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Long-Term Performance of the Pennsylvania Medicaid

Behavioral Health Program

Compass Health Analytics, Inc.

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This white paper was prepared by James P. Highland, PhD, Andrea Clark, MS, and Lisa Manderson, ASA, MAAA of Compass Health Analytics, Inc. We thank the Pennsylvania Department of Public Welfare for providing data on spending and performance measures, and Community Care Behavioral Health Organization for providing access to their claim and eligibility data and for providing funding for analysis and writing.

**Long-Term Performance of the Pennsylvania Medicaid
Behavioral Health Program**

Summary

The Pennsylvania Medicaid Behavioral HealthChoices program saved an estimated \$4 Billion between 1997 and 2008 in the Southeast, Southwest, and Lehigh/Capital regions at the same time it increased access to behavioral services overall and for key vulnerable sub-populations, and also demonstrated improvement on key quality performance measures. The cost savings estimates were carefully vetted and consistently use conservative assumptions to arrive at the total of \$4 Billion.

The HC program has the following features which are unique and likely contribute to this performance:

- A single contractor for each county unit
- County right of first opportunity to contract with DPW to run their county-level HealthChoices program¹
- A collaborative model capitalizing on the historic strengths and expertise of Pennsylvania's County public behavioral health systems, other county-level human

¹ Pursuant to the Mental Health and Mental Retardation Act of 1966 (50 P.S. § 4201).

service systems, local providers, and managed care partners, many with local nonprofit roots

- Earnings by counties are retained in the program or reinvested in behavioral health system infrastructure
- Accountability to a County or joinder-level oversight board or governance body, responsible for financial performance, access, and quality

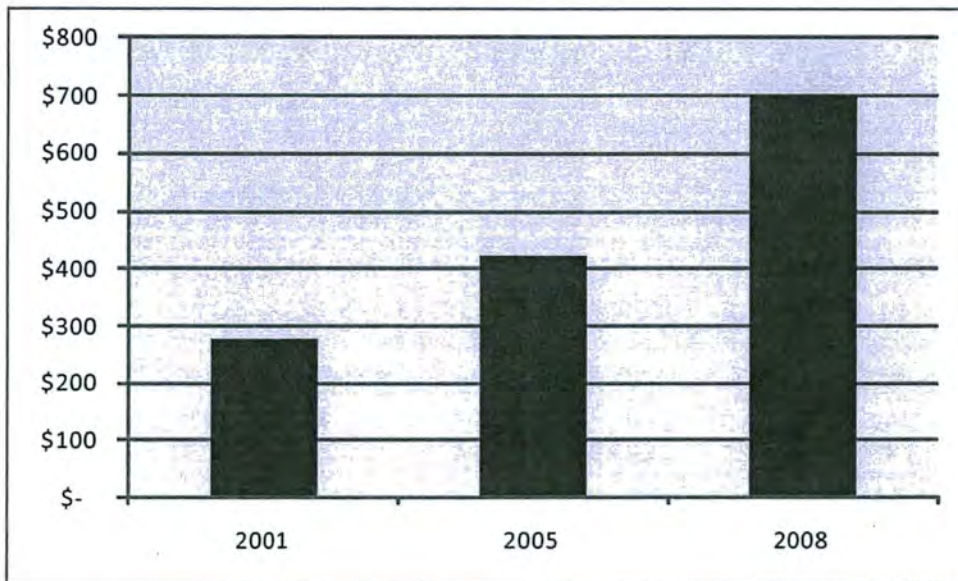
The design of the "county right of first opportunity" HealthChoices behavioral carve-out was a reaction to the "carved-in" voluntary managed care program preceding HealthChoices, which was alleged to have serious problems with adverse selection among plan choices related to behavioral status and diversion of behavioral dollars into managed care company profits. Issues in other states where Medicaid managed care programs have resulted in documented and newsworthy performance problems have been shown to be related to lack of expertise in public behavioral health issues. To illustrate the importance of that issue, this study begins with a comparison of rates of behavioral diagnoses in a Pennsylvania County in its Medicaid vs. commercial insurance population from the same region, and shows that the Medicaid population has a rate of major depression that is 3 times higher, a rate of bipolar disorder 3 times higher, and a rate of schizophrenia/

schizoaffective disorder 20 times higher than the commercial population from the same area. Expertise with the Medicaid population's behavioral issues and interfaces with the range of other human service systems aiding these individuals and operated by Pennsylvania counties is cited as a key to effective management of the program.

To arrive at the \$4 Billion cost savings estimate relative to projected FFS payments that would have occurred in the absence of HealthChoices, data prepared by the Commonwealth's actuarial consultant (Mercer Government Human Services) were obtained and evaluated. Key assumptions were tested and each assumption used by Mercer was found to be more conservative than the multiple validation checks performed. For example, the HealthChoices per-person rate of cost growth was well below the assumed rate of cost growth in Fee-For-Service estimated by Mercer at 5.5%. The 5.5% assumption was used even though the pre-HealthChoices behavioral cost growth in Pennsylvania Fee-for-Service Medicaid was 9.5%, and the national rate of Medicaid behavioral health cost growth during the same period was approximately 4.5% at a time when the great majority of these programs had recently converted to managed care. This conservatism in assumptions makes the cost savings estimates conservative, such that a figure of \$5 billion or higher could

also be defensible. The study also assesses and fails to find any evidence for cost-shifting from the behavioral program into the physical health system, into pharmaceutical spending, or into County base funding.

Exhibit E-1
Pennsylvania Behavioral HealthChoices Savings Relative to FFS by Year
(In \$ Millions)



Of the \$4 Billion in estimated savings, approximately \$1.2 Billion was used to absorb into the Medicaid program those discharged from State Hospital closures (State Hospital care is not financed with Medicaid funds), to absorb residential treatment providers previously paid by the Office of Children, Youth, & Families, and to build behavioral health infrastructure through reinvestment of savings achieved by county HealthChoices contractors.

While saving approximately \$4 billion under conservative assumptions, HealthChoices also demonstrated dramatic increases in access to services and significant improvements in quality measures. Resources were used more efficiently by achieving large increases in access to services among Medicaid recipients. For example, the percentage of individuals with SMI receiving services increased 50%-60% over the period between 2003 and 2008. The disabled, who in some managed behavioral health programs have had decreases in access to care, had an increase in the percentage of individuals receiving behavioral services of 25%. African-Americans had an increase in the percentage of recipients receiving services of 30%-40%. Of the eight access performance measures tracked by DPW, one declined 1% and the other seven increased by between 27% and 65%. Similarly, seven of eight quality metrics tracked by DPW increased over the same 2003-2008 period, with one showing a small decline.

The ongoing savings generated by the program, its superior performance measurement results, and its stability, all over a period of more than 10 years, make it a remarkably successful public policy initiative.

Introduction

Pennsylvania first implemented its HealthChoices mandatory Medicaid managed care program under a Federal 1915(b) waiver in 1997 in the five counties comprising the Philadelphia metropolitan region, subsequently expanded the program in 1999 to the 10 counties in the Pittsburgh metropolitan region, and in late 2001 to the 10-county Lehigh/Capital region, including Harrisburg, Reading, and Allentown. Programs in these three "legacy regions" have, then, been operating for between 9 and 13 years (beginning in 2006-2007 the program was expanded to the rest of the state). The waiver uses a relatively unique design in which the County is generally the geographic contracting unit. Multiple plans compete for "physical health" business in each county, but behavioral health is administered by a single management entity for the full Medicaid population of the county. The County itself is given right of first opportunity to manage the behavioral health program as a contractor with the state, and is awarded the contract if it can demonstrate that it has developed an approach to management that is sound clinically, programmatically, and financially. In the legacy regions all of the counties (or multi-county entities in some cases) except one elected to exercise their right of first

opportunity and were subsequently approved by the state to oversee their own behavioral health programs covering all Medicaid recipients in their county catchment areas¹. This approach followed from the long history of strong county government in Pennsylvania, including extensive behavioral health program infrastructure at the county level. The experience in the voluntary managed care waiver which preceded HealthChoices was also influential in the HealthChoices design, in that the voluntary program's fully "carved-in" model resulted in reports of significant problems with risk-avoidance based on behavioral status for some plans, and resulting adverse selection for the Medicaid fee-for-service (FFS) system².

The federal Patient Protection and Affordable Care Act has important provisions applying to Medicaid that will be an additional impetus for states to review their Medicaid programs. A clear understanding of available evidence and proper distinctions between different models and their lessons for financing, delivery system, payment methods, and information infrastructure requirements will be important to states in making system design decisions.

