02/11/16 PRESENTATION: MEDICAID REDESIGN AND EXPANSION TECHNICAL ASSISTANCE INITIATIVE

<TARGET><BILL></BILL><SUBJECT>02-11-16 PRESENTATION MEDICAID REDESIGN AND EXPANSION TECHNICAL ASSISTANCE INITIATIVE</SUBJECT><COMM>HHSS29</COMM></TARGET>

MEDICAID REDESIGN AND EXPANSION TECHNICAL ASSISTANCE INITIATIVE

Consultant Team Final Report: Key Findings and Recommendations

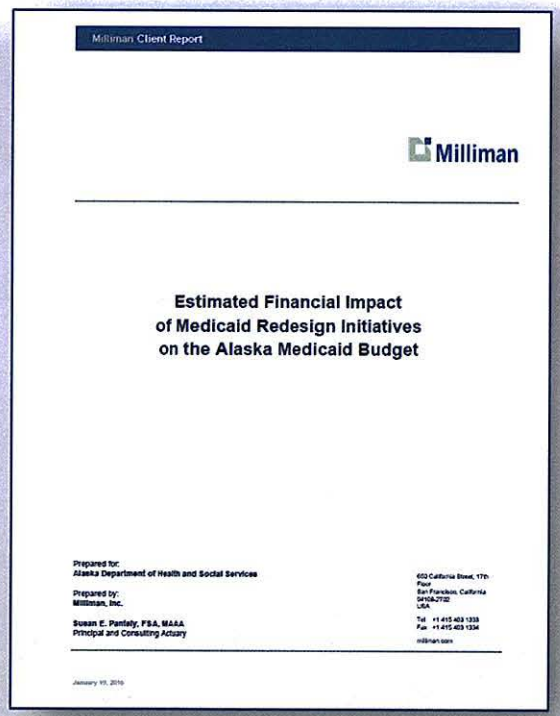
Presented to the House Health and Social Services Committee
Thursday, February 11, 2016 • 3:00 p.m.

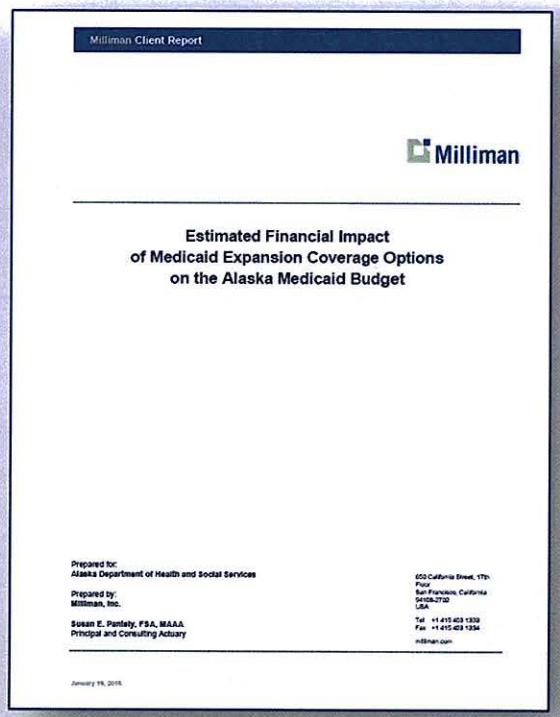
Thea Agnew Bemben, Agnew::Beck Consulting
Nora Leibowitz, Health Management Associates
Susan Pantely, Milliman, Inc.

Project Update

Final Reports Released January 22nd!





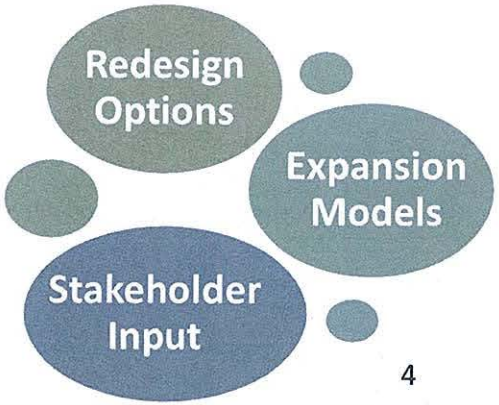


Project Overview

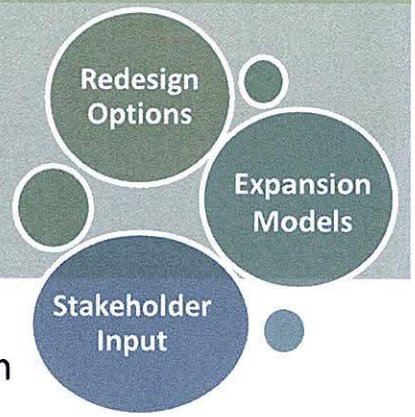
1. Environmental Assessment
2. Analysis of Medicaid Reform Initiative Options
3. Analysis of Alternative Coverage Models for the Expansion Population
4. Final Report with Recommended Package of Reforms and Action Steps
5. Evaluation Plan *[pending refinement of reform package]*

Broad Stakeholder Engagement

- Over 500 Stakeholders Participated
- Three Key Partner Meetings
  - Joint work sessions with DHSS and representatives from key partner organizations
- Six Sector Engagement Meetings
  - *Alaska State Hospital & Nursing Home Association*
  - *Alaska Primary Care Association*
  - *Long Term Services & Support Providers*
  - *Physicians*
  - *Tribal Health Organizations*
  - *DBH Change Agent Conference*
- More than 30 public presentations
- Five Project Webinars



Key Partner Organizations



Alaska Association on Developmental Disabilities
Alaska Behavioral Health Association
Alaska Commission on Aging
Alaska Dental Society
Alaska Geriatric Exchange Network (AGENet)
Alaska Legislature: House of Representatives
Alaska Legislature: State Senate
Alaska Mental Health Trust Authority
Alaska Native Health Board
Alaska Native Tribal Health Consortium
Alaska Nurse Practitioner Association
Alaska Nurses Association
Alaska Osteopathic Medical Association *(invited)*
Alaska PCA Association
Alaska Pharmacists Association
Alaska Primary Care Association
Alaska Psychological Association
Alaska State Hospital & Nursing Home Association
Alaska State Medical Association
American Academy of Family Physicians
American Academy of Pediatrics *(invited)*
American College of Physicians
American College of Emergency Physicians
Community Care Coalition
Governor's Office
Governor's Council on Disabilities and Special Education
Lt. Governor's Office
Mat-Su Health Foundation
Statewide Independent Living Council of Alaska

Final Report Outline

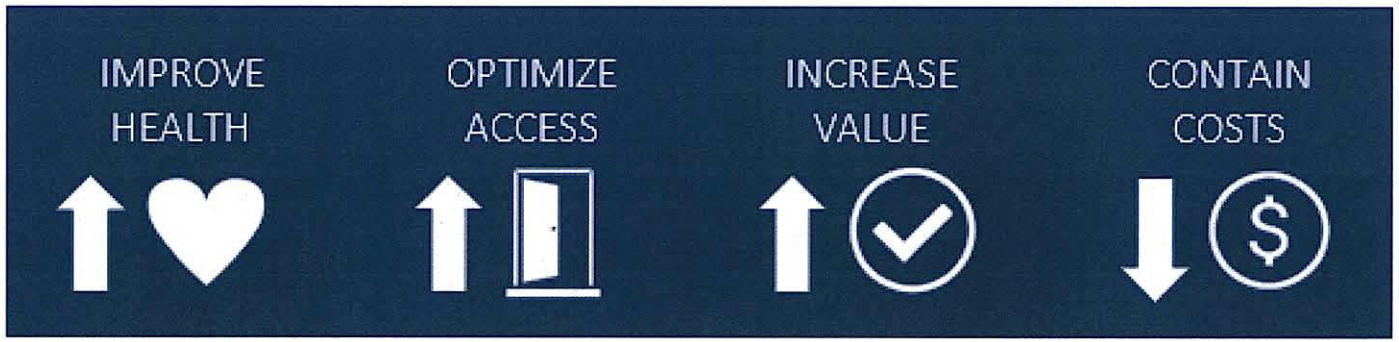
Executive Summary of Recommendations

1. Introduction + Roadmap for Reform
2. Background (Environmental Assessment Summary)
3. Recommended Reform Initiatives
    A. Foundational Reforms
    B. Pay for Value Pilots
    C. Workgroups for Further Exploration
    D. Reforms Explored but Not Recommended
4. Potential Expansion Coverage Models
5. Appendices: Reference Material

Final Report:
Roadmap for Reform

Goals for Medicaid Redesign + Expansion

1. Improve enrollee health **outcomes**
2. Optimize **access** to care
3. Drive **increased value** (quality, efficiency, and effectiveness) in the delivery of services
4. Provide **cost containment** in Alaska's Medicaid budget and general fund spending



Alaska Medicaid Redesign: A Phased Journey to Peak Performance



Phase 1: Reforms Underway	Phase 2: Foundation for Transformation	Phase 3: Towards Paying for Value	Phase 4: High Functioning, High Value System
FY 2014-2016	FY 2017-2018	FY 2019-2020	Beyond FY 2020

Final Report: Recommended Package of Reforms

Final Report: Recommended Package of Reforms

A. Foundational System Reforms	1. Primary Care Improvement Initiative 2. Behavioral Health Access Initiative 3. Data Analytics + IT Infrastructure Initiative
B. Paying for Value, Pilot Projects	4. Emergency Care Pilot Initiative 5. Accountable Care Organizations Pilot: Shared Savings/Losses Model
C. Workgroups to Support Reform Efforts	1. Define Appropriate Use of Telemedicine and Expand Utilization 2. Medicaid Business Process Improvements 3. Ongoing Medicaid Redesign Key Partner Engagement

Final Round of Analysis Included Actuarial Analysis by Milliman, Inc.

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.

Summary of Actuarial Results for Reform Initiatives

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 Room	($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.*

Analysis of Reform Initiatives

- Each initiative includes:
  - Description and key features of the initiative
  - Considerations for special populations, if any
  - Actuarial analysis of projected costs and savings
  - Experience of other states
  - Potential challenges for implementation
  - Proposed timeline and phases

Recommended Package of Reforms

- Initiative 1: Primary Care Improvement
  - Every enrollee assigned to a primary care or behavioral health provider who coordinates care.
  - Health Risk Assessments identify enrollees with higher health needs and risks.
  - Health Homes and other enhanced care management programs are provided to those with higher needs.
  - Contract with Administrative Services Organization to perform key support functions.

Actuarial Results: Primary Care Improvement Initiative

MEDICAID REDESIGN INITIATIVES: PRIMARY CARE IMPROVEMENT INITIATIVE (VALUES IN $MILLIONS)*					
SERVICE CATEGORY	**FY17**	**FY18**	**FY19**	**FY20**	**FY21**
Facility Inpatient	($0.4)	($1.6)	($9.8)	($10.8)	($11.8)
Facility Outpatient	($0.9)	($3.4)	($10.0)	($12.4)	($15.2)
Professional	($0.2)	($0.9)	($4.6)	($5.0)	($5.4)
Pharmacy Drugs	($0.2)	($1.1)	($4.4)	($5.7)	($7.2)
PCCM Fee	$1.1	$3.1	$4.6	$4.7	$4.7
Capitation	$0.0	$0.0	$0.0	$0.0	$0.0
Other	($0.0)	($0.1)	($0.5)	($0.6)	($0.7)
TOTAL CHANGE IN MEDICAL COST	**($0.7)**	**($4.0)**	**($24.6)**	**($29.8)**	**($35.5)**
ASO Fees	$7.0	$17.5	$26.2	$27.7	$29.2
TOTAL EXPENDITURE CHANGE	**$6.3**	**$13.5**	**$1.5**	**($2.2)**	**($6.3)**
After Shared Savings	$6.3	$13.5	$1.5	($2.2)	($6.3)
FMAP Share	$3.9	$8.4	$1.0	($1.4)	($3.8)
NET ALASKA COST (SAVINGS)	**$2.4**	**$5.0**	**$0.5**	**($0.8)**	**($2.4)**

** 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.*

Recommended Package of Reforms

- Initiative 2: Behavioral Health Access
  - Apply for a Section 1115 waiver to help finance reforms: 5-year demonstration period + potential 3-year extension.
  - Establish new standards of care to support expanded delivery of substance use and mental health services.
  - Remove the grantee requirement to bill Medicaid.
  - Allow a broader range of licensed and credentialed behavioral health providers to bill Medicaid.
  - In second year, amend Section 1115 waiver to include a federal waiver of the IMD exclusion for residential substance use treatment.
  - Address gaps in the crisis response system.
  - Contract with an Administrative Services Organization to perform key support functions.

Actuarial Results: Behavioral Health Access Initiative

MEDICAID REDESIGN INITIATIVES: BEHAVIORAL HEALTH ACCESS INITIATIVE VALUES IN $MILLIONS*					
SERVICE CATEGORY	**FY17**	**FY18**	**FY19**	**FY20**	**FY21**
Facility Inpatient	$0.0	($0.2)	($0.5)	($0.9)	($1.5)
Facility Outpatient	$0.0	$0.0	$0.1	$0.1	$0.2
Professional	$0.0	$1.2	$5.0	$9.4	$14.3
Pharmacy Drugs	$0.0	$0.0	$0.1	$0.1	$0.2
PCCM Fee	$0.0	$0.0	$0.0	$0.0	$0.0
Capitation	$0.0	$0.0	$0.0	$0.0	$0.0
Other	$0.0	$0.0	$0.0	$0.0	$0.0
TOTAL CHANGE IN MEDICAL COST	**$0.0**	**$1.1**	**$4.6**	**$8.7**	**$13.2**
ASO Fees	$0.0	$3.5	$5.3	$5.5	$5.8
TOTAL EXPENDITURE CHANGE	**$0.0**	**$4.6**	**$9.9**	**$14.2**	**$19.1**
After Shared Savings	$0.0	$4.6	$9.9	$14.2	$19.1
FMAP Share	$0.0	$2.9	$6.3	$8.9	$11.8
NET ALASKA COST (SAVINGS)	**$0.0**	**$1.7**	**$3.6**	**$5.3**	**$7.2**

** 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.*

Recommended Package of Reforms

- Initiative 3: Data Analytics + IT Infrastructure
  - Securely collect and share health information among providers and analyze health data to improve outcomes and decrease costs.
  - Use Alaska's Health Information Exchange to connect hospitals, Emergency Departments and providers, and integrate the Prescription Drug Monitoring Program database.
  - Contract with an advanced data analytics firm to support value-based care.

Recommended Package of Reforms

- Initiative 4: Emergency Care
  - A private-public partnership.
  - Emergency Departments would use best practices and Alaska's Health Information Exchange to
    - Share necessary Medicaid enrollee patient data to improve patient care;
    - Reduce preventable Emergency Department use;
    - Facilitate follow up with primary care and behavioral health providers; and,
    - Improve prescription monitoring to reduce opioid misuse.
  - Shared savings to incentivize value-based care.

Actuarial Results: Emergency Care Initiative

MEDICAID REDESIGN INITIATIVES: EMERGENCY CARE INITIATIVE VALUES IN $MILLIONS*					
SERVICE CATEGORY	**FY17**	**FY18**	**FY19**	**FY20**	**FY21**
Facility Inpatient	$0.0	$0.0	$0.0	$0.0	$0.0
Facility Outpatient	($4.6)	($9.7)	($12.4)	($14.6)	($17.1)
Professional	($0.5)	($0.8)	($0.8)	($0.9)	($1.1)
Pharmacy Drugs	$0.0	$0.0	$0.0	$0.0	$0.0
PCCM Fee	$0.0	$0.0	$0.0	$0.0	$0.0
Capitation	$0.0	$0.0	$0.0	$0.0	$0.0
Other	$0.0	$0.0	$0.0	$0.0	$0.0
TOTAL MEDICAL COST	**($5.0)**	**($10.5)**	**($13.1)**	**($15.5)**	**($18.2)**
ASO Fees	$0.0	$0.0	$0.0	$0.0	$0.0
TOTAL EXPENDITURE CHANGE	**($5.0)**	**($10.5)**	**($13.1)**	**($15.5)**	**($18.2)**
After Shared Savings	($3.5)	($7.3)	($9.2)	($10.9)	($12.7)
FMAP Share	($2.2)	($4.7)	($5.8)	($6.8)	($7.9)
NET ALASKA COST (SAVINGS)	**($1.3)**	**($2.7)**	**($3.4)**	**($4.1)**	**($4.8)**

** 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.*

Recommended Package of Reforms

- Initiative 5: Accountable Care Organizations Pilot
  - Pilot value-based payments in regions by contracting with groups of providers who form Accountable Care Organizations.
  - Use a shared savings approach, with shared losses in later years, to promote service delivery changes that incentivize high quality care and cost containment.

Actuarial Results: Accountable Care Organizations Pilot Initiative

MEDICAID REDESIGN INITIATIVES: ACCOUNTABLE CARE ORGANIZATIONS VALUES IN $MILLIONS*					
SERVICE CATEGORY	**FY17**	**FY18**	**FY19**	**FY20**	**FY21**
Facility Inpatient	$0.0	$0.0	($0.9)	($1.8)	($3.6)
Facility Outpatient	$0.0	$0.0	($1.8)	($3.2)	($6.8)
Professional	$0.0	$0.0	($0.9)	($2.2)	($4.5)
Pharmacy Drugs	$0.0	$0.0	($0.7)	($1.6)	($3.4)
PCCM Fee	$0.0	$0.0	$0.0	$0.0	$0.0
Capitation	$0.0	$0.0	$0.0	$0.0	$0.0
Other	$0.0	$0.0	($0.1)	($0.2)	($0.3)
TOTAL MEDICAL COST	**$0.0**	**$0.0**	**($4.5)**	**($8.9)**	**($18.6)**
ASO Fees	$0.0	$0.0	$0.0	$0.0	$0.0
TOTAL EXPENDITURE CHANGE	**$0.0**	**$0.0**	**($4.5)**	**($8.9)**	**($18.6)**
After Shared Savings	$0.0	$0.0	($2.7)	($5.3)	($11.2)
FMAP Share	$0.0	$0.0	($1.7)	($3.3)	($6.9)
NET ALASKA COST (SAVINGS)	**$0.0**	**$0.0**	**($1.0)**	**($2.0)**	**($4.2)**

** 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.*

Recommended Package of Reforms

- Form workgroups to guide:
  - Expansion of Telemedicine,
  - Medicaid Business Process Improvements, and
  - Ongoing Medicaid Redesign

Actuarial Results: Potential Savings from a Telemedicine Initiative

MEDICAID REDESIGN INITIATIVES: TELEMEDICINE VALUES IN $MILLIONS*					
SERVICE CATEGORY	**FY17**	**FY18**	**FY19**	**FY20**	**FY21**
Facility Inpatient	$0.0	($0.5)	($1.0)	($1.5)	($2.0)
Facility Outpatient	$0.0	($2.2)	($4.5)	($7.2)	($10.1)
Professional	$0.0	($8.7)	($18.1)	($28.2)	($37.5)
Pharmacy Drugs	$0.0	$4.2	$7.8	$12.0	$15.0
PCCM Fee	$0.0	$0.0	$0.0	$0.0	$0.0
Capitation	$0.0	$0.0	$0.0	$0.0	$0.0
Other	$0.0	($0.0)	($0.1)	($0.1)	($0.1)
TOTAL MEDICAL COST	**$0.0**	**($7.1)**	**($15.9)**	**($25.0)**	**($34.8)**
ASO Fees	$0.0	$0.0	$0.0	$0.0	$0.0
TOTAL EXPENDITURE CHANGE	**$0.0**	**($7.1)**	**($15.9)**	**($25.0)**	**($34.8)**
After Shared Savings	$0.0	($7.1)	($15.9)	($25.0)	($34.8)
FMAP Share	$0.0	($4.5)	($10.1)	($15.7)	($21.6)
NET ALASKA COST (SAVINGS)	**$0.0**	**($2.6)**	**($5.8)**	**($9.4)**	**($13.2)**

** 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.*

Reform Initiatives Considered but Not Recommended

Full Risk Managed Care *Administered by a Managed Care Organization (MCO)*	***Analyzed But Not Recommended***
Dementia Care Access Initiative	***Moved to Separate Project***
Bundled Payment Demonstration	***Not Prioritized for Analysis***
Pre-Paid Ambulatory and Inpatient Health Plans	***Not Prioritized for Analysis***
Health Savings Accounts (HSAs)	***Not Prioritized for Analysis***

Alternative Coverage Models for Expansion Population

Option 1: Current Medicaid Benefit Package	***Recommended***
Option 2: Alternative Benefit Package based on Qualified Health Plan *Administered by Medicaid*	***Not Recommended***
Option 3: Private Coverage Option based on Qualified Health Plan *Administered by private insurer*	***Not Recommended***

Actuarial Results for 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.*

Actuarial Results: Expansion Option 1 Current Alternative Benefit Package

EXPANSION OPTION 1: CURRENT ALTERNATIVE BENEFIT PACKAGE*					
	FY17	**FY18**	**FY19**	**FY20**	**FY21**
Newly Eligible Adults	41,980	42,050	42,120	42,190	42,260
Take-Up Rate	55.4%	63.0%	63.0%	63.0%	63.0%
New Enrollees	23,273	26,492	26,535	26,580	26,623
COST PER ENROLLEE	**$7,913**	**$8,275**	**$8,658**	**$9,062**	**$9,489**
Medical	$7,854	$8,213	$8,593	$8,994	$9,418
Admin	$59	$62	$65	$68	$71
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**

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

Actuarial Results: Expansion Option 2 Qualified Health Plan Package

EXPANSION OPTION 2: ALTERNATIVE BENEFIT PLAN (ABP) BASED ON QUALIFIED HEALTH PLAN (QHP)**					
	FY17	**FY18**	**FY19**	**FY20**	**FY21**
Newly Eligible Adults	41,980	42,050	42,120	42,190	42,260
Take-Up Rate	55.4%	63.0%	63.0%	63.0%	63.0%
New Enrollees	23,273	26,492	26,535	26,580	26,623
COST PER ENROLLEE	**$7,418**	**$7,770**	**$8,141**	**$8,534**	**$8,950**
Medical	$7,326	$7,672	$8,039	$8,427	$8,838
Admin	$93	$97	$102	$107	$112
TOTAL COST	**$172,648,000**	**$205,831,000**	**$216,021,000**	**$226,831,000**	**$238,266,000**
Federal Cost	$167,699,000	$194,394,000	$202,076,000	$208,115,000	$215,396,000
STATE COST	**$4,949,000**	**$11,437,000**	**$13,945,000**	**$18,716,000**	**$22,870,000**
COMPARISON TO EXPANSION OPTION 1					
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)**

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

Actuarial Results: Expansion Option 3 Private Coverage Option

EXPANSION OPTION 3: PRIVATE OPTION BASED ON A QUALIFIED HEALTH PLAN (QHP)***					
	FY17	**FY18**	**FY19**	**FY20**	**FY21**
Newly Eligible Adults	41,980	42,050	42,120	42,190	42,260
Take-Up Rate	55.4%	63.0%	63.0%	63.0%	63.0%
New Enrollees	23,273	26,492	26,535	26,580	26,623
COST PER ENROLLEE	**$10,387**	**$11,010**	**$11,673**	**$12,380**	**$13,134**
Medical	$10,288	$10,904	$11,561	$12,262	$13,009
Admin	$99	$105	$112	$118	$126
TOTAL COST	**$241,747,000**	**$291,668,000**	**$309,741,000**	**$329,062,000**	**$349,671,000**
Federal Cost	$179,294,000	$207,471,000	$215,331,000	$221,394,000	$228,761,000
STATE COST	**$62,453,000**	**$84,197,000**	**$94,410,000**	**$107,668,000**	**$120,910,000**
COMPARISON TO EXPANSION OPTION 1					
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.*

Caveats about Actuarial Results

Limitations

This analysis is intended for use by DHSS in support of Medicaid program evaluation. Any user of the data must possess a certain level of expertise in actuarial science and health care modeling so as not to misinterpret data presented.

