

HOUSE FINANCE COMMITTEE  
March 28, 2016  
1:31 p.m.

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CALL TO ORDER

Co-Chair Thompson called the House Finance Committee meeting to order at 1:31 p.m.

MEMBERS PRESENT

Representative Mark Neuman, Co-Chair  
Representative Steve Thompson, Co-Chair  
Representative Dan Saddler, Vice-Chair  
Representative Bryce Edgmon  
Representative Les Gara  
Representative Lynn Gattis  
Representative David Guttenberg  
Representative Scott Kawasaki  
Representative Cathy Munoz  
Representative Lance Pruitt  
Representative Tammie Wilson

MEMBERS ABSENT

None

ALSO PRESENT

Heather Shadduck, Staff, Senator Pete Kelly; Jeff Jessee, Chief Executive Officer, Alaska Mental Health Trust Authority; Karen Forrest, Deputy Commissioner, Department of Health and Social Services; Randall Burns, Director, Division of Behavioral Health, Department of Health and Social Services; Kate Burkhart, Executive Director, Alaska Mental Health Board and Advisory Board on Alcoholism and Drug Abuse, Division of Behavioral Health, Department of Health and Social Services; Jon Sherwood, Deputy Commissioner, Medicaid and Health Care Policy, Department of Health and Social Services; Valerie Davidson, Commissioner, Department of Health and Social Services; Duane Mayes, Director, Division of Senior and Disabilities Services, Department of Health and Social Services.

PRESENT VIA TELECONFERENCE

Charlie Curie, CEO, The Curie Group LLC, Maryland; Shane Spotts, Contractor, Senior Disability Services, Health Management Associates.

SUMMARY

CSSB 74(FIN) am

MEDICAID REFORM;TELEMEDICINE;DRUG DATABASE

CSSB 74(FIN) am was HEARD and HELD in committee for further consideration.

Co-Chair Thompson discussed housekeeping.

#sb74

CS FOR SENATE BILL NO. 74(FIN) am

"An Act relating to diagnosis, treatment, and prescription of drugs without a physical examination by a physician; relating to the delivery of services by a licensed professional counselor, marriage and family therapist, psychologist, psychological associate, and social worker by audio, video, or data communications; relating to the duties of the State Medical Board; relating to limitations of actions; establishing the Alaska Medical Assistance False Claim and Reporting Act; relating to medical assistance programs administered by the Department of Health and Social Services; relating to the controlled substance prescription database; relating to the duties of the Board of Pharmacy; relating to the duties of the Department of Commerce, Community, and Economic Development; relating to accounting for program receipts; relating to public record status of records related to the Alaska Medical Assistance False Claim and Reporting Act; establishing a telemedicine business registry; relating to competitive bidding for medical assistance products and services; relating to verification of eligibility for public assistance programs administered by the Department of Health and Social Services; relating to annual audits of state medical assistance providers; relating to reporting overpayments of medical assistance payments; establishing authority to assess civil penalties for violations of medical assistance program requirements;

relating to seizure and forfeiture of property for medical assistance fraud; relating to the duties of the Department of Health and Social Services; establishing medical assistance demonstration projects; relating to Alaska Pioneers' Homes and Alaska Veterans' Homes; relating to the duties of the Department of Administration; relating to the Alaska Mental Health Trust Authority; relating to feasibility studies for the provision of specified state services; amending Rules 4, 5, 7, 12, 24, 26, 27, 41, 77, 79, 82, and 89, Alaska Rules of Civil Procedure, and Rule 37, Alaska Rules of Criminal Procedure; and providing for an effective date."

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HEATHER SHADDUCK, STAFF, SENATOR PETE KELLY, referred to the document, "Medicaid Reform Topic and Section Reference", which detailed which section and page number specific Medicaid topics could be found in the legislation. She said that the hope was that behavioral health would be integrated into the reformed Medicaid system. She said that the sections that referred to behavioral health were as follows:

Sec. 28 - Medicaid Reform Program (b) - Comprehensive Behavioral Health Program

Ms. Shadduck read from the section:

(b) The department shall, in coordination with the Alaska Mental Health Trust Authority, efficiently manage a comprehensive and integrated behavioral health program that uses evidence-based, data-driven practices to achieve positive outcomes for people with mental health or substance abuse disorders and children with severe emotional disturbances. The goal of the program is to assist recipients of services under the program to recover by achieving the highest level of autonomy with the least dependence on state-funded services possible for each person. The program must include

(1) a plan for providing a continuum of community-based services to address housing,

employment, criminal justice, and other relevant issues;

(2) services from a wide array of providers and disciplines, including licensed or certified mental health and primary care professionals; and

(3) efforts to reduce operational barriers that fragment services, minimize administrative burdens, and reduce the effectiveness and efficiency of the program.

Sec. 30 - (f) 1115 Waiver for behavioral health

Ms. Shadduck explained that Section 30 pertained specifically to waivers and would be discussed further by the departments.

Sec. 31 - ER Project - (a)(4)

Ms. Shadduck relayed that the section called for 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.

Sec. 31 - Coordinated Care Project (a)(1)

Ms. Shadduck relayed that behavioral health would be an option under the program.

Sec. 33 - Removal of Grantee Requirement for Community Mental Health Clinics

Sec. 34 - Removal of Grantee Requirement for Drug & Alcohol treatment centers & Community Mental Health Clinics

Ms. Shadduck explained that Sections 33 and 34 would remove the requirement for a clinic, or rehabilitative service, to receive a grant from the Division of Behavioral Health in order to bill Medicaid.

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Ms. Shadduck spoke to Section, "Waivers (1915 i & k options, 1945 Health Homes, 1115 Waivers". She cited a document from the department that delineated basic waiver information (copy on file).

Ms. Shadduck continued to Section 41, "Medicaid State Plan; Waivers; Instructions; Notice to Revisor of Statutes". She said that Section 38, "Implementing the Federal Policy on Tribal Medicaid Reimbursement" would conclude the discussion.

Co-Chair Thompson asked Ms. Shadduck for a list of the sections under discussion.

Ms. Shadduck referred back to the document that had been previously distributed, "Medicaid Reform Topic and Section Reference". She reiterated that the sections pertaining to behavioral health were: 28, 30, 31, 33, 34; for waivers: 30 and 41; for the federal rule change: 38.

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JEFF JESSEE, CHIEF EXECUTIVE OFFICER, ALASKA MENTAL HEALTH TRUST AUTHORITY, provided context for the presentation. He asserted that beneficiaries of the mental health trust included more than people with behavioral health problems. He avowed that behavioral health would be a key element for successful Medicaid reform. He believed in moving away from a fee-for-services, to a value based system: paying for outcomes, rather than activities. He shared that the trust had made a substantial investment in assisting the state with Medicaid reform, and had retained the services of experts on the matter. He introduced Charlie Curie and provided information about his employment background, which involved time spent in Alaska.

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CHARLIE CURIE, CEO, THE CURIE GROUP LLC, MARYLAND (via teleconference), provided additional history of his time in Alaska. He said that he had visited every corner of the state and had met with Alaska Native Corporations during his research into healthcare in Alaska. He had formerly been Deputy Secretary for Mental Health and Substance Abuse Services for the State of Pennsylvania, where he had implemented a behavioral health Medicaid program. He said he would be drawing on all of his past experiences in the

field to bring his expertise to our unique, frontier state. He credited the legislature and the administration for prioritizing the topic. He provided a PowerPoint presentation, "Behavioral Health System Transformation" dated March 28, 2016 (copy on file). He spoke to Slide 2, "Trends in Public Behavioral Health":

- States Facing "Intractable" Challenges
- Opioid Epidemic identified by Public Officials
  - Governors and Legislatures Have Prioritized Issue
  - Congress Has Identified Issue and Funded
  - Issues with MAT Diversion (Methadone/Suboxone)

Mr. Curie informed the committee that the opioid epidemic had been identified by public officials in nearly every state. He asserted that the problem needed to be dealt with in a multi-faceted manner, both in terms of prescription pain medication, which had contributed to the heroin crisis, and the assurance of access to treatment and healthcare. He urged the employment of evidence based solutions and access to the latest science.

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Mr. Curie addressed Slide 3, "Trends in Public BH continued..."

- High Profile Mental Health Related Violent Incidents-Crisis Stabilization Access
- Prevention & Wellness
  - Look at what is preventing cost savings
    - Obesity, diabetes, risk for heart disease
    - Even more expensive when combined with BH disorders
  - Focus shifting to health behavior change

He proclaimed that there was a need in communities to examine pathways to the appropriate assessment of patients, and crisis stabilization with the training of frontline workers and members of the police force. He explained that people with serious mental illnesses and addictive

disorders had a higher rate of illness, and the illnesses were more likely to be detrimental and life threatening.

