SB 74 (2016) Implementation Update

House Health & Social Services Committee
April 25, 2019

Presented by: Heather Carpenter – Health Care Policy Advisor

SB 74 Implementation Update

Topics:

- 1115 Behavioral Health Waiver
- State Plan Options
- Superutilizers
- Coordinated Care Projects
- Medicaid Reform Program
- Tribal Reclaiming
- Fraud, Waste & Abuse
- Pioneer Home – Proof of Medicaid
- Telehealth
- Prescription Drug Monitoring Program (PDMP)

1115 Behavioral Health Waiver

- Goals
  - **Intervene as early as possible** in the lives of Alaskans to address behavioral health symptoms before they cascade into functional impairments
  - **Increase access** to robust and sustainable community- or regionally-based and culturally appropriate outpatient treatment services that have been designed to promote **family** wellness, stability and reunification, and child health and development
  - **Rebalance** the current behavioral health system of care to reduce Alaska's over-reliance on acute, institutional care and shift to more community- or regionally-based care
  - **Increase access** to local crisis and community- and regionally-based sub-acute treatment and wrap-around services designed to prevent over-utilization of deep-end, acute services
  - **Increase access** to a comprehensive continuum of SUD services designed to maintain individuals in community settings and to address long-standing gaps in services and needs related to Alaska's **opioid crisis**
  - Improve overall behavioral health system **accountability** by reforming the existing system of care

1115 Behavioral Health Waiver

- Substance Misuse Disorder Treatment Component
- Approved in November 2018
- Effective January 1, 2019-December 31, 2023
- Requires that Alaska **achieve 6 major milestones** through the approved Waiver:
  - Ensure access to 9 critical levels of care for substance use disorder (SUD) treatment
  - Ensure use of evidence-based, SUD-specific patient placement criteria
  - Ensure use of nationally-recognized, SUD-specific program standards for residential treatment facility provider qualifications
  - Ensure sufficient provider capacity at critical levels of care

1115 Behavioral Health Waiver

Substance Use Disorder Components

- Adolescents, Adults, and Elderly with **substance use disorders (SUD)**
  - Includes those with at least one diagnosis from the DSM-5 for substance-related and addictive disorders **and** meet the American Society of Addiction Medicine (ASAM) treatment criteria for addictive, substance-related, and co-occurring conditions definition of medical necessity

- The State is targeting this population to increase access to a comprehensive continuum of SUD services designed to maintain individuals in community settings and to address long-standing gaps in services and needs related to Alaska's current opioid crisis and long-standing alcohol-related problems.

1115 Behavioral Health Waiver

What is Next?

- Get regulatory house in order—draft/publish May 2019
- Ensure readiness provider network—June 2019
- Hire administrative entity—June-July 2019
- Initiate SUD service delivery—July 2019
- Negotiate for federal approval of the remaining components of the waiver – target approval and implementation within FY 20

1115 Behavioral Health Waiver

Components Pending Approval from CMS:

- Children, Adolescents and their Parents or Caretakers **with, or at risk of** mental health and substance use disorders
- The state is targeting this population as an **early intervention strategy**, which represents a **significant shift** in the approach to delivering behavioral health services.
- Transitional Age Youth, Adults, and Elderly with **acute mental health** needs
- The State is targeting this population to increase access to community-based crisis and sub-acute treatment and wrap-around services designed

1115 Behavioral Health Waiver

An Administrative Services Organization (ASO) is an arrangement in which:

- A State contracts with a third party organization with special expertise in behavioral health systems management
- They provide certain specified administrative services necessary to manage the system of care
- The work is done in accordance with state policies and procedures

Potential functions of an ASO:

- Utilization management
- Provider development and support
- Recipient Outreach, Communication and Support
- Quality management
- Data management
- Claims Processing

Notice of Intent to Award was issued on April 22, 2019

Comprehensive Integrated Mental Health Program Plan

- Plan Development:
  - "Strengthening the System" was developed by the Department of Health and Social Services (DHSS) in collaboration with the Alaska Mental Health Trust Authority and their advisory boards.
  - This plan is coordinated with other plans and programs addressing specific services developed by the Alaska Mental Health Trust Authority, the Alaska Mental Health Board, the Governor's Council on Disabilities and Special Education, the Governor's Advisory Board on Alcoholism and Drug Abuse, the Statewide Suicide Prevention Council, and the Alaska Commission on Aging.

Comprehensive Integrated Mental Health Program Plan

- Timeline:
  - Public Comment: March 11 - April 12 (closed)
  - Finalize the Plan content and incorporate data and indicators: April 18 – May 14
  - Plan Publication: May 15 – June 15
  - Final Department Review: June 17 – 24
  - Website Development: May 15 – June 30
  - Plan and Website Go Live: July 1

State Plan Options

- 1915(c) - Individual Supports Waiver
  - Go-live date was October 1, 2018
  - The IDD Unit reports that over 600 individuals have been drawn from the Registry (waitlist) and sent a Notice to Proceed;
  - Implementation Hurdles:
    - Families understanding the new program
    - Coordinating with Division of Public Assistance on eligibility requirements
    - Number and Capacity of Care Coordinators

State Plan Options

- 1915(k) – Community First Choice
  - Go-live date was October 1, 2018
  - SDS Auto-enrolled recipients who met the level of care for CFC
  - Serving 816 individuals
  - Implementation Update:
    - Technical assistance and training needs for Providers
    - Additional paperwork tasks for care coordinators
    - Training curriculum for care coordinators

Superutilizer Reduction

- Alaska Emergency Department Coordination Project – ASHNHA

- Primary Care Case Management
  - Care Management Program aka Lock In Program
  - Alaska Medicaid Coordinated Care Initiative

Why the Alaska Emergency Department (ED) Coordination Project?