Milliman makes no representations or warranties regarding the contents of this presentation to third parties. Similarly, third parties are instructed that they are to place no reliance upon this analysis prepared for DHSS by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other parties receiving this report must rely upon their own experts in drawing conclusions about the individual insurance market rates, assumptions and trends. It is the responsibility of any insurance carrier to establish required revenue levels appropriate for their risk, management and contractual obligations for the prospective population.

Caveats about Actuarial Results

Limitations (cont.d)

This analysis has relied extensively on data provided by the State of Alaska, including population surveys, and claims data of the Medicaid population. Errors in data reporting may flow through analysis, and as such would impact the results.

Actual results will vary from our projections for many reasons, including differences from assumptions regarding future enrollment within the Alaska Medicaid Program, the relative morbidity of the uninsured population, cost and utilization trends, as well as other random and non-random factors. Experience should continue to be monitored on a regular basis, with modifications to the program as necessary.

Actuarial Statement of Qualification

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Susan Pantely is a member of the American Academy of Actuaries, and meet the qualification standards for performing this analysis. This presentation includes high level findings. A complete written report has been provided to the DHSS for Medicaid program evaluation.

Next Steps

- Consultant team presentations to the Legislature, including:
  - Feb 5 + 10: Senate Finance, Medicaid Reform Subcommittee
  - Feb 11: House Health + Social Services Committee
- Consultant team to develop evaluation measures for selected reform package.

Thank You!

The consultant team's final report, presentations and materials are available at

http://dhss.alaska.gov/healthyalaska
on the **Medicaid Redesign Initiative** page

Contact:

Thea Agnew Bemben, thea@agnewbeck.com

THE STATE of ALASKA
GOVERNOR BILL WALKER

Department of Health and Social Services

Office of the Commissioner

3601 C Street, Suite 902
Anchorage, Alaska 99503-5924
Main: 907.269.7800
Fax: 907.269.0060

January 22, 2016

Dear Alaskans,

I am pleased to release the *Recommended Medicaid Redesign + Expansion Strategies for Alaska* report. The report, recordings of previous webinars, and meeting materials can be found at dhss.alaska.gov/HealthyAlaska/Pages/Medicaid_Redesign.aspx

Many Alaskans participated in key partner meetings, webinars and presentations and submitted written comments. Thank you for contributing your time and expertise, which have been invaluable to this process.

The contracting team consisted of a local Alaska firm, Agnew::Beck, Health Management Associates who provided the national policy analysis and Milliman, Inc. who conducted the actuarial analysis. Thank you to the contracting team who engaged stakeholders and completed a quality report.

A webinar on the findings of the report will be held on January 26, 2016 at 12:00 p.m. For more information on the webinar, please visit dhss.alaska.gov/HealthyAlaska.

The Department believes reform is continual process. This report provides us additional opportunities to improve coordination, efficiency, and effectiveness for health care delivery.

We look forward to continuing to work with Alaskans to redesign our Medicaid system to ensure that our most vulnerable Alaskans have access to health care while addressing our current fiscal challenges.

Quyana (thank you),

Valerie Davidson
Commissioner
Department of Health & Social Services

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

[this page intentionally left blank]

TABLE OF CONTENTS

ACKNOWLEDGMENTS

EXECUTIVE SUMMARY

1. INTRODUCTION **1**

A. PROJECT PURPOSE 1

B. ROADMAP FOR REFORM 2

Factors Shaping Alaska's Health Care System Today 3

Vision for Alaska Medicaid Redesign and Expansion 3

Proposed Sequencing of Reforms 4

D. PROJECT METHODOLOGY AND TEAM 6

E. REPORT ORGANIZATION 8

2. BACKGROUND: ENVIRONMENTAL ASSESSMENT **9**

A. KEY FACTORS SHAPING STATE MEDICAID PROGRAMS 9

B. FEDERAL FINANCING AUTHORITIES AVAILABLE FOR REFORM AND EXPANSION 11

C. STATE APPROACHES TO COORDINATED CARE AND VALUE-BASED PURCHASING 16

Models of Care Overview 17

D. CURRENT MEDICAID REFORM INITIATIVES IN ALASKA 20

3. RECOMMENDED PACKAGE OF INITIATIVES **22**

A. FOUNDATIONAL SYSTEM REFORMS 22

Initiative 1. Primary Care Improvement Initiative 22

Initiative 2. Behavioral Health Access Initiative 39

Initiative 3. Data Analytics and Information Technology Infrastructure Initiative 59

B. PAYING FOR VALUE: PILOT INITIATIVES 69

Initiative 4. Emergency Care Initiative 69

Initiative 5. Accountable Care Organizations Pilot: Shared Savings/ Shared Losses Model 76

C. WORKGROUPS TO SUPPORT REFORM EFFORTS 93

Workgroup 1. Define and expand Appropriate Use of Telemedicine 94

Workgroup 2. Medicaid Business Process Improvements 98

Workgroup 3. Ongoing Medicaid Redesign Key Partner Engagement 100

D. INITIATIVE CONSIDERED BUT NOT RECOMMENDED 101

Full-Risk Managed Care Initiative 102

4. POTENTIAL EXPANSION COVERAGE MODELS **114**

EXPANSION MODEL 1. CURRENT ALTERNATIVE BENEFIT PLAN 116

EXPANSION MODEL 2. ALTERNATIVE BENEFIT PLAN BASED ON QUALIFIED HEALTH PLAN 120

EXPANSION MODEL 3. PRIVATE COVERAGE OPTION BASED ON QUALIFIED HEALTH PLAN 127

5. LIST OF APPENDICES **137**

APPENDIX A. TABLE OF ACRONYMS AND ABBREVIATIONS A-1

APPENDIX B. STAKEHOLDER ENGAGEMENT B-1

APPENDIX C. RULES FOR MEDICAID POPULATIONS BY PROGRAM TYPE C-1

APPENDIX D. BEHAVIORAL HEALTH CONTINUUM OF CARE D-1

Appendix E. Current Alaska Medicaid Benefits E-1
Appendix F. Qualified Health Plan, Benefits and Limits F-1
Appendix G. Healthy Alaska Plan: Medicaid Redesign and Expansion Environmental Assessment (separate document available at dhss.alaska.gov/healthyalaska)
Appendix H. Estimated Financial Impact of Medicaid Expansion Coverage Options on the Alaska Medicaid Budget (separate document available at dhss.alaska.gov/healthyalaska)
Appendix I. Estimated Financial Impact of Medicaid Redesign Initiatives on the Alaska Medicaid Budget (separate document available at dhss.alaska.gov/healthyalaska)

LIST OF TABLES

Table S-1. Summary of Actuarial Analysis for Recommended Package of Reforms: Net Costs and Savings iv
Table S-2. Reform Initiatives Considered and Not Recommended v
Table S-3. Recommendations and Rationale for Coverage of the Expansion Population vi
Table S-4. Actuarial Analysis and Comparison of Alternative Expansion Coverage Models vii

Table 1. Key Elements of Affordable Care Act Section 1115 Expansion Waivers 12
Table 2. Current Alaska Reform Initiatives 21
Table 3. Proposed Level of Care Designations and Services Provided 25
Table 4. Actuarial Results for the Primary Care Improvement Initiative 30
Table 5. Federal Authorities, Flexibilities and Limitations 31
Table 6. Actuarial Results for the Behavioral Health Access Initiative 47
Table 7. Benefits and Costs of Selected Evidence Based Treatments with Significant Net Benefits 52
Table 8. Actuarial Results for the Emergency Care Initiative 71
Table 9. Actuarial Results for the Accountable Care Organizations Initiative 81
Table 10. Actuarial Results for Telemedicine 95
Table 11. Status of Telemedicine in Alaska's Medicaid Program 96
Table 12. Status and Rationale for Full-Risk Managed Care Initiative 101
Table 13. Actuarial Results for the Full-Risk Managed Care Initiative 105
Table 14. Examples of States' Full-Risk Managed Care Programs 110
Table 15. Recommendations and Rationale for Coverage of the Expansion Population 115
Table 16. Actuarial Results for Expansion Option 1: Current Alternative Benefit Package 117
Table 17. Actuarial Results for Expansion Option 2: Alternative Benefit Plan based on a Qualified Health Plan 122
Table 18. Actuarial Results for Expansion Option 3: Private Option based on a Qualified Health Plan 130

Table A. Table of Acronyms and Abbreviations, Updated December 2015 ..... A-1
Table B. Stakeholders Engaged During Medicaid Redesign and Expansion Technical Assistance Project, 2015 ..... B-2
Table C. Rules for Medicaid Populations by Program Type C-1
Table D. Behavioral Health Continuum of Care, as Defined by the Substance Abuse and Mental Health Services Administration (SAMHSA) D-1
Table E. Table of Medicaid Benefits and Coverage in Alaska, U.S. States and Territories E-1
Table F. Premera Alaska Heritage Select Envoy Plan, Benefits and Limits (2017) F-1

LIST OF FIGURES

Figure 1. A Journey to Peak Performance: Proposed Sequencing of Medicaid Redesign Recommended Initiatives 5
Figure 2. Iterative Process for Exploring and Selecting Medicaid Redesign Recommendations 6
Figure 3. Models of Care, Characterized by Level of Financial Risk and Reporting 16
Figure 4. Phased Approach for Primary Care Improvement Initiative 38
Figure 5. Phased Approach for Behavioral Health Access Initiative 58
Figure 6. Phased Approach for Data Analytics and Information Technology Infrastructure Initiative 68
Figure 7. Phased Approach for Emergency Care Pilot 75
Figure 8. Phased Approach for Accountable Care Organizations Pilot 92

ACKNOWLEDGMENTS

This report could not have been completed without the support and engagement of a wide range of individuals and organizations. Over the past six months, key partners from nearly 30 associations and organizations and hundreds of individual stakeholders provided valuable input into Medicaid Redesign and Expansion in Alaska (see Appendix B). The consultant team would like to express gratitude to the many stakeholders who came together to inform the recommendations presented in this report.

The team would also like to thank the Alaska Department of Health and Social Services leadership team and the Alaska Mental Health Trust Authority who contributed many hours to guiding this important effort.

This report recommends a path toward a coordinated system of care that prioritizes prevention and primary care intended to help prepare Alaska's health care leaders for the journey ahead.

EXECUTIVE SUMMARY

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



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

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

RECOMMENDED PACKAGE OF REFORMS

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

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

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

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

INITIATIVE 1. PRIMARY CARE IMPROVEMENT INITIATIVE

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

INITIATIVE 2. BEHAVIORAL HEALTH ACCESS INITIATIVE

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

INITIATIVE 3. DATA ANALYTICS AND INFORMATION TECHNOLOGY INFRASTRUCTURE INITIATIVE

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

INITIATIVE 4. EMERGENCY CARE INITIATIVE

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

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

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

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

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

ACTUARIAL RESULTS FOR RECOMMENDED PACKAGE OF REFORMS

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

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

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

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

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

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

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

INITIATIVES CONSIDERED AND NOT RECOMMENDED

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

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

Table S-2. Reform Initiatives Considered and Not Recommended

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

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

ANALYSIS AND RECOMMENDATION OF ALTERNATIVE EXPANSION COVERAGE MODELS

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

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

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

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

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

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

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

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

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

1. INTRODUCTION

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. Across the nation, states in similar situations are looking for and finding opportunities for cost savings in their Medicaid programs. States typically consider two pathways for driving down costs. The first path is to cut provider rates and enrollee benefits, but this approach often leads to increased costs and unintended impacts in other areas. The second path is to pursue systems transformation and move from paying for volume to paying for value. Paying for value means incentivizing efficient, high quality care and transforming the delivery system to engage individuals earlier in the continuum of care through prevention and primary care, rather than at the later end with higher cost and intensity acute care. The overarching goal of system transformation is to provide more value from health care spending by improving health outcomes while ultimately reducing public investment over time.

During this project, stakeholders from across health care sectors came together to reflect on the forces influencing the current system and to begin to articulate a vision for Medicaid Redesign in Alaska. Stakeholders offered their ideas for and commitment to reform, reviewed the experiences of other states, and refined and prioritized the proposed reforms developed by the consultant team. Many supported strategies to deliver whole person, coordinated care that prioritizes wellness, prevention and self-care; strengthen the role of primary care and improve access to behavioral health services; and, provide a comprehensive continuum of care that gives enrollees timely access to appropriate care and care settings.

As states across the country have found, no single reform is sufficient to transform a health system. States are improving their Medicaid programs through collaboration with providers and other payers, and through interrelated reforms that implement change in increasingly comprehensive ways. The following report represents the culmination of a collaborative effort to systematically review and select a package of reforms to meet the goals to transform the Medicaid program. This is an important first step in an ongoing dialogue in which all parties must continue to engage.

A. PROJECT PURPOSE

In June of 2015, the Alaska Department of Health and Social Services (DHSS), in partnership with the Alaska Mental Health Trust Authority, contracted with Agnew::Beck Consulting, an Alaska-based firm, and Health Management Associates and Milliman, Inc., two national firms specializing in health policy and actuarial analysis, to provide technical assistance for the Medicaid Redesign and Expansion Project. The goals of the Medicaid Redesign and Expansion Project are to improve enrollee health outcomes; optimize access to care; drive increased value (quality, efficiency, and effectiveness) in the delivery of services; and, provide cost containment in Alaska's Medicaid budget and general fund spending.



As part of the Medicaid Redesign and Expansion Technical Assistance Project, the consultant team was asked to develop and analyze five to ten Medicaid Reform Initiative Options, and two to three Alternative Medicaid Expansion Coverage Models to compare the programmatic and cost implications for DHSS. Additionally, the consultant team was asked to recommend a package of reforms and a Medicaid Expansion Coverage Model based on the four project goals, stakeholder input, other states' experiences, Alaska's current Medicaid system, and the results from actuarial analysis. Stakeholder engagement helped to marry national and local expertise to Alaska issues and concerns to develop a package of reforms that is appropriate for Alaska.

In August 2015, Governor Bill Walker announced that Alaska would move forward with Medicaid Expansion, accepting federal funds to offer health care coverage to an additional 42,000 Alaskans newly eligible under this program. Newly-eligible individuals include adults between ages 19 to 64, with incomes below 138 percent of the federal poverty level who are not eligible for another type of Medicaid or Medicare. Expansion of the Medicaid program to cover more individuals is projected to bring approximately $145 million in federal funds to the State in its first year.[1] In *The Healthy Alaska Plan: A Catalyst for Reform*, released February 2015, describes Expansion as "a catalyst for meaningful Medicaid reform."[2] Medicaid Expansion began on September 1, 2015 and is projected to enroll 20,066 individuals in its first year. As of December 14, 2015, slightly more than one-third of that total, 7,010 individuals, had been determined eligible under the Expansion.[3]

B. ROADMAP FOR REFORM

Between July and December 2015, hundreds of stakeholders came together in an iterative process to discuss Medicaid Redesign and develop a roadmap for reform. Key partners from nearly 30 associations and organizations were invited to three key partner work sessions, during which options and analysis were presented to key partners and DHSS leadership and valuable input was collected to propel the next round of analysis and engagement. Each work session was followed by a live webinar for the public, during which participants heard firsthand from the project team about the options under consideration. Draft project materials were posted to a dedicated page on the Healthy Alaska website,[4] and individuals were invited to submit questions and additional ideas for reform via email. The reform options were continuously refined and strengthened as stakeholder engagement informed the direction of the consultant team's analysis. Agnew::Beck and the DHSS team also worked with key partners to coordinate six sector engagement sessions with Community Health Centers, physicians, Tribal health providers, Long-term Services and Supports providers and advocates, hospital and nursing home administrators, and behavioral health providers. In addition, between September and December 2015, DHSS and Agnew::Beck staff collectively delivered more than 30 public presentations on the Medicaid Redesign and Expansion Technical Assistance Project. For a full list of stakeholders, see Appendix B.

[1] Medicaid Expansion Population Estimates: Project Population, Enrollment, Service Costs and Demographics of Medicaid Expansion Beginning in FY2016, Evergreen Economics, February 2015. http://dhss.alaska.gov/HealthyAlaska/Documents/Evergreen_Medicaid_Expansion_Analysis-020615.pdf

[2] The Healthy Alaska Plan and other information about changes to the Medicaid program is available on the Healthy Alaska website, Alaska Department of Health and Social Services http://dhss.alaska.gov/healthyalaska/

[3] The Healthy Alaska Plan Presentation by DHSS at AK Health Reform Conference on December 16, 2015.

[4] Alaska Department of Health and Social Services, *Healthy Alaska Plan* (http://dhss.alaska.gov/HealthyAlaska).

FACTORS SHAPING ALASKA'S HEALTH CARE SYSTEM TODAY

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.

VISION FOR ALASKA MEDICAID REDESIGN AND EXPANSION

The underlying premise for the vision developed during this project is that Medicaid's transformation can spark innovation across the health care system to contain costs and improve the value of health care services in Alaska. This section includes a preliminary recommended vision statement and guiding principles for further discussion and development by DHSS and stakeholders.

PRELIMINARY VISION STATEMENT

The Alaska Medicaid system provides whole person, quality care in a manner that is cost effective, culturally and regionally appropriate, and easy to navigate.

PRELIMINARY GUIDING PRINCIPLES

- Collaborate to transform the Medicaid system to deliver and pay for high value care.
- Use Medicaid Expansion as a catalyst for reform. Leverage federal dollars to create new opportunities for coordination, early intervention, and prevention and increase access to needed services.
- Promote self-care and healthy behaviors and emphasize prevention to maintain and improve health.
- Deliver care through an integrated, well-designed system with minimal red tape and easy access to the right services from appropriate providers.
- Work with enrollees to help them improve their health and social conditions, to participate to their full potential in family, community, and work life.
- Connect providers and payers through secure information infrastructure to share and analyze appropriate health data. The use of data analytics drives high-value care.
- Use telehealth to bring services to patients and allow flexibility for regions to meet health access needs in different ways.

PROPOSED SEQUENCING OF REFORMS

This report proposes a package of five interconnected reform initiatives aimed at improving the health and well-being of Alaskans while reducing overall costs to DHSS and the State. The recommended package of reforms is outlined in the executive summary and each initiative is described in detail in Part 3 of this report. Initiatives 1 through 3 propose foundational reforms that together 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 pilot initiatives that would allow DHSS to test value-based payment mechanisms.

FOUNDATIONAL REFORM INITIATIVES:

Initiative 1. Primary Care Improvement Initiative
Initiative 2. Behavioral Health Access Initiative
Initiative 3. Data Analytics and Information Technology Infrastructure Initiative

VALUE-BASED PAYMENT PILOT INITIATIVES:

Initiative 4. Emergency Care Initiative
Initiative 5. Accountable Care Organizations Initiative: Shared Savings/Shared Losses Model

Additionally, the consultant team recommends establishing structures, including workgroups, to support ongoing partner engagement and develop recommendations for expanded use of telemedicine and Medicaid business process improvements.

Figure 1 provides a snapshot of the proposed sequencing of the initiatives recommended through this project by State Fiscal Year (SFY). The column to the left highlights the many reform efforts currently underway and those to the right summarize the reforms recommended in this report. Two broad, time-based goals informed the proposed sequencing. By SFY 2021, the Medicaid program will:

- Develop the foundational components of a high functioning system capable of paying for value on a greater scale.
- Pilot at least two value-based payment mechanisms and use that experience to develop statewide strategies for paying for value.

Redesign is a continuous process, a journey to peak performance that requires climbing many intermediate peaks. DHSS is already undertaking reforms to achieve the goals of Medicaid Redesign and Expansion. Together, with the reforms proposed in this report, DHSS is well on its way to improve the performance and management of the Medicaid program. DHSS will need to determine how many reforms it can reasonably pursue and how to sequence reforms to capture near-term cost savings while making the necessary investments to improve health, optimize access, increase value and contain costs over the long term.