Background

The phrase "Behavioral health carve-out" is used to describe a wide range of arrangements that generally involve management of behavioral health services in a contractual and organizational structure separate from the one responsible for management of insurance for "physical health." These arrangements differ along a variety of dimensions, including whether the population is commercial or Medicaid, the size of the geographic/population unit for each management contract, the locus of performance responsibility, and the form of ownership of the contacted behavioral health MCO (BHMCO). A recent comprehensive literature review through 2004 by Frank and Garfield, which addresses the general concept of behavioral "carve out", finds a range of financial and quality outcomes for these arrangements which are generally positive but exhibit significant variation across the dimensions described above. Medicaid carve-out arrangements overall were found to save between 17%-33% in spending³. Savings were in significant part based on cost per unit and to a lesser extent on units per user; they were not based on denial of service. There is evidence in some cases of cost shifting to other services outside of carve-out such as behavioral pharmacy costs, and there is mixed evidence on access

and quality issues for more seriously ill populations. The arrangements described and the degree of variation in them suggests that specific features of these carve-outs may be relevant to their success or problems. For example, prior experience managing publicly financed populations was cited as a potential explanatory factor in variation in Medicaid program outcomes.

Program evaluations in the literature generally and those specifically reviewed by Frank and Garfield often study the first few years of a program's operation and are typically completed two or more years after the period being evaluated. The literature generally does not contain assessments covering a longer time frame. Can a Medicaid behavioral carve-out perform positively in reducing cost growth and in maintaining or improving access and quality over a time horizon of 10 years or more? While a large-scale, comprehensive program evaluation of Pennsylvania Behavioral HealthChoices would be valuable, this more focused examination of the long-term changes in basic program financial, access, and quality measures provides useful information about how this model has functioned over the past decade.

Study Data and Methods

DATA The Pennsylvania Department of Public Welfare (DPW) Office of Mental Health and Substance Abuse Services (OMHSAS) provided several types of data which allow examination of historical program experience for Behavioral HealthChoices. The DPW data included summary (region-level for the three legacy regions) information on the pre-HealthChoices FFS spending, summarized capitation payments to HealthChoices contractors for 1997-2008, and access and quality performance measures for 2003-2008. More detailed cost data for specific policy and program changes added to HealthChoices during the 1997-2008 timeframe were also provided by DPW. In addition, DPW provided actuarial factors prepared by its consultants, Mercer Government Human Services ("Mercer"), for aspects of the calculations discussed further below. More detailed information was not readily available from DPW. Community Care Behavioral Health Organization, a nonprofit MCO covering the largest number of members in the Pennsylvania Behavioral HealthChoices program, provided detailed claim and eligibility data for its HealthChoices operations over 10 years in 34 Pennsylvania counties, as well as commercial behavioral health spending levels for one geographic unit in which it manages both Medicaid and commercial populations.

ANALYSIS OF MEDICAID POPULATION DIAGNOSTIC PROFILE In order to assess a behavioral health program, it is important to be clear about the nature of the program and its covered population. It is generally understood that the Medicaid population has a greater burden of behavioral health issues than commercial or Medicare populations, and that it is frequently the primary payer for persons with serious mental illness. In order to quantify and clarify this general understanding, and set the context for the analysis of the program's performance, an analysis was conducted comparing the behavioral health diagnostic and spending profiles of a commercial population and a Medicaid population in the same geographic area. Because these comparative data are not generally available, and because data from both covered populations were available from Community Care for Allegheny County, Pennsylvania as part of another ongoing study, an analysis was conducted using Allegheny County as an example of the degree of difference between the Medicaid and Commercial populations. The Medicaid data covered all Medicaid HealthChoices enrollees in Allegheny County in 2008, and the commercial data covered all members of UPMC Health Plan residing in Allegheny County during the same period. The commercial population is not all-inclusive for the County, but as a plan sponsored by UPMC Health System, which has tertiary care services for all specialties, its diagnostic profile is

likely to be at least average in acuity for commercial enrollees in the region. Using claims data for both populations, individuals were assigned into a mutually exclusive set of behavioral diagnostic categories, and a comparison between the Medicaid and commercial populations in the prevalence of diagnoses and amount of spending on a per member basis was made.

ANALYSIS OF PROGRAM SPENDING The analysis of program spending was conducted in several steps, including analyses testing the validity of the assumptions used in the spending comparison calculations.

➤ **PROJECTION OF FEE-FOR-SERVICE SPENDING:** DPW's actuarial consultant used Pennsylvania Medicaid's FFS claims to construct a history of baseline FFS spending levels immediately prior to HealthChoices implementation, then projected it over the timeframe of HealthChoices program operation using a trending factor to provide a comparison point for the HealthChoices spending levels⁴. Two important assumptions were made in this calculation. First, some counties operated the voluntary (i.e., not full-population) "carved in" managed care program prior to HealthChoices implementation, and claims data were not available for the managed care portion of the population. Mercer applied an actuarial selection factor to adjust (downward) the available FFS baseline data to represent

an average cost profile for the full-population baseline. Second, Mercer measured the trend in FFS claims for those portions of the state for which no managed care was implemented (i.e., other than the three legacy zones), and used the measured trend rate to inflate the legacy zone FFS baseline into projected FFS spending to estimate the impact of HealthChoices relative to FFS. A 3.6% administrative load, representing the Commonwealth of Pennsylvania's administrative overhead rate for its Medicaid program, was then added. The selection factor and trend rate assumptions are the key sensitivity variables in this calculation. In order to test the actuaries' assumptions as part of this study, archived benefit-equivalent FFS spending summaries for legacy region counties were collected. The selection assumption was tested by measuring the rate of growth in claims since HealthChoices implementation for those counties with a starting point of 100% FFS membership. The spending reduction rate implied by this calculation (which did not require a selection adjustment) was made to those produced using data from all the counties and Mercer's selection adjustment. To assess the assumption of counterfactual FFS growth during the HealthChoices period, the pre-HealthChoices FFS spending trend for 100% FFS counties was measured and compared to post-HealthChoices spending growth. In addition, a comparison was made to national Medicaid behavioral health spending growth.

➤ HEALTHCHOICES SPENDING: Spending on HealthChoices is measured by DPW's capitation payments to the counties for operation of their HealthChoices programs. These payments were available for all three legacy regions, with program inception dates in 1997, 1999, and 2001 for the Southeast, Southwest, and Lehigh/Capital regions. Capitation spending provided by DPW contained the component for services, and was adjusted for average MCO administration and county oversight. Benefits covered by this capitation include all "in-plan" Medicaid services, with allowed substitution for DPW-approved cost-effective alternatives.

➤ ADJUSTMENT FOR ADDITIONAL BENEFITS: Three major initiatives not in the historic fee-for-service program that increased Medicaid costs were implemented into HealthChoices over the period being evaluated. First, there were state hospital closures in the legacy regions, and spending for individuals receiving treatment in state hospitals was not covered by Medicaid. DPW made adjustments to the capitation rates to allow for the marginal effect of high-use individuals on the average rate. Second, a large material program change was made to Medicaid via the Integrated Children's Service Initiative (ICSI). Residential providers previously paid by the Commonwealth's Children and Youth program were re-contracted as residential treatment providers and paid by Medicaid,

resulting in large marginal spending increases by the Medicaid program. Costs for these providers were not present in the FFS data. Third, savings earned by the counties from their net income on the Healthchoices program were required to be applied to "reinvestment" which funded start-up of Medicaid services, development of cost effective alternatives, or, on a more limited basis, one-time-only infrastructure improvements. All three of these new initiatives were paid for from the capitation payment history described above, and none of them were in the FFS history to which the capitation payments are to be compared. In order to make the comparison of the HealthChoices program payments to the counterfactual FFS projections "apples to apples", spending detail for these three items by region and year, provided by DPW, were subtracted to get a net "FFS comparable capitation spending." The comparison of FFS to capitation payments is made both on a gross basis (without adjustment to the capitation rates for the three factors), and on a net basis (removal from the capitation of these new spending items)⁵.

➤ ASSESSMENT OF POTENTIAL COST SHIFTS: There are several ways in which costs could have been shifted from the HealthChoices program into other funding channels. In order to be sure that such cost-shifting is not responsible for any program spending reductions measured, these potential avenues

were investigated. First, theoretically, costs could have been shifted into the physical health system component of the Medicaid program. However, the Pennsylvania program has specific benefits and provider networks for the respective physical and behavioral programs, and direct shifting of service costs is not possible. While denials of service in the behavioral system could lead indirectly to increased spending on physical services (e.g., additional accidents related to restrictions on substance abuse services), as discussed in the results section, all indications are that access to care increased dramatically under HealthChoices. Specific analysis of this issue was not pursued.