- Increasing health care costs
- Decreasing state budget
- Need for a better design
- Part of the Medicaid Redesign solutions

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Seven Best Practices Model

1. Adopt an electronic emergency department information system
2. Implement patient education
3. Institute an extensive case management program
4. Identify frequent users of ED
5. Develop patient care plans for frequent users of ED
6. Implement narcotic guidelines to discourage narcotic-seeking behavior and monitor patients who are prescribed controlled substances
7. Track progress of the plan to make sure steps are working

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Alaska's ED Coordination Project

Partnership between State of Alaska, ACEP, and ASHNHA

(1) an **interdisciplinary process for defining, identifying, and minimizing the number of frequent users of emergency department services**;

(2) to the extent consistent with federal law, a system for **real-time electronic exchange** of patient information, including recent emergency department visits, hospital care plans for frequent users of emergency departments, and data from the controlled substance prescription database;

(3) a procedure for **educating patients** about the use of emergency departments and appropriate alternative services and facilities for nonurgent care;

(4) a process for assisting users of emergency departments in making appointments with **primary care or behavioral health providers within 96 hours** after an emergency department visit;

(5) a collaborative process between the department and the statewide professional hospital association to establish uniform **statewide guidelines for prescribing narcotics in an emergency department**; and

(6) designation of health care personnel to **review successes and challenges** regarding appropriate emergency department use.

(7) shared savings

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Implement Electronic ED information system

Goal: Exchange patient information among Emergency Departments

- Pertinent information is pushed to providers and used to provide efficient and safe care
- Emergency departments receive flags identifying high utilizers
- The information system will reduce unnecessary medical tests
- It will provide access to care/treatment plans
- Went live in February 2017 at four Providence hospitals in Alaska. Live at 11 hospitals and at 6 other entities today.

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Participating Organizations

- 673d Medical Group, JBER
- Alaska Innovative Medicine
- Alaska Native Medical Ctr
- Alaska Primary Care Association
- Alaska Regional Hospital
- Alaska State Hospital and Nursing Home Association
- American College of Emergency Physicians – Alaska Chapter
- Anchorage Fire Department
- Bartlett Regional Hospital
- Central Peninsula Hospital
- Fairbanks Memorial Hospital
- LaTouche Pediatrics
- Links ADRC HUMS
- Mat-Su Regional Medical Ctr
- Peace Health Ketchikan Medical Center
- Providence Alaska Medical Ctr
- Providence Kodiak Island Medical Ctr
- Providence Seward Medical Center
- Providence Valdez Medical Center
- State of Alaska
- South Central Foundation
- South Peninsula Hospital
- State of Alaska – DHSS
- Wrangell Medical Center

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ED Narcotic Guidelines

Goal: Reduce drug-seeking and drug-dispensing to frequent ER users

- Implemented statewide guidelines for prescribing and monitoring of narcotics
- Endorsed by providers and hospitals and matches efforts in other states
- We anticipate reduction in ED prescriptions
- Direct patients to better resources
- Track data and follow up with providers who excessively prescribe
- Integrated ED information system and Prescription Drug Monitoring Program (PDMP). Eight emergency departments are connected to PDMP through EDie.

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Alaska Emergency Department Opioid and Controlled Substances Prescribing Guidelines

Alaska's Emergency Care Providers are committed to compassionate, timely, quality care. Regardless of the reason for your visit or insurance status, we will always do a medical screening exam and strive to provide you with the safest possible care. As part of providing safe care, Emergency Providers in the State of Alaska have adopted the following consensus guidelines for prescribing and administering controlled substances in the Emergency Department. We have developed these guidelines because controlled medications have potentially deadly side effects and are commonly associated with addiction. These guidelines will be applied at the discretion of the emergency provider and decisions about treatment are generally made based on objective (visible) evidence of acute painful conditions. These guidelines do not apply to patients with painful terminal illness.

If you have any questions, please speak with an ED team member.

1. A single medical provider should prescribe all opioids to treat a patient's chronic pain both on a long-term basis and with acute exacerbations. The best practice is for this provider to be the patient's primary care provider or pain management specialist.

2. The Emergency Department Providers will not administer intravenous or intramuscular opioids for the relief of acute exacerbations of chronic pain.

3. Emergency Department Providers will not provide replacement prescriptions for controlled substances that were lost, destroyed, or stolen.

4. Long-acting or controlled-release opioids (such as OxyContin, fentanyl patches and methadone) will not be prescribed from the Emergency Department.

5. Emergency Department Providers are encouraged to review other health records, care plans, and the Prescription Drug Monitoring Program (PDMP) prior to dispensing or administering opioids. They are encouraged to contact the patient's primary prescriber to discuss the patient's care.

6. Emergency Department Providers should perform brief screening for patients with suspected substance addiction or at risk for overdose. Caution should be used when administering or prescribing controlled substances for these patients and brief interventions and treatment referrals are encouraged.

7. Prescriptions for opioid pain medication from the Emergency Department should be for an acute injury, such as a fracture, and should be for the lowest dose and shortest time course possible (ideally no more than 3 days). Non-opioid therapies are encouraged when possible.

8. Emergency Departments should attempt to coordinate the care of patients who frequently visit the Emergency Department.

9. The combination of opiates and benzodiazepines significantly raises the risk of accidental overdose. The practice of prescribing this combination is discouraged.

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central peninsula hospital | heritage place | serenity house
South Peninsula Hospital
NorthStar Behavioral Health
Bartlett Regional Hospital
QUALITY in Community Healthcare
FAIRBANKS MEMORIAL HOSPITAL
MAT-SU REGIONAL MEDICAL CENTER
PROVIDENCE Alaska Medical Center
PROVIDENCE Kodiak Island Medical Center

Download at:
https://www.ashnha.com/edcp/

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CASE STUDY

Collective Medical Helps Providers Identify and Prevent Opioid Abuse

"When it comes to addressing the opioid epidemic, it's helpful to have real-time notifcations about patients and their risk. When a patient comes in with an opioid problem, I can see what her established care plan is, decide the best way to help her regain control, and try to alleviate her pain in the least harmful way possible."

- Anne Zink, FACEP and Emergency Medicine Director, Mat-Su Regional Medical Center

Mat-Su Regional Medical Center

It started with a question posed by a patient struggling with an opioid use disorder. When asked about his patterns of abuse, he stated, "I figured that if doctors were willing to just give [opioids] to me to help boost satisfaction scores, it must not be that big a deal. Are satisfaction scores more important than a life?"