Figure 1. A Journey to Peak Performance: Proposed Sequencing of Medicaid Redesign Recommended Initiatives

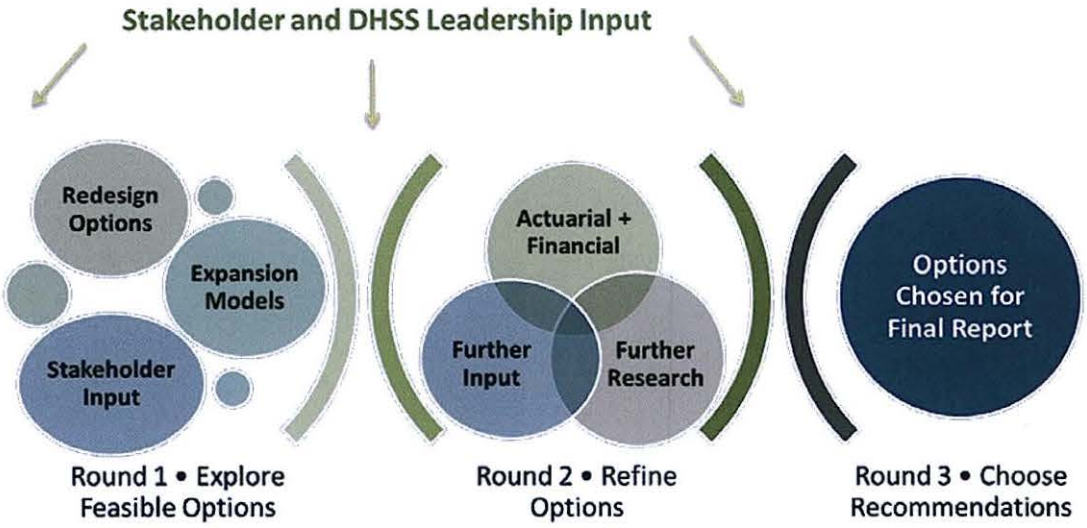


Phase 1: Reforms Underway SFY 2014 - 2016	Phase 2: Foundation for Transformation SFY 2017-2018	Phase 3: Towards Paying for Value SFY 2019 - 2020	Phase 4: High Value, High Functioning System Beyond SFY 2020
• Alaska Medicaid Coordinated Care Initiative • Certified Community Behavioral Health Clinic Planning • Utilization Controls and Policies for Dental, Durable Medical Equipment, Vision, Audiology, Personal Care Services, and Behavioral Health Benefits • Fraud and Abuse Control Improvement • Transportation Policy Implementation • Tribal Health NICU, Orthopedic, OB/GYN, Dental, and Long-Term Care Coordination • Tribal Health Federal Financing for Transportation and Referral • Pharmacy Reform Initiatives • Provider Tax Study • Planning for 1915(i) and 1915(k) Options for Home and Community-based Services	**Primary Care Improvement Initiative (*Foundational*)**		
	• Implement Primary Care Case Management • Secure Administrative Services Organization; begin Health Risk Assessments	• Manage Administrative Services Organization • Begin enrollee education • Establish §2703 Health Homes + Targeted Case Management for high-risk groups	• Continue to build network of primary care providers • Evaluate results and options for additional delivery system changes
	Behavioral Health Access Initiative (*Foundational*)		
	• Develop plan and assess readiness of DHSS/providers • Secure Administrative Services Organization to build management capacity • Develop standards of care and build provider network	• Manage Administrative Services Organization • Support network development and efforts to build a comprehensive continuum of care	• Evaluate results and continue system transformation efforts
	Data Analytics + Information Technology (IT) Infrastructure Initiative (*Foundational*)		
	• Support access to and use of real-time data to inform care • Connect more providers and provider data • Integrate prescription drug monitoring data • Secure data analytics vendor	• Support access to and of real-time data to inform care • Connect more providers and provider data • Build advanced data analytics and population reporting capacity	• Evaluate results and areas for continued capacity building
	Emergency Care Initiative (*Paying for Value*)		
	• Hospitals launch + lead initiative • Develop shared savings payment capacity	• Pilot shared savings payment mechanism	• Evaluate results and assess opportunities for expanding pilot
	Accountable Care Organizations (ACO) Initiative (*Paying for Value*)		
	• Engage stakeholders to develop conceptual design • Develop ACO capacity and approval	• Solicit interest and identify participants • Launch pilot in several regions with shared savings	• Move to shared savings/shared losses model • Evaluate pilot, next steps
	Form Cross-sector Workgroups to Support Redesign Efforts		
	• Define Appropriate Use of Telemedicine and Expand Utilization		
	• Medicaid Business Process Improvements		
	• Ongoing Medicaid Redesign Key Partner Engagement		

D. PROJECT METHODOLOGY AND TEAM

This project used a highly iterative approach (Figure 2), beginning with an environmental assessment that identified key factors shaping Medicaid programs across the nation and in Alaska. Three rounds of analysis followed, which explored a range of reform options and Alternative Medicaid Expansion Coverage Models. A robust stakeholder engagement process helped inform each round of analysis. This project benefited significantly from strong communication between DHSS leadership, the consultant team, key partners, and stakeholders from a range of health care sectors. See Appendix B for a detailed description of the stakeholder engagement process.

Figure 2. Iterative Process for Exploring and Selecting Medicaid Redesign Recommendations



The project included four streams of work that resulted in the recommendations included in this report: project management, stakeholder engagement, national policy analysis, and actuarial analysis.

PROJECT MANAGEMENT AND STAKEHOLDER ENGAGEMENT

Led by Agnew::Beck Consulting and the Department of Health and Social Services

Agnew::Beck Consulting is an award-winning, multidisciplinary consulting firm with offices in Anchorage, Alaska and Boise, Idaho. Agnew::Beck specializes in policy development, analysis, planning, public engagement, and project implementation. Agnew::Beck is a committed, practical partner that works alongside clients to identify and tackle a project's most important issues with smart, effective solutions, and with community stakeholders at the center of the process. Founded in Anchorage in 2002, Agnew::Beck has worked with a wide range of Alaska clients to build healthy systems and communities locally, regionally and statewide.

For this project, Agnew::Beck worked closely with DHSS to design the project approach and stakeholder engagement process. This partnership was critical to accomplishing the project's objectives within the allotted time. Agnew::Beck served as the contract lead and project manager, coordinating project work.

NATIONAL POLICY ANALYSIS

Led by Health Management Associates (HMA)

Health Management Associates (HMA) is a consulting firm specializing in the fields of health system restructuring, health care program development, health economics and finance, program evaluation, and data analysis. HMA is widely regarded as a leader in providing technical and analytical services to health care purchasers, payers, and providers, with a special concentration on those who address the needs of the medically indigent and underserved. Founded in 1985, HMA has 18 offices across the nation.

The HMA team led the completion of the Environmental Assessment and shared the findings with key partners in August 2015. This was the starting point for ongoing policy analysis that informed the development of reform initiative options and Alternative Medicaid Expansion Coverage Models. During each round of analysis, HMA shared policy expertise and national experience. HMA's ongoing technical support was essential to creating a package of reforms that was both robust and unique to Alaska.

ACTUARIAL ANALYSIS

Led by Milliman, Inc.

Milliman is among the world's largest independent actuarial and consulting firms. 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. Founded in Seattle in 1947, Milliman currently has 54 offices located in cities across the world. Milliman has been active in healthcare consulting since the late 1950's and is a leading healthcare consulting firm to employers, governments, health plans, providers, managed care organizations, and insurance companies.

A Milliman actuary attended all key partner work sessions, provided feedback on potential actuarial impact, and reviewed draft analyses throughout each round of the project. This level of involvement early in the project enabled Milliman team members to provide actuarial analysis on a range of initiatives. The baseline data provided for this analysis were paid Medicaid claims from calendar year 2014, adjusted for anomalies resulting from the conversion to the new Medicaid Management Information System. Key assumptions were developed to incorporate the Medicaid Expansion population and project overall Medicaid cost trends if no reforms were undertaken for SFY 2017 through 2021. Then, for each initiative, Milliman used proprietary national benchmark data to estimate the impacts of each initiative on utilization rates across a range of service areas. Net health care costs and savings estimates were based on projected expenditures related to changes in service utilization patterns and estimates for additional administrative costs (above baseline). The results of the actuarial analysis helped inform the final recommendations.

E. REPORT ORGANIZATION

This report includes a recommended package of reforms, providing information, analysis and potential next steps for each initiative and Expansion model for DHSS to consider. The report is organized as follows:

SECTION	CONTENTS
Executive Summary	Overview of recommendations and key findings.
1. Introduction	Provides context for the recommendations, including the overall vision for Medicaid redesign and other reform efforts currently underway, a proposed sequencing of the recommended reform package, and describes the project methodology.
2. Background: Environmental Assessment	Summary of findings from the Environmental Assessment report produced in August 2015.
3. Recommended Package of Initiatives	Description of the reform initiatives explored in the final round of analysis and the corresponding findings and recommendations.
4. Potential Expansion Coverage Models	Description of the three Alternative Medicaid Coverage Models explored in the final round of analysis and the corresponding findings and recommendations.
5. Appendices	Additional information, including a list of the many people who assisted and guided the team during this project.

2. BACKGROUND: ENVIRONMENTAL ASSESSMENT

This section includes an abbreviated version of the Environmental Assessment originally published in August 2015 by the consultant team and is organized as follows:

A. Key Factors Shaping State Medicaid Programs

B. Financing Authorities Available for Reform and Expansion

C. State Approaches to Coordinated Care and Value-Based Purchasing

D. Current Medicaid Reform Initiatives in Alaska

For more detailed information, see the Environmental Assessment referenced in Appendix G.

A. KEY FACTORS SHAPING STATE MEDICAID PROGRAMS

A range of factors shape Medicaid programs across the country, including the delivery system structure and functioning, population demographics, and each state's regulatory environment. In Alaska, a small population and a fee-for-service system pose additional challenges. Key factors shaping Medicaid across the United States and in Alaska include:

- *Reliance on a fee-for-service reimbursement system*. Along with Wyoming, Alaska is one of only two states that relies solely on a fee-for-service delivery system for its Medicaid population, although many states use a fee-for-service system for some Medicaid enrollees.
- *Fragmented care delivery*. Across the nation, there are separate provider systems for veterans and the military, commercial, Medicaid and Medicare consumers, and Tribal members. Within and across these systems, behavioral healthcare is often further siloed. In Alaska, no single repository of patient information exists to tie people across systems and providers, or departments, exacerbating fragmentation. Fragmented delivery systems such as Alaska's result in higher overall costs and inefficient use of resources.
- *An aging population*. Like the U.S. population in general, Alaska's population is aging. Between 2010 and 2035, the Alaska senior population (over 65 years old) is expected to triple from 55,237 to 155,382.[9] In an analysis of Medicaid enrollment and spending in Alaska, the Lewin Group and ECONorthwest identified Alaska's aging population as the most important factor in their projections due to the high growth expected among the 65 and older population, and much higher average per-enrollee costs of Medicaid services for the elderly compared to children.[10]
- *Rising rates of chronic disease and co-morbidities*. Similar to the rest of the United States, Alaska's population is experiencing rising rates of chronic disease due to an aging population, economic conditions, and other factors such as rising obesity rates.[11]

[9] Alaska Population Projections 2010 to 2035. State of Alaska Department of Labor and Workforce Development, 2012.

[10] Long-term Forecast of Medicaid Enrollment and Spending in Alaska: 2005-2025. February 15, 2006. Prepared for Alaska Department of Health and Social Services by the The Lewin Group and ECONorthwest.

[11] Chronic Disease in Alaska. 2014 Brief Report. Alaska Department of Health and Social Services Division of Public Health. http://dhss.alaska.gov/dph/Chronic/Documents/Publications/assets/2014_CDBriefReport.pdf

- *Social and physical determinants of health*. Health starts with people's families, where people live, learn, work, and play. Clean air and water, nurturing relationships, quality schools, and safe communities positively affect health. Factors such as poverty, lack of education, and limited access to healthy foods negatively affect health. Health literacy and access to health care, especially primary care, play an important role in addressing the social and physical determinants of health. [12]
- *Lack of integrated data*. Comprehensive, quality data on Medicaid enrollees' demographics, utilization, and conditions helps state programs and the providers with whom they work to identify service needs and gaps, determine where outcomes are meeting expectations and which conditions need more attention. Alaska's Department of Health and Social Services (DHSS) has made strides toward developing an integrated data system that allows enrollees' needs to be understood and better met by the programs that touch them, but work remains for hospitals, providers, and DHSS to tap its potential.
- *Health care market consolidation and evolving provider and insurer competition trends*. Three insurers recently exited Alaska's individual insurance market due to poor financial performance, indicating evolving and acute market pressures faced by payers.[13]
- *High unit prices of Alaska medical services lead to high total costs of care*. Alaska hospitals have higher operating costs than comparison states, particularly those outside of the state's metropolitan areas. Average hospital costs are approximately 138 percent of the average in the comparison states. Physician reimbursement in Alaska is approximately 160 percent of the average in the comparison states. Professional salaries are higher than comparison states across a range of provider types. [14]
- *Complex health care legal and regulatory environment*. In addition to complex federal Medicaid rules, state regulations also affect costs. Alaska law for example, requires providers in the commercial sector to be reimbursed at 80 percent of usual and customary charges for out-of-network services.[15]
- *Supply of the healthcare workforce*. Alaska experiences healthcare workforce shortages, particularly in rural and remote areas, that affect access patterns and drive up costs.[16] In some areas, workforce shortages are exacerbated by delays in licensure due to workload and staffing issues at the professional licensure boards.
- *Small population and large geographic area*. Alaska has higher than average per-capita health care costs.[17] Geographic isolation and sparsely populated areas are a defining feature of Alaska's health care landscape and certainly contribute to high costs. One quarter of the state's population lives in communities of fewer than 2,500 people.[18] In rural areas of the state, small patient populations, limited access to providers, and the need to travel for care, contribute to health care costs.

[12] http://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health

[13] For more details see: http://juneauempire.com/state/2015-06-23/3-insurers-plan-leave-market

[14] "Drivers of Health Care Costs in Alaska and Comparison States." Milliman Inc. November 2011.

[15] Alaska Administrative Code, 3 AAC 26.110(a)(2)(B) http://www.legis.state.ak.us/basis/aac.asp

[16] "Alaska's Health Workforce Vacancy Study: 2012 Findings Report." Katherine Branch, Alaska Center for Rural Health, Alaska's Area Health Education Center, University of Alaska Anchorage. August 2014.

[17] "Health Care Expenditures Per Capita by State of Residence (2009)" State Health Facts. The Henry J. Kaiser Family Foundation. 2011.

[18] "Alaska Maternal and Child Health Data Book 2014: Life Course Edition" Alaska Department of Health and Social Services Division of Public Health Section of Women's, Children's, and Family Health. September 2014.

B. FEDERAL FINANCING AUTHORITIES AVAILABLE FOR REFORM AND EXPANSION

Medicaid is a partnership between the federal government and the states. In every state, the program operates within a set of requirements established and maintained by the Centers for Medicare and Medicaid Services (CMS). CMS sets minimum eligibility guidelines, but allows states to expand beyond those minimums. States are required to cover certain "mandatory benefits," and have significant flexibility and federal match opportunity to configure a package of "optional benefits." Optional benefits often offer lower cost care alternatives. A good example is physical therapy, which can serve as an alternative to surgery. Some "optional benefits," such as prescription drugs, are part of the Essential Health Benefits defined in the Affordable Care Act and, thus, are mandatory for the Expansion population, although not the general Medicaid population.[19] States may also establish cost sharing for Medicaid participants within CMS rules, which determine who can be required to participate and limit the level of cost sharing.

Often a state will propose program changes that are outside of the general guidelines provided by CMS or otherwise represent a significant change in coverage, eligibility or other program factor. The Social Security Act authorizes multiple authorities under which states may request flexibility in operating their Medicaid programs. Each authority has a distinct purpose and requirements. This section addresses the federal authorities available to support Medicaid Redesign and Expansion efforts. See the Environmental Assessment for additional detail on financing authorities.

Some program changes can be made by amending the Medicaid State Plan. These State Plan Amendments are reviewed by CMS, but are less time and energy intensive than a state's alternative method, the waiver. Waivers, which states may use to test ways of delivering and paying for health care, allow states to be exempt from ("waive") provisions of federal Medicaid regulation. Waiver applications must meet cost neutrality requirements by demonstrating that the proposed program changes will not increase federal spending. CMS must approve waivers and often spends considerable time with the requesting state in negotiation about waiver provisions and requirements.

SECTION 1115 DEMONSTRATION WAIVERS

Section 1115 of the Social Security Act (SSA) allows states to test innovative policy solutions aimed at delivering more cost efficient and higher quality care to Medicaid populations. Section 1115 waivers have been used for a range of purposes, such as expanding Medicaid eligibility, redesigning benefit packages, and testing delivery system models that improve care, increase efficiency and reduce costs.[20] The Section 1115 waiver:

- Offers states significant flexibility, including the ability to gain exemptions from Medicaid requirements for statewide-ness, comparability of benefits, and freedom of provider choice;
- Allows states to simplify enrollment and renewal processes;
- Use Medicaid dollars to subsidize enrollment in Qualified Health Plans for certain populations;
- Utilize managed care for high-need populations;
- Address dual eligible populations in delivery and payment reform efforts; and,
- Provide family planning services.

[19] Medicaid Handbook: Interface with Behavioral Health Services. Module 3. Substance Abuse and Mental Health Services Administration. 2013. http://store.samhsa.gov/shin/content//SMA13-4773/SMA13-4773_Mod3.pdf

[20] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Section-1115-Demonstrations.html

CMS recently approved demonstration projects for individuals with Substance Use Disorders and introduced a Medicaid Innovator Accelerator Program to support this work.[21] States are granted Section 1115 waiver authority for up to five years, with the possibility of three-year renewal periods. These demonstrations must further the aims of the Medicaid program and demonstrate federal budget neutrality.[22] More than twenty states have used Section 1115 waivers to test innovative models of care delivery and financing.

While many states have expanded their Medicaid programs through State Plan Amendments, a Section 1115 demonstration waiver can provide states with significant flexibility to design alternative coverage models. Five states (Arkansas, Iowa, Indiana, Michigan and Pennsylvania) are using Section 1115 demonstration waivers to expand their Medicaid programs and Montana recently received approval to begin implementing its Section 1115 waiver. Table 1 highlights key features of alternative Medicaid Expansion plans from states that have been approved for or are pursuing Section 1115 demonstration waivers to expand Medicaid. See the Environmental Assessment for more detailed information about the plans for a subset of states.

Table 1. Key Elements of Affordable Care Act Section 1115 Expansion Waivers

STATE[23]	ENROLLEE CONTRIBUTES TO PREMIUM [a]	WELLNESS INCENTIVES [b]	PRIVATE COVERAGE OPTION [c]	BENEFITS DIFFER FROM SPA [d]	ENROLLEE PAYS COPAYMENT [e]
Arkansas	•		•		
Iowa	•	•	•	•	
Indiana	•	•	•	•	•
Michigan	•	•			
Montana	•			*(Same benefits other than excludes Long-term Care)*	•
Pennsylvania	•	•		•	

[a] PREMIUM CONTRIBUTION: Amount of the monthly premium the enrollee is expected to pay for their coverage.

[b] WELLNESS INCENTIVES: Activities intended to improve health that the state may offer Medicaid enrollees. Completion of an activity (e.g. taking a smoking cessation class) and/or success of the outcome (e.g. the person no longer smoking) can be tied to monetary or other awards.

[c] PRIVATE COVERAGE OPTION: Three states have received approval to use state and federal Medicaid funds to pay for enrollees to access commercial health plans. Medicaid dollars cover most or all cost of monthly plan premium.

[d] BENEFITS DIFFER FROM SPA: The state can offer a different set of benefits to the Expansion enrollees than is provided to most Medicaid beneficiaries. A set of coverage requirements guides which services may be changed.

[e] ENROLLEE COPAYMENT: Enrollee portion of the cost of a service. Federal rules limit the amount that can be charged and the state's ability to withhold services for non-payment.

[21] State Medicaid Director Letter. CMS. July 27, 2015.

[22] Federal Budget Neutrality: Proposed reforms must not cost the federal government more than it would have paid to cover the same population under the pre-reform system.

[23] "Issue Brief: The ACA and Medicaid Expansion Waivers." MaryBeth Musumeci and Robin Rudowitz. The Kaiser Commission on Medicaid and the Uninsured. Updated November 2015.

CMS is allowing a limited number of states to use Medicaid funds to pay premiums on behalf of enrollees and purchase insurance coverage in the private insurance market, referred to as the "private option." Arkansas, Iowa and New Hampshire have implemented private option models using Section 1115 authority.

Not all proposals have been approved. CMS has denied state proposals to charge premiums for individuals with incomes below 100 percent of the federal poverty level; require drug testing or work requirements as a condition of Medicaid participation; waive requirements to provide screening services to children; and limit freedom of choice of provider options for family planning services.[24] CMS has also grown increasingly wary of cost sharing requirements.

DELIVERY SYSTEM REFORM INCENTIVE POOL (DSRIP)

The Delivery System Reform Incentive Pool (DSRIP) initiative is a Section 1115 waiver option that provides funding for states to develop provider-focused delivery system reforms. While DSRIP was initially used to support safety net hospitals as they underwent system transformation, more recent projects are designed to implement far-reaching payment and delivery system reforms. These programs generally focus on four main program areas: infrastructure development; system redesign; clinical outcome improvements; and population-focused improvements.[25] DSRIP programs generally involve a hospital at the center, with other providers working with and through that hospital. Implementation requires significant participation and buy-in by a range of providers. Like other Section 1115 demonstrations, the costs and savings associated with a DSRIP program must be factored into a state's overall budget neutrality as required in Section 1115. As of August 2015, six states have been approved to run DSRIP programs (California, Kansas, Massachusetts, New Jersey, New York, Texas). DSRIP application review is rigorous; additional states have applied and been denied and renewal applications have also been denied.

SECTION 1915 AUTHORITY: WAIVER & STATE PLAN OPTION[26]

Section 1915(a) is used to establish a voluntary managed care program in a state. No waiver or state plan amendment is required to implement this authority, but CMS must approve the managed care contract. 1915(a) authority does not permit mandatory enrollment in managed care, but passive enrollment with opt out is allowed.

A 1915(b) managed care waiver allows states to implement managed care delivery systems that restrict the number and type of providers enrollees can see; allow county and local governments to act as a choice counselor or enrollment broker; and, permit states to use savings to provide additional services.[27] The 1915(c) waiver provides exemptions for comparability, statewide-ness, and income and resource limits for medically needy enrollees. Many states, including Alaska, have used 1915(c) waivers to provide

[24] Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services are federally-required benefits for children enrolled in Medicaid.

[25] "Issue Brief: An Overview of Delivery System Reform Incentive Payment (DSRIP) Waivers," Alexandra Gates, Robin Rudowitz and Jocelyn Guyer. The Kaiser Commission on Medicaid and the Uninsured. October 2014.

[26] For program changes that can be implemented by "State Plan Option" the State must amend its Medicaid State Plan (the document describing program rules, eligibility and other key elements) and submit changes to CMS. Changes to a State Plan are referred to as State Plan Amendments (SPAs).

[27] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html

long-term care services in home and community-based settings instead of institutional ones.[28] Under 1915(c) enrollees can self-direct Medicaid services. Both 1915(b) and 1915(c) waivers require federal budget neutrality. States can combine 1915(b) or 1915(a) and (c) waivers to deliver the respective services through a managed care delivery system.

The 1915(i) Home and Community-based Services and 1915(k) Community First Choice authorities are State Plan options for Home and Community-based Services, and personal attendant services.[29] These options, which must be implemented statewide, allow states to provide these services to specific populations under a State Plan. The 1915(i) option also enables states to establish separate needs-based criteria and allows services to be self-directed. The 1915(k) Community First Choice State Plan option authorizes states to provide home and community-based attendant services and supports to eligible Medicaid enrollees. Under the 1915(k) option, states receive a six percent increase in the federal Medicaid match rate for community-based attendant and other services to help people acquire and maintain the skills necessary to live independently. 1915(k) allows services to be provided through an agency or self-directed model. An additional related state option is the 1915(j) Self Directed Personal Assistance Services, which allows states to target 1915(c) waiver enrollees, limit those who can self-direct personal attendant services, and offer the self-direction option statewide or in a limited geographic area.

SECTION 1932(A) STATE PLAN AMENDMENT

The 1932(a) State Plan Amendment allows states to implement mandatory managed care for most populations without having to demonstrate budget neutrality, or adhere to comparability, "statewideness," or any-willing provider requirements. American Indian and Alaska Native enrollees, disabled children, and Medicare-Medicaid dual eligible individuals cannot be enrolled in managed care on a mandatory basis. (See Appendix C for the criteria for dual eligibility for Medicaid and Medicare.) 1932(a) options must adhere to a variety of consumer protection initiatives aimed at assuring enrollee choice.