The second potential cost shift is into pharmaceuticals, for which the behavioral program does not have fiscal responsibility. To assess this possibility, trend rates in behavioral pharmaceutical spending for legacy region counties in the more recent years for which it is available were evaluated, and the incentives for providers in the program are analyzed.

Third, costs could have been shifted into county "base funding" of behavioral services. Base funding to counties via the Commonwealth finance some behavioral services. The level and growth rate in base-funded behavioral services for Allegheny County, for which data were available, was evaluated to test this possibility.

ANALYSIS OF ACCESS AND QUALITY INDICATORS As part of its HealthChoices program, DPW measures a set of 8 access and 10 quality performance measures in the three regions, and publishes an annual performance report containing these measures for each of the legacy regions. The 2009 report contained measures for most cells in a region-performance measure matrix for the period 2003-2008⁶. A weighted average across the three legacy regions was calculated for each measure, and the percent change in these measures from 2003 to 2009 was calculated. Some measures contained missing observations for certain cells. In these cases, the percent change from first available observation to the most recent available observation was used.

Claim data for all Medicaid-eligible persons in the three legacy regions are not readily accessible from DPW to further explore access, so service penetration rates (number of individuals using the service in a year over the average number of eligible members in a year) couldn't be calculated at a greater level of detail than provided by the summary performance reports. As noted, Community Care Behavioral Health provided detailed claim data from its subset of legacy region counties. From these data, additional access measures were computed. Specifically, data were normalized to a "program inception" date for each legacy region, and percent change in penetration rates

were calculated across the subset from the inception year until the most recent year for which reasonably complete data were available (2009) for the 11 major service categories. Overall measures were also computed for children and adults separately, and for SSI individuals.

STUDY LIMITATIONS As noted in the foregoing, limitations on readily available data circumscribe the scope of the source data for some of the calculations, which are noted. Costs are generally more easily measured than access, and access more easily than quality. Service use is a proxy for access which is easily measured but which does not measure the more subtle aspects of accessibility to appropriate high-quality care. Quality is more difficult to measure than cost, and more careful and detailed assessment would require significant additional resources beyond those which the Commonwealth is already expending on performance measurement.

Study Results

COMPARATIVE DIAGNOSTIC PROFILE Exhibit 1 displays a series of ratios which serve as comparisons of the Allegheny County Medicaid population to the sample sub-set of commercial members from Allegheny County. The row headings describe the various

measures of behavioral illness prevalence and spending which were computed from each of the two data sources. The values in the table are the Medicaid measure divided by the commercial population measure. For example, the penetration rate for behavioral services in the Medicaid population is 3 times the behavioral penetration rate for the commercial population.

Exhibit 1
Ratio of Medicaid to Commercial on Key Measures of Behavioral Spending
Allegheny County, Pennsylvania

Measure	Ratio of Medicaid to Commercial
Behavioral Penetration Rate (annual BH users/average enrollment)	3
Behavioral percentage of total non-drug (PH+BH) spending	7
Percentage of Enrollees with Depression/Major Depression	3
Percentage of total medical dollars spent on individuals categorized as having Depression Or Major Depression $[(\$ PH+BH+Rx \text{ for D-MD individuals})/(\$ \text{ all PH+BH+Rx})]$	3
Percentage of behavioral dollars spent on Depression/Major Depression	1
Percentage of enrollees with Bipolar	3
Percentage of total medical dollars spent on individuals categorized as having Bipolar disorder $[(\$ PH+BH+Rx \text{ for Bipolar individuals})/(\$ \text{ all PH+BH+Rx})]$	10
Percentage of behavioral dollars spent on Bipolar	3
Percentage of enrollees with Schizophrenia/Schizoaffective	20
Percentage of total medical dollars spent on individuals categorized as having Schizophrenia Or Schizoaffective Disorder $[(\$ PH+BH+Rx \text{ for S/SA individuals})/(\$ \text{ all PH+BH+Rx})]$	90
Percentage of behavioral dollars spent on Schizophrenia/Schizoaffective	25

The results clearly illustrate the degree to which behavioral issues are dramatically more common, more acute, and more expensive in Medicaid populations than in commercial populations. The only measure for which the commercial population has comparable value is the percentage of behavioral dollars spent on major depression. However, major depression is three times more prevalent in the Medicaid population, and the commercial value is similar only because the total spending for

commercial behavioral services (the denominator of the measure in question) is so much smaller on a per member basis. Large differences in the level of behavioral illness and in the socioeconomic profile of Medicaid populations, particularly individuals with schizophrenia, indicate that research findings on carve-outs in commercial settings are not likely to be relevant for assessment of Medicaid behavioral carve-outs.

ESTIMATED SPENDING REDUCTIONS The results of the comparison between actual capitation payments for HealthChoices and the projected FFS costs are displayed in Exhibit 2.

Exhibit 2
Commonwealth of Pennsylvania
Projected Fee-For-Service Behavioral Health Medicaid Expenditures Including Administrative Expense
vs.
Historical Behavioral Health Choices Contracted Rates With and Without Reinvestment, ICSI and Hospital Closures
for Three Initial HealthChoices Regions (\$ Millions)

Calendar Year	Regions Implemented	Growth in HC Membership	BH HealthChoices Capitation Payments	FFS Benefit-Equivalent HealthChoices Capitation	Projected FFS Costs Including State Administration	Estimated Difference in Spending
1997	SE	N/A	\$ 409	\$ 354	\$ 559	\$ 205
1998	SE	0%	\$ 419	\$ 416	\$ 589	\$ 173
1999	SE and SW	42%	\$ 565	\$ 550	\$ 783	\$ 233
2000	SE and SW	6%	\$ 682	\$ 668	\$ 862	\$ 195
2001	SE, SW, and LC	4%	\$ 803	\$ 793	\$ 1,070	\$ 277
2002	SE, SW, and LC	15%	\$ 1,054	\$ 976	\$ 1,152	\$ 176
2003	SE, SW, and LC	9%	\$ 1,197	\$ 1,125	\$ 1,325	\$ 200
2004	SE, SW, and LC	5%	\$ 1,231	\$ 1,169	\$ 1,464	\$ 295
2005	SE, SW, and LC	11%	\$ 1,367	\$ 1,289	\$ 1,712	\$ 423
2006	SE, SW, and LC	9%	\$ 1,642	\$ 1,458	\$ 1,957	\$ 499
2007	SE, SW, and LC	1%	\$ 1,734	\$ 1,449	\$ 2,077	\$ 629
2008	SE, SW, and LC	-3%	\$ 1,745	\$ 1,433	\$ 2,134	\$ 702
All Years			\$ 12,849	\$ 11,680	\$ 15,685	\$ 4,005
Spending Difference HealthChoices vs. FFS :			-18%	-26%		

Source: Mercer, Commonwealth of Pennsylvania: HealthChoices Behavioral Health Program Historical Financial Review, 12/14/2009

The exhibit displays the timeframe over which the three legacy zones were implemented, and the projected FFS spending over those years for those regions that had implemented HealthChoices in each year. Mercer actuaries applied a 5.5% growth rate to estimated FFS expenditures in the base period (pre-HealthChoices) to arrive at estimated counterfactual spending levels (this assumption is discussed further below).

The exhibit also displays the sum of the calculated total HealthChoices capitation rates for each legacy region that had implemented the program in each year. The total estimated gross spending reductions relative to FFS over the timeframe is \$2.8 billion, which represents an 18% reduction from the costs projected under a continuing FFS arrangement. Exhibit 2 also displays the total capitation after subtracting the three new programmatic initiatives from each year. These spending components were not part of the FFS baseline, and so the gross comparison between capitation and the projected FFS spending understates the difference in spending, other things equal. After adjusting for these spending components the estimated reduction in spending increases to 26% of projected FFS totals, or just over \$4 billion. The estimated reduction relative to FFS of 26% is within the 17-33% savings found by Frank and Garfield in their literature review.

As discussed above in the methodology section, the baseline FFS spending levels were computed from FFS claims using two important adjustment factors. First, they were adjusted with a selection factor to reflect the difference in the unknown risk/spending level that the voluntary managed care population would have had if they had been in FFS prior to implementation. Second, the result was trended forward by 5.5% per year.