He directed attention to Slide 4, "Trends in Public BH continued..":

- Technological Advances
- Address Provider EHR Capacity
  - Clinically Driven
  - Facilitate Integrated Care
  - Efficient Data Collection
  - Required by ACA

Mr. Curie pointed out to the committee that these priorities had been established as far back as the Bush administration in the 1990s. He urged that, regardless of the Affordable Care Act, these were priorities that needed to be in place for a transformed system of care with greater accountability.

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Mr. Curie spoke to Slide 5, "Why Integrated Care?":

- Burden of behavioral health disorders is great.
- Behavioral and physical health issues are "interwoven".
- Treatment Gap behavioral health disorders is large.
- Primary care in Behavioral Health settings enhance access
- Providing MH & SA services in primary care settings reduces stigma.

Mr. Curie said that data had reflected that costs were reduced when behavioral and physical healthcare were address simultaneously; emergency room and inpatient care were utilized less if the right treatment was given, the right way, and at the right time. He stated that people with serious mental illness were more at-risk for diabetes and other life-threatening disorders, due in-part to medications, and also due to the challenges they faced in

attempting to lead a healthy lifestyle. He relayed that there were over 22 million Americans afflicted with an addictive disorder at any given time, and less than 2 million per year received treatment.

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Mr. Curie continued to address integrated care on Slide 6:

- Treating "common" behavioral health disorders in primary care settings is cost effective.
- Majority of people with behavioral health disorders treated in collaborative/integrated primary care settings have good outcomes.

Mr. Curie stated that screening was available for depression and substance use.

Mr. Curie spoke Slide 7, "Barriers to Integrated Care":

- BH and PH providers operate in "silos"
- Rare sharing of information
- Confidentiality Laws and Regulations
- Payment and parity issues still persist

Mr. Curie shared that, historically, mental health and addiction services had not been easily treated in mainstream healthcare settings. He shared that mental health systems had evolved out of state mental health hospitals and community based agencies, as well as drug and alcohol centers, and were not part of mainstream healthcare. He added that there had been challenges in information sharing between behavioral physical health systems. He said that there were confidentiality laws that addressed mental health and drug and alcohol issues. He relayed that there had been parity laws that required that mental illnesses and addiction disorders should be treated on par with physical health disorders, but that these laws had not been implemented across the entire county.

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Mr. Curie addressed Slide 8, "What does this mean for Alaska?":

- Streamlining

- Utilization Control
- Grant Reformation
- Medicaid Redesign

Mr. Curie stressed that the services should be streamlined and not unduly bureaucratic. He said that control and utilization management criteria should be in place to assure the people were reviewed and were receiving the right treatment, at the right time. He related that structures of accountability and management needed to be put into place. He continued to Slide 9, "How to Achieve the Vision?":

- Look at models from other States—MCO, ASO, ACO, Fee-for-Service, PCCM, PIHP, PAHP, health homes, etc.
- Make policy decisions (e.g., populations, system management, geographic area, benefit package, risk arrangements)
- Develop/improve capacity—at DBH and provider levels
- Implement the systems changes

Mr. Curie said that there were a range of models that could show what worked and what did not work. He believed that Alaska could learn from both the successes and failures of other states. He hoped that the state could build toward a system that had a value based payment system where there could be risk or shared savings arrangements.

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Mr. Curie turned to Slide 10, "Assessing Organizational Readiness":

- Leadership
- Capacity for Change
- Access, Services and Outcomes
- Business, IT, and Performance
- Clinical Infrastructure, CQI, and Sustainability
- At the State level, most important is Contract Management (role of state government)

Mr. Curie recommended that at the state level, the most important aspect would be in contract management and holding contractors accountable.

Mr. Curie moved to Slide 11, "What States have learned about Contract Management":

- Identify people with SMI and Kids with SED
  - Mine the data in states
  - Require plans to identify people with SMI & Kids with SED
  
- Implement ways to incent enrollment of people with SMI and Kids with SED
  - Higher rates for people with more complex and/or chronic conditions
  - Mitigation of risk approaches

Mr. Curie said that a range of other states had found that it was necessary to identify people with serious mental illness, and kids with serious emotional disturbances, by requiring plans to identify people with particular needs. He asserted that this most vulnerable population was the population for which the state was most responsible.

He continued to speak to contract management on Slide 12:

- Require acceptance in a plan regardless of severity of conditions
  
- Include the comprehensive array of services needed for People with SMI and SED
  - Recovery oriented services psycho social rehab (psycho social necessity)
  
- Linkage to: prevention wellness, peer supports

Mr. Curie related that if people were able to build a life in their communities, relapses were less likely to occur. He believed that it was important for any managed system of behavioral health services to address a holistic approach to recovery. He relayed that peer support had become an important part of both treating mental illness and addictive disorders.

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Mr. Curie spoke to Slide 13. "Behavioral Health Managed Care Contract Standards":

- Incentives to avoid cost shifting to other systems
- Consumer Choice & Protection
- Assertive outreach and access standards
- Network and providers should include those with demonstrated expertise with people with SMI and kids with SED (CMHC's)

Mr. Curie said that it would be important to have incentives for systems to assume responsibility for the population for which they were responsible. He highlighted that providers in Alaska had demonstrated expertise with severe mental illness and children with severe emotional disturbances, and had been providing services to those populations for years.

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Mr. Curie continued with contract standards on Slide 14:

- Clear standards for treatment planning and coordination consumer driven
- Integrated BH/PH care standards
- Consumer involvement
- Use of Peers
- Reinvestment of cost savings as an expectation

Mr. Curie spoke to reinvestment of cost savings in the Pennsylvania program. He continued to Slide 15:

- Performance measures
  - Access (timeliness, geography, MH, SU & PC)
  - Service utilization (in lieu of ER, IP, more community based)
  - Quality (readmission rates, timely follow up, level of independent living, school participation)

- Physical health metrics (hbp, cholesterol, diabetes, med compliance)
- BH metrics

Mr. Curie spoke to a white paper from the Pennsylvania program ["Long-Term Performance of the Pennsylvania Medicaid Behavioral Health Program" by Compass Health Analytics, Inc., dated December 2010 (copy on file)]. He said that after the first 10 years of implementation of a capitated system in Pennsylvania there was \$4 billion in realized cost savings, increased alcohol and drug providers, increased access to care by all populations, and successful quality of care. He recapped that the key was to evolve a managed system in a way that helped the system grow and maintain the capacity to be successful, while preserving a structure of transparent accountability for all parties involved.

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Representative Wilson queried the savings by the State of Pennsylvania.

Mr. Curie explained that Pennsylvania had realized savings by moving from a fee-for-service system to a managed care system: \$4 billion of savings realized over 10 years. He furthered that experts in behavioral health and managed care had been consulted during Pennsylvania's process, and Philadelphia had developed their own managed entity. He said that contracting with an entity that had expertise in the field was an essential element to a successful program.

Vice-Chair Saddler asked how much of the bill accomplished the transformation described by the presentation.

Mr. Curie believed the bill gave the foundational basis that the state would need to pursue a managed care system. He added that the 1115 waivers would be a great pathway to success.

Vice-Chair Saddler pointed to Slide 10. He wondered how ready the Department of Health and Social Services Division of Behavioral Health was for the system evolution.

Mr. Curie responded that some reorganization would be necessary and contractual management capacities would need to be assessed. He said that the key would be to have the

management oversight, and ongoing implementation of contract management and accountability.

Vice-Chair Saddler queried the top five behavioral disorders in Alaska.

Mr. Curie replied that depression, substance abuse and addiction, and mental illnesses that resulted in psychosis were they key essentials that needed to be addressed.

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Representative Guttenberg whether Mr. Curie had experienced resistance to change.

Mr. Curie believed that resistance to change was based in fear. He relayed a personal story about systemic change in Philadelphia. He said that providers often resisted change because they feared that they lacked the capacity to address the standards.

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Representative Guttenberg spoke about clients with mental and behavioral health disorders. He explored the idea that change could be difficult for people with mental health disorders. He asked whether Mr. Curie had received feedback from clients.

Mr. Curie replied in the affirmative. He said that consumer satisfaction had been high in Pennsylvania; consumers had felt like they had more and better choices. He said that consumers in other states had rated the reform measures highly and had felt like they were working with a better system.

Representative Guttenberg asked how long it took for the issues to settle out related to confidences in the system.

Mr. Curie replied that stakeholders had to be engaged upfront; the concerns of providers and consumers should be discussed, and the system being set up should be demonstrated. He stated that improvements were typically seen within the first year of system implementation. He felt that the waivers that the bill highlighted would give the state the opportunity to address longstanding issues and that people would be attracted to those new

opportunities. He stated that once the system was implemented and people became engaged, positive outcomes were witnessed within 2 years.

[2:13:43 PM](#)

Co-Chair Thompson referred to the white paper related to Pennsylvania, which was dated 2010. He asked if there continued to be success in the program after 2010.