SECTION 2703 HEALTH HOME STATE PLAN OPTION

Section 2703 of the Affordable Care Act created an optional Medicaid State Plan benefit for states to establish Health Homes to coordinate care for Medicaid enrollees who have chronic conditions. To be eligible for a Section 2703 Health Home, a person must have two or more chronic conditions; one chronic condition and risk of a second; or, a serious and persistent mental health condition. Section 2703 Health Home authority defines required services and allows states to target geographic areas without a waiver. Additionally, CMS will provide states with a 90 percent match for specific Health Home expenditures for the first eight quarters of operations.[30]

[28] Alaska has 1915(c) Waivers for four populations: Alaskans living independently; adults with physical and developmental disabilities; children with complex medical conditions; and people with intellectual and developmental disabilities.

[29] "Medicaid and Long-Term Services and Supports: A Primer", Erica L. Reaves and MaryBeth Musumeci, Kaiser Family Foundation. The Kaiser Commission on Medicaid and the Uninsured. May 2015.

[30] "Focus on Health Reform: Medicaid's New 'Health Home' Option." The Henry J. Kaiser Family Foundation. January 2011.

SECTION 1916 WAIVER

The 1916(f) waiver allows states to impose cost sharing above otherwise allowable amounts in order to test a unique and previously untested use of co-payments for up to two years.[31] American Indian and Alaska Native enrollees who have received a service directly from Indian Health Service, a tribally-operated facility, an urban Indian health program, or through a referral from Indian Health Service under its Purchased/Referred Care Program, previously known as Contract Health Services, are exempt from all cost sharing requirements.

SECTION 1332 ("WYDEN") WAIVER

Section 1332 of the Affordable Care Act allows states to waive certain provisions of the law to develop State Innovation Waiver programs. These waivers, which can start in 2017, offer unprecedented flexibility for states to meet the goals of the Affordable Care Act while making significant programmatic changes. States may request waivers of most major Affordable Care Act coverage requirements, including exchanges, benefit packages and individual and employer mandates. A participating state would receive the aggregate amount of subsidies, including cost-sharing reductions, premium tax credits, and small business tax credits that would have otherwise gone to the state's residents and would be responsible for ensuring that coverage for residents remains affordable and reaches a comparable number of people.[32] Federal budget neutrality would be required.

Before submitting a 1332 request, the state must provide the opportunity for public input (including but not limited to holding public hearings and consulting with Tribes). A successful application must include data and assumptions that show coverage under a waiver would be at least as comprehensive as would be provided absent the waiver, and will maintain coverage and cost sharing protections that ensure care would be at least as affordable and accessible to as many residents as it would be without a waiver, without increasing the federal deficit. Applicant states must also provide actuarial analyses and certifications to support State estimates that the waiver will comply with the comprehensive coverage requirement, the affordability requirement, and the scope of coverage requirement.

The waiver requires a ten-year budget that shows federal budget neutrality, analysis of how the proposal will support health insurance coverage, the state legislation enacted to support the proposal, and a detailed plan and timeline for how the waiver will be implemented.

ALTERNATIVE BENEFIT PLAN

While not a financing mechanism, the Alternative Benefit Plan is a tool for providing benefits under a state's plan. The Alternative Benefit Plan is a package of benefits that can differ from those offered under traditional Medicaid, or it can be similar to or the same as the traditional Medicaid benefit package. The Affordable Care Act requires that Expansion population enrollees be covered with an Alternative Benefit Plan (it may also be used for other populations, including children ages six and over). For the Expansion population, Alternative Benefit Plan coverage must either be equal to a specified benchmark plan or a federally-approved coverage option, and provide both mandatory state plan

[31] "Issue Brief: The ACA and Medicaid Expansion Waivers", Robin Rudowitz and MaryBeth Musumeci. The Kaiser Commission on Medicaid and the Uninsured. November 20, 2015.

[32] Heather Howard and Galen Benshoof, "Section 1332 Waivers and the Future of State Health Reform" *Health Affairs* blog, December 5, 2014.

services and the Essential Health Benefits. The Alternative Benefit Plan must be actuarially equivalent to a specified benchmark.[33] See the Environmental Assessment (Appendix G) for more information about Alternative Benefit Plan requirements, options, and state-specific programs, and Chapter 4. Potential Expansion Coverage Models.

C. STATE APPROACHES TO COORDINATED CARE AND VALUE-BASED PURCHASING

CMS has strongly signaled that it is shifting toward paying for value, and is taking steps to create systems that reward value and care coordination at the state level. States across the country are looking for ways to improve quality and value, taking steps to transform their programs in ways that change how services are provided and paid for. States are developing ways to manage care for Medicaid enrollees that improve quality while driving value and realigning provider and patient incentives.

As states pursue health system redesign that includes payment reforms, risk may be transferred from the state to managed care entities and providers (Figure 3).[34] Risk-based contracting offers states an opportunity to utilize value-based purchasing, align incentives with program goals and potentially capture savings.[35] Typically, savings increase as risk increases. The evidence on incremental care coordination and pay-for-performance programs has shown only modest reductions in utilization of inpatient and specialty care and costs.[36]

Figure 3. Models of Care, Characterized by Level of Financial Risk and Reporting



Most states pair care management efforts with payment reforms, exploring ways to move providers along the continuum from volume-based fee-for-service payments to value-based payment models. Value-based payment models require payers or providers to assume some or all of the financial risk to better align financial incentives to constrain cost growth. Value-based payment models include per member per month care coordination fees, bundled payments, shared savings and shared losses mechanisms, incentive payments, and partial and full-risk managed care. Simultaneously, states are implementing innovative practice strategies in efforts to provide more cost efficient care to remote and underserved areas, including enhanced patient communication platforms (such as physician messaging), telemedicine, and remote tele-diagnostics.

[33] State Medicaid Director Letter #12-003, CMS. November 20, 2012.

[34] For each of these models, states may "carve out" certain Medicaid populations or benefits, and serve and provide them separately.

[35] "Farewell to Fee-for-Service? A 'Real World' Strategy for Health Care Payment Reform." Working Paper 8. UnitedHealth Center for Health Reform & Modernization. December 2012.

[36] "Systematic review: Effects, design choices, and context of pay-for-performance in health care." Peter Van Herck, Delphine De Smedt, Lieven Annemans, Roy Remmen, Meredith B. Rosenthal, Walter Sermeus. Health Services Research. 2010; 10: 247.

MODELS OF CARE OVERVIEW

PRIMARY CARE CASE MANAGEMENT

In the Primary Care Case Management model, Primary Care Providers are responsible for coordinating and monitoring the care of enrollees based on criteria established by the state. Enrollees choose or are assigned a Primary Care Provider who ensures appropriate access to services and products. States typically pay participating Primary Care Providers for services rendered plus a monthly care management fee, often between $2 and $5 per member per month. Primary Care Case Management can be implemented without a waiver or extensive changes to the Medicaid State Plan. Primary Care Case Management is the easiest coordinated care model to implement because the model does not require as significant provider or state infrastructure or staff investments as other care management models. Colorado and some other states use Primary Care Case Management in rural areas where full-risk managed care is not practical;[37] some states integrate pay-for-performance incentives, for example, Pennsylvania's ACCESS Plus program.

PATIENT CENTERED MEDICAL HOME

This model focuses on "whole person" care, using a team-based approach to integrated care that includes additional care coordination supports and services. Patient Centered Medical Home (PCMH) recognition criteria typically require after-hours access; maintaining Electronic Health Records; tracking quality metrics; conducting comprehensive health assessments for all new patients; and proactively managing and reducing barriers for high-risk patients.[38]

The model can be supported in both urban and rural settings. Most states pay providers a per member per month care management fee, sometimes based on the level of Patient Centered Medical Home certification (level 1-3). Fees vary considerably from state to state and include a variety of adjustments for factors such as patient age, acuity and eligibility category. Robust data systems are necessary to ensure both capture and reporting of data supporting Patient Centered Medical Home quality metrics and payment structures. Research indicates that Patient Centered Medical Homes are most effective for high-utilizer and high-cost enrollees with complex needs.[39]

Alaska has undertaken two Patient Centered Medical Home initiatives, the Children's Health Insurance Program Reauthorization Act demonstration project and Alaska Patient Centered Medical Home Initiative. Notably, however, neither initiative piloted the per member per month payment mechanism typically associated with this model.

SECTION 2703 HEALTH HOMES

Section 2703 Health Homes are a variant of the Patient Centered Medical Home model with the advantage of a 90 percent federal match rate for care coordination services delivered through this model during the first eight quarters of program implementation. Section 2703 Health Homes must meet standards beyond the Patient Centered Medical Home recognition standards, including integrating

[37] "Wyoming Managed Care: Data Analysis Report." Health Management Associates. June 30, 2014.

[38] "Standards and Guidelines for Physician Practice Connections®— Patient-Centered Medical Home, CMS Version." National Committee for Quality Assurance. October 6, 2008.

[39] "Medical Homes and Cost and Utilization Among High Risk Patients." Susannah Higgins, MS; Ravi Chawla, MBA; Christine Colombo, MBA; Richard Snyder, MD; and Somesh Nigam, PhD. March 24, 2014.

physical and behavioral health services; targeting enrollees with specific high-risk behavioral health and chronic conditions; and including social and community supports in care coordination services. Health Homes may be created by a variety of provider types, including behavioral health providers, as long as they provide integrated care and can meet the required service criteria. As more states implement Section 2703 Health Homes, CMS has allowed some flexibility to include other chronic medical conditions and modify the list of services in the State Plan Amendment.[40] Some states are experimenting with shared savings, risk-adjusted payments, bundled payments, and capitated payments for Health Homes. The delivery system and various possible payment models that can be applied require robust information system and data sharing infrastructure in order to meet CMS reporting requirements and the state's management needs. Section 2703 Health Home providers generally have to alter their practice approaches to support integrated care across multiple providers, agencies, services, and systems. Early evaluations indicate that Section 2703 Health Homes can positively impact quality and cost outcomes for target populations, primarily through reduced inpatient admissions, emergency visits and pharmacy costs.[41]

ACCOUNTABLE CARE ORGANIZATIONS

Accountable Care Organizations (ACO) are a relatively new delivery reform effort based on health care providers coming together to share accountability for the care, health outcomes and costs for a defined group of enrolled individuals. Most often, providers form ACOs, but ACOs may also be formed by Managed Care Organizations or later transition to full-risk managed care. Currently, 17 states have implemented or plan to implement Medicaid ACOs.[42] Medicare has been the national ACO leader with three programs: the Pioneer ACO Model Program, the Medicare Shared Savings Program, and the Advance Payment ACO Model Program.[43]

Medicaid ACOs have a variety of organizational structures, populations served, benefits offered, and payment structures supporting them. The two main payment models for ACOs are the shared savings and shared losses model, and the full-risk capitation or global budget model. As ACOs feature increasingly integrated provider networks that include more specialists and post-acute providers, bundled payment financing mechanisms offer a promising path forward to further align provider incentives. The enhanced integration of ACOs allows provider networks to better manage the entire episode of care. Providers who develop effective care management and evidence-based protocols for the entire episode of care may capture additional savings.[44]

Timely and accurate patient data is vital for the success of an ACO. Providers working in ACOs must make substantial changes to their practices to ensure a team-based approach and focus on common outcomes. Many Medicare ACO demonstrations now are beginning to demonstrate cost savings; Colorado and Oregon have shown improvements in care quality and reduced cost for Medicaid ACOs.[45]

[40] "Focus on Health Reform: Medicaid's New 'Health Home' Option." The Henry J. Kaiser Family Foundation. January 2011.

[41] "Medicaid Health Homes: Implementation Update," Center for Health Care Strategies, March 2014.

[42] See http://nashp.org/state-accountable-care-activity-map and http://kaiserfamilyfoundation.files.wordpress.com/2013/10/8498-medicaid-in-a-historic-time-of-transformation.pdf

[43] https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html

[44] "The Future of Accountable Care Organizations." Navigant Healthcare. October 2014.

[45] See: Colorado Department of Health Care Policy and Financing, "Legislative Request for Information #1: Accountable Care Collaborative," November 1, 2013", and "Oregon Health System Transformation: Quarterly Progress Report," February 2014.

BUNDLED PAYMENTS

A bundled payment is a method of paying health care providers a set amount to provide all needed care for a defined condition or episode of care, rather than for individual services rendered. Bundled payments are generally used for episodes of care that are fairly well understood in terms of needed services, potential complications and other factors. The best known example is services related to pregnancy and birth, but bundled payments have also been used with orthopedic and cardiovascular services. As a single payment is made for the entire episode of care, it discourages duplication of services and supports coordination across providers. Some research has indicated that the use of bundled payments could significantly reduce health care spending.[46]

Bundled payments take significant work to implement and are more useful for certain services and conditions than others. To implement bundled payments, the payer and providers must have an accurate estimate of a discrete episode of care's associated costs, services included in the episode, reimbursement amounts, and the providers who would share reimbursement for the episode.

PRE-PAID AMBULATORY HEALTH PLAN AND INPATIENT HEALTH PLAN

Pre-paid health plans offer an alternative to ACOs that stop short of full-risk capitated managed care. Types of plans include Pre-paid Ambulatory Health Plans (PAHP) and Pre-paid Inpatient Health Plans (PIHP). States pay a per member per month rate to a health plan, in exchange for a covered set of services for enrollees. Ambulatory plans provide medical services to enrollees under contract with a state, do not provide or arrange any inpatient hospital or institutional services for enrollees, and do not have a comprehensive risk contract. Inpatient plans provide or arrange for inpatient hospital or institutional services for enrollees.[47]

States often use a PAHP to cover certain outpatient services such as dental or non-emergency medical transportation; similarly, they use PIHPs to cover specialized inpatient hospital and/or institutional services, such as for behavioral health. As of 2014, 20 states have implemented either or both ambulatory and inpatient health plans.[48] Both plan types are accountable to manage the required services and must meet similar quality and reporting requirements as for full-risk Managed Care Organizations. Recently proposed rules from CMS expand and clarify managed care requirements related to PAHPs and PIHPs.

FULL-RISK, CAPITATED MANAGED CARE

To date, 39 states, including the District of Columbia, enroll a portion of their Medicaid enrollees in capitated managed care organizations for some or nearly all benefits and services.[49] Medicaid Managed Care Organizations deliver a set of Medicaid benefits to a specific Medicaid population in exchange for a capitated per member per month rate. Many states now employ full-risk contracts that include or are specifically designed for enrollees with complex needs such as aged, blind and disabled enrollees and those with severe behavioral health needs.[50] Full-risk capitation rates must be actuarially-certified, and typically are adjusted for age, sex, whether the individual is also covered through Medicare or other third party insurance, and Medicaid eligibility category.

---

[46] Hussey PS, Eibner C, Ridgely MS, McGlynn EA (2009). New England Journal of Medicine. 361 (22).

[47] "Code of Federal Regulations. 42 CFR 438.2 – Definitions.

[48] "Medicaid Managed Care Enrollment by Plan Type." The Henry J. Kaiser Family Foundation. Data as of July 2013.

[49] "Medicaid Managed Care Market Tracker." The Henry J. Kaiser Family Foundation.

[50] "Medicaid Managed Care: A Primer and National Overview." (presentation) Julia Paradise. Kaiser Commission on Medicaid and the Uninsured. September 15, 2014.

Establishing full-risk capitation requires significant communication with providers, including those with little experience with capitated payments and those not prepared to meet rigorous quality and performance metrics. The managed care model faces particular challenges in rural areas, where low-population or dispersed areas make it difficult to achieve economies of scale, develop adequate provider networks, and ensure the presence of infrastructure necessary to meet all performance and reporting requirements. Capitation has the benefit of predictability for the state as a payer, which pays the organization a monthly per member fee that is not dependent on service use. Whether full-risk models ultimately generate true cost savings is debatable. When cost savings have been achieved, it is most often due to reductions in inpatient and other high-cost service utilization, which may or may not contribute to better health outcomes, if those services were needed.

Federal managed care regulations released in 2015 indicate that CMS is continuing to support more robust quality measurement requirements, more closely aligned insurance markets, and stronger incentives to coordinate enrollee care. The proposed regulations also more closely align requirements for Medicaid, the Children's Health Insurance Program (CHIP), Medicare and Medicare Advantage (MA), and qualified health plans, creating administrative efficiencies and lowering costs for providers and payers operating in multiple markets.[51] The proposed rule calls for more aggressive quality measurement and care coordination activities, while providing flexibility for states to design individualized plans to meet the broadly defined proposed goals.

The proposed rule also changes what constitutes "actuarially sound" rates, as well as other requirements that states and organizations must meet for enrollee experience and choice, program integrity, information standards, quality improvement programs, and provider network adequacy and access. The proposed rules include requirements related to serving individuals who need Long-term Services and Supports.

D. CURRENT MEDICAID REFORM INITIATIVES IN ALASKA

Alaska has already begun its journey toward reform. To build on existing and concurrent work, this project sought to establish a cohesive framework for Medicaid Redesign that complements and enhances the work underway. As shown in Table 2, Alaska has experience implementing a range of waivers and is currently engaged in planning and implementation of several reform initiatives.

[51] Federal Register, May 26, 2015. https://s3.amazonaws.com/public-inspection.federalregister.gov/2015-12965.pdf

Table 2. Current Alaska Reform Initiatives

INITIATIVE	DESCRIPTION
Alaska Medicaid Coordinated Care Initiative	Two-year pilot that provides one-on-one case management and care coordination services for Medicaid enrollees with complex needs identified as high users of Emergency Department services.
Certified Community Behavioral Health Clinic Planning Grant	Federal planning grant supports certification of community behavioral health clinics, stakeholder input collection, establishment of prospective payment systems for demonstration reimbursable services, and preparation of an application to participate in the demonstration program.
Dental Benefit Changes	Limit and restrict benefits to encourage more appropriate use; establish guidelines for orthodontia; lengthen denture replacement timeframes; recommendations for dental films.
Durable Medical Equipment (DME), Vision, Audiology Benefit Changes	Limit and restrict benefits to encourage more appropriate use; fee schedule adjustments for audiology equipment.
Eligibility Changes for Personal Care Assistance (PCA) Services	Establish more stringent eligibility requirements for PCA and study feasibility of other eligibility changes.
Fraud and Abuse Control Improvement	DHSS has implemented a range of fraud and abuse controls.
Transportation Policy Review	Includes efforts to reinforce current policies; adopt fee schedule for ground transportation; analyze utilization data; consolidate family travel needs.
Tribal health System Coordination: Neonatal Intensive Care Unit (NICU), Orthopedic, Obstetrics, Dental, and Long Term Care	Expansion of service capacity in the Tribal health system statewide is expected to result in a shift in American Indian / Alaska Native Medicaid patients from non-Tribal to Tribal providers.
Tribal Health System Partnership: Transportation and Referral Policy	Originally pursued as a Section 1115 demonstration waiver, DHSS sought to expand the scope of Medicaid reimbursable services and enhance referral coordination for American Indian / Alaska Native enrollees to enhance receipt of 100% federal match. A newly proposed federal policy may realize these goals.[52]
Pharmacy Reform	Ongoing; increase use of generic drugs; Utilization Management of specialty drugs; established State Maximum Allowable Cost controls (2012) and prescription pain drug controls (2013).
Provider Tax Proposal	Provider Tax feasibility study and recommendations being developed by consulting firm.
1915(i) and 1915(k) Options for Home and Community-based Services Planning	Develop a comprehensive implementation plan for a 1915(i) State Plan Home and Community-Based Services Benefit and a 1915(k) Community First Choice option.

[52] Medicaid Services "Received Through" an Indian Health Service / Tribal Facility: A Request for Comment. October 2015. Centers for Medicare and Medicaid; Center for Medicaid and CHIP Services. http://medicaid.gov/medicaid-chip-program-information/by-topics/indian-health-and-medicaid/downloads/tribal-white-paper.pdf

3. RECOMMENDED PACKAGE OF INITIATIVES

A. FOUNDATIONAL SYSTEM REFORMS

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 their health. The program includes enrollee education, enrollees selecting or being assigned to a Primary Care Provider, early detection of physical and behavioral health conditions, and two levels of care management.[53]

DESCRIPTION

This initiative proposes a Primary Care Case Management model in which Primary Care Providers contract with the Department of Health and Social Services (DHSS) to furnish case management services. Providers would be paid under the existing fee-for-service model for medical services rendered, plus a monthly case management fee.[54] This initiative would make Primary Care Case Management available to all enrollees, with Section 2703 Health Homes for individuals who have chronic conditions that meet the criteria for a higher level of management and support.[55] For those who require higher levels of support but do not meet the criteria for Section 2703 Health Homes, enrollees would receive Targeted Case Management or be enrolled in the existing Alaska Medicaid Coordinated Care Initiative, which is focused on high utilizers of emergency care.

The environmental assessment completed for this project describes a range of care management options, which include a variety of structures and systems used to organize health care to manage cost, utilization and quality. The federal managed care regulations, found in 42 CFR 438, recognize four types of managed care models in Medicaid programs:

1. Managed Care Organizations
2. Primary Care Case Management
3. Prepaid Inpatient Health Plan
4. Prepaid Ambulatory Health Plan

Most managed care programs use tools such as enrollee education, assignment to a Primary Care Provider, and assessments of current health conditions and potential risks to reduce Medicaid program costs and better manage utilization of health services.

This initiative pairs the Primary Care Case Management with Section 2703 Health Homes to develop a tiered payment and delivery system. Section 2703 Health Homes are similar to Patient Centered Medical

[53] Care management includes but is not limited to Primary Care Case Management or Health Home services. This initiative also proposes the use of Targeted Case Management for some enrollees. Targeted case management is case management services provided only to specific classes of individuals, or to individuals who reside in specified areas of the state (or both). Case management includes services that assist eligible individuals to gain access to needed medical, social, educational, and other services.

[54] For more about managed care, select "Managed Care Overview" at the following URL, then "Managed Care Delivery Systems." http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-site.html

[55] A Section 2703 Health Home is a Medicaid State Plan Option that provides a comprehensive system of care coordination for individuals with chronic physical and behavioral health conditions.

Homes where primary care and behavioral health services are integrated, with the additional requirement of providing care coordination of community and social supports. Section 2703 Health Homes target high-risk populations. The added benefit of Section 2703 Health Homes to DHSS is that care coordination services are eligible for 90 percent federal match for the first eight quarters of implementation. Certified Patient Centered Medical Home practices would be good candidates for the first wave of Section 2703 Health Homes.

Through the initial and ongoing use of Health Risk Assessments, DHSS could identify physical and behavioral health needs of new enrollees, including chronic conditions. The initiative would facilitate early detection of health issues and promote the development of plans of care to address health issues and reduce the need for more expensive specialty and hospital care.

This proposed structure for this initiative would require DHSS to contract with a third party Administrative Services Organization, an entity that provides administrative functions, to perform key support functions for this initiative. The Administrative Services Organization would provide national expertise in planning, implementation and ongoing program support. Some of the functions that the Administrative Services Organization could provide include enrollee orientation and provider recruitment, administering Health Risk Assessments, risk stratification, and providing data sharing and Information Technology (IT) infrastructure. The Administrative Services Organization can also provide additional resources and reporting functionality that Primary Care Providers require to be successful, such as web-based portals and reporting tools.