To test the plausibility of the selection adjustment in the comparative FFS spending level sequence, we examined summary level FFS spending profiles that were published beginning in 1996 for counties that were scheduled to be converted to HealthChoices. A few counties in these profiles had a mixed FFS/voluntary managed care population in all their annual data, but many had 100% FFS either immediately prior to HealthChoices or in a recent year before HealthChoices. The most recent observation of FFS claims spending for those counties with 100% FFS pre-HealthChoices observations (i.e., no voluntary managed care and no selection adjustment required) was compared to 2009 HealthChoices claims spending levels for the same counties. The implied annual growth rate between these two points was calculated. The average annual growth implied on a gross basis (not excluding ICSI, reinvestment, and state hospital impacts from the 2009 HealthChoices number) was 1.2%, which is 4.3%

lower than the FFS growth assumed by Mercer. The spending reduction implied by this 4.3% difference over the 1997-2008 period, after allowing for the higher administrative percentage in HealthChoices, would be 20% of total FFS spending, 11% larger than the 18% gross-basis percentage spending reduction implied by the Mercer FFS projection shown in Exhibit 2. This suggests that Mercer's selection adjustment to arrive at the total FFS baseline produces a more conservative answer than that implied by the comparison of 100% FFS counties to HealthChoices costs.

To test the 5.5% trend assumption, we also used the FFS summaries. Between 3 and 6 years of pre-HealthChoices FFS data were published for counties in the legacy regions and for counties in the recently implemented counties in the rest of the state. The average annual rate of claims growth prior to HealthChoices implementation was measured for those counties which were entirely FFS from both legacy and non-legacy regions, covering the period 1993-2006. The average rate of growth from this calculation, which unlike Mercer's calculation includes FFS growth in the legacy regions before HealthChoices, was 9.5%, far larger than the 5.5% growth assumed by William M. Mercer actuaries. The 5.5% assumption appears to be reasonable and possibly conservative in comparison.

As another test of the 5.5% FFS trend assumption, we compared it to national trend rates for behavioral health services in a study by Frank, McGuire, and Goldman⁷. The study contains indexed cost levels for Medicaid inpatient services as well as other mental health services for the period 1996-2006. Using the supplementary appendix to the study shows that the indexed level of combined behavioral services (inpatient plus other, excluding pharmacy) was essentially flat over this period. The authors used the CPI to index all the observations to a common year, so for the purposes here the results were "de-indexed" using the medical services CPI published by the Bureau of Labor Statistics⁸. The average annual growth over the 1996-2006 period nationally for Medicaid behavioral health services implied by this calculation is 4.3%. This 4.3% national growth figure is composed heavily of data from other Medicaid managed care programs. Eighty five percent of the 66 approved 1915(b) Medicaid waivers displayed on the CMS website have first-approved dates in the period 1991-2004.⁹ The 5.5% unmanaged FFS trend assumption would also appear reasonable, or conservative, when compared to the 4.3% national Medicaid behavioral growth rate with significant managed care composition.

In addition to testing assumptions, two sources of potential cost-shifting from the behavioral program to other programs were

investigated. The first potential cost shift is to county non-Medicaid "base-funded" services, provided by counties directly to individuals. State-wide data were not available for mental health and substance abuse services provided under base funding, though overall approximately 30% of base funds are for MH/SA services. Base-funded spending on MH/SA services for Allegheny County was available. In Allegheny, only 9.6% of services paid for with base funding were for MA eligible persons in 2008. From 2002 (the first full year for which the data are available) through 2008, the ratio of base-funded service dollars provided to MA enrollees to HealthChoices service dollars provided to MA enrollees remained essentially constant at $\frac{1}{2}$ of one percent of HealthChoices spending. Based on Allegheny County data, the constant and tiny relative ratio in spending indicates strongly that shifting cost into base-funding does not explain the spending trajectory for the HealthChoices program. This result, though limited in scope, is supported by the general perceptions of those participating in HealthChoices that base-funded services are small relative to Medicaid and that a small proportion of these services go to Medicaid-eligible persons.

The second possible avenue for cost shifting from the behavioral HealthChoices program is into behavioral pharmaceuticals. Behavioral HealthChoices includes all

behavioral services, but not any pharmaceuticals, which are paid for by the HealthChoices physical health plans. The modest growth rate in behavioral services could have been dampened by shifting patients to treatment with pharmaceuticals rather than treatment services. Since HealthChoices programs maintain separate provider networks for behavioral and physical health, a significant part of behavioral pharmaceuticals are prescribed by PCPs not in the behavioral network. Mark, et. al. found in a recent study that general practitioners prescribed 59% of psychotropic medications, including 65% of anxiolytics, 62% of anti-depressants, 52% of stimulants, 37% of anti-psychotics, and 22% of anti-mania medications.¹⁰ For there to be an intentional cost-shift from the behavioral program to behavioral pharmaceuticals would require an incentive to do so. Much of the behavioral drug spending is being prescribed by providers not in the behavioral network and so not susceptible to the capitation incentives of the behavioral program. Furthermore, behavioral HealthChoices programs pay their contracted providers almost universally on a fee-for-service basis, which provides an incentive for increasing behavioral service use rather than cost shifting. While the insurance program may have a theoretical incentive to shift costs due to its capitated payments, any incentive to shift toward pharmaceuticals has not been passed down to the providers.

It is also possible that behavioral services grew slowly simply due to technological substitution of drug treatments for services as new pharmaceuticals became available, rather than by intent. Frank, McGuire, and Goldman (op. cit.) found that behavioral pharmaceuticals grew very rapidly over the 1996-2006 period in Medicaid populations, while spending on inpatient mental health services declined and other mental health services grew slowly¹¹. Data available to confirm whether a shift to behavioral pharmaceuticals occurred or not in Pennsylvania is limited; however, data were available to analyze trend rates in HealthChoices pharmaceutical spending for Community Care Behavioral Health legacy counties for the 2007-2009 period.¹² During this period behavioral drug spending increased at an annual rate of 5.3%, and anti-psychotics, which are much more likely to be prescribed by psychiatrists in the behavioral network, grew at an annual rate of only 1.2%. Given the lack of incentive for providers to shift costs away from services, and the lack of evidence in the limited data available, the analysis did not find support for a cost shift to pharmaceuticals.

Because the various validations describe above support the assumptions used in a manner which makes them appear conservative, the \$4 Billion estimated savings figure is a

conservative estimate. Actual savings estimates of \$5 Billion or higher could be defensibly calculated from historical data.

ACCESS AND QUALITY As noted, some prior studies have found issues with access and/or quality in Medicaid behavioral carve-out programs. Exhibit 3 displays the results for Pennsylvania DPW's access and quality measures, which with one exception each, have improved by large percentages over the program's history.

Exhibit 3
Percent Change in HealthChoices Performance Measure Between 2003 and 2008*

Access Performance Indicators (Penetration Rate)	SE	SW	LC	All
PI #1a, SMI and No Substance Abuse, Ages 18-64	40%	60%	75%	52%
PI #1b, SMI and Substance Abuse, Ages 18-64	50%	100%	100%	65%
PI #2.1, Mental Health Service, Ages 18-64, African American	25%	45%	36%	33%
PI #2.2, Substance Abuse Service, Ages 13-17, African American	0%	100%	0%	41%
PI #2.3, Substance Abuse Service, Ages 18-64, African American	20%	29%	50%	27%
PI #2.4, Mental Health Service, Ages 18-64	42%	58%	44%	46%
PI #2.5, Substance Abuse Service, Ages 13-17	0%	0%	0%	-1%
PI #2.6, Substance Abuse Service Ages 18-64	14%	80%	25%	30%

Quality/Process Performance Indicators	SE	SW	LC	All
PI #3a, At Least One Day in a Residential Treatment Facility, Under Age 21, Mental Health	67%	0%	0%	35%
PI #3b, Cumulative RTF Bed Days 120 or Greater, Under Age 21, Mental Health	0%	0%	0%	1%
PI #4a, Psychiatric Inpatient Readmitted Within 30 Days Post-Discharge, Under Age 21	7%	7%	0%	5%
PI #4b, Psychiatric Inpatient Readmitted Within 30 Days Post-Discharge, Ages 21-64	11%	15%	13%	12%
PI #4c, Psychiatric Inpatient Readmitted Within 30 Days Post-Discharge, Ages 65+				
PI #5a, Discharged from RTF With Follow-Up Service(s) Within 7 Days Post-Discharge	-13%	-6%	28%	-3%
PI #5b, Discharged From Psychiatric Inpatient With Follow-Up Service(s) Within 7 Days Post-Discharge, Under Age 21	26%	13%	13%	19%
PI #5c, Discharged From Psychiatric Inpatient With Follow-Up Service(s) Within 7 Days Post-Discharge, Ages 21-64	34%	15%	22%	20%
PI #5d, Discharged From Psychiatric Inpatient With Follow-Up Service(s) Within 7 Days Post-Discharge, Ages 65+	NC	NC	NC	NC
PI #5e, Discharged From Non-Hospital Residential Detox, Rehabilitation and Halfway House Services for D&A Dependency or Addiction with Follow-Up Services Within 7 Days Post-Discharge, Under Age 65	13%	-7%	30%	9%

*Note: Penetration rate is the proportion of members accessing service during the year. Percentages shown are the percentage increase in the penetration rate.