Mr. Curie answered in the affirmative. He elaborated that the Office of Mental Health and Substance Abuse Services, within their Department of Health and Social Services, executed evaluations each year. He noted that the system had been phased in in Pennsylvania, which was something to consider for Alaska. He added that the maturing of the actuarial rate setting process had continued to keep cost contained.

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Mr. Jessee testified that he did not have prepared testimony and relayed that he would speak to the committee the following day.

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KAREN FORREST, DEPUTY COMMISSIONER, DEPARTMENT OF HEALTH AND SOCIAL SERVICES, explained that she would walk through the significant reforms in the behavioral health system that were outlined in SB 74. She mentioned that the Alaska Behavioral Health System Assessment, completed in 2015, confirmed that the state had a fragmented behavioral health system with significant gaps, especially in the area of substance abuse services. She said that there were a number of barriers impeding access and impacting quality and cost. She relayed that the behavioral health reform projects found in the bill would help to build out the continuum of care, which would lead to improved access; additionally, quality of care would be improved through integration with primary care, and barriers and administrative burdens would be reduced. She stated that the reforms would reduce general fund costs to other state agencies, such as the Department of Corrections, the Court System, and the Office of Children's Services. She related that Sections 1, 2, 6, and 7 of the bill would expand, and encourage, the use of telehealth for behavioral health by licensed professional

counselors, marital and family therapists, psychologists and psychological associates, and social workers.

Representative Wilson asked which document the testifier was speaking to.

Ms. Forrest explained that she would highlight the sections of the bill that were connected to the articulated vision for the changes in the behavioral health system highlighted by Mr. Curie.

Co-Chair Thompson asked Ms. Forrest to repeat the bill sections that she was speaking to.

Ms. Forrest repeated the sections that she was referring to.

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Ms. Forrest spoke to Sections 3, 4, and 5, which related to telehealth for physicians. She anticipated that the changes would help expand psychiatric coverage. She said that the provisions dovetailed with the provisions in Section 30 of the bill, which allowed the department to provide incentives for telehealth. She stated that the first step in implementing that provision would be to convene a workgroup in order to identify legal technological and financial barriers to increasing telehealth. She relayed that Section 28 would create the Medical Assistance Reform Program; subsection B, page 26, line 18, would require the department, in coordination with AMHTA to efficiently manage a comprehensive and integrated behavioral health program that used evidence based and data driven practices to achieve positive outcomes. She said that gaps would be addressed in the continuum, particularly in the lower levels of care, but also in higher levels of care. She said that the program required under Section 28 must include a plan for providing a continuum of community based services. She related that the section also required that services should be provided from a wide array of providers and disciplines. Regulations and practices already in place would be examined to determine which providers could provide which services, in which settings, and under which conditions. She concluded that the intent of the section was to address the fragmented system. She said that the program must also include efforts to reduce operational

barriers and administrative burdens that impeded access for consumers.

[2:23:16 PM](#)

Ms. Forrest addressed Section 30 of the bill, beginning on page 29. She said that the waivers section was the key to reform in the area of behavioral health. She spoke to Page 30, line 9, which required the department to apply for the 1115 Behavioral Health Medicaid Waiver from the Centers for Medicare and Medicaid Services (CMS) in order to establish a demonstration project focused on improving the behavioral health system for Medicaid recipients. The department would be required to engage the stakeholder in the community. She relayed that the purpose of the 1115 waiver was to create and evaluate an innovative service delivery system that improved care, increased efficiency, and managed cost. She said that the general criteria that CMS used to review waiver applications included questions pertaining to increased access and the stabilization of providers and provider networks. She stated that the application would need to reflect that health outcomes would be improved, and would be budget neutral. She relayed that during the course of the waiver federal Medicaid expenditures could not exceed federal spending without the waiver. The array of services proposed would have to be offset by reductions elsewhere; such as reducing emergency department expenditures by providing lower cost crisis stabilization. She articulated that the waivers generally had a five-year lifespan, with the option of a three-year extension. She verbalized that an administrative services organization would be used to help move the system from program management to quality management; a system based on outcomes as opposed to fee-for-service.

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RANDALL BURNS, DIRECTOR, DIVISION OF BEHAVIORAL HEALTH, DEPARTMENT OF HEALTH AND SOCIAL SERVICES, focused on what it would take to apply for an 1115 waiver. He reiterated that the waiver was for five years, and was a research demonstration, required to have a foundational hypothesis that could be tested throughout the process of the demonstration. He imparted that the process had to have a strong, ongoing evaluation component that measured the effects of the redesign on the system of care. He reiterated that it could not cost the federal government

more than without the waiver; however, the cost neutrality could be shown at the end of the demonstration, without extending additional Medicaid. He said that the various involved parties would draft a concept paper within the next six months that would be introduced to CMS, which would mark the beginning of intense communication with all of the stakeholders. He highlighted two other things: there would be a readiness assessment of current Division of Behavioral Health (DBH) staff, and a review of providers. He elaborated on what the assessments would entail. He said that once the concept paper was filed with CMS, the department would begin drafting the application. He detailed the application particulars.

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Mr. Burns relayed that the application could take from a few months to 3 years. He stated that as the application was being written, the request for information concerning the Administrative Services Organization (ASO) would be drafted simultaneously. He explained that an ASO was a third party with whom the department would contract to manage Alaska's redesigned behavioral health system. The ASO would provide the department with national expertise around a managed Medicaid system of care, and help the transition of the division to a program management model. He relayed that the contract with the ASO could include significant incentives within the payment structure, with flexibility for the ASO to pass on incentives to providers for achievement of quality in the network targets. He shared that a request for information (RFI) was often use in the solicitation of a request for proposal (RFP). The department intended to release the RFI for the ASO in February 2017. He stated that the information that was received during the RFI process about the interest of any ASO in working in Alaska, and under what conditions, would help inform the drafting of the waiver application. He warned that some of the ASO could take issue with the limitations that were due to the geography of Alaska. He elucidated that based on the quality and the nature of the responses, and assuming negotiations with CMS were promising, the department would release an RFP for the services during the first quarter of FY18. He conveyed that if the RFP was successful the ASO would be contracted and working to create the networks and have services in place by the time the 1115 waiver was granted. He communicated

that the integration and primary case management health home models were key to the redesign effort.

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Mr. Burns relayed that after 1 to 2 years under the waiver, the state would apply for a substance use disorder (SUD) waiver, with the hope to eliminate the Medicaid Institutions for Mental Diseases (IMD) exclusion for substance use disorder treatment.

Ms. Forrest spoke to Section 31, pages 30 and 31:

**Section 31** (page 30-34)

**AS 47.07.038. Collaborative, hospital-based project to reduce use of emergency department services.**

Requires the department to partner with a statewide professional hospital organization to design and implement a demonstration project to reduce non-urgent use of emergency departments by Medicaid recipients.

**AS 47.07.039. Coordinated care demonstration projects**

**AS 47.07.039 (a)**

Requires DHSS to solicit and contract with one or more third-party entities for coordinated care demonstration projects for individuals who qualify for Medicaid benefits on or before December 31, 2016. DHSS may use an innovative procurement process as described under AS 36.30.308. A proposal for consideration must include three or more of the following:

- (1) Comprehensive primary-care-based management, including behavioral health services and coordination of long-term services and support;
- (2) Care coordination, including the assignment of a primary care provider located in the local geographic area of the recipient;
- (3) Health promotion;
- (4) Comprehensive transitional care and follow-up care after inpatient treatment;
- (5) Referral to community and social support services, including career and education training services;

- (6) Sustainability and the ability to replicate in other regions of the state;
- (7) Integration and coordination of benefits, services, and utilization management;
- (8) Local accountability for health and resource allocation.

Ms. Forrest mentioned Section 33, page 35:

**Section 33** (page 35) ***Removal of Grantee Requirement***  
**47.07.900(4)**

Amends Medicaid Administration definitions, by removing the grantee status requirement for outpatient community mental health clinics serving Medicaid patients.

Ms. Forrest read from Section 34:

**Section 34** (page 35) ***Removal of Grantee Requirement***  
**AS 47.07.900(17)**

Amends by removing the grantee/contractor status requirement from drug and alcohol treatment centers and outpatient community mental health clinics. This change, and the one in the previous section, allows mental health and drug treatment service providers who do not receive grants from the department to become enrolled Medicaid providers and deliver services to Medicaid recipients.

Ms. Forrest informed the committee that the changes were required by CMS. She stated that in the last on-site evaluation, CMS had told the department that the requirements had to be removed. She furthered that there was a general provision that Medicaid allow any willing and qualified provider to participate in Medicaid, as directed by the Freedom of Choice provision, the requirements had restricted Medicaid recipients in their freedom of choice. She relayed that, as the state Medicaid agency, the department had the ability to set reasonable standards related to the qualifications of the provider; CMS generally questioned state established qualification that limited services only to the providers of the states choosing. She said that the sections of the bill needed to remain in order for the state to be able to bill Medicaid.