Once the Administrative Services Organization is under contract, enrollee education and orientation could include additional modes of outreach, particularly those better suited to enrollees with special needs, such as behavioral health conditions or homeless individuals, for whom traditional outreach methods may not be as effective. Under this initiative, the Administrative Services Organization would not take over claims processing and payment functions.

KEY FEATURES

This initiative includes four key features a) enrollee education and orientation; b) assignment to a Primary Care Provider; c) early detection of physical and behavioral health needs; and d) two levels of care management. Education and early identification of health care needs serve as a first step in the development of a more organized fee-for-service delivery system that includes Primary Care Case Management and Section 2703 Health Homes for populations of individuals that are likely to most benefit from these services.

a) Enrollee Education and Orientation

1. Upon enrollment, Medicaid enrollees would receive a welcome package similar to those commercial health plans distribute to new members. The welcome package would include a description of Medicaid benefits, guidance on proper use of benefits, the *Alaska Medicaid Program Guide to Care*, program contact information and information regarding maintaining program eligibility. Alaska Medicaid should consult with Tribal health partner organizations for guidance to ensure materials are culturally relevant and engaging for American Indian / Alaska Native enrollees. The package would be sent to new enrollees and annually at redetermination.[56]

[56] An example of an outreach and enrollment kit can be found here: https://mmcp.dhmh.maryland.gov/healthchoice/Pages/MCO-Outreach-and-Enrollment-Toolkit.aspx

2. The welcome package would direct the enrollee to select a Primary Care Provider to serve as the individual's medical home, and indicate the timeframe for selection. It would also provide guidance and methodology for those who are able to opt out of the assignment.

b) Assignment to a Primary Care Provider

1. At the outset, DHSS would recruit Primary Care Providers interested in participating in this initiative, and negotiate agreements with them. This would require DHSS staff resources to develop the initial provider network. Once DHSS has secured the Administrative Services Organization, it could transfer this function to the contractor.

2. Primary Care Providers would include licensed primary care physicians, advanced nurse practitioners and physician assistants active in the practice of family medicine, primary care internal medicine, or pediatric medicine. A behavioral health provider may serve as the Primary Care Provider if the enrollee's primary diagnosis is a behavioral health condition. For specific types of enrollees, a Community Behavioral Health Provider may be the best choice. In these instances, the behavioral health provider would be required to have integrated primary medical services within their practice, or demonstrate an adequate relationship with a medical Primary Care Provider to ensure access to those services, when needed.

3. Enrollees would select a participating Primary Care Provider within a specified timeframe. If an enrollee declined to select a Primary Care Provider, Alaska Medicaid would assign them to one using the following conditions:

   i. Enrollees who are not American Indian/Alaska Native would not be allowed to opt out of the Primary Care Provider assignment, but they would be able to change to a different provider.

   ii. American Indian/Alaska Native enrollees would be assigned to a Primary Care Provider at a Tribal Health Organization, or to a care team if a specific provider is not available. By federal law, these enrollees must be allowed to opt out of the assignment or to opt to be enrolled with a non-Tribal Primary Care Provider.

4. Selection of or assignment to a Primary Care Provider would begin in State Fiscal Year (SFY) 2017 for individuals already identified as having a primary source of care. The roll out would take approximately six to nine months, implemented by region. The second assignment wave would start in the second half of SFY 2017 and would take twelve to eighteen months.[57]

5. Once an enrollee has selected or is assigned to a Primary Care Provider, the provider would help to manage the enrollee's care, ensuring appropriate access to services, especially high-cost and specialty services and medications. This role would not extend to gatekeeping, but would serve as the coordination and communication hub for the enrollee's health care.

[57] Other states have indicated that an overly quick roll out was detrimental to the program's success.

c) Early Detection of Physical and Behavioral Health Needs

1. The initial Health Risk Assessment is a general assessment of ongoing and acute health issues faced by the enrollee.[58] The third party Administrative Services Organization would administer the Health Risk Assessment to every enrollee on an annual basis. Individual enrollees may receive additional assessments based on needs identified in the Health Risk Assessment or based on the provider deeming them necessary. Claims data is not sufficient to provide a complete picture of an enrollee's health because it is often limited and not timely as a result of claims processing timeframes. In addition, new enrollees do not have claims data within DHSS's Medicaid Management Information System (MMIS).

2. The Health Risk Assessment would be completed within 120 days of an enrollee's assignment to a provider and would establish a risk score for the enrollee, which would identify individuals with need for specific services, including eligibility for Section 2703 Health Homes. Enrollee risk scores and stratification would determine the Level of Care designation One, Two or Three. See Table 3 for an outline of services provided at each level. The specific scoring rubric would be determined during planning for implementation of this initiative.

3. The Administrative Services Organization would share the results of the Health Risk Assessment with the Primary Care Provider assigned to the enrollee and with DHSS. The provider would include the enrollee's Health Risk Assessment in his or her medical record.

4. The Primary Care Provider and the enrollee would develop a care plan to address the enrollee's emergent and ongoing health care needs, using the assessment results as a point of information. Care plans would be coordinated with existing treatment plans for those engaged with behavioral health services, and existing care plans for those receiving Home and Community-based Services through a 1915(c) waiver.

Table 3. Proposed Level of Care Designations and Services Provided

LEVEL OF CARE	SERVICES PROVIDED	FREQUENCY
Level One	Health and wellness screenings, as appropriate for age and gender; follow-up care plan and management, if needed	Health Risk Assessment conducted annually to determine any changes in status or when there is a change in health status that warrants reassessment sooner
Level Two	Health and wellness screenings, as appropriate for age and gender; follow up care plan and management, if needed; mid-year office visit; referral to specialists, as needed; medication review	Health Risk Assessments or similar assessment conducted semi-annually to determine if there are any changes in status or when there is a change in status that warrants reassessment sooner
Level Three	Health and wellness screenings, as appropriate for age and gender; quarterly follow-up care plan and management; referral to specialists, as needed; medication management; referral to Section 2703 Health Homes program, if eligible; or, Targeted Case Management or the Alaska Medicaid Coordinated Care Initiative	Health Risk Assessments or similar assessments conducted quarterly to determine if there are any changes in status or when there is a change in status that warrants reassessment sooner

[58] For an example of a Health Risk Assessment used in Maryland for Medicaid managed care enrollment, see https://mmcp.dhmh.maryland.gov/docs/Health Risk Assessment-form-rev0699.pdf

d) Care Management

1. DHSS would establish a $5 per member per month payment for participating Primary Care Providers, beginning in SFY 2017. Initially, the fee would be the same for all enrollees, regardless of Level of Care; DHSS would calculate and distribute the fee.

2. Until Health Risk Assessment data are reliably available statewide, DHSS would use MMIS claims data to identify enrollees eligible for referral to a Section 2703 Health Homes program. Once data is available, DHSS should review the risk stratification and payment mechanism to ensure desired outcomes are being achieved.

3. Enrollees with a Level Three designation would be connected to a Section 2703 Health Homes program, if they meet the specified chronic condition criteria; alternatively, they would be connected with Targeted Case Management or the Alaska Medicaid Coordinated Care Initiative, based on availability and suitability.

4. Section 2703 Health Home is a Medicaid State Plan Option that provides a comprehensive system of care coordination for Medicaid enrollees with chronic physical and behavioral health conditions. Enrollees eligible for Section 2703 Health Homes must have two chronic conditions; have one chronic condition and be at risk for another; or have one serious and persistent mental health condition. Under Section 2703, Health Home providers will integrate and coordinate all primary, acute, behavioral health and Long-term Services and Supports to treat the "whole-person" across the lifespan. Health Home services must include comprehensive care management; care coordination; health promotion; comprehensive transitional care and follow-up; patient and family support; and referral to community and social support services, including referral for supportive housing and other basic needs.

5. Providers who operate a Section 2703 Health Home would receive a separate, higher per member per month payment of $15.

6. The first group of Patient Centered Medical Home certified practices and Community Behavioral Health Clinics would be authorized to provide Section 2703 Health Home services under this program beginning in late SFY 2017 or early SFY 2018, depending on DHSS developing or procuring the capacity to conduct data analysis supported by required IT infrastructure. This includes the capacity to fulfill the reporting requirements of Section 2703 Health Homes, and the existence of a reporting process for participating providers.

7. Depending on provider readiness, Section 2703 Health Homes can be made available geographically and by condition in order to maximize the 90 percent federal match for the first eight quarters.

TRIBAL PARTICIPATION

To comply with federal law, participation in this program would be voluntary for American Indian/Alaska Native enrollees. Special notification packages would be sent providing information on the benefits of the program, including the additional benefits of the Section 2703 Health Homes program enrollment for enrollees who meet program criteria.

For Tribal providers, per member per month payments for participation as a Primary Care Provider would be considered its own cost center that would be removed from the calculation of the daily encounter rate. It is a decision between the Tribal Health Organization and the Indian Health Service whether to carve out such a fee. The Primary Care Improvement Initiative would coordinate with Tribal Health Organizations to develop approaches that would ensure program participation is available to American Indian/Alaska Native enrollees without adversely affecting other services.

DHSS should investigate opportunities with CMS and Tribal Health Organizations for Tribal Health Organizations to assume some or all of the functions for American Indian/Alaska Native enrollees that the Administrative Services Organization would provide for non-Native enrollees. This would take advantage of the current interest at CMS in strengthening linkages between state Medicaid programs and Tribal Health Organizations.

SPECIAL POPULATIONS

Special populations are eligible to participate in the Primary Care Improvement Initiative. See Appendix C for a full description of special populations and associated rules.

RELATED PROJECTS

DHSS established the Care Management Program, formerly known as the Lock-In Program, under the Alaska regulatory authority of 7 AAC 105.600. The Care Management Program restricts an enrollee to a Primary Care Provider and a single pharmacy to reduce inappropriate utilization of services paid for by the Alaska Medicaid program, encourage continuity of care and promote communication between the enrollee's Primary Care Provider and pharmacy. Participation in the Care Management Program generally lasts for 12 months. With the exception of emergency services, an enrollee must receive advance written referral from the Primary Care Provider to seek treatment from other providers. This program serves approximately 300 of the highest utilizers of services.

In order to address the needs of other high utilizers who could benefit from enhanced care management but who do not require the severe limits of the Care Management Program, DHSS applied for and was selected by the National Governors Association to participate in the "Developing State-level Capacity to Support Super Utilizers Policy Academy." Alaska is one of six states (and Puerto Rico) participating in a collaborative effort to design and improve state-level health systems to ensure better provision of coordinated and targeted services for super utilizers.[59]

Alaska is currently engaged in a two-year pilot project, the Alaska Medicaid Coordinated Care Initiative, which aims to reduce Emergency Department use by super utilizers, defined as those who have accessed emergency services five or more times in an 18-month period. The pilot program uses case managers who help connect participants to Primary Care Providers, pharmacy and behavioral health services, help schedule appointments and provide assistance when participants have medical issues or need help getting care. Case managers also review patient records to identify whether and how participant needs can be addressed in more appropriate settings.

The Primary Care Improvement Initiative can build on the efforts of this pilot program, by taking a proactive approach to identifying those at risk for potentially overusing emergency services or those who need enhanced care management. This proposed initiative focuses on chronic disease management

[59] State of Alaska DHSS, Alaska Medicaid Coordinated Care Initiative RFP No. 0614-075, April 2013.

to avoid deterioration in an enrollee's health that could lead to unnecessary Emergency Department use or hospitalizations.

Alaska has also been working to lay the foundation of certified Patient Centered Medical Homes, which will also support this initiative. In 2010, through the Children's Health Insurance Program Reauthorization Act (CHIPRA) demonstration project funded by Centers for Medicare and Medicaid Services (CMS), Alaska received a five-year grant to work with Oregon and West Virginia through a federally funded Tri-State Child Health Improvement Consortium (TCHIC). This project tests measures of quality of children's care; promotes the use of Health Information Technology in reporting on and improving children's health care delivery; and, demonstrates the effectiveness of practice-based models for improved care for children.[60] In 2012, the Alaska legislature provided two years of funding to the Alaska Primary Care Association and the Department of Health and Social Services, which was matched with funds from the Alaska Mental Health Trust Authority, to support the Alaska Patient-Centered Medical Home Initiative. This initiative provided grants to providers to support the implementation of the Patient Centered Medical Home model statewide.

Another related project is the recent successful application for Substance Abuse and Mental Health Services Administration funding to plan for and certify two Community Behavioral Health Clinics. Certified Community Behavioral Health Clinics are designed to serve individuals with serious mental illnesses and substance use disorders and are required to provide the following scope of services: a comprehensive array of behavioral health services, including crisis services; screening, assessment, and diagnosis; treatment planning; outpatient mental health and substance use disorder treatment services; outpatient primary care screening and monitoring; targeted case management; psychiatric rehabilitation services; peer support; family services; and community-based behavioral health treatment for members of the armed forces and veterans.

During the planning period, Alaska is required to establish prospective payment systems for Medicaid reimbursable services, and prepare an application to participate in a two-year demonstration program.[61] Planning for Section 2703 Health Homes should be aligned with the planning period for Certified Community Behavioral Health Clinics and, if funding is secured for implementation, the certified clinics could be considered as Section 2703 Health Homes for individuals with serious mental illnesses and substance use disorders.[62]

ANTICIPATED IMPROVEMENTS TO SERVICE DELIVERY

This proposed initiative would help enrollees learn how to access and use their Medicaid benefits appropriately. This would promote shared responsibility by ensuring enrollees have information about accessing services, appropriate use of the Emergency Department, and services and supports for specific health care needs.

Data gleaned from Health Risk Assessments would help DHSS identify the needs of the Medicaid population and ways to address those needs on a statewide, regional, and community level. This might include expansion of telemedicine, improved care coordination, or focused behavioral health services.

[60] More information about this project is available at: http://dhss.alaska.gov/dph/HealthPlanning/Pages/tchic.aspx

[61] Substance Abuse and Mental Health Services Administration, Planning Grants for Certified Community Behavioral Health Clinics, Request for Applications (RFA) No. SM-16-001, Catalogue of Federal Domestic Assistance (CFDA) No.: 93.829. August 2015.

[62] Suggested by the Alaska Mental Health Board and Advisory Board on Alcoholism and Drug Abuse in a letter of public comment, November 24, 2015.

This initiative would allow DHSS to better estimate cost of care and services, which is important as DHSS considers future payment reforms.

Section 2703 Health Homes have begun to show modest to significant savings in costs and improvements in quality and outcomes among target populations served in other states. The care coordination requirements support enrollees with complex needs such as multiple chronic conditions including serious behavioral health diagnoses.

This initiative also creates the opportunity to build upon the work of providers who have secured Patient Centered Medical Home certification, the current effort to plan for and implement Certified Community Behavioral Health Clinics and the whole person model of care that many Tribal Health Organizations provide. This initiative would create the opportunity for these practices to develop Section 2703 Health Homes, supported by appropriate reimbursement and quality assurance mechanisms.

In addition, Section 2703 Health Homes could potentially provide a source of Conflict Free Case Management (or Conflict Free Care Coordination, as it is referred to in Alaska) for providers of Home and Community-based Services. This could also provide a strong connection with the current efforts to develop Permanent Supportive Housing for the Medicaid enrollees who require it. As DHSS's plans for the 1915(i) and (k) options develop, Section 2703 Health Homes could also provide a central point for enrollees who qualify to access those services.

ANTICIPATED IMPROVEMENTS TO OUTCOMES AND ACCESS

By choosing a Primary Care Provider, the enrollee can begin building a relationship with his or her "medical home." Encouraging enrollees to seek care early and routinely would also help Primary Care Providers support these patients before they require higher intensity services. By identifying the specific needs of each enrollee as quickly as possible after enrollment, both DHSS and providers can engage enrollees in a care plan designed to help them stop further progression of diseases or health issues and prevent them from developing new health issues. This empowers enrollees with information about their unique risks and health needs, and provides them a partner (their Primary Care Provider) to help address those needs. It also can reduce more expensive care by helping enrollees with chronic conditions coordinate among multiple providers and manage their medications. This model helps DHSS begin building the solid primary care infrastructure and foundation critical to all health reform efforts.

The literature on Section 2703 Health Homes is showing increasing evidence that they improve health outcomes and support enrollees with multiple morbidities and complex physical, behavioral, and social needs. For example, a 2014 study by the Center for Health Care Strategies showed that in New York, "early data for a subset of the Health Home population shows a 14 percent increase in primary care visits and a 23 percent decrease in hospital admissions and emergency department visits."[63] In Missouri, the first state to implement Section 2703 Health Homes, a Kaiser Family Foundation report found that the state "has enrolled close to 19,000 Medicaid beneficiaries in Community Mental Health Center-led health homes. Preliminary results indicate that the percentage of beneficiaries in these health homes who had at least one hospitalization declined by 27 percent between 2011 and 2012. In addition, adults continuously enrolled since the inception of the program (approximately 2,800 individuals) showed marked improvement in key quality metrics related to management of diabetes, blood pressure, and cholesterol levels."[64]

[63] Seizing the Opportunity: Early Medicaid Health Home Lessons, Kathy Moses, Brianna Ensslin, Center for Health Care Strategies, Issue Brief, March 2014 http://nyshealthfoundation.org/uploads/resources/early-medicaid-health-home-lessons-brief-march-2014.pdf

[64] Medicaid Health Homes: A Profile of Newer Programs, Kaiser Family Foundation, Aug 06, 2014, Julia Paradise and Mike Nardone, http://kff.org/medicaid/issue-brief/medicaid-health-homes-a-profile-of-newer-programs/

PROJECTED COSTS AND SAVINGS

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. 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 timelines reflected in the actuarial analysis correspond with the proposed timeline for this initiative.

Under the Primary Care Improvement Initiative, Milliman projects service utilization will increase for preventive and primary care and decrease for a range of other services. The 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 SFY 2020 as providers gain experience managing care and become more effective, and as Section 2703 Health Homes are implemented (Table 4). Milliman assumes 30 percent of eligibles are enrolled in Primary Care Case Management in SFY 2017, 70 percent in SFY 2018, and all eligibles are enrolled in SFY 2019 and later. Section 2703 Health Homes begin in SFY 2019. For this analysis, Milliman excludes managed care optional enrollees[65] and assumes that 50 percent of Tribal members would opt-out and remain in traditional fee-for-service Medicaid. See Appendix I for futher details of Milliman's analysis.

Table 4. Actuarial Results for the Primary Care Improvement Initiative

MEDICAID REDESIGN INITIATIVES: PRIMARY CARE IMPROVEMENT INITIATIVE (VALUES IN $MILLIONS)*					
SERVICE CATEGORY	**FY17**	**FY18**	**FY19**	**FY20**	**FY21**
Facility Inpatient	($0.4)	($1.6)	($9.8)	($10.8)	($11.8)
Facility Outpatient	($0.9)	($3.4)	($10.0)	($12.4)	($15.2)
Professional	($0.2)	($0.9)	($4.6)	($5.0)	($5.4)
Pharmacy Drugs	($0.2)	($1.1)	($4.4)	($5.7)	($7.2)
PCCM Fee	$1.1	$3.1	$4.6	$4.7	$4.7
Capitation	$0.0	$0.0	$0.0	$0.0	$0.0
Other	($0.0)	($0.1)	($0.5)	($0.6)	($0.7)
TOTAL CHANGE IN MEDICAL COST	**($0.7)**	**($4.0)**	**($24.6)**	**($29.8)**	**($35.5)**
ASO Fees	$7.0	$17.5	$26.2	$27.7	$29.2
TOTAL EXPENDITURE CHANGE	**$6.3**	**$13.5**	**$1.5**	**($2.2)**	**($6.3)**
After Shared Savings	$6.3	$13.5	$1.5	($2.2)	($6.3)
FMAP Share	$3.9	$8.4	$1.0	($1.4)	($3.8)
NET ALASKA COST (SAVINGS)	**$2.4**	**$5.0**	**$0.5**	**($0.8)**	**($2.4)**

** 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.*

[65] The eligibility categories that are managed care optional include foster care children, Title IV-E subsidized adoption children, and juveniles court ordered into state custody.

If DHSS chooses to pursue this initiative and secures the authority and resources to proceed, it would need to make programmatic and policy decisions that address the mechanics of securing contractor support, administering the Health Risk Assessment, and developing provider payment structure. As proposed, DHSS would also need to invest internal resources at the outset of the initiative to recruit and negotiate agreements with Primary Care Providers, implement modifications to Information Technology systems and conduct initial enrollee orientation, prior to contracting with the Administrative Services Organization. The costs of mailing provider contact information to the members and communicating with providers, even if only electronically, would begin in SFY 2017. DHSS can claim reimbursement for the additional administrative costs of implementing this program as a Medicaid Administrative expense and receive federal reimbursement of 50 percent for each state dollar spent on these new functions.

FEDERAL REQUIREMENTS FOR IMPLEMENTATION

This model can be implemented under Section 1932(a) or Section 1915(a) State Plan authority. Since this model would utilize DHSS's existing fee-for-service delivery system, enrollees already have free choice of providers. While DHSS would require enrollees to select a Primary Care Provider, the enrollees would not be locked into enrollment with a specific Primary Care Provider; they could select a new provider of their choice within the timeframe defined by DHSS. State Plan Authorities are listed in Table 5. DHSS can selectively contract under the 1932(a) State Plan Authority if it chooses to use an Administrative Services Organization to perform key functions of the program.

Table 5. Federal Authorities, Flexibilities and Limitations

AUTHORITY	DESCRIPTION	KEY FLEXIBILITIES AND/OR LIMITATIONS
Section 1915(a) Exception to State Plan Requirements for Voluntary Managed Care	Used to authorize voluntary managed care programs on a statewide basis or in limited geographic areas implemented through CMS Regional Office approval of the managed care contract. The State has the ability to use passive enrollment with an opt-out within this authority.	• No waiver or State Plan Amendment required • No mandatory enrollment or selective contracting allowed
Section 1932(a) State Plan Amendment Authority	State plan authority for mandatory and voluntary managed care programs on a statewide basis or in limited geographic areas. States may choose to include dual eligible individuals as part of a broader managed care program authorized under Section 1932(a).	• Permanent State Plan Authority • No cost-effectiveness or budget-neutrality requirement • Allows selective contracting • No mandatory enrollment of dual eligible, but dual eligible individuals may voluntarily enroll • Comparability of services, freedom of choice

Section 2703 Health Homes can be implemented through a State Plan Amendment. Section 2703 provides for waiver of the comparability requirement and allows states to offer Health Home services in a different amount, duration, and scope than services provided to individuals who are not enrolled in Health Homes. Additionally, the law allows for discretion by the Secretary of Health and Human Services to determine if it is necessary to waive any other provisions requested by a state. Further, states may develop standards and protocols for Health Home providers, through their provider designation, that serve a particular age group. Since the Health Home statute provides states with the flexibility to

determine the provider arrangements, states may not specifically target by age in their State Plan Amendment, but can limit, through provider designation, who can provide the Health Home services.

States will receive a 90 percent enhanced federal match for the specific Health Home services authorized under Section 2703 of the Affordable Care Act. The enhanced match does not apply to the underlying Medicaid services also provided to individuals enrolled in a Health Home. The 90 percent enhanced match is available for the first eight quarters in which the program is effective. A state may receive more than one period of enhanced match, understanding that they will only be allowed to claim the enhanced match for a total of eight quarters.