The eight access measures increased between 27% and 65%, with the exception of drug and alcohol services for 13-17 year olds, which decreased by 1%. The eight quality assessments measured increased between 1% and 35%, with the exception of follow-up to residential treatment facility discharge within 7 days, which declined 3%.

Exhibit 4 displays more detailed service level increases in penetration (users of service divided by average membership), which can be calculated from the more detailed data made available by Community Care Behavioral Health. Of particular note is the reduction in inpatient service for both mental health (-13%) and substance abuse (-44%), and the large growth in alternative less-restrictive services that the Medicaid waiver allows (400% since the second contract year). A separate calculation of overall growth in penetration for the SSI population over the same time frame shows an increase of over 25%, ameliorating the concerns about access to care for more vulnerable populations under managed care.

improving almost all access and quality measures tracked by the Commonwealth. Several features distinguish the program's design. First, the programs are managed by the county behavioral health authorities, in partnership with Pennsylvania-based managed care entities in a de-centralized relationship with the Commonwealth. The strong understanding of the system and shared values of these parties has allowed the historical strengths of the system to be a foundation for improved rationality of resource allocation and coordination. Second, the county entities and their MCO partners have responsibility for the entire Medicaid population in their catchment areas, eliminating adverse selection issues that plagued the prior voluntary "carved in" managed care program. Third, the single management entity brings to bear expertise in public behavioral health issues and allows simplified interface with juvenile justice, children and youth services, and other human service systems accessed by the Medicaid population.

NOTES

¹ Some highly vulnerable sub-populations were excluded from managed care but the vast majority of eligible Medicaid recipients were enrolled in HealthChoices.

² McCoy CR, Stark K. An HMO finds lots of money in poverty. *The Philadelphia Inquirer*. 1997 AUGUST 3:A01.

³ Frank RG, Garfield RL. Managed behavioral health care carve-outs: past performance and future prospects. *Annu. Rev. Public Health* 2007;28:303-320.

⁴ Commonwealth of Pennsylvania Department of Public Welfare, Office of Mental Health and Substance Abuse Services. HealthChoices Behavioral Health performance report 2009. Dec 2009; 1-152.

⁵ The applicable administrative percentage was added to the ICSI and state hospital closure estimates; the reinvestment dollars had no administration added.

⁶ Commonwealth of Pennsylvania Department of Public Welfare, Office of Mental Health and Substance Abuse Services. HealthChoices Behavioral Health performance report 2009. Dec 2009; 1-152.

⁷ Frank RG, McGuire T, Goldman H. Trends in mental health cost growth: an expanded role for management? *Health Affairs* 28, no. 3 (2009): 649

⁸ Due to relatively static provider prices in many Medicaid programs, it may be that indexing Medicaid data with the CPI will tend to over-flatten the resulting Medicaid indexed growth over time. In any case, for our purposes the index was removed and so does not create an issue for the calculations.

⁹ On CMS website:

<https://www.cms.gov/MedicaidStWaivProgDemoPGI/MWDL/list.asp?intNumPerPage=all&sortByDID=4a&submit=Go&filterType=none&filterByDID=%252D99&sortOrder=ascending&submit=Go>

¹⁰ Mark TL, Levit KR, Buck JL. Psychotropic drug prescriptions by medical speciality. *Psychiatric Services* 2009; 60, 1167.

¹¹ Frank, McGuire, Goldman, *ibid*.

¹² DPW began making pharmacy data available to plans in 2007.

3/28/16

Behavioral Health System Transformation

March 28, 2016

Charles Curie, MA, ACSW
The Curie Group, LLC

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)

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



Trends in Public BH continued...

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



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.

Why Integrated Care?

- 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.

Source: Collins, C., Hewson, D. L., Munger, R., Wade, T., (2010). Evolving Models of Behavioral Health Integration in Primary Care. Milbank Memorial Fund.

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.

Source: Collins, C., Hewson, D. L., Munger, R., Wade, T., (2010). Evolving Models of Behavioral Health Integration in Primary Care. Milbank Memorial Fund.

What does this mean for Alaska?

DBH Vision for BH Reform

- Streamlining
- Utilization Control
- Grant Reformation
- Medicaid Redesign

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

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)

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

Contract Management continued

- 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,

BH 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)

Contract Standards continued

- 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

Contract Standards continued

- 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

QUESTIONS?



THANK YOU!

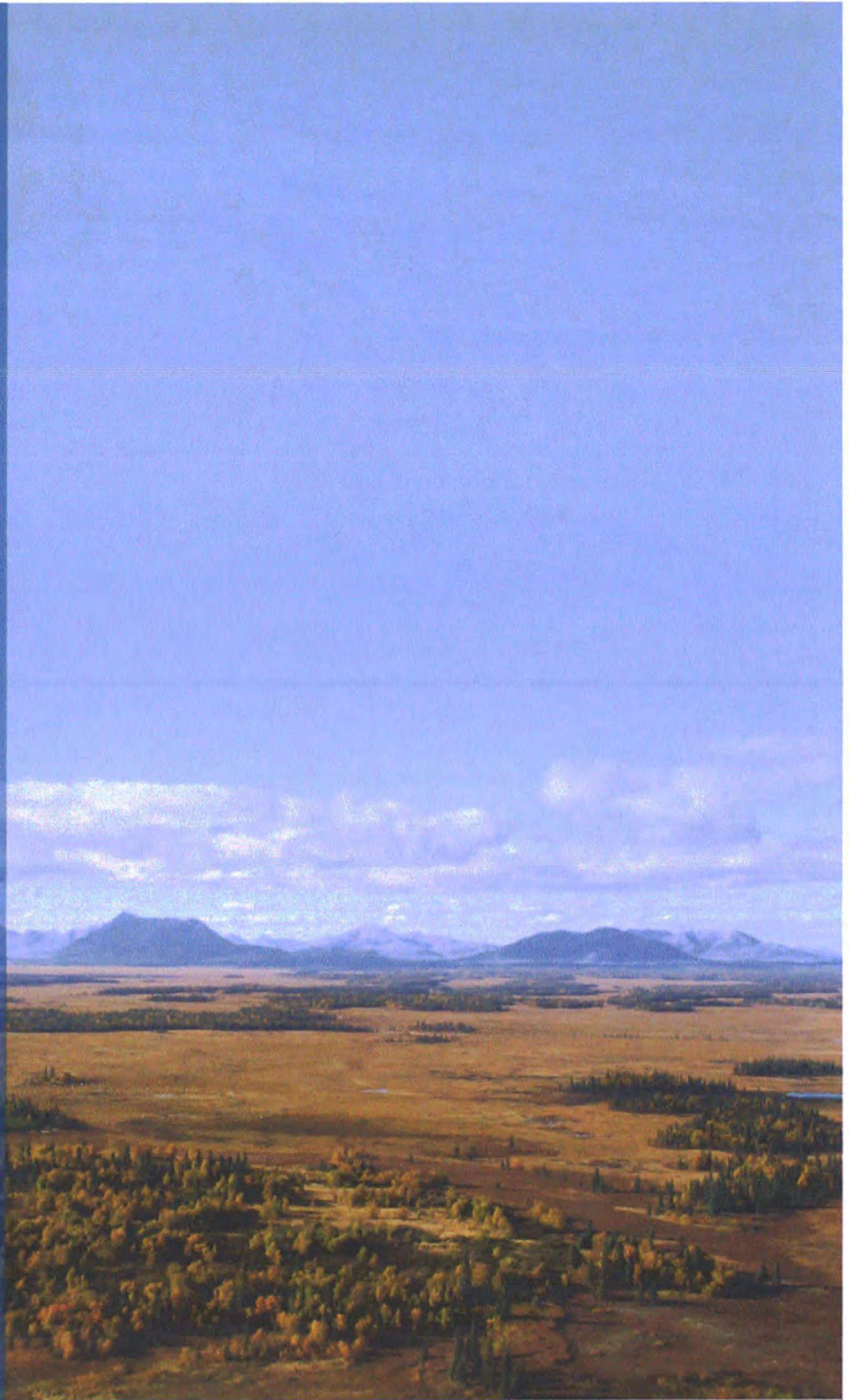
Executive Summary

Alaska Behavioral Health Systems Assessment

January 22, 2016

The data analyzed over the course of this project tell an important story about the behavioral health system in Alaska and the barriers and opportunities to meet the behavioral health needs of Alaskans.