Mat-Su Regional Medical Center is a 74-bed rural hospital located in Palmer, Alaska. But its small size is no reflection of the big impact it's having on prescription opioid abuse in Alaska.

The Challenge

Leaders at Mat-Su knew they needed to find a way to better qualify which patients were truly in need of opioids and which were not. However, establishing these key metrics was difficult. When should opioids be given? When shouldn't they?

A group of ED physicians met from around the state to determine key metrics and develop best practices for prescribing opioids to patients. While the guidelines were initially introduced as encouraged—but not mandatory—resources for physicians, many of these guidelines were later implemented statewide. The state was then able to support these guidelines with public and physician education, state-and-physician-created educational materials, and other community resources.

With care guidelines in place, the ED implemented the Collective Platform to further track opioid use. The Platform delivers real-time essential patient data at the point of care—allowing doctors to quickly view other facilities the patient was frequenting and any problems with substance use disorder the patient could be facing.

www.collectivemedical.com

CollectiveMedical

The Solution: A Collaborative Effort

With new care guidelines and the Collective Platform, the staff at Mat-Su had the resources they needed to start sitting down with these patients and discussing what each patient really needed. Dr. Anne Zink, FACEP and Emergency Medicine Director at Mat-Su, explains:

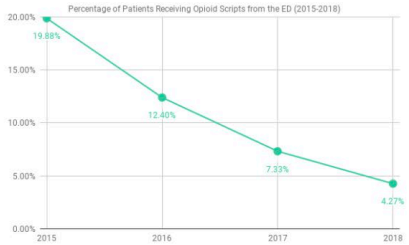
"With Collective, rather than making judgements about patients, we have actual data to reference. This makes it a lot easier to have a conversation with the patient, starting with 'Let's see what you're facing, what the underlying problem is, and why you're really bouncing between providers."

With patient, physician, platform, and state cooperation, Mat-Su expanded its efforts to include the community. Now, community care and non-profit organizations further improve patient transitions from ED to home or rehabilitation by helping patients get plugged into the system and accompanying patients to rehabilitation.

Clinic Outcomes

With the local efforts of hospital and community—supported by statewide initiatives, PDMP integration, and care collaboration through the Collective Platform—Mat-Su was able to see dramatic results, including a

79.36% reduction in opioid scripts written within the first three years of implementation (2015-2018)



During these changes, Mat-Su was able to maintain positive patient satisfaction results. Despite worries that reducing opioids given could reduce satisfaction scores, the caring and collaborative approach taken by providers at Mat-Su has kept the hospital patient satisfaction rates top-notch.

www.collectivemedical.com

PDMP Integration

As part of its statewide initiatives, Alaska enabled PDMP integration with the Collective Medical Platform. With this, ED physicians are able to get real-time notification alerts that inform them of important prescription histories according to preset-qualifiers determined by each hospital. This has been helpful in tracking patient opioid use and avoiding over-prescribing opioids.

In one case, a woman with major medical problems was coming into the ED with complaints of high pain levels. Physicians did not realize she was already getting those opioid prescriptions from her primary care provider.

Once the PDMP program was connected with their Collective notifications, physicians were able to see the woman's actual opioid prescription history—alerting them to a potential problem with substance use disorder. They were then able to sit down and have a conversation with the woman and her other care providers to discuss the root of the problems and start getting her the help she needed most.

About Collective Medical

Collective Medical provides the nation's largest and most effective network for care collaboration. Our risk-adjusted event notification and care collaboration platform spans across all points of care—including hospitals, payers, behavioral and physical ambulatory, and post-acute settings. The Collective Platform uses the network to identify at-risk, complex patients and share actionable, real-time information with diverse care teams, leading to better care decisions. Care decisions and plans become a collaborative effort, improving patient outcomes by executing on a single, shared, and consistent plan of care.

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Ultimate Goal

- Improve patient care via timely, coordinated care in the emergency department
- Reduce over all health care cost by minimizing redundancy and improving care

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https://www.ashnha.com/edcp/

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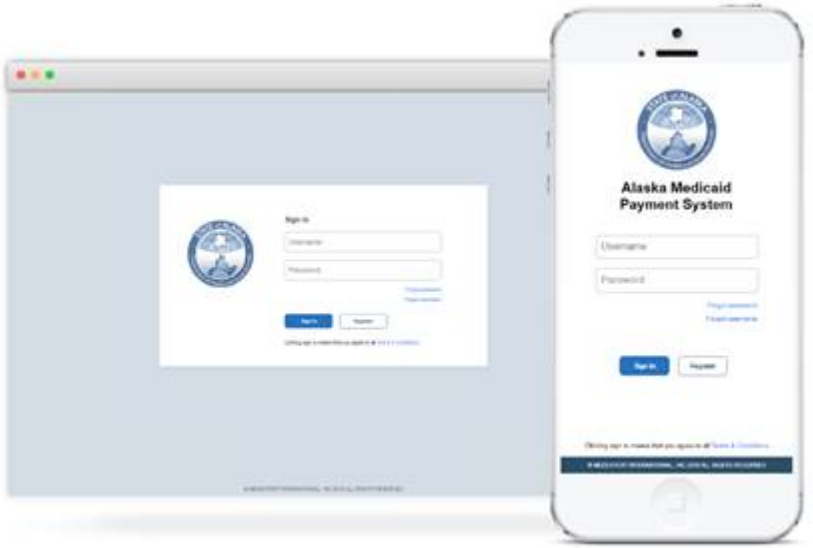
Coordinated Care Projects

- Providence Family Medicine Center - Patient Centered Medical Home model
  - Go-live date was September 1, 2018
- United Health Care Managed Care Organization
  - Anticipated go-live date of October 1, 2019

Medicaid Reform Program

- Electronic Explanation of Medical Benefits (EOMBs)
  - Register for online access at https://alaska.medexperthealth.com