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Ms. Forrest referred to Section 39:

**Section 39** (page 37-38)

**Uncodified: Health Information Infrastructure Plan.**

Requires DHSS to develop a plan to strengthen the health information infrastructure, including health data analytics capability, to support transformation of the health system in Alaska.

Ms. Forrest attested that there was a need to connect behavioral health providers to the Alaska Statewide Health Information Exchange, to improve care coordination. She spoke to Section 40:

**Section 40** (page 38-39)

**Uncodified: Feasibility Studies for the Provision of Specified State Services.**

(a) Requires DHSS to conduct a study analyzing the feasibility of privatizing the Alaska Pioneers' Homes and select facilities of the division of juvenile justice.

(b) Requires DHSS in conjunction with the Alaska Mental Health Trust Authority to conduct a study analyzing the feasibility of privatizing the Alaska Psychiatric Institute.

(c) Requires the Department of Administration to conduct a study analyzing the feasibility of creating a health care Authority to coordinate health care plans and consolidate purchasing effectiveness for all state employees, retired state employees, retired teachers, Medicaid Assistance recipients, University of Alaska employees, employees of state corporations, and school district employees.

(d) Provides a definition for "school district"  
Section 40 (page 38-39)

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(d) Provides a definition for "school district"

Ms. Forrest believed that all sections of the bill set the stage for a comprehensive vision of behavioral health reform that would result in improved access and quality of healthcare, while reducing overall costs.

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KATE BURKHART, EXECUTIVE DIRECTOR, ALASKA MENTAL HEALTH BOARD AND ADVISORY BOARD ON ALCOHOLISM AND DRUG ABUSE, DIVISION OF BEHAVIORAL HEALTH, DEPARTMENT OF HEALTH AND SOCIAL SERVICES, testified that the boards had been involved in healthcare and Medicaid reform efforts for many years, the process over the past 18 to 24 months being the most inclusive. She relayed that the board had participated in conversations with stakeholders and providers, and had offered to engage with Medicaid recipients, which the department had granted. She stated that the board engaged in 8 separate community conversations in fall of 2015, and had reviewed public input from community town hall meetings, other public meetings, and the streamlining initiative, to compile consumer input to inform the process. She shared that recipients and experts had many of the same ideas and concerns for reform. She imparted that access to high quality services, at appropriate levels of care, made up the bulk of the comments. She said that the community groups spoke of the need to have increased access to medication management and psychiatry services. She explained that the telehealth and coordinated care provisions in the bill spoke to the issue by encouraging increased access to private mental health professionals that were not practicing within community behavioral health centers. She furthered that the ability to receive care when it was needed, and not later, was essential to addressing many of the relevant social problem that stemmed

from unaddressed behavioral health disorders. She communicated that the consumers had talked about the need to address the quality of primary and behavioral health care services that were currently available. She said that the quality of the actual medical services provided had not been an issue, but that the context for which that care was provided had been mentioned; the issues of stigma and discrimination, as well as a lack of understanding of how to serve someone with a serious mental illness who also had some kind of co-morbidity. Families, especially those of children with serious emotional and behavioral disorders talked about how they had to aggressively advocate for their children's primary care needs as well as their mental health needs. She said that SB 74 would provide a framework through which the primary case care management project, and the 1115 waiver, would foster patient advocacy and navigation through complex healthcare systems. She noted that the complicated nature of insurance was lamented by testifiers from all areas of usage. She felt that the bill would implement reforms that would make it easier for people to get to the services that they needed, rather than accessing acute care services. She disclosed that coordination of care was a reoccurring issue during conversations with community members. She revealed that parents and care providers often found themselves without time and resources for self-care, prompting the need for family-based care. She spoke to primary case management, and gave the example of a young man with significant mental health and primary care needs who did not want to go to all of his necessary appointments; family members had suggested that someone could be employed who would make sure that the young man received the care he needed, which would take the burden off of the family. She spoke to the need for administrative efficiencies. Providers and the board had testified to the need to streamline the administrative burden in order to reduce costs and make it easier to access care. She said that when paperwork drove care, rather than the person's needs, patients did not receive the care needed to help them get better. She spoke to the need for supportive services, which SB 74 would provide by reforming the Medicaid system in a way that correlated the reforms to the healthcare services with the needed community support. She asserted that open conversation with all involved parties should continue throughout the development of the 1115 waivers as well as the implementation of many of the provisions in the legislation. She said that the boards were committed to

supporting the implementation of the efforts. She said the inclusive nature of the reform efforts so far had been greatly appreciated.

2:50:48 PM

Vice-Chair Saddler asked whether there were two different 1115 waivers.

Ms. Forrest answered in the affirmative.

Vice-Chair Saddler asked whether all of the same conditions and timelines would apply for both waivers.

MS. Forrest deferred the question to Jon Sherwood, Deputy Commissioner, Medicaid and Health Care Policy, Department of Health and Social Services.

Vice-Chair Saddler asked whether the Division of Behavioral Health was ready for the transformation described in the legislation.

Mr. Burns replied in the affirmative. He said that people were aware of the systemic problems and that most of the staff were program managers who dealt with services issues on a daily basis. He said that his employees were committed to improving the system.

Vice-Chair Saddler queried the effectiveness of the Division of Behavioral Health.

Mr. Burns replied that the division was very effective and had successfully served many individuals in the state. He admitted that there were gaps in the system, but that most recently the system had been focused on treating the seriously mentally ill and severely emotionally disturbed children, who were the most difficult population to serve because their needs changed quickly and medication management could be difficult. He believed that the division had done the best work possible given the range of services that were available to their clientele. He maintained that the division was highly effective in providing the services that it was capable of providing.

Vice-Chair Saddler referred Page 30, line 1, which spoke to the 1915(i) waiver. He asked how "area" would be defined,

and which area would most likely receive the demonstration project.

Ms. Forrest replied that the geographic area had yet to be defined. She said that utilization, and needs within communities, would be considered. She added that the area could be as large as Anchorage, or an entire region of the state, she reiterated that it was yet undefined.

[2:55:32 PM](#)

Mr. Burns interjected that the hope was that the ASO would be interested in a statewide system, and subcontract if there were entities that were interested in providing the services on a regional basis. He stated that there could be a statewide system with subcontractors for specific regions.

Vice-Chair Saddler worried that the bill had too wide a scope. He said that he supported the legislation.

Mr. Burns replied that the goal was to improve the system while keeping costs under control.

Co-Chair Neuman echoed concerns made by Vice-Chair Saddler. He elaborated that there were many new requirements, commitments, regulation changes, and requests for changes that the legislature could not predict because regulations had yet to be written. He spoke to the collaborative hospital based project on Page 30. He wondered how many statewide professional hospital associations existed in the state.

Co-Chair Thompson replied that the answer was one.

Co-Chair Neuman understood there were many professional organizations that communicated with each other, but noted that the consumer had not been involved in the conversations. He hoped that the effectiveness of the regulation changes could be measured before they were implemented. He expressed distain for federal regulations being tied to federal funds. He asked for a list of federal requirements that were tied to federal funds.

[2:59:54 PM](#)

Representative Kawasaki asked whether federal statute required going through a managed care or accountable care organization for the 1115 waiver.

Mr. Burns answered in the negative. He added that management of the waiver would be entirely up to the state.

Representative Kawasaki surmised that an accountable care model was being considered by the department because it had worked in other states.

Mr. Burns replied that it was part of the reason. He elaborated that accountable care organizations brought a depth of expertise to the table. He said that the state would perform the RFP to see what kind of interest there was in assisting the state in moving forward with a managed Medicaid system.

Representative Kawasaki asked whether the state could run its own managed care organization under the 1115 waiver.

Mr. Burns answered in the affirmative. He explained that the state could decide not to contract with an ASO, and run it through the department.

Representative Kawasaki spoke about the Behavioral Access Initiative that was expected to produce net cost to Medicaid because of the expected accessibility of service to enrollees. He asked about the five-year term requirement for the waiver to prove net-neutrality, and whether general fund savings would be off-set elsewhere.

Mr. Burns answered that other savings to the system would be measured, like possible savings from the demonstration projects for emergency rooms, which was partially associated with behavioral health treatment.

Representative Kawasaki relayed that he had a list of the current optional and mandatory waivers and services under Medicaid. He said that 19 were mandatory for adults, and 26 that the state had applied to optionally, some of which were waived. He asked what the overall cost would be for the 1115 waivers.

Co-Chair Thompson thought that the question was in-depth and may require more time.

Ms. Forrest deferred the question to a later time when discussing the fiscal notes.