The goals of the Alaska Behavioral Health Systems Assessment were to describe the system, assess the need for services and capacity to meet the need, develop a framework for regular monitoring of the system, and identify barriers, opportunities and recommendations for system improvement.



Prepared for the Alaska Mental Health Trust Authority
by Agnew::Beck Consulting, LLC and Hornby Zeller Associates, Inc.

PARTNERS: Alaska Department of Health and Social Services Division of Behavioral Health
| Alaska Native Tribal Health Consortium | Mat-Su Health Foundation |
Alaska Mental Health Board | Advisory Board on Alcoholism and Drug Abuse

Trust
Alaska Mental Health
Trust Authority

ESTIMATED PREVALENCE | Behavioral Health Issues Among Alaskans in 2013

UTILIZATION | Behavioral Health Services Provided with Support from State Medicaid and Grant Funds in State Fiscal Year 2013

YOUTH

Risk Behaviors ¹

Approximately One in Five

4,641 traditional high school students had a moderate or high-risk behavior for substance use.

- The prevalence of this behavior was similar for male and female students (20.3% compared to 16.4%)



Mental Health Issues ^{1,2}

Approximately One in Four

7,214 traditional high school students experienced a mental health issue in the past year.

- The prevalence of mental health issues among female students was higher than among male students (37.8% compared to 19.4%)

Among 9 to 17 year olds, 5,550 (6%) were estimated to have had a serious emotional disturbance in the past year.



Youth Clients Served ⁴

Approximately One in Nine

12,147 unique youth clients were served with support from state Medicaid and/or behavioral health grant funds.



Breakdown of Youth Served

By diagnosis category:

- Substance Use Disorder: 1,324 (11%)
- Serious Emotional Disturbance: 9,350 (77%)
- Mild or Moderate Mental Illness: 2,215 (18%)
- Co-occurring Disorders: 482 (4%)

By gender:

Male: 7,129 (59%) | Female: 5,018 (41%)

ADULTS

Total Prevalence ³

Approximately One in Four

145,790 adults needed treatment for illicit drug or alcohol use and/or experienced a mental illness in the past year.



Alcohol & Illicit Drug Use ³

Approximately One in Nine

62,815 adults needed treatment for an illicit drug or alcohol problem.

- Estimated need for treatment among low income adults was higher than among adults above 138% of the federal poverty level (16.7% compared to 11.5%)
- Estimated need for treatment among adult males was higher than among adult females (15.5% compared to 7.5%)
- About one-third of those that needed treatment (22,990 adults) also experienced a mental illness in the past year



Mental Illness ³

Approximately One in Five

105,966 adults had a mental illness in the past year.

- 61,176 adults (11.2%) had a mild mental illness, 23,487 adults (4.3%) had a moderate mental illness and 21,302 (20%) had a serious mental illness
- Estimated mental illness among low income adults was higher than among adults above 138% of the federal poverty level (23.8% compared to 19.4%)
- Estimated mental illness among adult females was higher than among adult males (24% compared to 15%)



Adult Clients Served ⁴

Approximately One in Twenty

27,728 unique adult clients were served with support from state Medicaid and/or behavioral health grant funds.



Breakdown of Adults Served

By diagnosis category:

- Substance Use Disorder: 14,442 (52%)
- Serious Mental Illness: 16,841 (61%)
- Mild or Moderate Mental Illness: 2,061 (7%)
- Co-occurring Disorders: 3,690 (13%)

By gender:

Male: 11,480 (41%) | Female: 16,232 (59%)

Behavioral health services in Alaska are funded through a mix of Medicaid, state and federal grants, Indian Health Service Compact and other Tribal funds, private insurance, self-pay and uncompensated care so the utilization data analyzed tells only part of the story. Nonetheless, the report's findings reinforce what we heard from stakeholders: the behavioral health needs of many Alaskans are going unmet resulting in higher costs and poorer health outcomes.

OPPORTUNITIES, BARRIERS AND RECOMMENDATIONS

Ten priority opportunities and barriers facing the Alaska Behavioral Health System are presented here along with recommended strategies. These recommendations were developed with input from stakeholder interviews, survey results and qualitative and quantitative analyses performed during 2014 and the first half of 2015.

1. Statewide gaps in the continuum of care combined with gaps in health care coverage perpetuate a cycle of crisis response and create costly inefficiencies.

RECOMMENDATIONS

- Increase health insurance coverage by expanding Medicaid.
- Continue to explore ways to secure funding to address statewide gaps in the continuum of care and maximize federal Medicaid reimbursement.
- Identify strategies to promote greater financial stability among providers, including the possibility of increasing state match to capture Alaska's full entitlement to federal Disproportionate Share Hospital funds.
- Support regional continuum of care assessments to identify service gaps and strategies at the regional level.
- Ensure the necessary linkages are in place to meet the demands of the child welfare, criminal and juvenile justice, education and aging systems.

2. Medicaid presents a challenging, yet essential, revenue opportunity for Alaska's behavioral health system; optimizing the system's Medicaid billing capacity will be particularly important as grant funding declines in the years to come.

RECOMMENDATIONS

- Establish a Medicaid rate structure for non-tribal providers that adequately compensates for care.
- Step up efforts to provide technical assistance and training to providers to optimize their Medicaid billing capacity and reduce the risk of Medicaid denials and paybacks.
- Develop strategies to tap the Medicaid billing potential that exists within the current community behavioral health Medicaid billing regulations.

3. Behavioral health systems leaders must develop a coordinated vision and efficient pathway for integrated care and payment reform.

RECOMMENDATIONS

- Address regulatory barriers to billing for behavioral health services in primary care settings. Expand efforts to integrate primary and behavioral health care.
- Update the comprehensive integrated mental health plan to establish a vision and approach for meeting more of Alaska's behavioral health needs.
- Support provider efforts to share essential client health data across settings. Assist with navigating federal health information privacy and confidentiality requirements and ensure current efforts by Alaska Division of Behavioral Health to develop capacity to exchange data through the Health Information Exchange remain a priority.

4. Documentation requirements place excessive administrative burden on providers.

RECOMMENDATIONS

- Continue efforts to streamline Alaska Division of Behavioral Health reporting requirements.
- Support development of standard documentation guidelines, templates, and practices and increase availability of trainings and technical assistance to reduce time associated with documentation.

5. In a time where information technology and data analysis are needed more than ever, Alaska Division of Behavioral Health's technology, research and analysis staffing model is insufficient and unsustainable; analytic capacity is key to system transformation.

RECOMMENDATIONS

- Data must be the basis for decision-making at all levels; prioritize investments in technology infrastructure and data analysis.
- Develop an annual assessment cycle. Explore possibilities for external analysis resources that could assist Alaska Division of Behavioral Health with production of the assessment and other analyses throughout the year; the university working in concert with a data collaborative might serve as a good permanent home for this function.
- Advocate for the addition of at least one senior analyst position at Alaska Division of Behavioral Health to move beyond the current staffing model, where an enormous amount of institutional knowledge about the system's data rests with a limited number of individuals.

6. Limited access to the electronic data interface and delays in rolling out the Medicaid billing module have severely capped the utility of the Alaska Automated Information Management System (AKAIMS) and resulted in costly inefficiencies.

RECOMMENDATIONS

- Prioritize efforts to modernize reporting infrastructure and eliminate costly inefficiencies.
- Implement the billing module in AKAIMS and expand data exchange capabilities to providers that do not use AKAIMS as their electronic health record.

7. Continued focus on workforce development is key to closing existing gaps in training and meeting the increased demand for behavioral health services.

RECOMMENDATIONS

- Provide continued support to workforce development efforts to ensure the behavioral health workforce has the training and supervision necessary at all levels to provide evidence-based, culturally competent therapies, bill Medicaid, use data to drive improvements to care and pursue innovations such as team-based care and integration with primary care.
- Work at all levels of the system to fill key gaps in the behavioral health workforce and tap the full potential of behavioral health aides and other paraprofessionals to deliver needed care close to home.

8. Geographic distances can make it difficult to know which resources are available in the statewide continuum of care.

RECOMMENDATIONS

- Explore methods for increasing awareness of available resources, including a web-based directory of resources and/or expansion of 211 web-based services.
- Implement system-wide reports that foster awareness and dialogue about utilization patterns.
- Consider creating a learning community using facilitated monthly teleconference calls on topics such as optimizing Medicaid billing and making clinical improvements.