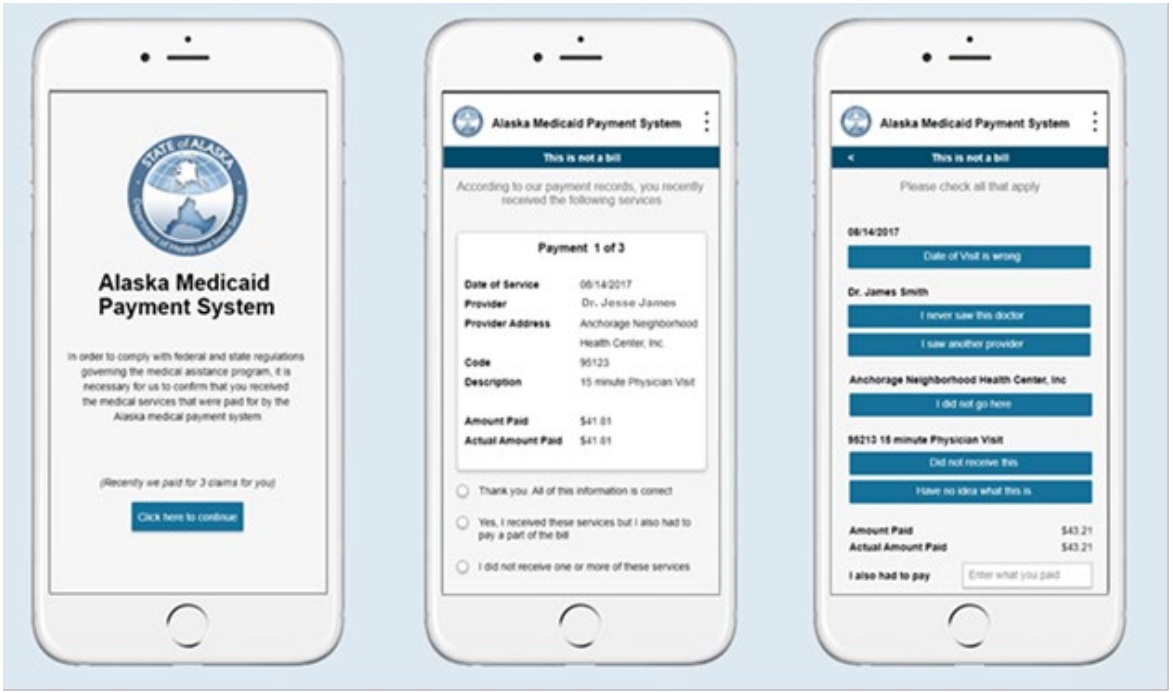


  - Questions or problems registering, please call MedExpert at 800-999-1999

  - FAQ Document: http://manuals.medicaidalaska.com/docs/dnld/Update_Medicaid_EOMB_FAQ.pdf

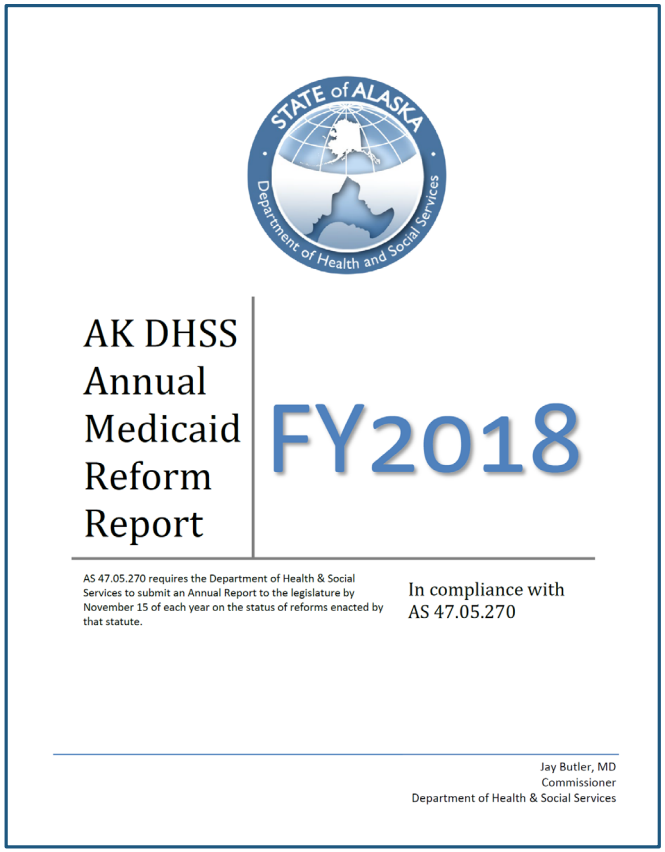
Medicaid Reform Program

- Electronic Explanation of Medical Benefits (EOMBs)



Medicaid Reform Program

- Redesign payment process
- Stakeholder involvement – quality targets
- Annual Medicaid Reform Report to legislature
  - http://dhss.alaska.gov/HealthyAlaska/Documents/redesign/FY-2018_Annual_Medicaid_Reform_Report_with_Appendices.pdf
- MMIS certification update
  - Certified by CMS on September 28, 2018



Tribal Health Reclaiming Efforts

What is Tribal Reclaiming?

- Tribal Medicaid beneficiary claims have been reimbursed at 100% federal match for services provided by or through a tribal health facility.
- State Health Official Letter #16-002; 2/26/16 distribution requiring 3 elements:
  - Care Coordination Agreements
  - Referrals
  - Exchange of Records

3 Year Snapshot of Efforts

- SFY17: Look at high dollar/low volume claims to meet target:
  - Transportation (air and ground ambulance, travel broker services)
  - Hospital inpatient/outpatient, case managed complex kids
  - Accurate IHS Coding in MMIS

- SFY18: Continue to add care coordination agreements and strategize
  - Continue with services from SFY17 plus:
  - Pharmacy, Long-Term Care, Out of State Residential Psychiatric Treatment Facilities
  - Tribal Providers in Non-Tribal Facilities
  - Non-IHS Mothers with IHS Newborns

- SFY19
  - Continue with services from SFY17 and SFY18 plus:
  - Waiver Services
  - Service Authorizations with date spans on travel itineraries
  - Optical Services