[3:04:20 PM](#)

Representative Guttenberg referred to the final report from Agnew::Beck Consulting, LCC: "Recommended Medicaid Redesign Expansion Strategies for Alaska, which cited the goals of improved health, optimizing access, increasing value, and containing costs. He hoped that within the process that the department would illustrate how those goals might be accomplished. He argued that there were significant barriers for delivering telemedicine in Alaska. He hoped that the state current broadband capabilities would be considered before performing RFPs.

Ms. Forrest agreed that broadband capability was a concern. She added that an organized and structured conversation should take place about the capabilities of systems already in place, and the broadband capabilities of the state. She added that there had been success using telemedicine in the Tribal Health System.

Representative Guttenberg referred to a question from Representative Kawasaki related to ASOs. He asked about the administrative overburden of too many program managers.

[3:08:42 PM](#)

Mr. Burns replied that other states had managed their projects individually by region and had not tried implementing an overarching ASO. He added that the state could make its own choices about the delivery of care within the state.

Representative Guttenberg understood that the pilot program would include regional delivery of services. He worried about the ability to translate from region to region. He expressed concern that a program that worked in one region would not be appropriate for a different region.

Mr. Burns responded that one of the advantages of the system was that the RFP would specifically address the unique needs of different regions. He stressed that generic RFPs would not be written.

[3:11:10 PM](#)

Representative Wilson wondered whether the department already had the authority to do some of the things stipulated in the bill.

Mr. Burns replied that the division could probably still pursue an 1115 waiver, but thought that there might be Medicaid provisions that would require the authorization extended by the legislation.

Representative Wilson was disturbed that the Medicaid system was not more efficient. She expressed interest in the managed care model. She understood that the department had not before had the authority to address the problems through managed care.

Mr. Burns responded that one of the reasons for the gap in service was that until recently Medicaid had not covered a large portion of the population. He said that the expansion had exposed the system on a holistic level, which had revealed the systemic limitations.

[3:14:16 PM](#)

Representative Wilson opined that Medicaid had already been funded with billions of state dollars. She said that she could not understand what the bill would do without first understanding all of the issues with the system. She expressed apprehension that the system could function successfully solely online.

Ms. Burkhart stated that one of the most critical issues was workforce capacity. She shared that one of the goals of the system redesign was alleviate the workforce capacity issues in the community behavioral health system by allowing private practitioners to bill Medicaid services. Currently, private licensed marriage and family therapists were not able to provide therapy to Medicaid recipients. Medicaid recipients with mild to moderate behavioral health disorders often went without care until they developed an acute mental illness, and then the community behavioral health center will serve them because they become part of the priority population. She pointed out that SB 74 would allow for private licensed mental health professional to provide reimbursable services to Medicaid, which opens up workforce capacity for the mild to moderate needs that were currently going unaddressed. The hope was that this would

relieve some of the pressure on community mental health centers.

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Representative Wilson shared that her problem with the bill was that she did not understand what was already required by statute. She wanted to know what the department could currently do, without the bill. She requested a chart comparing the department's current authority, versus what was proposed in the bill.

Representative Gara surmised that the bill addressed some reform issues by relieving workforce shortages and leveraging federal funding. He understood that the 1115 waiver was projected to save the state over \$200 million in general funds over the next 5 years.

Ms. Forrest clarified that Representative Gara had spoken to savings attached to the Tribal Policy portion of the bill, which did not require a waiver.

Representative Gara asked whether the non-tribal part of the 1115 waiver leveraged additional federal funds.

Ms. Forrest answered that the 1115 Behavioral Health Medicaid waiver gave the department the opportunity to provide additional services in an effective manner.

Representative Gara asked whether it would qualify services that could be paid for by Medicaid.

Ms. Forrest answered in the affirmative.

Representative Gara understood that those services would otherwise be paid for with general funds.

Ms. Forrest replied in the affirmative.

Representative Gara probed the dividing line between the 1115 waiver and behavioral health. He understood that current law limited behavioral health treatment to federally qualified medical centers, or with a psychiatrist present.

Ms. Forrest answered in the affirmative.

Representative Gara recognized that the number of qualifying psychiatrists in the state was limited.

Ms. Forrest illuminated that federal law required that services in a physician's clinic had to be provided under the general direction of a physician. She said that regulation had been established for both physician clinics and community mental health clinics. She expressed that regulations could be changed, and that the 1115 waiver would be examined for expanding access while maintaining budget neutrality.

[3:21:40 PM](#)

Representative Gara surmised that if the 1115 waiver was pursued and successful, the state would be able to provide behavioral health services without the supervision of a physician, a psychologist, and without being inside a federally qualified medical health center.

Ms. Forrest answered that that 1115 waiver would allow the department to examine its utilization patterns across the state and provide the opportunity to refine regulations.

Representative Gara asked whether the behavioral health treatment under the waiver included substance abuse treatment.

Ms. Forrest replied that it referred to clinic services, which could be applied to substance abuse treatment.

Representative Gattis wanted to have a broad conversation about the 26 optional services Representative Kawasaki spoke of, particularly the fiscal aspects of the options.

Vice-Chair Saddler understood that the currently system did not allow for marital or family therapists to bill Medicaid because they did not provide services under contract. He spoke to the provision on Page 35, line 12 and 13 that removed the requirement for rehabilitative services to be provided by someone at a community mental health establishment that was under contract. He asked whether changing that requirement would expand capacity.

Ms. Forrest answered in the affirmative.

Vice-Chair Saddler asked whether there was enough capacity to maintain the existing mental behavioral health services until the bill was implemented.

Ms. Forrest answered in the affirmative. She added that it would be a challenge to reform the system, while simultaneously providing services, and that it would take coordinated and concentrated effort and good communication.

[3:26:15 PM](#)

Ms. Burkhart elaborated that providers had been working in anticipation of the change contemplated in SB 74. She said that community mental health centers and behavioral health centers had added primary care capacity around the integration of primary care and behavioral health and coordination of care and case management. She relayed that the Juneau Alliance for Mental Health had added a primary care clinic to their establishment and the Anchorage Community Mental Health Services had had primary care capacity for several years. She explained that providers would inform through their experiences and help to bring their peers along in the process. She stated that the department had received a planning grant for certified community behavioral health clinics, which was a federally supported model for integrated and coordinated healthcare. She related that the funds had been applied for with the support of the behavioral health provider community; provider organizations had a greater capacity for change because they had been engaged in preparing for change.

Vice-Chair Saddler referred to a 2009 report on health clinics throughout Alaska. He was interested in a report on behavioral services. He asked how well the department was staffed to handle the transformation.

Ms. Forrest answered that the department could do it, but that it would be a large amount of work. She voiced that resources were limited, but the change was needed. She shared that staff and providers were enthusiastic to make the change.

Vice-Chair Saddler asked whether the Indian Health Service (IHS) provided behavioral health services.

Mr. Burns replied in the affirmative. He added that all Tribal Health organizations provided behavioral health

divisions and provided significant behavioral health services.

[3:30:12 PM](#)

Representative Munoz asked whether family and marriage counselors had to be associated with a drug and alcohol treatment center, or an out-patient mental health clinic, in order to bill Medicaid for services.

Mr. Burns answered that currently the person did have to be associated with a clinic that was managed by a physician.

Representative Munoz restated the question.

Ms. Burkhart clarified that she was referring to language in SB 74 that removed language in statute requiring that a facility be a grantee. She said that if SB 74 passed with the aforementioned language, a licensed mental health professional would be able to bill Medicaid for behavioral health clinic services, both mental health and substance abuse.

Representative Munoz asked for clarification concerning marital counselors.

Ms. Burkhart answered that if the bill passed individual marital counselors would be able to bill directly to Medicaid.

[3:32:30 PM](#)

JON SHERWOOD, DEPUTY COMMISSIONER, MEDICAID AND HEALTH CARE POLICY, DEPARTMENT OF HEALTH AND SOCIAL SERVICES, clarified that Section 33 addressed clinic services, which by federal definition must be supervised by a physician; rehabilitative services did not have the requirement.

Representative Munoz asked for verification that a rehabilitative service would include marriage counseling.

Mr. Sherwood answered in the affirmative.

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Co-Chair Thompson discussed housekeeping.