9. Divides still exist between the community behavioral health system, other healthcare providers and systems that serve individuals with behavioral health needs.

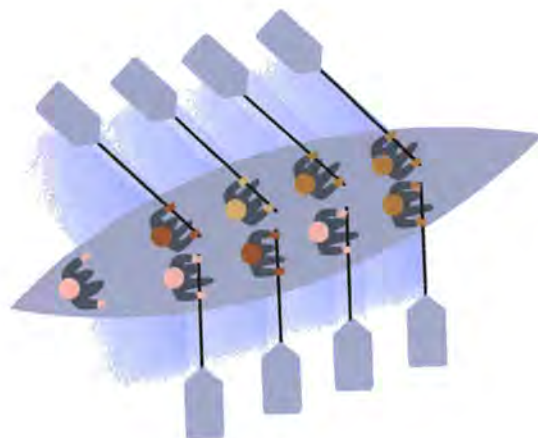
RECOMMENDATIONS

- Work across departments, sectors and organizations to ensure the necessary linkages are in place to more seamlessly meet the demands of the child welfare, criminal and juvenile justice, education and aging systems.

10. The behavioral health system is like a canoe that needs all of the paddles in the water pulling in the same direction to move forward.

RECOMMENDATIONS

- Embrace the call to action issued in this report and work together to synchronize the many paddles on this canoe we call the Alaska Behavioral Health System.
- Update the Comprehensive Integrated Mental Health Plan, develop a clear vision that spans sectors and solidifies access to behavioral health services for populations in need.
- Leverage the plan to clarify roles and responsibilities and leverage the full capacity of the system's leadership and partner resources.



Alaska Behavioral Health Systems Assessment Resources

To access the full report, regional data reports and methodology documents, please visit:

<http://mhtrust.org/impact/behavioral-health-systems-assessment/>

Alaska Behavioral Health Systems Assessment

To access the full report, regional data reports and methodology documents, please visit:
<http://mhtrust.org/impact/behavioral-health-systems-assessment/>

Executive Summary Footnotes

¹ Alaska Youth Risk Behavior Surveillance System 2013. Based on analysis completed for the Alaska Behavioral Health Systems Assessment by the Section of Chronic Disease Prevention and Health Promotion, Alaska Department of Health and Social Services, 2015. A respondent was categorized as having “moderate/high risk behavior” if they met the criteria for one or more of the below: (1) Used cocaine, inhalants, heroin, methamphetamines, or ecstasy drugs three or more times for at least one of the drugs in their life; (2) OR had five or more drinks of alcohol in a row within a couple of hours two or more times in the past 30 days; (3) OR used marijuana and unprescribed drugs three or more times in the past 30 days. A respondent was categorized as having a “past year mental health issue” if the student reported feeling so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months OR had seriously considered attempting suicide during the past 12 months.

² The estimated prevalence of Serious Emotional Disturbance was generated using a methodology recommended by the Center for Mental Health Services that applies a prevalence rate based on the percentage of children living in poverty for the state or region. As with Serious Mental Illness, prevalence rates for Serious Emotional Disturbance take into account the presence of psychiatric diagnosis and significant functional impairment. Caution is advised when comparing these estimates to utilization data, which is based solely on diagnosis and not level of functioning. Poverty estimates are from U.S. Census Small Area Income and Poverty Estimates for 2012. More details on methodology can be found in Costello, E.J., Messer, S.C., Bird, H.R., Cohen, P., Reinherz, H.Z. (1998). The prevalence of serious emotional disturbance: a re-analysis of community studies. *Journal of Child and Family Studies*, 7(4): 411-432.

³ All Adult Prevalence Rates were created for DBH by Special Data Request in April 2014 and are from the Substance Abuse and Mental Health Services Administration’s Center for Behavioral Health Statistics and Quality (CBHSQ), National Survey on Drug Use and Health (NSDUH), 2009-2011 (revised 10/13). Rates are specific to adult (18+) population and based on a survey conducted each year in-person by professional interviewers throughout Alaska using a scientific random sample of households. Prevalence rates were multiplied by Alaska Department of Labor 2013 population estimates. CBHSQ classified respondents as needing treatment for an illicit drug or alcohol problem if they met at least one of three criteria during the past year: (1) dependent on illicit drugs or alcohol; (2) abuse of illicit drugs or alcohol; or (3) received treatment for illicit drug or alcohol use at a specialty facility (i.e., drug and alcohol rehabilitation facility [inpatient or outpatient], hospital [inpatient], or mental health center). Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically, including data from original methamphetamine questions but not including new methamphetamine items added in 2005 and 2006. Mental Illness is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder that met the criteria found in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). Three categories of mental illness severity are defined based on the level of functional impairment: mild mental illness, moderate mental illness, and serious mental illness. Any mental illness includes persons in any of the three categories.

As with Serious Emotional Disturbance, prevalence rates for Serious Mental Illness take into account the presence of psychiatric diagnosis and significant functional impairment. Caution is advised when comparing these estimates to utilization data, which is based solely on diagnosis and not level of functioning.

⁴ State Fiscal Year 2013 utilization figures based on analysis of combined service data from five different datasets: Alaska Automated Information Management System (AKAIMS); data submitted to DBH through their electronic data interface (EDI); the Alaska Psychiatric Institute electronic health record system - Meditech; the DBH Designated Evaluation & Treatment (DET) databases; and the Alaska Medicaid JUCE database. All data was provided by DBH. The Medicaid JUCE dataset included claims data for all individuals who received services from behavioral health specific provider types and for individuals who received services from other providers of behavioral health services with a primary or secondary behavioral health diagnosis. The DET dataset included only clients who received hospital services that were paid for by DBH (transport services excluded). Client counts are unduplicated. Percentages do not equal 100 percent because of co-occurring disorders. Our method used diagnostic code to assign clients to diagnosis categories and, thus, does not include a level of functioning assessment (in contrast to prevalence estimates), which may result in an overcount of individuals served with Serious Mental Illness and Serious Emotional Disturbance. For planning purposes, however, this methodology paints a clear picture of a system that serves predominantly higher levels of mental health need. Youth client counts include clients ages 0 to 17 and adult client counts include clients ages 18 and older.

RECOMMENDED MEDICAID REDESIGN + EXPANSION STRATEGIES FOR ALASKA

FINAL REPORT

Submitted January 22, 2016
to the Alaska Department of Health and Social Services

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



GOALS FOR MEDICAID REDESIGN + EXPANSION

IMPROVE
HEALTH



OPTIMIZE
ACCESS



INCREASE
VALUE



CONTAIN
COSTS



EXECUTIVE SUMMARY

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



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

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

RECOMMENDED PACKAGE OF REFORMS

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

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

The first three initiatives propose engaging third-party entities (two Administrative Services Organizations¹ and an advanced data analytics firm) to enable DHSS to more quickly implement the needed systems changes to improve performance.