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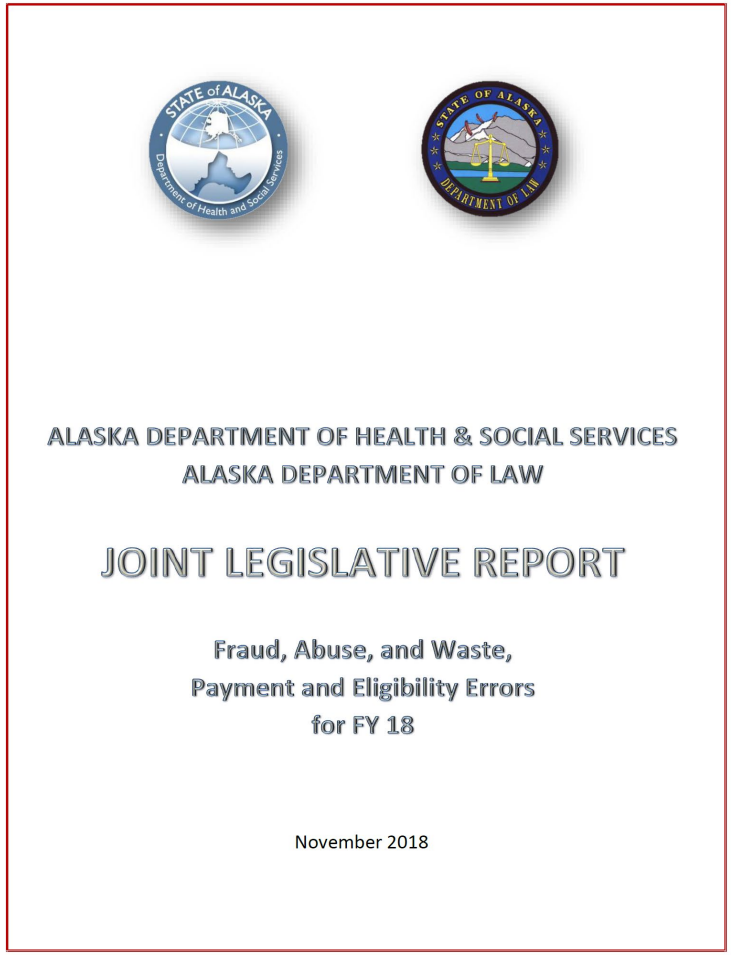
Savings

SFY	ORIGINAL TARGET	ADDITIONAL FMAP ACHIEVED
SFY17	$ 32,000,000.00	$ 34,781,839.28
SFY18	$ 42,000,000.00	$ 45,186,960.05
SFY19	$ 84,000,000.00	$ 65,194,564.82
Grand Total	$ 158,000,000.00	$ 145,163,364.15

*** Note: Total Additional FMAP achieved for SFY19 only includes three quarters to date*

Fraud, Waste & Abuse

- DHSS & Dept. of Law Joint Legislative Annual Report on Fraud, Abuse, and Waste, Payment & Eligibility Errors
  - http://dhss.alaska.gov/HealthyAlaska/Documents/redesign/Medicaid_Fraud_Abuse_Waste_Report-SB74-Nov2018.pdf



ALASKA DEPARTMENT OF HEALTH & SOCIAL SERVICES
ALASKA DEPARTMENT OF LAW

JOINT LEGISLATIVE REPORT

Fraud, Abuse, and Waste,
Payment and Eligibility Errors
for FY 18

November 2018

Fraud, Waste & Abuse

- Eligibility Verification system
  - CMS also requires an Asset Verification System (AVS) and an Independent Verification and Validation (IV&V) System
  - Request for Interest for an Asset Verification System and Eligibility Verification System was issued in November 2018
  - Division of Public Assistance plans to implement both systems within the next 6 months to satisfy both federal requirements under Food Nutrition Services and CMS

Pioneer Home – Proof of Medicaid

- Required individuals applying for Pioneer Home payment assistance to show proof of having applied for Medicaid
- Has been a successful strategy to reduce elder's indebtedness by using Medicaid waiver dollars
  - Medicaid receipts to AKPH:
    - FY 16 - $4,135.8
    - FY 17 - $4,352.8
    - FY 18 - $4,509.5

Telehealth

- Falls under the jurisdiction of Department of Commerce, Community & Economic Development
  - Division of Corporations, Business and Professional Licensing
- Expanded options for Alaskans
- Flexibility for Outside providers to treat Alaskans
- Currently 245 registered telemedicine businesses

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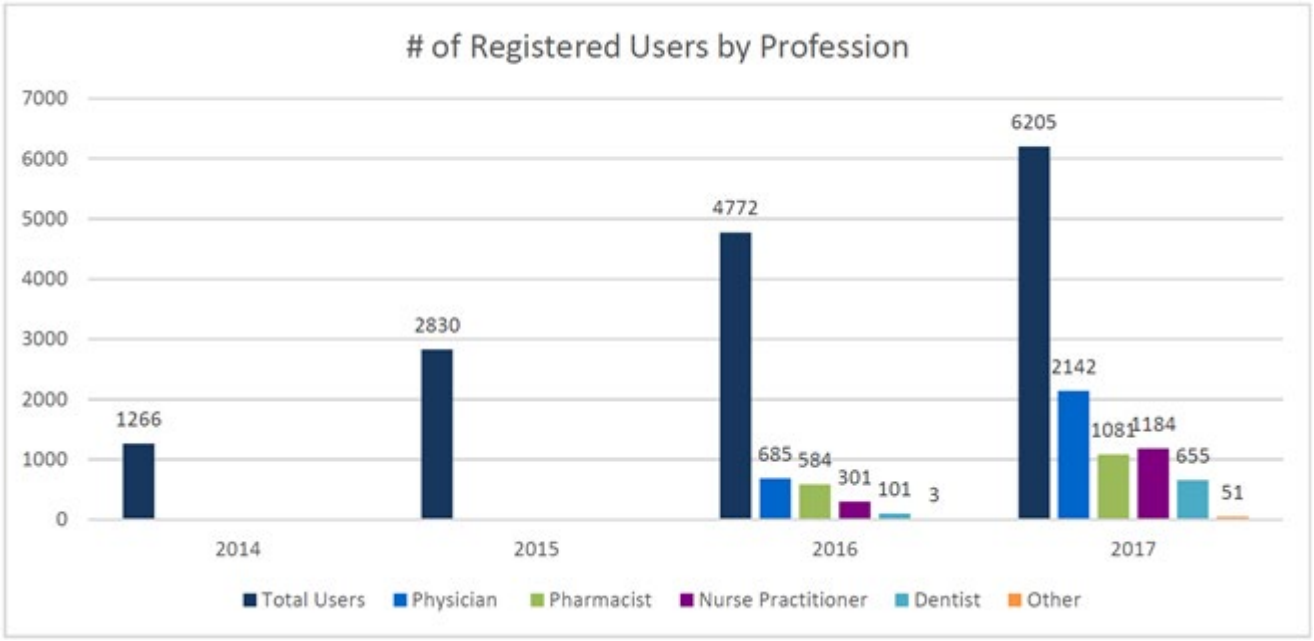
Prescription Drug Monitoring Program (PDMP)