VALERIE DAVIDSON, COMMISSIONER, DEPARTMENT OF HEALTH AND SOCIAL SERVICES, spoke to Section 38, page 37 of the bill, which dealt with the federal policy on tribal Medicaid reimbursement. She introduced her support staff. She reminded the committee of previous conversations concerning the 100 percent federal match policy, and stated that she would be giving an update on recent developments. Historically, CMS had allowed states to claim 100 percent federal match for Medicaid services provided to IHS beneficiaries under certain circumstances. In order to qualify the person had to be an IHS beneficiary, enrolled in Medicaid, and the care must be provided through an IHS facility. She said that CMS had construed the words "Indian Health Services" narrowly in the past; an IHS facility was construed as within the four walls of the facility. She opined that what that had meant was that medically necessary travel and accommodation services, as well as care referred outside of the IHS facility (or tribally operated facility) would not be able to claim 100 percent federal match. She said that the 1115 waiver would allow for 100 percent federal match for medically necessary travel and accommodation services, and care that was provided in a non IHS or tribally operated facility, but had been a referral from one of those entities. She shared that the Secretary of the Department of Health and Human Services, Sylvia Burwell, had indicated that national policy could be changed, rather than require an 1115 waiver. She said that CMS had issued a request for comment and had recently issued a health official letter, providing additional guidance to states regarding reimbursement services on February 26, 2016. She relayed that CMS had changed national policy to accommodate Alaska, and would provide 100 percent federal match for medically necessary travel and accommodation services, and full referrals from IHS to non-IHS facilities, as long as certain conditions were met. She said that the department had anticipated that approximately \$12.5 million in savings would be realized in FY17, which had increased to \$32 million, and would increase to \$92 million by 2022. She said that Section 38, lines 2 through 19, required the department to collaborate with Tribal Health and the federal government to implement the policy, and required the department to report the estimated savings and to fully implement the policy within 6 months.

[3:49:33 PM](#)

Co-Chair Thompson understood that there would be 100 percent federal match for IHS travel, which meant 50 percent state, 50 percent federal.

Commissioner Davidson clarified that under the Medicaid program the federal government paid the Federal Medical Assistance Percentage (FMAP). For regular Medicaid it was a 50 percent match, 50 percent federal and 50 percent state. However, for the services described through the tribal policy change, the match would be 100 percent federal, meaning that zero state dollars would be used. She referenced a letter from CMS dated February 26, 2016 (copy on file). She discussed page 3:

*Permitting a Wider Scope of Services*

In this letter, we are re-interpreting the scope of services considered to be "received through" an IHS/Tribal facility. Under our previous interpretation, in order to be "received through" an IHS/Tribal facility, and therefore, qualify for 100 percent FMAP, the service had to be a "facility service." By that, we meant that it had to be within the scope of services that a Medicaid facility of the same type (e.g., inpatient hospital, outpatient hospital, clinic, Federally Qualified Health Center/Rural Health Clinic, nursing facility) can provide under Medicaid law and regulation. Under our new interpretation, as described more fully below, the scope of services that can be considered to be "received through" an IHS/Tribal facility for purposes of 100 percent FMAP includes any services that the IHS/Tribal facility is authorized to provide according to IHS rules, that are also covered under the approved Medicaid state plan, including long-term services and supports (LTSS). Medicaid coverable benefit categories include all 1905(a), 1915(i), 1915(j), 1915(k), 1945, and 1915(c) services set forth in the state plan, as well as any other authority established in the future as a state plan benefit.

This scope of service change also applies to transportation that is covered as a service under the state Medicaid plan. Under regulations at 42 CFR 440.170(a), a state can elect to cover transportation

and other related travel expenses determined necessary to secure medical examinations and treatment for a beneficiary. Related travel expenses include the cost of meals and lodging en route to and from medical care, and while receiving medical care, as well as the cost for an attendant to accompany the beneficiary, if necessary. Covered transportation services can include both emergency medical transportation and non-emergency medical transportation.

*Medicaid Beneficiary and IHS/Tribal Facility Participation is Voluntary*

This new interpretation does not provide authority for states to require any AI/AN Medicaid beneficiary to receive services through an IHS/Tribal facility. Nothing in this letter affects the entitlement of AI/AN Medicaid beneficiaries to freedom of choice of provider under section 1902(a)(23) of the Social Security Act. State Medicaid agencies may not, directly or indirectly, require AI/ANs who are eligible for Medicaid to receive covered services from IHS/Tribal facilities for the purpose of qualifying the cost of their services for 100 percent FMAP. Similarly, neither state Medicaid agencies nor IHS/Tribal facilities may require an AI/AN Medicaid beneficiary to receive services from a non-IHS/Tribal provider to whom the facility has referred the beneficiary for care. Nor can a state delay the provision of medical assistance by requiring that beneficiaries initiate or continue a patient relationship with the IHS/Tribal facility. Finally, federal Medicaid law does not require either IHS/Tribal facilities or non-IHS/Tribal providers to enter into the written care coordination agreements described in this SHO.

Commissioner Davidson continued to Page 4 of the letter:

*Request for Services In Accordance With a Written Care Coordination Agreement*

In this letter, CMS also revises its interpretation to provide that a service may be considered "received through" an IHS/Tribal facility when an IHS/Tribal facility practitioner requests the service, for his or her patient, from a non-IHS/Tribal provider (outside

of the IHS/Tribal facility), who is also a Medicaid provider, in accordance with a care coordination agreement meeting the criteria described below. The purpose of this revised policy interpretation is to enable IHS/Tribal facilities to expand the scope of services they are able to offer to their AI/AN patients while ensuring coordination of care in accordance with best medical practice standards.

A covered service will be considered to be "received through" an IHS/Tribal facility not only when the service is furnished directly by the facility to a Medicaid-eligible AI/AN patient, but also when the service is furnished by a non-IHS/Tribal provider at the request of an IHS/Tribal facility practitioner on behalf of his or her patient and the patient remains in the Tribal facility practitioner's care in accordance with a written care coordination agreement meeting the requirements described below. Under this policy, both the IHS/Tribal facility and the non-IHS/Tribal provider must be enrolled in the state's Medicaid program as rendering providers. Second, there must be an established relationship between the patient and a qualified practitioner at an IHS/Tribal facility. Third, care must be provided pursuant to a written care coordination agreement between the IHS/Tribal facility and the non-IHS/Tribal provider, under which the IHS/Tribal facility practitioner remains responsible for overseeing his or her patient's care and the IHS/Tribal facility retains control of the patient's medical record.

A non-IHS/Tribal provider from which an IHS/Tribal facility practitioner could request services could include an Urban Indian Health Organization that participates in Medicaid, or any other Medicaid-participating provider. Furthermore, the relationship between the IHS/Tribal facility practitioner and the patient could be based on visits, including the initial visit, through telehealth procedures that meet state and/or IHS standards for such procedures, if the IHS/Tribal facility has that capacity.

A self-request by the beneficiary, or a request from a non-IHS/Tribal provider, does not suffice for purposes of 100 percent FMAP; in such circumstances, the non-

IHS/Tribal provider could furnish the service and bill the state Medicaid program, but the state expenditure for the service would not qualify for 100 percent FMAP. Similarly, the non-IHS/Tribal provider may refer the facility patient to another non-IHS/Tribal provider; however, if the patient receives a covered service from that other provider without a request from the IHS/Tribal facility practitioner, or the IHS/Tribal facility practitioner does not remain responsible for the patient's care, the state expenditure for the service would not qualify for 100 percent FMAP.

At a minimum, care coordination will involve:

- (1) The IHS/Tribal facility practitioner providing a request for specific services (by electronic or other verifiable means) and relevant information about his or her patient to the non-IHS/Tribal provider;
- (2) The non-IHS/Tribal provider sending information about the care it provides to the patient, including the results of any screening, diagnostic or treatment procedures, to the IHS/Tribal facility practitioner;
- (3) The IHS/Tribal facility practitioner continuing to assume responsibility for the patient's care by assessing the information and taking appropriate action, including, when necessary, furnishing or requesting additional services; and
- (4) The IHS/Tribal facility incorporating the patient's information in the medical record through the Health Information Exchange or other agreed-upon means.

Written care coordination agreements under this policy could take various forms, including but not limited to a formal contract, a provider agreement, or a memorandum of understanding and, to the extent it is consistent with IHS authority, would not be governed by federal procurement rules. The IHS/Tribal facility may decide the form of the written agreement that is executed with the non-IHS/Tribal provider.

Commissioner Davidson spoke to Page 5:

## *Medicaid Billing and Payments to Non-IHS/Tribal Providers*

For services provided to Medicaid-eligible AI/AN beneficiaries that are rendered by a non-IHS/Tribal provider in accordance with a written care coordination arrangement, there are several options regarding how those services may be billed to Medicaid.

The first option is for the non-IHS/Tribal provider to bill the Medicaid agency directly. If the non-IHS/Tribal provider bills the state Medicaid program directly, the provider would be reimbursed at the rate authorized under the Medicaid state plan applicable to the provider type and service rendered. To support the application of the 100 percent FMAP, the state should ensure that claims include fields that document that the item or service was "received through" an IHS/Tribal facility. When a non-IHS provider bills a state directly, the state's payment rate for a covered service furnished by a non-IHS/Tribal provider to an AI/AN Medicaid beneficiary under a written care coordination agreement must be the same as the rate for that service furnished by that provider to a non-AI/AN beneficiary or to an AI/AN beneficiary who self-refers to the provider. Similarly, a state agency cannot establish one rate for services furnished by the facility to AI/AN beneficiaries and another for the same services provided by that facility to non-AI/AN Medicaid beneficiaries.