STATE STATUTORY AND/OR REGULATORY CHANGES

Implementing this initiative would not require State statutory changes, but it would require DHSS to modify definitions of which providers are considered Primary Care Providers, for the purpose of assignment of enrollees and enhanced payment for services. Similarly, DHSS would need to create a provider type for Section 2703 Health Homes to be able to assign enrollees for care and to manage the enhanced payments to providers for specified Health Home services.

Implementing a per member per month payment to Primary Care Providers may require a regulatory change, but is covered under the current Alaska statutory authority (AS 47.07.030(d)) that permits Medicaid to fund Primary Care Case Management services. The Health Risk Assessment is allowed as an administrative service paid by Medicaid administrative funds. A Section 2703 Health Home may be considered a variant of Primary Care Case Management covered under AS 47.07.030(d). Additional confirmation is required from the Alaska Department of Law. Previous legislation (Alaska HB 148, introduced in the 29th Legislative Session in 2015) references Patient Centered Medical Home and proposed adding Section (e) to AS 47.07.036 to cover this service.

DHSS has the authority to make program changes that are intended to contain program costs, particularly when these steps avoid reductions to program eligibility rules or covered services.

RATE STRUCTURES AND PAYMENT MECHANISMS

This initiative recommends DHSS pay a $5 per member per month fee to Primary Care Providers for the care coordination, including developing care plans and managing the care of their assigned enrollees. DHSS would continue to pay providers for health services on a fee-for-service basis. For Level Three enrollees, DHSS would pay an additional $15 per member per month to provide Section 2703 Health Home services. In this model, providers are not assuming any financial risk. The monthly rates would need to be sufficient for both Section 2703 Health Homes and Primary Care Providers to be able to offer the enhanced services.

Over time, DHSS also could begin to implement some modest risk sharing for both Primary Care Providers and Section 2703 Health Homes if they achieve either or both quality and cost targets established by DHSS.

MONITORING AND REPORTING REQUIREMENTS

The initial program reporting requirements are minimal and based on state determination. CMS does not require reporting of outcome measures for Primary Care Case Management programs. As

suggested, the Administrative Services Organization contracted by DHSS would aggregate individuals' Health Risk Assessment results and conduct risk stratification. DHSS should analyze Health Risk Assessment and risk stratification results against enrollee claims data to capture cost and baseline care management data. It is recommended that DHSS contract with an experienced Administrative Services Organization with this capability or a stand-alone data analytics contractor that can put the necessary data infrastructure in place to build monitoring and reporting processes that can be modified as the program evolves.

CMS does require structured reporting related to Section 2703 Health Homes, due to the enhanced match rate, which is only available for specified Health Home services. Providers of Section 2703 Health Home services are required to report quality measures to the state as a condition for receiving enhanced payment. These measures are intended to help the state and federal governments learn how the specific interventions are affecting the quality of care for enrollees. States have to collect and report utilization, expenditure and quality data for an interim survey and an independent evaluation. The Secretary of Health and Human Services is required to conduct a survey of states that have implemented Section 2703 Health Homes and submit an independent evaluation and report to Congress in 2017 to demonstrate if the program has effectively helped to reduce hospital admissions, emergency visits, and admission to skilled nursing facilities. CMS has developed a two-pronged quality strategy for Section 2703 Health Homes that includes the core set of measures, as well as state-specific goals and measures.

EXPERIENCE OF OTHER STATES

State Medicaid programs have operated variations of the Primary Care Case Management model since the early 1980s. The Primary Care Case Management structure initially involved linking enrollees with a Primary Care Provider who would serve as a "gatekeeper" providing authorizations for emergency and specialist services to assigned enrollees in return for being paid a per member per month payment. In recent years, states have begun to enhance Primary Care Case Management models with additional features such as intensive care management and care coordination for high-need beneficiaries, improved financial and other incentives for Primary Care Providers, and increased use of performance and quality measures such as Healthcare Effectiveness Data and Information Set (HEDIS),[66] Consumer Assessment of Healthcare Providers and Systems (CAHPS), provider profiles, and similar measures.

Several states have implemented Primary Care Case Management program enhancements paid for by savings that may result from improved care coordination or that might be justified by the improvements in the quality of care provided. Many of these states may not have the option of contracting with fully capitated at-risk Managed Care Organizations (MCOs), or may consider non-MCO options as a better fit in particular areas of the state, rural areas, for example, or for certain Medicaid populations, such the chronically ill or disabled. In addition, the Health Home concept has been gaining traction as a way to support and manage individuals with high and complex care needs. In 2014, 15 states had at least one type of Health Home, an increase of nine states in two years.[67] Three states' examples are provided below: Connecticut, Oklahoma and Oregon.

In January of 2012, Connecticut completed the transition of its entire Medicaid program to an Administrative Service Organization model. The goal of the transition was to create a more person-

[66] For more about Healthcare Effectiveness Data and Information Set (HEDIS), see: http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures.aspx

[67] Medicaid Health Homes: A Profile of Newer Programs, Kaiser Family Foundation, Aug 6, 2014.

centered model of care that included an emphasis on care coordination. The state was focused on achieving program savings by reassuming all of the risk of the program, which previously had relied on a managed care model for the HUSKY TANF (Children and Families) and CHIP programs.

Connecticut has a unique Administrative Services Organization arrangement in contrast to almost all other Medicaid programs. Connecticut has adopted a self-insured, managed fee-for-service approach. In support of achieving better heath and care experience outcomes for beneficiaries, and engagement with Medicaid providers, the State Medicaid agency has entered into contracts with Administrative Services Organizations for each of the four major service types: Medical (CHN), Behavioral Health (ValueOptions), Dental (BeneCare) and Non-emergency Medical Transportation (Logisticare). The structure of each of the Administrative Services Organization contracts supports the program's desired results. A percentage of each Administrative Services Organization's 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 instead of contributing to the profit of a managed care organization. The state directly oversees the Pharmacy component. Each of the four Administrative Services Organizations are contracted to administer services and to achieve improved health and satisfaction outcomes for enrollees, as well as improved experience for providers enrolled in the Medicaid program.

In 2004, SoonerCare Choice, Oklahoma's self-managed fee-for-service delivery system for Medicaid, became the sole model of care in the state, supplanting the fully capitated risk-based managed care system. This program provided most Medicaid enrollees with acute, primary, specialty, and behavioral health services on a fee-for-service basis, while care coordination and limited primary care services were covered through a fixed per member per month fee paid to contracted Primary Care Providers. In 2009, Oklahoma adopted a Patient Centered Medical Home model for SoonerCare in which Primary Care Providers are paid a bundled care coordination payment and are eligible for additional performance payments; all medical services continue to be paid on a fee-for-service basis. Children and families, pregnant women, children and adults with disabilities, and older adults are mandatorily enrolled in the program; American Indian/Alaska Native enrollees have the choice of selecting either an Indian Health Service or non- Indian Health Service provider to receive care under SoonerCare. The state began a Health Management Program in 2006 to conduct intensive nurse care management with the highest need patients, and to facilitate practice transformation.

Oregon piloted Section 2703 Health Homes for two years only, electing not to continue to pay the per member per month once eligibility for the federal match ended. However, the State reported finding significant improvements in practice delivery.[68]

POTENTIAL CHALLENGES

This initiative would require extensive provider input and feedback. The success of the model would depend on the availability of Primary Care Providers willing to participate and embrace the model. Because it proposes to use the existing Alaska Medicaid fee-for-service structure with enhanced per member per month payments for care management, providers may be more willing to embrace the structure. Providers are concerned about what they describe as the 'heavy administrative burden' associated with the current Medicaid program, and stated that future reform initiatives would need to address and decrease administrative burdens.

[68] AK Health Reform Now. Presentation of Oregon Care Coordination Organization Model. October 20, 2015.

Administrative burden is a common concern among Primary Care Providers, so coupling the recommended changes in this initiative with the IT improvements recommended in Initiative 3 would allow Primary Care Providers to use the existing Health Information Exchange (HIE) as a provider portal to share Health Risk Assessment data between the provider, DHSS, and the Administrative Services Organization. Those with Electronic Health Records may need some investment to link to the HIE but could benefit from reduced time for the completion of tasks. It would be important to work through how providers can easily and readily see the risk scores and Level of Care designations for their own patients, as well as how to best look across the system as a whole. Tools to help providers and their clinical staff to track the progress of enrollees and ensure timely follow-up also would be needed. The HIE could potentially provide this functionality. One example of a state structure to support this kind of provider reporting is North Carolina's data system for their primary care homes' initiative, in place for many years. It has been extremely useful to providers and has expanded to include information on all case managers.

PROVIDER ROLES

This initiative offers the Alaska Medicaid provider community an unprecedented opportunity to build a model founded on primary care and identifying enrollees with the highest needs as quickly as possible so they can get in to the most appropriate systems of care. It will be vital to keep both enrollees and providers fully engaged and actively participating in this redesign effort.

Because Primary Care Providers would be the leaders in directing care of enrollees, and would serve as the main source of care management, it is critical for the Primary Care Provider community to embrace this initiative. The Primary Care Provider relationship with enrollees and their families is foundational to this model; however, because Primary Care Providers are limited in Alaska, the program must be designed to maximize other resources where feasible. The education of enrollees at the front end would assist Primary Care Providers by helping enrollees understand why it is important to have and stay connected with their medical home.

The Health Risk Assessment would give Primary Care Providers concrete evidence of the needs of each enrollee. Early risk stratification of all enrollees and designation into Levels of Care allows Primary Care Providers to see across their assigned enrollees to allocate time and track enrollees' progress.

As described above, for the Section 2703 Health Homes to meet their potential for improving health outcomes and containing costs, Tribal Health Organizations, behavioral health providers and Community Behavioral Health Centers, care coordinators and providers of Home and Community-based Services and other community service providers, including supportive housing, would need to be engaged in the planning and implementation of this initiative.

Connecting Primary Care Providers to the HIE will be necessary as providers move towards the use of Electronic Health Records (EHR) capable of transmitting patient level data to a central repository. As Medicaid Expansion brings new Medicaid enrollees into provider practices, allowing them to meet patient volume requirements, the Health Information Exchange can also assist providers in meeting the requirements of the Medicaid EHR program. Providers could possibly receive an incentive payment for adoption, implementation, or upgrade of current EHRs, or for achieving Meaningful Use, which may also serve as an incentive for providers to take on more Medicaid enrollees.

As DHSS, Medicare and private payers continue to move toward value-based payment models and care coordination requirements, Primary Care Providers would need to engage in the development of these foundational tools and infrastructure.

OPPORTUNITIES FOR COLLABORATION WITH OTHER PAYERS

As other payers seek to improve care coordination, applying this model across a Primary Care Provider's patient population could lead to providers negotiating alternative payment approaches with commercial plans and expand resources to address complex care needs of patients across their practices. Alaska could also look to direct the plans serving State employees to consider this model of care of enhancing primary care and care coordination to lower overall State spending for health care, after assessing its impact in the Medicaid population.

Payers across the country are implementing initiatives such as this in both the public and private markets. Because Medicaid enrollees often move back and forth between public and commercial coverage, reforms will ensure payers inherit healthier enrollees, as well as supply payers with information on enrollees who obtain commercial coverage, as gleaned through the Health Risk Assessment.

PROJECTED TIMELINE AND STATE RESOURCE REQUIREMENTS

DHSS would incrementally phase-in components of the proposed initiative. In order to proceed with implementing this initiative, as described in this section, DHSS would need to secure the necessary funding. If this is successful, work in SFY 2017 would be focused on program implementation and building the foundational operational functions such as:

a) Contract with an Administrative Services Organization for key support functions;

b) Enrollee education and orientation;

c) Formal designation of specific providers as recognized Primary Care Providers, development of payment methods and reporting requirements;

d) Primary Care Provider selection or default assignment;

e) Conduct Health Risk Assessments, risk stratification activities and Level of Care designations;

f) Begin soliciting interest and working with providers who wish to become Section 2703 Health Homes;

g) Enrollment of subgroups into Section 2703 Health Homes, the existing Alaska Medicaid Coordinated Care Initiative, or Targeted Case Management;

h) Development of quality and performance metrics that can be used to move towards more value-based payments.

During SFY 2017, DHSS would draft and release a Request for Proposal (RFP) solicitation to secure an Administrative Services Organization. The awarded contract must meet CMS contracting requirements necessary to receive federal approval for administrative match. The RFP would be released and an Administrative Services Organization secured by early SFY 2018. Administrative Services Organizations

may also contract to provide other functions, such as provider and member services, data reporting, provider network development, care coordination and disease management services.

During SFY 2017, DHSS would recruit and negotiate agreements with Primary Care Providers who would like to participate in this initiative, and begin working with providers who have the capacity and desire to become Section 2703 Health Homes. It is important for DHSS and providers to fully prepare for this program, as the opportunity to receive a 90 percent federal match rate for Health Home services only applies for the first eight quarters of operations. CMS has indicated that while the rollout can be done regionally, the program should not allow services for a given enrollee to be subject to more than eight quarters of the higher match. Additionally, this rate is for the specific services the statutes requires Section 2703 Health Homes to provide. States also must be able to identify enrollees who qualify for Health Home enrollment: those who have two chronic conditions, or have one chronic condition and are at risk for another, or have one serious and persistent mental health condition.

Enrollee assignment to a Primary Care Provider would begin in SFY 2017 with individuals already identified as having a primary source of care. The roll out would take approximately six to nine months, implemented by region. Other enrollees would choose a Primary Care Provider or be assigned in a second wave of regionally-based assignments. This wave would take approximately 12-18 months to complete. Once the Administrative Services Organization was under contract, DHSS could transfer this function to the contractor.

In SFY 2019, DHSS could increase the functionality of the Administrative Services Organization, to include quality improvement, utilization management, and provider and member services. As DHSS formalizes the processes of the initiative, it could begin to transform the program into a more robust, enhanced Primary Care Case Management model similar to the State of Connecticut's Medical Home Model, or Oklahoma's SoonerCare Program. This would allow DHSS to begin exploring alternate payment methodologies. Additionally, by SFY 2019, both DHSS and providers should be ready to fully implement the Section 2703 Health Homes program (or perhaps some providers even sooner) to begin taking advantage of the 90 percent federal match rate available for provision of Health Homes services.

The proposed timeline (Figure 4) does not factor in resource constraints or the time required for DHSS to secure budgetary resources and authority to implement the initiative, but rather assumes availability of DHSS resources and is based on the anticipated effort and timing of steps associated with obtaining federal approval. If the decision is made to move forward with the recommended reforms, DHSS would then determine the resources and time required to implement the initiative.

Figure 4. Phased Approach for Primary Care Improvement Initiative



Phase 1: Reforms Underway SFY 2014 - 2016	Phase 2: Foundation for Transformation SFY 2017 - 2018	Phase 3: Towards Paying for Value SFY 2019 - 2020	Phase 4: High Value, High Functioning System Beyond SFY 2020
• Alaska Medicaid Coordinated Care Initiative • Certified Community Behavioral Health Clinic Pilot • Patient Centered Medical Home Initiative	• Develop enrollee education and orientation program and materials • Build basic Health Risk Assessment and risk stratification algorithm • Develop Level of Care designation • Recruit and negotiate agreements with Primary Care Providers eligible to participate • Develop internal capacity to assign enrollees to Primary Care Providers, track changes, and make per member per month payments • Begin assigning enrollees to Primary Care Providers • Begin payment of per member per month fees for Primary Care Providers • Develop RFP for Administrative Services Organization and secure vendor • Transfer select functions to the Administrative Services Organization • Begin work with identified providers on Health Home program design	• Manage Administrative Services Organization • Begin enhanced enrollee education and orientation • Continue collaboration with Primary Care Providers to make adjustments to Health Risk Assessment, Risk Scores and Level of Care Designation • Develop more robust reporting and tracking data analytics and Primary Care Provider profiles/Health Home profiles for providers • Launch any Health Homes that are ready • Adjust per member per month rates as appropriate per experience	• Complete launch of Health Homes • Continue to identify providers for possible participation • Begin exploring additional value-based payment options (e.g., incentive payments, shared savings) • Evaluate options for ACO, full-risk managed care or other delivery systems changes built on the Primary Care Improvement Initiative • Implement any new delivery system models identified

INITIATIVE 2. BEHAVIORAL HEALTH ACCESS INITIATIVE

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

DESCRIPTION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

KEY FEATURES

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

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

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

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

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

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

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

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

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

---

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

[79] Alaska Statute 47.07.030

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

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

[82] Alaska Statute 47.07.900

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

TRIBAL PARTICIPATION

Collaboration between the Tribal and non-Tribal health systems will be essential to implementing this initiative. Tribal Health Organizations serve a significant proportion of the Medicaid population in Alaska and are uniquely positioned to leverage increased federal match through Medicaid, which will likely be a key strategy in Alaska's efforts to expand its behavioral health continuum of care. The call for increased

[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.

care coordination will require new partnerships to support individuals in accessing needed behavioral health services across the Tribal and non-Tribal systems. DHSS should investigate opportunities with CMS and Tribal Health Organizations for Tribal Health Organizations to assume some or all of the functions for American Indian/Alaska Native enrollees that the Administrative Services Organization would provide for non-Native enrollees. This would take advantage of the current interest at CMS in strengthening linkages between state Medicaid programs and Tribal Health Organizations.

Pursuing a Section 1115 waiver would require DHSS to consult with and solicit advice from Tribal health providers, as required by 1902(a)(73) of the Social Security Act.[91]

This initiative also includes a provision to increase the Medicaid reimbursable services a Behavioral Health Aide can perform. This provider type exists only within the Tribal health system and is analogous to the Community Health Aide/Practitioner that provides primary care services in village-level health clinics under the supervision of a physician.

SPECIAL POPULATIONS

This initiative addresses many of the special health care needs of medically frail individuals and increases access to needed services.[92]

RELATED PROJECTS

As with all of the initiatives proposed through this project, acknowledgement of interdependencies and close alignment with other reform efforts during planning and implementation is essential. Related projects include:

- Behavioral Health rate rebasing project
- Planning for Certified Community Behavioral Health Clinics[93]
- 1915(i) and (k) State Plan Options Implementation study, which includes exploration of housing transition services, tenancy sustaining services, and crisis respite services[94]
- Division of Behavioral Health System of Care Efforts and Stakeholder Workgroups
- Strategic Plan for Permanent Supportive Housing, a collaborative effort by Alaska Housing Finance Corporation, DHSS, and the Alaska Mental Health Trust Authority
- Alaska Prisoner Reentry Initiative, a collaborative effort by the Department of Corrections, DHSS, and the Alaska Mental Health Trust Authority
- Medicaid Innovation Accelerator Program Support for targeted technical assistance on housing-related supports and partnerships and incentivizing quality and outcomes in community-based Long-term Services and Supports programs[95]

[91] 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

[92] Federal guidelines define "medically frail" to, at minimum, include children with serious emotional disturbances; children in certain other circumstances such as those in foster care or receiving adoption assistance; individuals with disabling mental disorders; individuals with serious and complex medical conditions; individuals with physical or mental disabilities that significantly impair their ability to perform one or more activities of daily living; and, individuals with chronic Substance Use Disorders. The definition of medically frail is codified in federal regulations finalized in July 2013 § 440.315(f)). See Appendix C for more information.

[93] Alaska in one of 24 states that received a planning grant for the creation of Certified Community Behavioral Health Clinics; eight states will receive funding to proceed to the implementation phase. http://www.samhsa.gov/Section-223. If Alaska is awarded implementation funding and proceeds with the development of two Certified Community Behavioral Health Clinics in 2016, this could serve as a pilot and alternative model to the Section 2703 Health Homes for individuals with serious behavioral health conditions, depending on a region's capacity and needs.

[94] http://dhss.alaska.gov/dsds/Pages/MRICC/MRICC.aspx

ANTICIPATED IMPROVEMENTS TO SERVICE DELIVERY

Stakeholders engaged through this project repeatedly prioritized this initiative as the most important initiative DHSS could support. Lack of behavioral health service availability impacts service delivery in every setting, leading to gaps in care, unnecessary handoffs and travel, and long waits. The Behavioral Health Access Initiative, paired with Medicaid Expansion and the Primary Care Improvement Initiative, would lead to profound improvements in service delivery.

This initiative proposes that DHSS secure contracted assistance from an Administrative Services Organization to provide national expertise to help transition from a program management model to a contract and outcomes management model. This will greatly increase DHSS's ability to manage the utilization, outcomes and costs related to behavioral health services, while also expanding access to needed services in order to help contain costs in other areas of State expenditures such as child protection, law enforcement and corrections.

Allowing more provider types to bill for behavioral health services increases the available, qualified workforce to provide integrated care in primary care settings. This would facilitate the development of Primary Care Case Management and Section 2703 Health Homes to coordinate care, including making referrals and follow-up. Substance abuse and mental health screening and interventions in the primary care setting would lead to more referrals to behavioral health services before crisis occurs.[96] Greater utilization of mental health and Substance Use Disorder services would alleviate pressure on Alaska's acute psychiatric crisis service delivery system and reduce costs for high-intensity services.

ANTICIPATED IMPROVEMENTS TO OUTCOMES AND ACCESS

This initiative would increase use of behavioral health services and normalize patterns of usage among adults enrolled in Medicaid and children covered through Denali KidCare. Provision of early childhood mental health services presents an important opportunity to address mental health needs early in life.

Extensive evidence shows the impact of mental health and Substance Use Disorders, and the effectiveness of treatment. In 2010, mental health and Substance Use Disorders were the leading cause of non-fatal illness worldwide; together, they account for approximately 23 percent of the world's disease burden, and were the leading cause of Years Lived with Disability. Depression accounted for 40.5 percent of Disability Adjusted Life Years attributable to mental health and Substance Use Disorders.[97]

Both Alaska and national experience demonstrates that treatment works. Access to treatment can cut drug use in half, reduce criminal activity up to 80 percent, and reduce arrests up to 64 percent.[98] Research shows that the younger a person starts using drugs, the greater the likelihood of a future disorder,[99] making prevention and early intervention key. Likewise, the rate of improvement among

---

[95] http://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/ci-ltss-program-overview.pdf

[96] Department of Health and Social Services National Institute on Alcohol Abuse and Alcoholism Brief Training Increases Pediatricians' Use of Substance Abuse and Mental Health Interventions. http://www.niaaa.nih.gov/news-events/news-releases/brief-training-increases-pediatricians%E2%80%99-use-substance-abuse-and-mental

[97] Cassandra Cassels. Mental Disorders Leading Cause of Mental Illness Worldwide. August 28, 2013. Medscape. http://www.medscape.com/viewarticle/810132

[98] As cited in: Preventing and Treating Substance Use Disorders: A Comprehensive Approach. Published by the National Council for Community Behavioral Healthcare. http://www.thenationalcouncil.org/wp-content/uploads/2013/05/Substance-Use-Disorders.pdf

[99] As cited in: Preventing and Treating Substance Use Disorders: A Comprehensive Approach. Published by the National Council for Community Behavioral Healthcare. http://www.thenationalcouncil.org/wp-content/uploads/2013/05/Substance-Use-Disorders.pdf

individuals with mental health issues who receive treatment is significant; those with bipolar disorder experienced an 80 percent rate of improvement; major depression, panic disorder, and obsessive-compulsive disorder a 70 percent rate; and, schizophrenia a 60 percent rate.[100] These rates compare to the rates of improvement seen among individuals with physical issues, including asthma and diabetes (70 to 80 percent), cardiovascular disease (60 to 70 percent) and heart disease (41 to 52 percent).[101] Early diagnosis and treatment among children is also effective and can have lifelong positive impacts.[102]

PROJECTED COSTS AND SAVINGS

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 timelines reflected in the actuarial analysis correspond with the proposed timeline for this initiative.

