral Health Services, Module 4: Providers of Behavioral Health Services. http://store.samhsa.gov/shin/content//SMA13-4773/SMA13-4773_Mod4.pdf

[84] Intensive Outpatient Services (for individuals at ASAM level 2.1) are a key part of the step up/step down continuum of care and help individuals recover and stay in their communities; these services are particularly important in areas where access to residential services is constrained. Intensive Outpatient Services require participants to have a minimum of nine hours of therapeutic contact each week. Source: Substance Abuse: Clinical Issues in Intensive Outpatient Treatment. Chapter 4, Services in Intensive Outpatient Treatment Programs. http://www.ncbi.nlm.nih.gov/books/NBK64093/pdf/TOC.pdf

[85] If necessary, hospitals seek an involuntary commitment court order or pursue voluntary-in-lieu placement. AS 47.30.655 states that "persons be given every reasonable opportunity to accept voluntary treatment before involvement with the judicial process."

[86] Using a Notice for Emergency Detention and Application for Evaluation under AS 47.30.655

resources and treatment coordination, and a lack of inpatient capacity, which are tied to state general funding issues, and the fact that psychiatric services are relatively unprofitable and often perceived as less of a need. [87]

1. Expand access to detoxification services, particularly Ambulatory Detoxification services. Detoxification is a set of interventions aimed at managing acute intoxication and withdrawal.[88] Continue discussions with the Alaska Board of Nursing to identify ways to develop the appropriate workforce to support detoxification services.

2. Develop Medicaid billable Assertive Community Treatment and mobile crisis response services.

3. Expand Crisis Residential / Stabilization services by reimbursing for medium-term residential crisis stabilization services and investing in workforce development for this service.

4. Evaluate the outcomes of the "Psychiatric Emergency Department" at Providence Alaska Medical Center in Anchorage, and consider expanding to other facilities by identifying appropriate billing mechanisms to allow hospitals to develop this service. This pilot provides on-site access to psychiatric and other behavioral health professionals for individuals who present in crisis and who are evaluated at the Emergency Department.

5. Identify measures to address the lack of inpatient mental health services, including strategies to ensure full operational capacity at the Alaska Psychiatric Institute (API), possible use of increased state and federal match under Disproportionate Share Hospital Funding to help sustain one to two additional mental health units,[89] and applying to participate in the recently announced Medicaid Emergency Psychiatric Demonstration project extension.[90] If selected, Alaska would be exempted from the IMD exclusion rule for delivery of emergency psychiatric services for the demonstration period, which would allow providers to bill for acute inpatient psychiatric services provided to individuals of all ages.

[87] Medicaid Emergency Psychiatric Demonstration; Demonstration Design and Solicitation from CMS https://innovation.cms.gov/Files/x/MedicaidEmerPsy_solicitation.pdf. DHSS citation refers to: DHHS, ASPE, A Literature Review: Psychiatric Boarding, David Bender, Nalini Pande, Michael Ludwig, The Lewin Group, Office of Disability, Aging and Long-Term Care Policy, Office of the Assistant Secretary for Planning and Evaluation, US DHHS, October 28, 2008 contract number HHS-100 03 0027

[88] Three levels of Detoxification services are currently covered by Alaska Medicaid: Ambulatory Detoxification, Clinically Managed Residential Detoxification, and Medically Monitored Residential Detoxification. Ambulatory Detoxification services are typically provided as an outpatient service in a physician's office or as a day service in a hospital. Source: Detoxification and Substance Abuse Treatment: A Treatment Improvement Protocol Guide. U.S. Department of Health and Social Services, Substance Abuse and Mental Health Services Administration. 2006. http://store.samhsa.gov/product/Detoxification-and-Substance-Abuse-Treatment/SMA06-4225

[89] See Overview of Medicaid DSH Funding in Alaska. ASHNHA. November 2013 http://25d1t615zk143unonqw6pglz.wpengine.netdna-cdn.com/wp-content/uploads/2012/11/Alaska-Medicaid-DSH-Payments-FY13-9-9-14.pdf and Behavioral Health Scan Report #1: Crisis Response, Recommendation 3A. Mat-Su Health Foundation. November 2014 http://www.healthymatsu.org/focus-areas/BHES.

[90] Joint State Advisory 15-43: President Signs Legislation to Extend IMD Demonstrations. December 14, 2015 Memo to clients from Covington describing the expanded participation in the Medicaid Emergency Psychiatric Demonstration under the Improving Access to Emergency Psychiatric Care Act.