A second option is for the IHS or Tribal facility to handle all billing. In that case, the IHS/Tribal facility would have to separately identify services provided by non-IHS/Tribal providers under agreement that can be claimed as services of the IHS/Tribal facility ("IHS/Tribal facility services") from those that cannot. Inpatient services that are furnished by non-IHS providers outside of IHS/Tribal facilities could never be claimed as IHS/Tribal facility services. For IHS, other services provided by non-IHS providers outside of an IHS facility generally cannot be claimed as IHS facility services. Tribal facilities generally may have more flexibility than IHS and should consult with their state to determine the circumstances in which other services provided by

non-Tribal providers can be claimed as Tribal facility services. The circumstances under which Tribal facilities may claim services as their own are the same as those that apply for other similar facilities in the state (e.g., inpatient or outpatient hospitals, nursing facilities, Federally Qualified Health Centers, etc.). Services that can properly be claimed as IHS/Tribal facility services may be billed directly by the IHS/Tribal facility and are paid at the applicable Medicaid state plan IHS/Tribal facility rate. For all other services provided by non-IHS/Tribal providers, IHS or the Tribe could bill for these services as an assigned claim by that provider and the payment rate would be the state plan rate applicable to the furnishing provider and the service, not the applicable Medicaid state plan IHS/Tribal facility rate. These services are still eligible for the 100 percent FMAP, provided other requirements have been met.

The billing arrangement should be reflected in the written agreement between the IHS/Tribal facility and the non-IHS/Tribal provider. Payment methodologies for facility services furnished by both the IHS/Tribal facility and rate methodologies paid to non-IHS/Tribal providers must be set forth in an approved state Medicaid plan. Payment rates can reflect the unique access concerns in particular geographic areas, or with respect to certain types of providers. However, rates may not vary based on the applicable FMAP. States should review existing state plans to ensure compliance with the policy articulated in this letter.

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Commissioner Davidson continued with Page 6:

*Managed Care*

The discussion above assumes that the Medicaid-eligible AI/AN has "received [services] through" the IHS/Tribal facility on a fee-for-service basis. In some cases, however, Medicaid-eligible AI/ANs may be enrolled in a risk-based Medicaid managed care organization (MCO), prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP), in which case the state Medicaid agency is making monthly

capitation payments on behalf of the AI/AN enrollee to the MCO, PIHP, or PAHP. The state may claim 100 percent FMAP for the portion of the capitation payment attributable to the cost of services "received through" an IHS/Tribal facility if the following conditions are met:

(1)The service is furnished to an AI/AN Medicaid beneficiary who is enrolled in the managed care plan;

(2)The service meets the same requirements to be considered "received through" an IHS/Tribal facility as would apply in a fee-for-service delivery system and the managed care plan maintains auditable documentation to demonstrate that those requirements are met;

(3)The non-IHS/Tribal provider is a network provider of the enrollee's managed care plan;

(4)The non-IHS/Tribal provider is paid by the managed care plan consistent with the network provider's contractual agreement with the managed care plan; and

(5)The state has complied with section 1932(h)(2)(C)(ii) of the Act consistent with CMS guidance.

States would be permitted to claim the 100 percent FMAP for a portion of the capitation payment for AI/ANs who are enrolled in managed care, even though the state itself has made no direct payment for services "received through" an IHS/Tribal facility. The portion of the managed care payment eligible to be claimed at 100 percent FMAP must be based on the cost of services attributable to IHS/Tribal services or encounters received through an IHS/Tribal provider meeting the requirements outlined in this section.

Commissioner Davidson concluded with Page 7:

*Compliance and Documentation*

To ensure accountability for program expenditures, in states where IHS/Tribal facilities elect to implement the policy described in this letter, the Medicaid agency will need to establish a process for documenting claims for expenditures for items or services "received through" an IHS/Tribal facility.

The documentation must be sufficient to establish that (1) the item or service was furnished to an AI/AN patient of an IHS/Tribal facility practitioner pursuant to a request for services from the practitioner; (2) the requested service was within the scope of a written care coordination agreement under which the IHS/Tribal facility practitioner maintains responsibility for the patient's care; (3) the rate of payment is authorized under the state plan and is consistent with the requirements set forth in this letter; and (4) there is no duplicate billing by both the facility and the provider for the same service to the same beneficiary.

#### *Applicability to Section 1115 Demonstrations*

State expenditures for services covered under section 1115 demonstration authority are eligible for 100 percent FMAP as long as all of the elements of being "received through" an IHS or Tribal facility that are described in this SHO are present.

#### *Relationship Between 100 Percent FMAP for Tribal Services and Other Federal Matching Rates*

The 100 percent FMAP for services "received through" an IHS/Tribal facility is available for services provided to AI/ANs as described in this SHO instead of the regular FMAP rate described in section 1905(b) of the Act, the newly eligible FMAP rate described in section 1905(y) of the Act, the enhanced FMAP rate for breast and cervical cancer, or the enhanced rate for Community First Choice services.

[3:57:08 PM](#)

Mr. Sherwood addressed a document titled "Federal Medicaid Authorities for Restructuring Medicaid Health Care Delivery or Payment" dated March 25, 2016 (copy on file), which explained each demonstration waiver by the authority it extended, a brief description of the waiver, key flexibilities and /or limitations, and where it could be located in the bill. He explained that waiver authority under the federal Medicaid program meant that the federal government had the ability to waive certain federal provisions that would normally apply to Medicaid. He said

that the three main provisions were: a service must be available statewide (statewideness), comparability of service, and freedom of choice. He said that the different waiver authorities allowed the waiving of one or more of the requirements. The 1115 demonstration waiver was the broadest waiver authority that extended beyond Medicaid. He said that the waiver allowed states to test policy innovations that were likely to further the objectives of the Medicaid program. The waiver would be granted for up to 5 years, and could be renewed, although not in perpetuity. He shared that the state of Arizona operated its entire Medicaid program under an 1115 waiver and had always been a managed care program. He relayed that a key feature of the waiver was that a demonstration hypothesis containing evaluation assessments had to be present, and it must be budget neutral to the federal government. He added that Section 30 of the bill contained the 2 demonstration waivers; one for behavioral health, and another for an innovative payment model. He continued to the Health Homes Option, which examined care management, primary care, and acute behavioral health long-term services and supports for individuals with chronic illnesses. He stated that to qualify individuals had to have 2 chronic conditions, 1 chronic condition with the risk of another, or a serious and persistent mental health condition. States had the choice to select the chronic condition that would be addressed and participation had to be voluntary and allow a choice of providers. He said that there was an incentive for states to start the waiver; because savings might not be immediately realized the federal government would provide 90 percent federal funds for the Health Home payments for the first 8 quarters. States implementing the waiver must take part in an impact assessment involving survey and independent evaluation of the program.

[4:02:26 PM](#)

Mr. Sherwood spoke to Home & Community-Based Services Waivers and Options on page 2 of the document. He explained that, historically, long-term care had meant institutionalization and over the years different alternatives had been provided under the Medicaid program. The oldest alternative was the 1915(c) Home and Community Based Waiver Program, which was the program the state currently operated; 4 waivers were currently offered for different populations. The waivers required the demonstration of the necessity for an institutional level

of care and had to be offered the choice of institutional services. He furthered that there were waivers renewable for 5 year periods that had to demonstrate cost neutrality to the Medicaid program as a whole and not to the federal government. The maximum number of participants for each waiver had to be specified and the criteria for entrance selection. He said that 2 options that were offered in the bill similar to the waiver were the Section 1915(i) and Section 1915(k). He said that the 1915(k) option required individuals to meet an institutional level of care to receive services. As an incentive to states to use the option, states were provided a 6 percentage point increase in the federal matching payments for services. He said that the state was already making services available to people in the program without issues of cost neutrality or limitations on the number of individuals served. He noted that the remainder of the document discussed managed care authorities, both waivers and options in federal statute that were not specifically cited in the bill. He said that some ways of doing managed care were voluntary and some could mandate participation.

[4:07:42 PM](#)

DUANE MAYES, DIRECTOR, DIVISION OF SENIOR AND DISABILITIES SERVICES, DEPARTMENT OF HEALTH AND SOCIAL SERVICES, introduced the presentation "1915(i) and 1915(k) Options for the State of Alaska" dated March 28, 2016 (copy on file).