- Falls under the jurisdiction of Department of Commerce, Community & Economic Development
  - Division of Corporations, Business and Professional Licensing
- Mandated registration for providers and pharmacists



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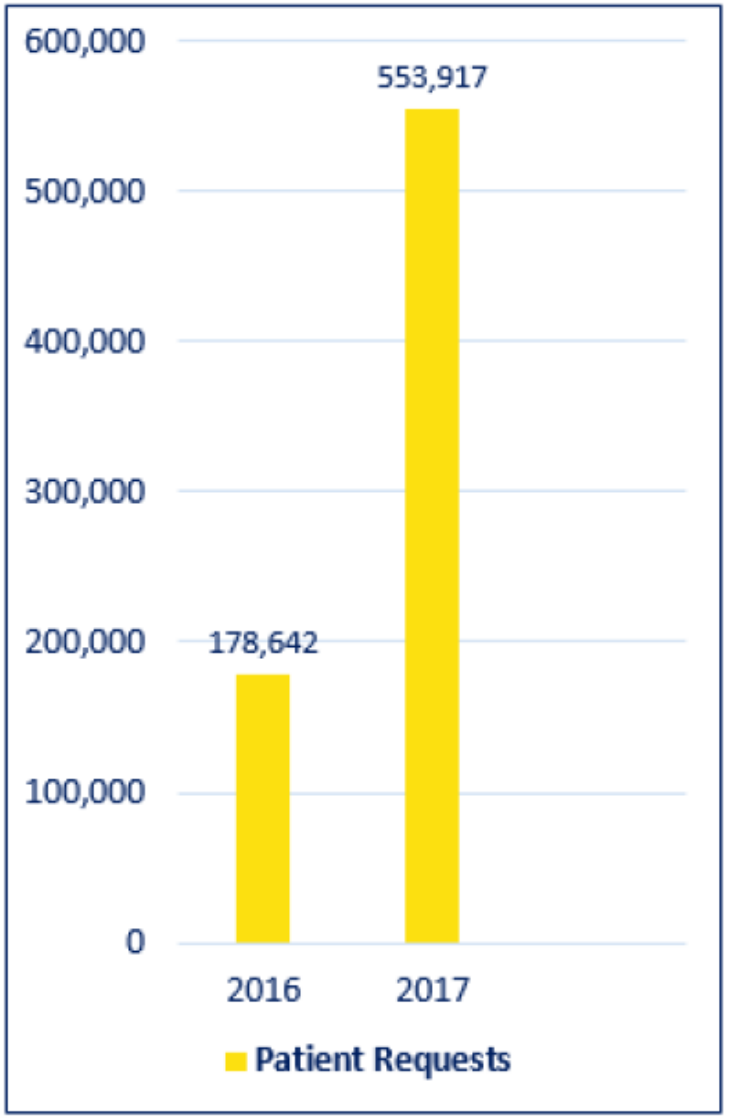
PDMP

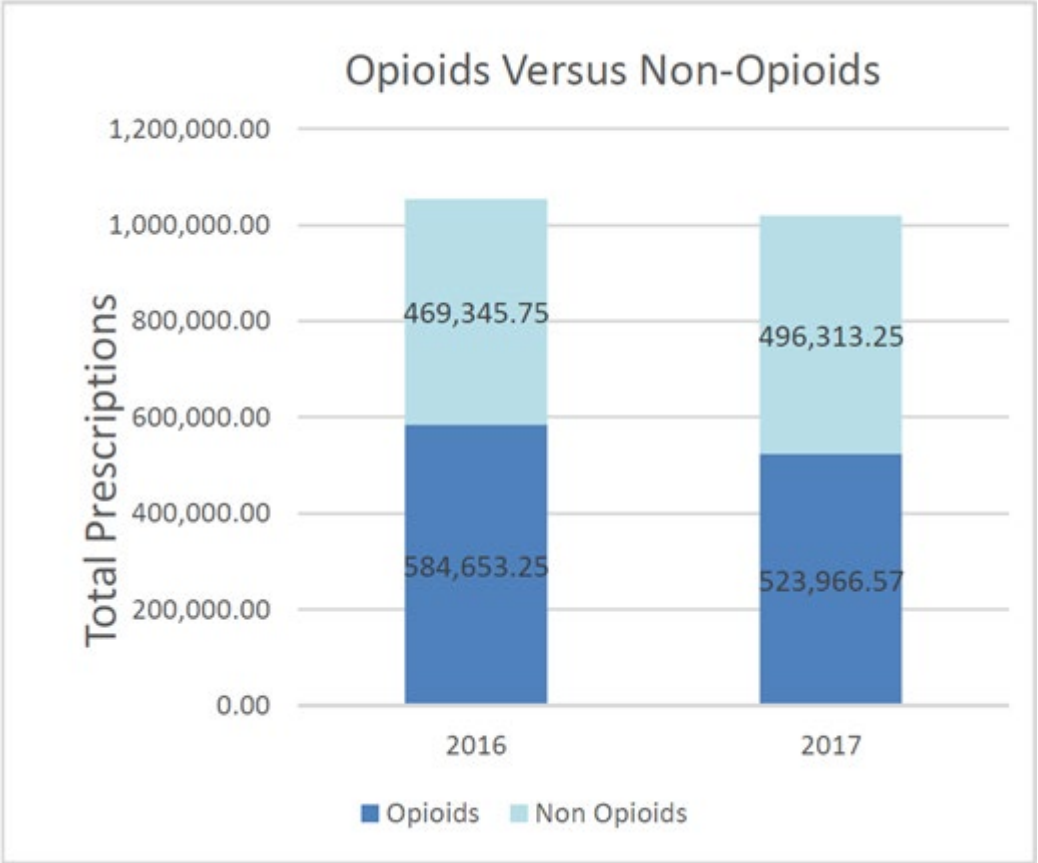
- Requires providers to check before prescribing or dispensing