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

INITIATIVE 1. PRIMARY CARE IMPROVEMENT INITIATIVE

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

INITIATIVE 2. BEHAVIORAL HEALTH ACCESS INITIATIVE

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

INITIATIVE 3. DATA ANALYTICS AND INFORMATION TECHNOLOGY INFRASTRUCTURE INITIATIVE

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

INITIATIVE 4. EMERGENCY CARE INITIATIVE

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

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

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

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

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

ACTUARIAL RESULTS FOR RECOMMENDED PACKAGE OF REFORMS

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

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

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

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

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

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

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

INITIATIVES CONSIDERED AND NOT RECOMMENDED

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

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

Table S-2. Reform Initiatives Considered and Not Recommended

INITIATIVE ³	STATUS	RATIONALE
Full-Risk Managed Care Initiative	<i>Analyzed but not recommended at this time</i>	<ul style="list-style-type: none"> Alaska, with large rural areas and sparse population, presents significant difficulties for Managed Care Organizations (MCO) to achieve typical economies of scale and adequate provider networks. Anchorage and Fairbanks have sizeable populations, but high provider costs even in these areas would likely mean that MCOs would want robust rates to ensure they could make at least a small margin. Current research is mixed on the extent to which full-risk managed care improves quality and saves money for Medicaid enrollees, particularly in rural areas where limited plan competition and provider participation present challenges. Lack of experience among Alaska providers with alternative reimbursement methodologies, limited data sharing capabilities, and the quality and performance monitoring typically required of providers in managed care plan networks may reduce participation, which would make it difficult for an MCO to meet network adequacy standards and result in high out-of-network costs. Lack of full-risk managed care in the commercial health care market in Alaska makes the learning curve steeper for providers and DHSS. Other similarly situated Medicaid programs have struggled to implement full-risk managed care by MCOs, and DHSS does not currently have the operational infrastructure and capacity to support full-risk managed care, which comes with extensive federal requirements. Actuarial analysis does not project cost savings.
Dementia Care Access Initiative	<i>Explored during Round 2; moved to another project for analysis</i>	<ul style="list-style-type: none"> This initiative is now being considered as part of the parallel reform effort to assess the feasibility of the 1915(i) and (k) Medicaid authority options for Alaska.
Bundled Payment Demonstration	<i>Explored in Round 1 but not prioritized for Round 2 analysis</i>	<ul style="list-style-type: none"> While bundled payments may be a promising approach for Alaska in the future, this payment model requires significant actuarial modeling for a limited number of services. Once DHSS has increased its data analytics capacity, this payment model could be explored.
Pre-paid Ambulatory and Inpatient Health Plans	<i>Explored in Round 1 but not prioritized for Round 2 analysis</i>	<ul style="list-style-type: none"> These payment models have not been tested widely by other states. The consultant team advised DHSS to explore reforms with substantial experience elsewhere.
Health Savings Accounts	<i>Explored in Round 1 but not prioritized for Round 2 analysis</i>	<ul style="list-style-type: none"> Health Savings Accounts are typically established as a tax benefit to allow individuals to contribute pre-tax income to their health spending. This same incentive does not exist for low-income individuals. DHSS's cost of administering Health Savings Accounts would likely outweigh the potential gains in enrollee cost-sharing.

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

ANALYSIS AND RECOMMENDATION OF ALTERNATIVE EXPANSION COVERAGE MODELS

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

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

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

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

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

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

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

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

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

INITIATIVE 2. BEHAVIORAL HEALTH ACCESS INITIATIVE

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

DESCRIPTION

The need for behavioral health services in Alaska is great. Alaska grapples with the highest rates of suicide in the nation.^{69,70} Heroin use has increased sharply in recent years, along with its corresponding impacts and costs.⁷¹ Alaska's correctional system has experienced a steady increase in the prisoner population.⁷² An analysis completed in 2014 estimated that Alaska Mental Health Trust beneficiaries⁷³ account for more than 40 percent of incarcerations each year.⁷⁴ When compared to five other states (Arkansas, Louisiana, New Mexico, Tennessee, and Washington), Alaska adults reported rates of Adverse Childhood Experiences in three categories that were higher by a statistically significant margin than the five-state cohort: incarcerated family member, household substance abuse, and separation and divorce.⁷⁵ The Alaska Behavioral Health Systems Assessment estimated that 145,790 Alaskan adults (more than a quarter of the adult population) needed treatment for illicit drug or alcohol use and/or experienced a mental illness in 2013.⁷⁶

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

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

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

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

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

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

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

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

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

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

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

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

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

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

KEY FEATURES

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

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

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

2. Contract with an Administrative Services Organization to perform key support functions for the behavioral health system. These functions would include developing and managing a network of behavioral health providers; utilization management; outcomes reporting; and, fraud, waste and abuse auditing.
- b) Expand access to behavioral health services, both Substance Use Disorder treatment and mental health services, and integrate with primary care.
1. Establish standards of care to allow DHSS-authorized nationally accredited providers to bill Medicaid for behavioral health services.
 2. Allow licensed and credentialed behavioral health providers to bill Medicaid regardless of setting. Medicaid billing limitations for behavioral health services present a barrier to current integration efforts and constrain the available workforce. Psychologists and Licensed Clinical Social Workers are recognized as rendering providers in Alaska statute⁷⁹ and can bill Medicaid for clinic services delivered in Federally Qualified Health Centers under federal authority. However, they are not authorized by current Alaska Medicaid regulations to provide clinic services, such as psychotherapy, in other settings unless a psychiatrist is located on-site at least 30 percent of the time. Even if the cost of a part-time psychiatrist were surmountable, the estimated vacancy rate for psychiatrists was 22 percent in 2012.⁸⁰ Other qualified behavioral health professionals and paraprofessionals that could provide early intervention and clinic services within their scope of practice either in a primary care setting or independently include Licensed Psychological Associates, Licensed Professional Counselors, Licensed Marriage and Family Therapists, and Tribal health system Behavioral Health Aides,⁸¹ but these professionals and paraprofessionals are not currently recognized as rendering providers within Alaska statute. Given Alaska's workforce challenges, such barriers significantly limit the health care system's capacity to meet the behavioral health needs of Alaskans, including routine behavioral health screening and referral and access to mild and moderate mental health services.
 3. Change the definition of rehabilitative service provider to remove the requirement from Alaska Statute that limits Medicaid behavioral health rehabilitative service providers to those who are grantees of the Division of Behavioral Health.⁸²

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

⁷⁹ Alaska Statute 47.07.030

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

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

⁸² Alaska Statute 47.07.900

4. Seek a federal waiver of Section 1905(a) of the Social Security Act, which prohibits the federal government from reimbursing states under the Medicaid program for services provided in Institutions for Mental Diseases (IMDs), to allow residential Substance Use Disorder treatment providers to bill Medicaid for services. Generally, the IMD exclusion applies to any institution whose primary purpose is diagnosis, treatment or care of individuals with mental health and Substance Use Disorders. The IMD exclusion does not apply to individuals under 21 and over 65 or for institutions with 16 or fewer beds.⁸³ The IMD exclusion remains a barrier to billing for Medicaid for treatment providers who operate a facility with more than 16 beds or may wish to expand beyond 16 beds.
 5. Work with Medicaid behavioral health providers to increase access to Medicaid billable services, which are both evidence-based and lower-cost alternatives to higher-level services, for example, group and family clinic and rehabilitative services; peer support; use of telemedicine in provision of Substance Use Disorder and mental health services; Medication Assisted Treatment; and Intensive Outpatient Substance Use Disorder treatment.⁸⁴
 6. Increase the use of Screening, Brief Intervention, and Referral to Treatment (SBIRT) in primary care settings and introduce a new billable service to promote the delivery of mental health screening and assessment using a DHSS-approved tool.
 7. Connect enrollees recovering from mental illness with evidence-based supported employment services, such as Individual Placement and Support services.
- c) Identify and fill key gaps in the behavioral health system, especially for higher needs individuals who are in crisis, cycling in and out of corrections, and those who are homeless. In hub communities, individuals experiencing psychiatric crises often present at Emergency Departments, which provide crisis stabilization and/or psychiatric boarding and, if necessary, arrange for escort and transport through the Secure Patient Transport Program to the Alaska Psychiatric Institute (API), or the nearest available psychiatric care.⁸⁵ When an individual experiences an acute psychiatric crisis in a village or community without a hospital, the individual is frequently held in a jail until s/he can be safely escorted to the nearest hospital.⁸⁶ Emergency Departments are often ill-equipped to address psychiatric crises due to lack of appropriate space and staffing. The Centers for Medicare and Medicaid Services (CMS) described psychiatric boarding as follows:

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

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

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

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

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

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

1. Expand access to detoxification services, particularly Ambulatory Detoxification services. Detoxification is a set of interventions aimed at managing acute intoxication and withdrawal.⁸⁸ Continue discussions with the Alaska Board of Nursing to identify ways to develop the appropriate workforce to support detoxification services.
2. Develop Medicaid billable Assertive Community Treatment and mobile crisis response services.
3. Expand Crisis Residential / Stabilization services by reimbursing for medium-term residential crisis stabilization services and investing in workforce development for this service.
4. Evaluate the outcomes of the “Psychiatric Emergency Department” at Providence Alaska Medical Center in Anchorage, and consider expanding to other facilities by identifying appropriate billing mechanisms to allow hospitals to develop this service. This pilot provides on-site access to psychiatric and other behavioral health professionals for individuals who present in crisis and who are evaluated at the Emergency Department.
5. Identify measures to address the lack of inpatient mental health services, including strategies to ensure full operational capacity at the Alaska Psychiatric Institute (API), possible use of increased state and federal match under Disproportionate Share Hospital Funding to help sustain one to two additional mental health units,⁸⁹ and applying to participate in the recently announced Medicaid Emergency Psychiatric Demonstration project extension.⁹⁰ If selected, Alaska would be exempted from the IMD exclusion rule for delivery of emergency psychiatric services for the demonstration period, which would allow providers to bill for acute inpatient psychiatric services provided to individuals of all ages.

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

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

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

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