The Behavioral Health Access Initiative aims to build a more comprehensive continuum of care within the Medicaid program and is expected to produce net costs to the Medicaid program (Table 6). Milliman projects annual increases in service utilization for professional outpatient behavioral health services and prescription drugs starting in SFY 2018. Utilization of Emergency Department and a range of other services will decrease as enrollees are better able to access needed services. Delivering needed behavioral health services through Medicaid where possible allows DHSS to tap federal funds and could lead to additional reductions in behavioral health grant funds and/or Department of Corrections spending. This initiative is also expected to reduce the many social costs associated with current service utilization patterns, where behavioral health needs often remain unmet until crisis occurs. See Appendix I for futher details of Milliman's analysis.

A core anticipated function of the Administrative Services Organization proposed in this initiative is to perform utilization management. Robust utilization management practices can help control costs, monitor gains in access, and ensure the Medicaid program invests in services that help to establish a robust continuum of care and are likely to have a high return on investment. Contracting with an Administrative Services Organization may allow for some reductions in Division of Behavioral Health administrative costs; however, further analysis is needed to understand the extent to which overlap in proposed functions might exist. The planning and implementation phases are expected to require significant investment of DHSS leadership time and may also require consultant services to assist with developing the Section 1115 waiver application to CMS. Further actuarial analysis and discussions with CMS will be required to determine whether the cost neutrality requirement associated with the Section 1115 waiver can be met given that access to behavioral health services has historically been limited.

[100] The Case for Mental Health Treatment. Published by the National Council for Behavioral Health http://www.thenationalcouncil.org/wp-content/uploads/2015/01/14_Business-Case_Mental-Health.pdf

[101] The Case for Mental Health Treatment. Published by the National Council for Behavioral Health http://www.thenationalcouncil.org/wp-content/uploads/2015/01/14_Business-Case_Mental-Health.pdf

[102] http://www.cdc.gov/ncbddd/childdevelopment/mentalhealth.html/

Table 6. Actuarial Results for the Behavioral Health Access Initiative

MEDICAID REDESIGN INITIATIVES: BEHAVIORAL HEALTH ACCESS INITIATIVE VALUES IN $MILLIONS*					
SERVICE CATEGORY	**FY17**	**FY18**	**FY19**	**FY20**	**FY21**
Facility Inpatient	$0.0	($0.2)	($0.5)	($0.9)	($1.5)
Facility Outpatient	$0.0	$0.0	$0.1	$0.1	$0.2
Professional	$0.0	$1.2	$5.0	$9.4	$14.3
Pharmacy Drugs	$0.0	$0.0	$0.1	$0.1	$0.2
PCCM Fee	$0.0	$0.0	$0.0	$0.0	$0.0
Capitation	$0.0	$0.0	$0.0	$0.0	$0.0
Other	$0.0	$0.0	$0.0	$0.0	$0.0
TOTAL CHANGE IN MEDICAL COST	**$0.0**	**$1.1**	**$4.6**	**$8.7**	**$13.2**
ASO Fees	$0.0	$3.5	$5.3	$5.5	$5.8
TOTAL EXPENDITURE CHANGE	**$0.0**	**$4.6**	**$9.9**	**$14.2**	**$19.1**
After Shared Savings	$0.0	$4.6	$9.9	$14.2	$19.1
FMAP Share	$0.0	$2.9	$6.3	$8.9	$11.8
NET ALASKA COST (SAVINGS)	**$0.0**	**$1.7**	**$3.6**	**$5.3**	**$7.2**

** 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.*

FEDERAL REQUIREMENTS FOR IMPLEMENTATION

To implement this initiative, the consultant team proposes that in SFY 2017, DHSS develop and apply for a Section 1115 waiver to secure authority and additional resources to broaden the behavioral health services array and to increase management capacity at DHSS.

Section 1115 allows states to test innovative policy solutions aimed at delivering more cost efficient and higher quality care to Medicaid populations. Section 1115 waivers have been used for a range of purposes including expanding Medicaid eligibility, redesigning benefit packages, and testing delivery system models that improve care, increase efficiency and reduce costs.[103] An important advantage of pursuing a Section 1115 waiver is the ability to secure federal funds upfront to invest in necessary system delivery changes based on anticipated savings in future years. A Section 1115 waiver spans a five-year period, with the option for an additional three years, must demonstrate budget neutrality, and requires formal evaluation.

This initiative proposes one possible approach that would provide DHSS with the flexibility and resources to pursue widespread system delivery reforms while ensuring that mental health and Substance Use Disorder services remain integrated. Such a demonstration project might also include the behavioral health-related services such as housing transition services, tenancy sustaining services, crisis respite services, currently under investigation for inclusion under the 1915(i) State Plan option. Using the Section 1115 waiver rather than the 1915(i) State Plan option would allow behavioral health services to be managed through one federal mechanism. This approach could potentially extend the initial approval period to five years from two years, as would be the case under the State Plan option.

[103] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Section-1115-Demonstrations.html

Once the demonstration project is underway, DHSS could propose an amendment to undertake Substance Use Disorder treatment delivery system transformation efforts. The purpose of the amendment would be, in part, to request an exemption from the IMD exclusion for residential Substance Use Disorder treatment services.

In July 2015, CMS issued a State Medicaid Director Letter noting the option for states to improve services for individuals with Substance Use Disorder "including a new opportunity for demonstration projects approved under Section 1115 of the Social Security Act to ensure that a continuum of care is available to individuals with Substance Use Disorder."[104] The specific goals of CMS's initiative to allow states to pursue 1115 demonstrations to improve the care and outcomes for individuals with Substance Use Disorder include:

- Promote strategies to identify individuals with substance use issues or disorders.
- Enhance clinical practices and promote clinical guidelines and decision-making tools for serving youth and adults with Substance Use Disorder.
- Build aftercare and recovery support services, such as recovery coaching.
- Coordinate Substance Use Disorder treatment with primary care and Long-term Services and Supports.
- Coordinate with other sources of local, state and federal funds for an efficient use of resources consistent with program objectives.
- Encourage increased use of quality and outcome measures to inform benefit design and payment models.
- Identify strategies to address prescription and illicit opioid addiction, consistent with national efforts to curb this epidemic.

Substance Use Disorder 1115 demonstration projects must include:[105]

a) Systemic reforms such as developing a comprehensive continuum of care, promoting evidence-based practices and testing managed care payment models, and practice reforms such as implementing care coordination models, improving integration with primary care, and using interoperable health information exchange.

b) Comprehensive evidence-based benefit design.

c) Appropriate standards of care; for example, third party (non-providers) must use American Society of Addiction Medicine (ASAM) criteria to perform multidimensional assessments of enrollees, place enrollees at appropriate levels of care, and make recommendations for length of services.

d) Provider network development and resource plans that are robust enough to cover potential loss of providers over time.

e) Care coordination, such as seamless transitions and information sharing between levels and settings of care; collaboration between health care provider types; focus on health information exchange.

f) Integration of physical health and Substance Use Disorder services. This could include establishment of Health Homes or other integrated care models.

[104] http://www.medicaid.gov/federal-policy-guidance/downloads/SMD15003.pdf

[105] Analysis completed for the Alaska Division of Behavioral Health by The Curie Group, October 2015 based on July 2015 CMS Letter to State Medicaid Directors.

g) Program integrity safeguards, including rigorous protocols to guard against fraudulent billing.

h) Benefit management, such as utilization management or capitated approaches.

i) Plans for community integration and person-centered service planning.

j) Demonstrate strategies to address prescription drug abuse; for example promoting the use of Prescription Drug Monitoring Programs and encourage adoption of electronic prescribing of controlled substances.

k) Address opioid use disorder, including how the state will increase access to naloxone and develop opioid prescribing guidelines.

l) Services for adolescents and youth with Substance Use Disorder, and show how the state will meet Early Prevention, Screening, Diagnosis and Treatment (EPSDT) requirements.

m) Quality measures to include Adult and Children's Core Sets for individuals with Substance Use Disorder, how the state will evaluate demonstrations in terms of health outcomes, health care costs, and service utilization. They also should include a framework to evaluate successful care transitions to outpatient care.

n) State's method for collaboration with the Social Security Administration to coordinate funding.

STATE STATUTORY AND/OR REGULATORY CHANGES

This initiative proposes that in 2017, the Alaska Legislature and DHSS, as appropriate, would make the following changes:

- Remove the requirement from Alaska Statute that limits Medicaid behavioral health providers to those who receive grant funding from the Division of Behavioral Health;
- Expand provider types that can bill Medicaid for clinical services to include Psychologists, Licensed Clinical Social Workers, Licensed Psychological Associates, Licensed Professional Counselors, and Licensed Marriage and Family Therapists;
- Establish Behavioral Health Aides as rendering providers of early intervention and other clinic services under the supervision of a physician.

This would require a change to the following statutes and regulations:

- *AS 47.07.030 Medical Services to be Provided.* This state statute outlines the services that may be provided under the Medicaid program. These Section requires provision of all mandatory services under Title XIX of the Social Security Act (a) and grants authority to offer a specified list of optional services (b), including (but not limited to) clinic services; rehabilitative services for substance abusers and emotionally disturbed or chronically mentally ill adults; psychologists' services; and clinical social workers' services.
    - Licensed Psychological Associates services, Licensed Professional Counselors services, and Licensed Marriage and Family Therapists services would need to be added to AS 47.07.030.
- Supporting regulations would need to be developed to allow all of these provider types, including psychologists and Licensed Clinical Social Workers, to bill Medicaid for clinic services.

- Because Behavioral Health Aides would be authorized to bill under the supervision of a physician, this recommendation likely would not require a statutory change but could be accomplished by modifying the regulations associated with Physician's Services.
- *Alaska Statute 47.07.036 Cost Containment Measures Authorized.* This statute grants DHSS broad authority to implement cost containment measures to manage program costs. It is unclear whether the type of performance-based contract proposed for the Administrative Services Organization would fall under this authority, although it certainly falls within the continuum of care management and cost containment options that states are pursuing.
- *AS 47.07.900 Definitions.* The definition in statute for "rehabilitative services" means services for substance abusers and emotionally disturbed or chronically mentally ill adults provided by (A) a drug or alcohol treatment center that is funded with a grant under AS 47.30.475; or (B) an outpatient community mental health clinic that has a contract to provide community mental health services under AS 47.30.520 - 47.30.620. The definition outlined in 47.07.900 would likely need to be modified and regulations would need to be updated to reflect these changes.

This section's preliminary analysis of statutory and regulatory changes that would be necessary to implement this initiative must be analyzed further by DHSS.

RATE STRUCTURES AND PAYMENT MECHANISMS

The DHSS Office of Rate Review is currently conducting a rate review for behavioral health services and, as such, broader rate reform was not explored as part of this initiative. DHSS is exploring various payment models, including tiered payments, incentive payments, and capitated payments that could support the changes recommended as part of this initiative.

MONITORING AND REPORTING REQUIREMENTS

CMS requires states to maintain and/or improve quality metrics throughout the demonstration period. States should be prepared to demonstrate to CMS the health outcomes, health care costs, and service utilization associated with their Section 1115 demonstration projects. This includes assessments of the impact of providing services on readmission rates to the same level of care or higher, Emergency Department utilization, and inpatient hospital utilization.

If DHSS applied for an amendment to the Section 1115 waiver to focus on Substance Use Disorder services, it must meet and will be subject to program requirements specific to Substance Use Disorder that will be incorporated into the Standard Terms and Conditions of the demonstration project. States will be required to report the relevant quality measures from the Medicaid Adult and Children's Core Sets for individuals with Substance Use Disorder, including the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (NQF #0004).[106] States also will be required to report the SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and the SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge (NQF #1664) measures. States are encouraged to use the Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence (NQF #2605) measure in their evaluation design. States are also encouraged to include the Pharmacy Quality Alliance opioid performance measures in their design for evaluating efforts to reduce prescription opioid drug abuse.[107]

[106] http://www.medicaid.gov/federal-policy-guidance/downloads/SMD15003.pdf

[107] Ibid.

EXPERIENCE OF OTHER STATES

Many states have successfully improved health outcomes and reduced costs of care by increasing access to appropriate behavioral health services to reduce more expensive crisis and inpatient services. An April 2014 national study by Milliman, Inc. identified that "because of fragmented care, general medical costs for treating people with chronic medical problems, as well as mental conditions, are two-to-three times higher than those for treating people with physical health conditions only." The study estimated that "effective integration of medical and behavioral care could save $26-$48 billion annually in general healthcare costs. Most of the projected reduced spending is associated with facility and emergency room expenditures in hospital facilities."[108]

Identifying and implementing practices with strong clinical outcomes and low costs is critical to the successful integration of behavioral health and primary care. A comprehensive system of behavioral health care provides services for those diagnosed with mild to moderate disorders as well as those with serious disorders. With the integration of behavioral health with primary care, the identification of behavioral health disorders as well as treatment for those diagnosed with mild to moderate disorders will increasingly occur within the primary care environment.

The Washington State Institute of Public Policy, a non-partisan research organization working on behalf of the Washington legislature, has completed a meta-analysis of high quality research studies of evidenced based treatments that have achieved improvements in outcomes and the costs to taxpayers. Table 7 identifies those practices with the highest likelihood of successful treatment with benefits outweighing the costs. "Total benefits" includes estimates of labor market and health care benefits. Program costs estimate the cost of service. "Health Care Benefits (Direct to Taxpayer)" provides an estimate of the reduced cost of taxpayer-funded services. "Total Health Care Benefits" includes taxpayer benefits, participant benefits, as well as other benefits such as reduced crime, spillover from improvement in human capital outcomes, reduction in victimization from crimes, and benefits to private and employer-sponsored insurance companies. "Chance Benefits Will Exceed Costs" provides the Institute's calculated likelihood (percentage) that service benefits will exceed costs.

[108] Economic Impact of Integrated Medical-Behavioral Healthcare Implications for Psychiatry, April 2014. Milliman, Inc.

Table 7. Benefits and Costs of Selected Evidence Based Treatments with Significant Net Benefits[109]

	TOTAL BENEFITS	PROGRAM COSTS	HEALTH CARE BENEFITS (DIRECT TO TAXPAYER)	TOTAL HEALTH CARE BENEFITS	CHANCE BENEFITS WILL EXCEED COSTS
MENTAL HEALTH PROGRAMS FOR ADULTS					
Cognitive Behavioral Therapy for anxiety	$39,597	($357)	$637	$1,955	99%
Cognitive Behavioral Therapy for PTSD	$37,354	($351)	$3,107	$9,519	100%
Cognitive Behavioral Therapy for depression	$29,162	($237)	$1,692	$5,183	100%
Collaborative Primary Care for anxiety	$25,903	($808)	$423	$1,297	92%
Collaborative Primary Care for depression	$8,264	($808)	$605	$1,855	100%
Collaborative Primary Care for depression with comorbid medical conditions	$4,390	($862)	$614	$1,881	94%
PTSD prevention following trauma	$4,991	($839)	$467	$1,434	98%
MENTAL HEALTH PROGRAMS FOR CHILDREN					
Remote Cognitive Behavioral Therapy for anxiety	$22,720	($777)	$845	$2,592	99%
Group Cognitive Behavioral Therapy for anxiety	$7,380	($411)	$263	$807	99%
Individual Cognitive Behavioral Therapy for anxiety	$5,224	($769)	$186	$570	94%
Parent Cognitive Behavioral Therapy for anxiety	$1,845	($637)	$63	$194	99%
Behavioral Parent Training for children with ADHD	$347	($111)	$21	$64	90%
Triple P Positive Parenting Program: Group	$1,015	($550)	$121	$372	100%
Cognitive Behavioral Therapy for child trauma	$6,169	($332)	$521	$1,599	98%
SUBSTANCE ABUSE TREATMENT: EARLY INTERVENTION					
Brief Intervention in primary care	$7,554	($270)	$93	$243	94%
Brief Intervention in a medical hospital	$6,343	($158)	$78	$203	74%
Brief Intervention in emergency department (SBIRT)	$4,367	($427)	$137	$378	74%
Brief Alcohol Screening and Intervention of College Students (BASICS): A Harm Reduction Approach	$1,925	($72)	$50	$130	71%
Brief intervention for youth in medical settings	$1,176	($328)	$30	$78	67%
SUBSTANCE ABUSE TREATMENT FOR ADULTS					
Cognitive Behavior Coping Skills Therapy	$35,687	($262)	$769	$1,975	98%
Brief Marijuana Dependence Counseling	$7,656	($549)	$67	$202	91%
Methadone maintenance treatment	$10,870	($3,706)	$375	$979	95%
Buprenorphine/Buprenorphine-Naloxone (Suboxone and Subutex) treatment	$6,162	($,4538)	$306	$800	98%

[109] Washington State Institute for Public Policy. http://www.wsipp.wa.gov/BenefitCost

In 2005, Washington increased its funding of treatment services for chemically dependent adults and substance-abusing youth with the intent of increasing access to services to more residents and decreasing overall costs. Ninety-seven percent of the funding ($31 million) for increased services came from anticipated savings (cost offsets) in medical and long-term care. After three years, results showed that more people could be treated successfully for a lower overall cost.

- *Treatment expansion reduced medical and nursing home costs for substance use treatment.* 2008 savings per patient after substance use treatment expansion were significantly greater than the 2005-2007 appropriation. In 2008, medical savings for adult Medicaid Disabled patients were $321 per patient per month, $121 more than projected; nursing home savings for this population were estimated to be $82, $24 more than projected; medical savings for General Assistance Unemployable patients were $162 per patient per month, $43 more than projected.
- *With increased access to substance use treatment, more adults and youth engaged in and completed treatment.* During FY 2008, 5,413 more adults engaged in substance use treatment in Washington than in FY 2005 when 18,378 engaged in treatment. 6,425 youth engaged in treatment in FY 2008 compared with the 6,296 in FY 2005. Likewise, outpatient treatment completion rates increased for youth residential from 51 percent to 81 percent and for youth intensive inpatient treatment from 62 percent to 73 percent. Outpatient treatment rates for all identified populations (with the exception of the Medicaid aged population) also increased. [110]

Pennsylvania also transformed its behavioral health system resulting in increased access to care with lower program costs. According to a 2010 study by Compass Health Analytics, commissioned by the Pennsylvania Department of Public Welfare, the Pennsylvania Medicaid Behavioral HealthChoices program saved an estimated $4 Billion between 1997 and 2008 in the three most populous regions of the state. In the same period, it increased access to behavioral services and demonstrated improvements on key quality performance measures.

Key features of the Medicaid Behavioral HealthChoices program include:

- A single contractor for each county unit.
- Counties were offered right of first opportunity to contract with the Pennsylvania Department of Public Welfare to run their county-level HealthChoices program.
- Each county uses a collaborative model that brings together county behavioral health systems, other county-level human services systems, local providers, and managed care partners.
- Counties retain earnings in the program or reinvest them in behavioral health system infrastructure.
- Each county program is accountable to a County or joinder-level oversight board or governance body, responsible for financial performance, access, and quality.

The HealthChoices per-person rate of cost growth was well below the assumed rate of cost growth in fee-for-service estimated at 5.5 percent. The 5.5 percent assumption was used even though the pre-HealthChoices behavioral cost growth in Pennsylvania fee-for-service Medicaid was 9.5 percent, and the national rate of Medicaid behavioral health cost growth during the same period was approximately 4.5 percent at a time when the great majority of these programs had recently converted to managed care.

[110] Division of Alcohol and Substance Abuse Treatment Expansion: Spring 2009 Update, Washington State Department of Social and Health Services.

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 enrollees. For example, the percentage of individuals with serious mental illness receiving services increased 50 to 60 percent 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 percent. African-Americans had an increase in the percentage of enrollees receiving services of 30 to 40 percent. Of the eight access performance measures tracked by the Pennsylvania Department of Public Welfare, one declined 1 percent and the other seven increased by between 27 and 65 percent. Similarly, seven of eight quality metrics tracked by the Pennsylvania Department of Public Welfare increased over the same period (2003 to 2008), with one showing a small decline.[111]

New Hampshire is currently in the process of applying for and securing a Section 1115 waiver to transform its behavioral health system. New Hampshire submitted an initial application for a Section 1115 waiver in May 2014. Specifically, the waiver will develop infrastructure for high quality, integrated care, improve outcomes and reduce the rate of growth in Medicaid spending. In an analysis of trends in successful Section 1115 applications, New Hampshire concluded that the following principles were paramount: setting a clear vision with concrete metrics, defining clear pathways with established options for providers, establishing performance metrics tied to payment, and narrowing the scope of transition payments to cover infrastructure, technology, and human resource investments. Noteworthy projects included in New Hampshire's revised Section 1115 waiver initiative include:

- Investing in mental health workforce development to support access to behavioral health providers in underserved areas of the state, including those who serve individuals with co-occurring mental health and Substance Use Disorders.
- Establishing a specific workforce development initiative for Substance Use Disorder providers to promote increasing treatment capacity throughout the state.
- Increasing access to behavioral health community crisis, intervention, and stabilization services.
- Enhancing Assertive Community Treatment (ACT) services.
- Developing an evidence-based medication adherence program in community-based sites for behavioral health medication compliance.
- Implementing telemedicine programs to support and deliver behavioral health services.
- Creating and implementing a behavioral-health specific discharge plan for individuals moving between care settings, returning to the community, or leaving corrections facilities.

New Hampshire's funding model includes Transition Payments to help providers build capacity and to stabilize and/or increase capacity in the near-term and Ongoing Support Payments that can be used for staff training and infrastructure investments (including technology) tied to performance incentives. At the end of the waiver period, the hope is to transition to value-based contracting arrangements with private and public payers.[112,113]

[111] Provided to DHSS by The Curie Group: Long-term Performance of the Pennsylvania Medicaid Behavioral Health Program, Compass Health Analytics, Inc., December 2010.

[112] New Hampshire Department of Health and Social Services. Building Capacity for Transformation: Next Steps for NH's 1115 demonstration waiver http://www.dhhs.nh.gov/Section-1115-waiver/documents/overview-122014.pdf

[113] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/nh-building-capacity-transformation-pa.pdf

POTENTIAL CHALLENGES

The Alaska behavioral health system is currently undergoing significant change and transformation. The primary challenge is achieving the goals of transformation, which are improving health outcomes and reducing costs. Change requires systems and organizations to adapt practices and processes to new requirements. Some of the anticipated challenges for providers include organizational and clinical readiness; leadership and staff buy-in; organizational cultural change; financial capacity; workforce recruitment, retention, and training; relationship building; introduction of an Administrative Services Organization; use of data to drive care; navigating privacy requirements related to health information sharing for behavioral health clients; and, developing and adapting to new technologies.