SB 74 Implementation Update

PDMP

- Numbers of controlled substance prescriptions have decreased



SB 74 Implementation Update

PDMP

- Number of patients receiving opioid prescriptions has decreased. Ongoing challenges with high MME prescriptions for chronic pain management.

	2016	2017	Percent Change
# of patients receiving an opioid prescription	150,600	135,362	10.12% (decrease)
# of opioid prescriptions greater than 100mg MME per day	79,654	79,288	.46% (decrease)

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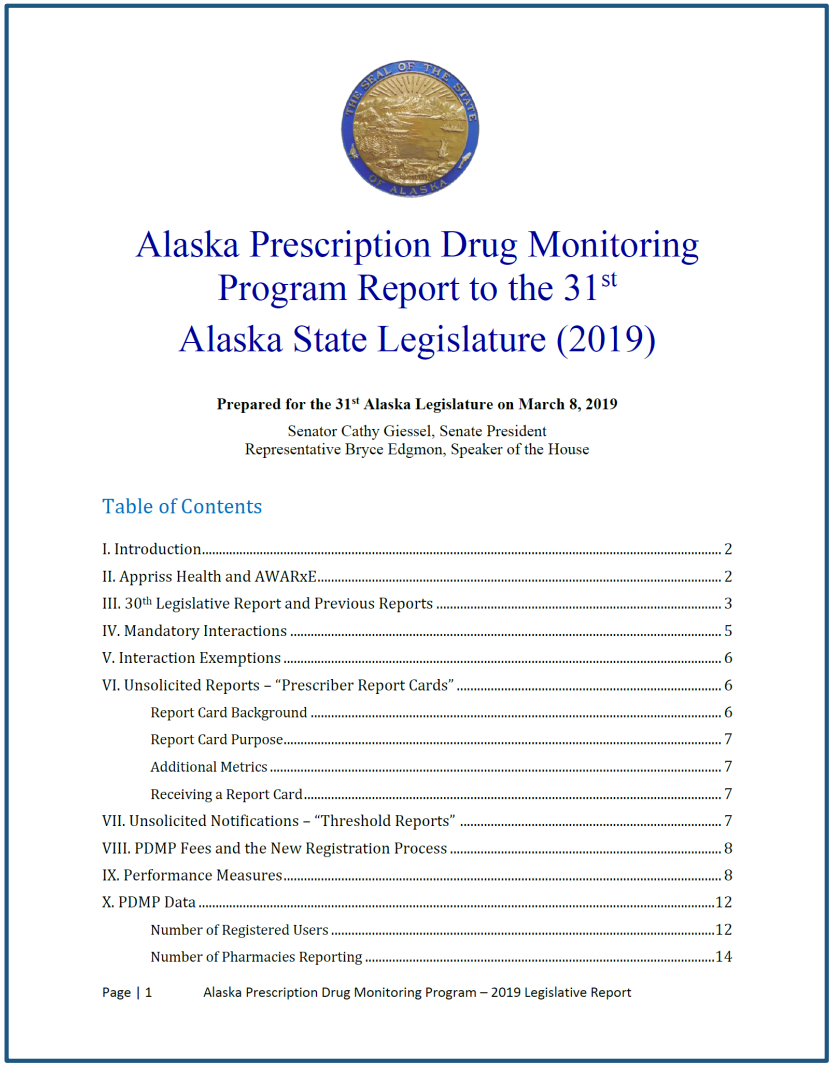
PDMP

- More details in the PDMP Annual Report
  - Emailed to Legislature March 21, 2019
  - Available at pdmp.alaska.gov



Alaska Prescription Drug Monitoring Program Report to the 31st Alaska State Legislature (2019)

Prepared for the 31st Alaska Legislature on March 8, 2019

Senator Cathy Giessel, Senate President
Representative Bryce Edgmon, Speaker of the House

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FY 2018 General Fund Savings and Cost Avoidance Resulting from Medicaid Reforms and Cost Containment Initiatives	
SB 74 Medicaid Reform GF Savings/Cost Avoidance — DHSS	
Federal Tribal Reimbursement Policy	$ 44,765,420
Alaska Medicaid Coordinated Care Initiative (Primary Care Case Management)	$ 2,850,000
Subtotal	**$ 47,615,420**
SB 74 Medicaid Reform GF Cost Avoidance — DOC	
Medicaid enrollment for prisoners; out-of-facility hospital services	$ 4,645,983
GF Savings/Cost Avoidance from Other Medicaid Reforms — DHSS	
Pharmacy Preferred Drug List	$ 2,500,000
Pharmacy Prospective Drug Utilization Reviews	$ 2,500,000
Pharmacy Payment Reform: NADAC Implementation	$ 12,250,000
Pharmacy Hepatitis C Initiatives	$ 3,000,000
On-going Tribal Health System Capacity Development	$ 22,500,000
Subtotal	**$ 42,750,000**
GF Savings/Cost Avoidance from On-Going Care Improvement/Cost Containment Initiatives — DHSS	
Home & Community Based Services Utilization Control & Process Improvement	$ 10,430,676
Surveillance & Utilization Review Subsystem (SURS) Overpayment Collections	$ 26,587
SURS Account Reconciliation Management Project	$ 18,000,000
Medicaid Program Integrity Overpayment Collected from Providers	$ 1,135,723
Third-Party Liability Contract and HMS Audit Recovery	$ 9,000,000
Care Management Program	$ 832,200
Case Management	$ 995,313
Utilization Management Services	$ 3,892,146
Subtotal	**$ 44,312,645**
TOTAL	**$139,324,048**