[4:08:37 PM](#)

SHANE SPOTTS, CONTRACTOR, SENIOR DISABILITY SERVICES, HEALTH MANAGEMENT ASSOCIATES (via teleconference), introduced himself and spoke to the presentation. He read from Slide 3:

- In 2012, 1915(k) became a new option to provide consumer-directed, home and community-based attendant services and supports
- Eligibility
  - Must meet functional eligibility equal to an institutional level of care
  - Medicaid eligible

- As long as eligibility criteria are met, benefits are available to all Alaskans statewide regardless of age or diagnosis
- Federal government contributes more money (56% instead of typical 50% Medicaid match to state dollars in Alaska)
- Agency model and consumer-directed model at state's discretion

[4:10:51 PM](#)

Mr. Spotts turned to Slide 4 and addressed the PCA state plan.

PCA total spend is \$85,200,043.36

- 49% (\$41,786,777.39) of expenditures by individuals currently on a waiver
- 1,603 individuals currently on a waiver receiving PCA services
- 3,308 individuals receiving PCA services not on a waiver

[4:12:27 PM](#)

Mr. Spotts moved to Slides 5 and 6 related to 1915(i) background. He addressed Slide 6:

- State plan option to provide consumer-directed, home- and community-based attendant services and supports
- Individuals do NOT need to be eligible for an institutional level of care currently required under 1915(c) HCBS waivers or 1915(k) (Community First Choice)
  - Medicaid eligible
  - Targeted populations
- Federal government contributes (50% match to state dollars in Alaska)

[4:13:33 PM](#)

Mr. Spotts continued on Slide 7 related to 1915(i) SDS general fund refinancing:

- GR Program: Estimated 349 of 545 recipients eligible for 1915i program.
- Adult Day Grants: Estimated 114 of 423 recipients eligible for 1915i program.
- Senior In-home Grants: Estimated 123 of 1,371 recipients eligible for 1915i program.
- Community Developmental Disability Grants: Estimated all recipients eligible for 1915i program.
- Estimated savings of shift to 1915i is \$8,530,000.

[4:14:40 PM](#)

Mr. Spotts addressed target dates on Slide 8:

- Implementation Plan Due- 7/31/2016
- Submit to CMS
- CMS Approval
- Begin Implementation

[4:15:30 PM](#)

Vice-Chair Saddler requested and estimated timeline for CMS to approve the 1915(i) waiver. He understood that the wait time could be as short as 3 months and as long as 3 years.

Mr. Spotts replied that the 1115 waivers were more complex and required significant negotiation with the federal government. He believed that the (i) option would require 3 to 6 months of negotiation with the federal government.

Vice-Chair Saddler understood that the 1915(k) offered the incentive of an extra 6 percent on the FMAP, but wondered whether the Medicaid expansion population would receive the higher FMAP under the 1915(k).

Mr. Sherwood replied that it was a 6 percent enhanced FMAP, 50 percent would be the default for most cases. He said that existing higher match rates should expect the enhanced 6 percent, up to 100 percent.

Vice-Chair Saddler clarified that a beneficiary under the expanded population would receive the FMAP in effect, plus an enhanced 6 percent, up to 100 percent.

Mr. Sherwood replied in the affirmative.

Mr. Spotts concurred.

[4:17:52 PM](#)

Representative Gara pointed to the estimated savings bullet on Slide 7. He asked whether the shift would be from a different waiver program, or a shift on to a Medicaid waiver altogether.

Mr. Spotts answered that it was a shift to the Medicaid program from a state funded only program. He explained that 100 percent state dollars were currently being paid for services, and the savings would occur from receiving the federal matching percentage of shifting individuals to the Medicaid program.

Representative Gara asked about the level of care requirements to receive the 1915(i) waiver.

Mr. Spotts answered that the waiver was still a Home and Community Based option, which meant that the services had to be provided in-home or out in the community. He relayed that the waiver lowered the institutional level of care threshold in order to give the states more flexibility to fill any gaps in underserved populations.

[4:20:14 PM](#)

Representative Gara asked how long the 1915(i) and 1115 waivers had been available.

Commissioner Davidson responded that the 1115 waiver authority had been around for a long time; however, the 1915(i) and (k) options had only been around for a few years.

Vice-Chair Saddler asked about possible difficulties for waiver renewal after 5 years.

Mr. Sherwood replied that some states had operated 1115 waivers for a long time but typically made program adjustments when up for renewal. He said that if a state wanted to execute the exact same program over and over again, CMS could take issue. He asserted that if programs were run as intended, with adjustments being made as states learned what worked and what didn't, waiver renewal should

not be a problem. He stated that waivers that were not demonstration waivers had no barriers to repeat renewals.

Vice-Chair Saddler understood that if the state went through the 1915 demonstration then the program would be implemented permanently.

Mr. Sherwood answered that it would have to be renewed after a five year period and there must be justification for renewal. He relayed that most managed care waivers and options had evolved out of 1115 demonstration projects.

[4:24:23 PM](#)

Vice-Chair Saddler expressed concern that the state would enter into the demonstration waiver application and then not be allowed to renew, leaving a segment of the population without care.

Mr. Sherwood believed the concern was legitimate. He elaborated that the state would be required under 1115 demonstration waivers to create a transition plan in case of termination of the waiver.

Vice-Chair Saddler wondered whether a new CMS director or Secretary of Health and Human Services could withdraw approval for a waiver.

Mr. Sherwood replied that the waiver could not be withdrawn prior to the end of the five-year period.

Representative Wilson asked if the state would be forced to keep supporting a program that was shown to be working and whether the state would have to pay for the working program.

[4:26:46 PM](#)

Mr. Sherwood clarified that the only waiver that could not be renewed automatically was the 1115 demonstration waiver. If the federal government determined that it was not going to renew the 1115 demonstration waiver, the state would not be obligated to spend state money or provide services otherwise covered by Medicaid. He reiterated that a transition plan would be considered which would ensure that people were informed of the changes that were happening and be made aware of other alternatives within the regular

Medicaid program or within other programs that might be appropriate for their situation.

Representative Wilson maintained concern for the future funding of the waivers.

Mr. Sherwood replied that 1115 demonstration waiver was the only waiver where there could be a renewal issue. He reiterated that the 1915 (i) and (k) options did not have the same demonstration requirement and in those cases, if the state decided not to continue and option, the state would revert back to the original match of 50/50, or the legislature to return to funding the grant programs that had previously provided services. He stressed that the state would have no obligation to continue to pay for services in the 1115 demonstration waivers that would not otherwise be covered under the regular Medicaid program.

Representative Gara asked whether managed care was barred in the private sector in Alaska.

Mr. Sherwood replied no; managed care was regulated through the Division of Insurance and the state had provisions for managed care written in statute.

[4:30:33 PM](#)

Mr. Mayes provided the Slides, "Community Developmental Disabilities Grants 1915(i) Impact" dated March 4, 2016. He shared that there were 19 states that had implemented the 1915(i) option. He said that 5 states had implemented the 1915(k) option. He relayed that it could take the state 3 to 6 months to get approval for the option. He explained that with the 1915(k) option CMS required a developmental council, which was composed of 11 voting members who were actual recipients of services, or family members of recipients of services. He continued that there were 8 advisory associations who were called upon after voting members voiced their opinions. He shared that the contract would end on July 30, 2016, at which time the contractor would provide a development plan for the state to carry forward.

[4:34:32 PM](#)

Representative Wilson where the programs that the waivers supported generated from.

Mr. Mayes replied that the department was refinancing all of its general fund programs with the 1915(i) option so that it could draw down 50 percent federal match. The department was taking existing people receiving services within the 1915(c) waiver and moving them to receive personal care attendant services with an additional federal match. He clarified that the program was not growing, the department was working to actualize deductions and not increases.

Representative Wilson queried how the state managed to spend nearly \$11.6 million in general funds for Community Developmental Disabilities Grants.

Mr. Mayes replied that the line item for the funding had existed in the Division of Senior Disabilities Services for several years.

Representative Wilson understood that the program was in the budget but wanted to know the genesis of the program.

Mr. Mayes deferred to Mr. Sherwood.

Mr. Sherwood replied that the programs were in statute and existed going back to the 1980s, prior to the development of the Home and Community Based waiver system. He said that there had been grant programs that provided home and community based services for people with developmental disabilities for at least the past 25 years.

[4:37:51 PM](#)

Representative Wilson understood that the programs had been established in statute and were not connected to Medicaid, and that this new waiver option under Medicaid expansion would continue the program, while providing federal matching funds.

Mr. Sherwood responded that the one of the duties that Alaska assumed with statehood was taking over the role of providing for people with developmental disabilities, which the state had done by building a facility in Valdez and by funding grant programs. Prior to statehood people with developmental disabilities had been sent to Oregon for care.

CSSB 74(FIN) am was HEARD and HELD in committee for further consideration.

Co-Chair Thompson addressed housekeeping.

#

ADJOURNMENT

[4:40:24 PM](#)

The meeting was adjourned at 4:40 p.m.