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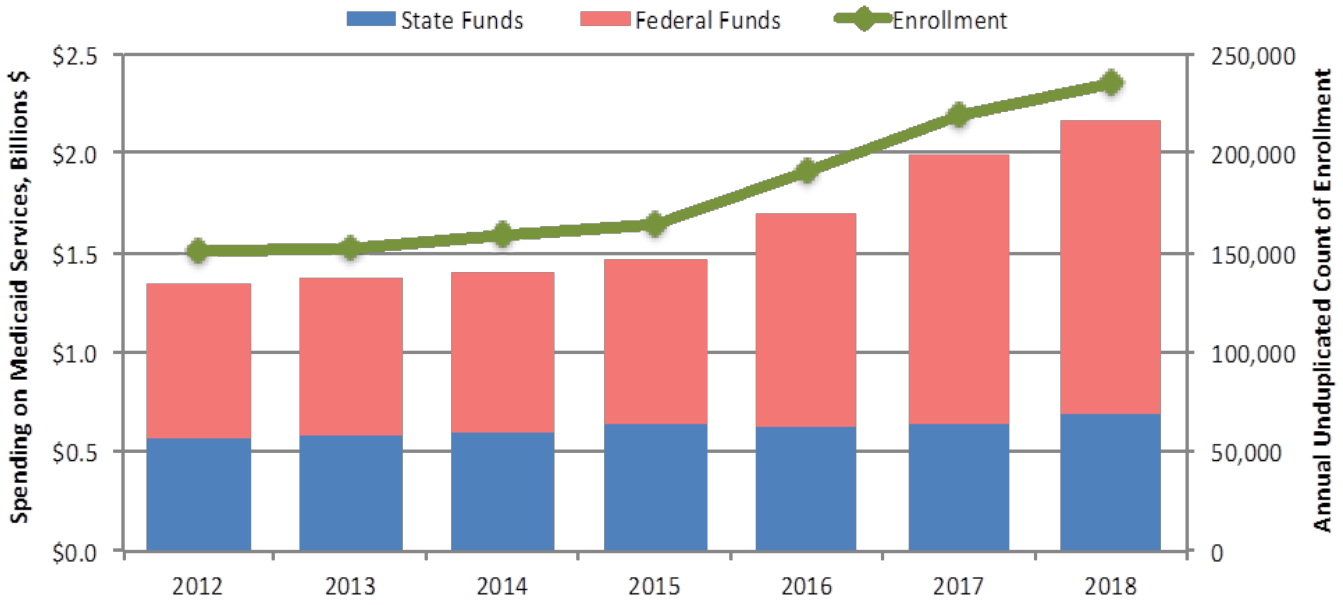
Medicaid Enrollment & Spending in Alaska
2012 – 2018 Date-of-Service Actuals



Source: Evergreen Economics. (September 25, 2018). Long Term Forecast of Medicaid Enrollment & Spending in Alaska ("MESA"): FY 2019 – FY 2039.

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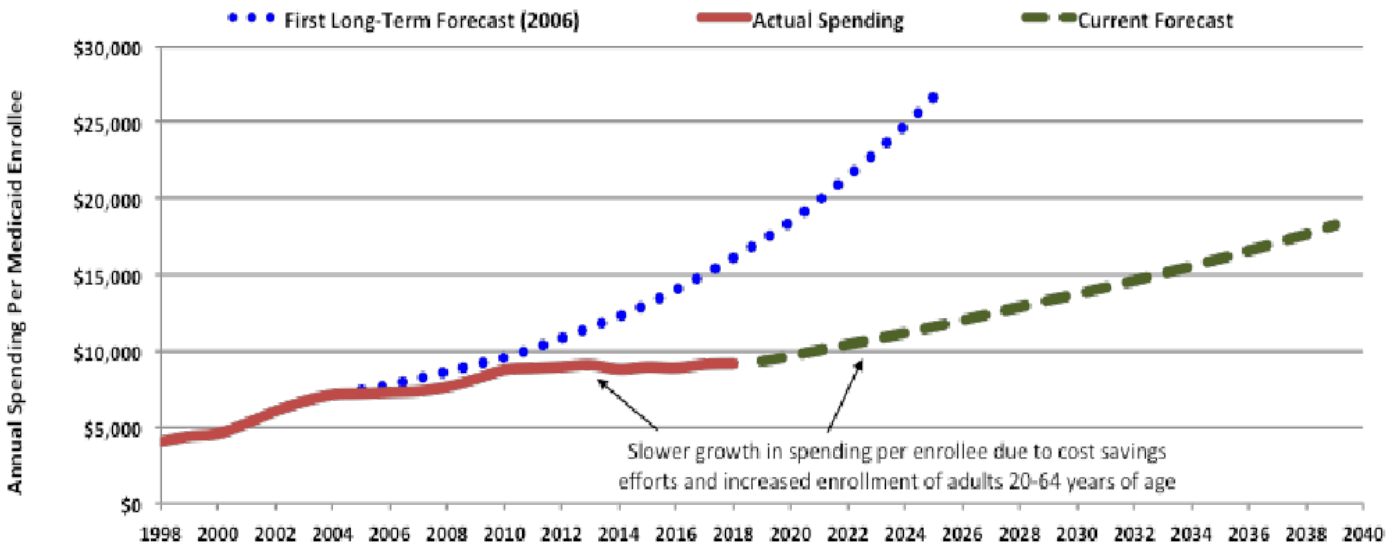
Total Medicaid Spending per Enrollee (all fund sources)
1998 – 2018 Actuals and 2019 – 2039 Projected



Source: Evergreen Economics. (September 25, 2018). Long Term Forecast of Medicaid Enrollment & Spending in Alaska ("MESA"): FY 2019 – FY 2039.

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Questions?