Some of the anticipated challenges for DHSS include balancing competing systems change priorities; limited staff availability; level of organizational readiness; organizational cultural change as DHSS moves from program management to contract management; working with an Administrative Services Organization; managing the transition from grant dollars to Medicaid dollars for specific services; grant reformation; DHSS-wide budget reductions; managing the pace of change; meeting CMS evaluation criteria; communications and collaboration; and, developing and adapting to new technologies and data analysis practices.

Unintended consequences could include threats to Community Behavioral Health Center financial stability by reducing grant funds and transitioning to Medicaid before providers are ready or spreading small client populations across more providers; and, increased workforce challenges as more positions become available.

PROVIDER ROLES

This initiative cannot be implemented without broad engagement between DHSS and providers and agreeing to a common vision. Behavioral Health providers will be asked to expand existing services and, in some cases, offer new types of services; they will also be asked to share and use data in ways they have not done previously. For Primary Care practices, the prospect of hiring a licensed behavioral health professional will become more feasible, improving the sustainability of integrated care. Primary Care practices and Community Behavioral Health Centers that take on Primary Care Case Management and Section 2703 Health Home responsibilities will be asked to take greater responsibility for assisting enrollees in navigating the health care system and improving their health.

OPPORTUNITIES FOR COLLABORATION WITH OTHER PAYERS

There may be opportunities to collaborate with private insurers who are interested in expanding access to mental health and Substance Use Disorder services. Potential areas for collaboration include aligning approved screening and assessment tools, aligning processes for pre-authorizations, developing shared goals and strategies for increased services, supportive employment programs, and workforce development. The Department of Corrections will also continue to be an important partner as the system of care becomes accessible to adults with Medicaid coverage.

PROJECTED TIMELINE AND STATE RESOURCE REQUIREMENTS

This initiative proposed securing CMS authority for a Section 1115 waiver for the behavioral health system and, subsequently for Substance Use Disorder services. If approved, the demonstration period could be up to eight years, five years initial approval with option for a three-year extension. Developing the proposal and implementing the Section 1115 demonstration project will require significant effort such as provider network development to achieve access targets, building out the continuum of care, and transitioning from grant to Medicaid funding. An important early step will be to conduct readiness assessments of both DHSS and providers.

This initiative will require ongoing commitment of time and support from DHSS leadership and staff resources to draft and communicate regulatory changes. Other specific tasks include developing and drafting the Section 1115 waiver application; managing stakeholder engagement process; securing an Administrative Services Organization; steering the transition from program management to contract management that will accompany the hiring of an Administrative Services Organization; building out data analytics and technology infrastructure; implementing business process improvements; and, developing the resources to manage the implementation and evaluation of the Section 1115 waiver. This initiative is also dependent on the related projects currently underway.

Proposed implementation steps:

a) In SFY 2017, DHSS develops a proposal for Section 1115 waiver for behavioral health services that identifies the desired continuum of care and priority service areas with the goal of securing CMS approval by the end of SFY 2017. This proposal would also identify the management structure for the proposed system transformation. During the development of the proposal, DHSS would issue a Request for Interest (RFI) from Administrative Services Organizations to identify the potential scope of services and other contract elements, followed by a Request for Proposals to secure the required services.

b) Upon approval from CMS, DHSS would establish a contract with an Administrative Services Organization to develop the system management structure. DHSS and the Administrative Services Organization would work to develop standards of care and prepare for expanded provider types and network development. The contract would include incentives to ensure the system moves toward the desired continuum of care and meets established benchmarks for quality and cost containment.

c) By 2017, the Alaska Legislature and DHSS, as appropriate, would make the required statutory and regulatory changes described in this initiative.

d) In SFY 2018, DHSS successfully applies to CMS a Section 1115 waiver related to Substance Use Disorder services to secure a waiver from the IMD exclusion to allow Alaska providers to begin billing for residential Substance Use Disorder treatment in facilities with more than 16 beds.

The submission process for Section 1115 Waivers requires states to provide the following:

a) Demonstration program description, and goals and objectives that will be implemented under the demonstration project.

b) Description of the proposed health care delivery system and benefit coverage.

c) Estimate of the expected increase or decrease in annual aggregate expenditures by population group impacted by the demonstration. If available, include historic data for these populations.

d) Estimate of historic coverage and enrollment data (as appropriate), and estimated projections expected over the term of the demonstration, for each category of beneficiary whose health care coverage is impacted by the demonstration.

e) Other demonstration program features that require flexibilities within Medicaid and CHIP programs.

f) Types of waivers and expenditure authorities that the State believes to be necessary to authorize the demonstration.

g) Research hypothesis or hypotheses that are related to the demonstration's proposed changes, goals, and objectives, a plan for testing hypotheses in an evaluation context, and if a quantitative evaluation design is feasible, identification of appropriate evaluation indicators.[114]

The proposed timeline (Figure 5) does not factor in resource constraints or the time required for DHSS to secure budgetary resources and authority to implement the initiative, but rather assumes availability of DHSS resources and is based on the anticipated effort and timing of steps associated with obtaining federal approval. If the decision is made to move forward with the recommended reforms, DHSS would then determine the resources and time required to implement the initiative.

[114] 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

Figure 5. Phased Approach for Behavioral Health Access Initiative



Phase 1: Reforms Underway SFY 2014 - 2016	**Phase 2: Foundation for Transformation** SFY 2017 - 2018	**Phase 3: Towards Paying for Value** SFY 2019 - 2020	**Phase 4: High Value, High Functioning System** Beyond SFY 2020
• Planning for 1915(i) and 1915(k) Options for Home and Community-based Services • Planning for Certified Community Behavioral Health Clinics • Behavioral Health Rate Rebasing Project • Division of Behavioral Health System of Care Efforts • Strategic Plan for Permanent Supportive Housing • Returning Citizens Initiative • Medicaid Innovation Accelerator Program Support	• Conduct a readiness assessment of DHSS and providers • Develop, conduct stakeholder process and negotiate Section 1115 behavioral health waiver request to CMS • Issue Request for Information for ASO services to Prospective Bidders • Develop standards of care for services/ settings • Issue Request for Proposals and select ASO vendor • Make and communicate statutory and regulatory changes • Make and communicate program changes • Invest in network development and Medicaid billing technical assistance • Submit amended 1115 application for Substance Use Disorder services	• Implement 1115 waiver program and evaluate results • Manage ASO vendor, support network development and other ASO efforts	• Implement 1115 waiver program and evaluate results • Manage ASO vendor, support network development and other ASO efforts • Build on success and continue system transformation

INITIATIVE 3. DATA ANALYTICS AND INFORMATION TECHNOLOGY INFRASTRUCTURE INITIATIVE

Through this initiative, Alaska's Department of Health and Social Services (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 proposes using the existing Health Information Exchange (HIE)[115] and DHSS's Data Warehouse Decision Support System (Data Warehouse) for this purpose. This initiative would increase the HIE's utility by connecting Alaska's hospitals, Emergency Departments and 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 and support 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.

DESCRIPTION

Data sharing and analysis are foundational to transforming Alaska's health system and achieving the goals of Medicaid Redesign and Expansion. DHSS must be able to access and analyze data to manage care, evaluate costs, improve health outcomes, and contain program expenditures. Performing data analytics at the system level is a critical responsibility of all payers and providers of health care services to manage resources and monitor outcomes. DHSS must also facilitate appropriate health information sharing among providers in order to coordinate care, for example, for a provider to know the results of tests performed at another facility or the health history of a new patient.

Advanced data analytics require robust data collection and management. Currently, disparate systems in Alaska's healthcare environment collect and manage health information. This initiative would build on current efforts to pull data into a single repository that would connect hospitals, providers, and the Medicaid program into a coordinated system. DHSS currently lacks capacity to analyze health data and connect providers. This initiative proposes contracting with an advanced data analytics organization to provide this function. This contractor would use data from the Data Warehouse and the HIE to build a platform to provide detailed program data and decision support tools to providers. This would empower primary and behavioral health care providers to manage their Medicaid patient populations.

The Health Insurance Portability and Accountability Act of 1996, commonly referred to as HIPAA, includes the Privacy Rule, which provides federal protections for individually identifiable health information held by covered entities and their business associates and gives patients an array of rights with respect to that information. The Privacy Rule is balanced so that it permits the disclosure of health information needed for patient care and other important purposes.[116] Any system that manages health data must comply with the HIPAA Privacy Rule to protect patient privacy.

Alaska's HIE is at the core of this proposed initiative. In May 2009, the Alaska legislature unanimously passed Senate Bill 133 (AK 18.23.300), to create a statewide health information exchange that is

[115] A Health Information Exchange is a translator, which allows information to be shared between disparate systems and programs. It allows providers to share data even when their Electronic Health Records operate using different software or other systems.

[116] 45 CFR Part 160 and Subparts A and E of Part 164; http://www.hhs.gov/ocr/privacy/hipaa/understanding/index.html

interoperable and compliant with state and federal specifications and protocols for exchanging health records and data. The HIE currently offers the following services: [117]

- Clinical portal access: query based exchange; ability to view a patient's entire record across multiple, disparate organizations over time; ability to import from the repository to an Electronic Health Record (EHR); and, national query access.
- Direct Secure Messaging: ability to send a single, encrypted message from point to point; available as stand-alone or embedded in EHR; national directory access.
- Electronic Health Record: a fairly robust EHR solution, which can be an alternative certified EHR solution for providers who do not own and implement an EHR;
- Patient Portal: provides consumer access to his/her protected health information to print or download; ability to receive secure messages from provider and upload documents to the provider.

The HIE allows for secure access, use, and transfer of data within Alaska's health care delivery system.

DHSS contracts with the Alaska eHealth Network (AeHN), the non-profit organization charged with managing the HIE. AeHN aims to connect Alaska's 28 hospitals and a multitude of the state's health care providers with near real-time actionable health information to address population health issues, improve enrollees' health care experience and control costs. AeHN provides technical assistance to providers for EHR selection and implementation; workflow analysis and re-design; Meaningful Use eligibility determination, registration, attestation, report tracking, risk assessment and audit preparation.

This initiative would provide support for the Primary Care Improvement Initiative, the Behavioral Health Access Initiative, the Emergency Care Initiative, Accountable Care Organization (ACO) Pilots, and expanded use of telemedicine. It would also potentially improve the business processes of the Medicaid program and reduce the administrative burden on providers. As the initiative evolves and more data becomes available and is used to manage the system, it would provide the infrastructure to support large-scale delivery system transformation.

The proposed initiative would support the integration of primary care and behavioral health services by facilitating appropriate access by providers to behavioral health service data using the HIE. The Division of Behavioral Health is currently analyzing the most cost effective option for collecting required behavioral health data from providers, while eliminating the current practice of separately entering data into both Electronic Health Records and program data reporting systems.

This initiative also proposes that the HIE would integrate the functionality of the Prescription Drug Monitoring Program, to allow for daily uploads of data rather than the current two to four week delay. Alaska's Prescription Drug Monitoring Program monitors controlled substances dispensed in the state. In 2008, the Alaska Board of Pharmacy was directed by Alaska Statute 08.80.030(b)(11) to establish and maintain a controlled substances prescription database to report dispensed prescriptions for all schedule IA-VA controlled substances under state law and Schedule II-V controlled substances under federal law.[118] The program is intended to improve patient care; reduce misuse, abuse, and diversion of controlled substances; and, to encourage cooperation and coordination among state, local, and federal

[117] Communication with Beth Davidson; http://www.legis.state.ak.us/basis/aac.asp#7.165.900 (Section 7 AAC 166.010 – 166.050 & 7 AAC 166.900

[118] For information on federal classification, see http://www.deadiversion.usdoj.gov/21cfr/cfr/2108cfrt.htm

agencies and other states to reduce the misuse, abuse, and diversion of controlled substances. Dispensers are required to electronically submit information about each prescription dispensed for a Schedule II to V controlled substance. The online reporting application allows users to see information on all scheduled prescriptions given to a specific patient during a determined period, which allows providers to make informed treatment decisions and provide appropriate patient care. Connecting primary care, behavioral health and Emergency Department providers to the Prescription Drug Monitoring Program will increase the validity and utility of the program to prevent the misuse of prescription drugs, especially opioids.

KEY FEATURES

a) Continue onboarding Medicaid providers to the HIE. DHSS would evaluate changing Medicaid regulations to require participation with the HIE for all Medicaid providers.

b) Complete DHSS's current efforts, using HITECH funding,[119] to populate the HIE clinical data repository with Medicaid claims data.

c) Division of Behavioral Health would complete its analysis and implement the most cost effective option for collecting required behavioral health data from providers while eliminating double data entry practices.

d) Integrate the Prescription Drug Monitoring Program into the HIE infrastructure to provide near real-time connection to the Prescription Drug Monitoring Program database to reduce misuse of prescription drugs, especially opioids.

e) Connect Emergency Departments with each other and with primary care and behavioral health providers to ensure follow up from emergency visits.

f) Contract with an advanced data analytics firm that would use information from the Data Warehouse to provide DHSS advanced utilization and programmatic reports. This includes data aggregation of enrollee-level information and the ability to drill-down at the enrollee level to identify utilization patterns. The contractor would provide the infrastructure to enable a two-way communications platform, provider dashboards and population management tools between Medicaid providers and DHSS. This could be especially powerful for the development of the Accountable Care Organization pilots.

TRIBAL PARTICIPATION

There are no special rules related to American Indian/Alaska Native enrollees in this initiative.

Many Tribal Health Organizations in Alaska have migrated from using the Indian Health Service Resource and Patient Management System (RPMS) to commercially available EHRs, particularly Cerner. Many Tribal Health Organizations are using data analytics derived from their system data to drive improvements in quality care. Connecting Tribal providers to the HIE would improve communication with non-Tribal providers related to patient care.

[119] The Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009, was signed into law on February 17, 2009, to promote the adoption and meaningful use of health information technology.

SPECIAL POPULATIONS

There are no special rules related to special populations in this initiative.

RELATED PROJECTS

DHSS and AeHN are currently working together to build the capacity of the HIE. While the majority of hospitals are on-boarded, other providers are just beginning to engage with the HIE. The Medicaid EHR Incentive Program was launched in Alaska in January of 2011 and DHSS began making payments to eligible providers and hospitals in 2011. This has increased the number of providers with access to EHR systems, and the ability to use them to meet Meaningful Use requirements.

ANTICIPATED IMPROVEMENTS TO SERVICE DELIVERY

Successful system transformation requires advanced data analytical capabilities, connectivity with health care providers, and timely identification of utilization events, to coordinate care and achieve cost efficiencies across the delivery system. This initiative can improve patient care and decision-making while supporting other health reform initiatives by improving the data set available to DHSS, as well as harnessing data to improve cost efficiency and care outcomes for the Medicaid population.

Increasing access to enrollee data at DHSS would allow Alaska Medicaid to analyze the effectiveness of specific services, and further enhance utilization review and quality monitoring. Detailed examination of high cost services across the Medicaid population, by regions or provider networks, enhances care management. This approach can complement the Alaska Medicaid Coordinated Care Initiative, which is focused on high utilizers of emergency care. For example, data on inappropriate Emergency Department use by region may help DHSS identify common triggers such as Primary Care Provider appointment wait times or limited access to specialty care, that prompt enrollees to seek emergency care. DHSS can then use enrollee information to identify and address the differing needs of population subsets.

This initiative provides the technological means for Primary Care Providers to see the overall population health of assigned enrollees and begins to break down the siloes that exist between physical and behavioral health sectors. The proposed improvements would enable providers to provide feedback on their patient population and transmit data to DHSS through dashboards or other reporting tools, with less administrative work. This could increase provider satisfaction, willingness, and ability to manage the healthcare needs of assigned enrollees. This is a valuable tool as DHSS moves towards value-based payment models such as shared savings or care management fees, as described in the reform initiatives in this report.

ANTICIPATED IMPROVEMENTS TO OUTCOMES AND ACCESS

Through coordinated efforts with the HIE and the Data Warehouse, DHSS can benefit from the operation of a single Information Technology (IT) infrastructure capable of supporting near real-time transfer, notification, and coordination of information. This would enable advanced data analytic capabilities to create opportunities for population health improvement.

With increased data analytics capacity, this approach can enhance the review of complaints, grievances, and appeals. Similarly, this fuller picture of care can improve quality assurance and fulfill CMS quality improvement requirements. Enhanced care management tools enable management and coordination of

enrollee care, and support and facilitate communications between the enrollee and participants of the enrollee's care team at the clinic level, and for DHSS and administrative vendors.

Providers can gain access to nationally-recognized, evidenced-based guidelines and standards of care to improve member outcomes and minimize unnecessary costs. Both DHSS and providers can benefit from data that could identify the cultural and linguistic needs of members which is often captured in clinical EHRs but not in the Medicaid claims database. Providers would be more likely to report data back to DHSS if they have an easy means to submit and access patient data. Importantly, helping providers and care managers better understand the Medicaid enrollee, their needs and their usage patterns, can improve patient satisfaction.

PROJECTED COSTS AND SAVINGS

This initiative primarily enables other reform efforts and the Medicaid program to achieve increased cost efficiencies; however, it is a challenging initiative to implement. Through the CMS Advanced Plan Document process (42 CFR 433.112) DHSS could leverage 90 percent federal funding for the design, development and installation of automated systems needed for this initiative. Ongoing operation costs to fund some of the features of the initiative can be claimed at 75 percent federal funding level (42 CFR 433.116). The funding environment is competitive and the process for obtaining CMS approval for proposals can be lengthy.

Many states rely on third parties to support selection, implementation, operations and hosting of data analytics solutions and to augment data analytics staff. Vendor costs are based on a variety of factors. Cost considerations in increasing and building out data analytics capacity include:

a) The cost of converting data housed in legacy platforms and interfacing to existing information systems, including the existing Medicaid Management Information System (MMIS), Medicaid program vendors, registries, and systems used by state agencies. These costs can be significant, and the effort can be very resource-intensive and time-consuming.

b) The size of the Medicaid program drives data volume and analytics. Many vendor solutions are priced based on program membership.

c) The infrastructure design, development, and implementation needs, such as those that enable two-way communications platforms, provider dashboards, population management tools and data collection from Emergency Departments.

d) The need to manage a variety of metrics. Currently, various programs and performance improvement efforts identify and require measurement and reporting on a wide array of performance metrics. Whenever possible, efforts should be made to standardize and streamline to common metrics. While this goal is not always achievable, a greater attention to streamlining and building upon metrics and capabilities that are already developed is beneficial.

e) The need for staffing for data analytics solution administration and maintenance, data analytics and performance reporting. Many states identify staffing as a key difficulty related to effective use of existing and future data analytics solutions, or the lack of staff to even identify and procure a useful solution.

f) The need for vendor technical support. Due to the staffing issue noted above, technical assistance and support from vendors is critical to the successful deployment and maintenance of a data analytics solution. States often have ongoing needs for ad hoc reporting and analytics and do not have staff who can perform these tasks.

g) Ensuring data quality and integrity.

For all of these elements, processes need to be in place along with an appropriate data governance structure to ensure there is an ongoing system of data checks and balances.

This initiative was not included in the actuarial analysis performed for this project.

FEDERAL REQUIREMENTS FOR IMPLEMENTATION

DHSS would investigate and pursue funding opportunities to implement this initiative. CMS supports system development through a variety of funding initiatives, including enhanced match (90 percent FMAP) for design, development, and implementation of automated systems, and through the CMS Advanced Plan Document process (42 CFR 433.112).

STATE STATUTORY AND/OR REGULATORY CHANGES

DHSS may consider changing Medicaid regulations to require participation in the HIE for all Medicaid providers. This would support robust data collection and coordination of care among providers.

To integrate the Prescription Drug Monitoring Program into the HIE will require Alaska Board of Pharmacy approval according to AS 08.80.030(b)(11). This indicates that the board is responsible for the control and regulation of the practice of pharmacy including "(11) establish and maintain a controlled substance prescription database as provided in 17.30.200."[120] It may require modification of this statute.

MONITORING AND REPORTING REQUIREMENTS

Federal monitoring and reporting are not required for this initiative.

EXPERIENCE OF OTHER STATES

The Georgia Department of Community Health, the state's Medicaid agency, developed a Virtual Health Record (VHR) to share information among members, their families, providers, state agencies and authorized users. The VHR connects to Georgia's Health Information Network and allows providers to access enrollee-specific health information. It hosts a portal for providers to report mandated enrollee health requirements, such as immunizations and wellness exams. The VHR is accessible statewide in many care settings and has improved service management, timeliness and continuity of care.

Oregon has implemented the Emergency Department Information Exchange (EDIE) in partnership with the Oregon Health Leadership Council and Oregon hospitals and health systems. The exchange alerts Emergency Department clinicians in real time when a patient who has been a high utilizer of services registers in their Emergency Department. These real-time alerts reduce duplicative services and assist clinicians in directing high utilizers to the right care setting. All of Oregon's hospitals have engaged with this project. Oregon has started to use the secure portal to exchange protected information through its HIE to benefit the Medicaid agency's review of complaints, grievances, and appeals.

[120] AS 17.30.200 can be found at http://www.legis.state.ak.us/basis/statutes.asp#17.30.200

The State of Colorado contracts with a data analytics vendor to provide statewide data analytics support to the State, Regional Coordinated Care Organizations, and providers. The Statewide Data Analytic Contractor (SDAC) was responsible for building a data repository, including hosting a web portal; data analytics and reporting; and, identifying data-driven opportunities to improve care and outcomes. In 2015, Colorado awarded $86 million to Truven Health Analytics to serve as the new Business Intelligence and Data Management vendor, replacing the SDAC and providing ongoing business intelligence and data management services to the State.

POTENTIAL CHALLENGES

The AeHN is still predominantly reliant on DHSS funding for operations. Although most hospitals have been on-boarded to the HIE or are in the process currently, the majority of other providers have not. Without broad participation, the utility of the HIE is limited. Engaging primary and behavioral health care providers will require ongoing effort and incentives, or requirements, to participate. In addition, in some parts of the state, there is competition with other platforms for sharing health information, such as the current hospital system information sharing that provides physician practices with relevant information for their shared patients. An example of this is the Epic Community Connect. This tool provides hospitals and other practices that use Epic as their EHR with structured methods for extending a shared EHR to independent physician practices.[121]

The success of the AeHN rests on its ability to onboard providers, connect them with registries and databases, and receive data submitted through their EHRs. Providers face their own challenges to meaningfully use EHR systems. The costs of installing, upgrading, and maintaining an EHR system can be prohibitive. For example, in order to participate in the AeHN, providers must have installed systems capable of transmitting data and meeting certain privacy and security standards. In some instances, systems purchased failed to meet requirements; in others, the cost of upgrading systems has meant providers have foregone upgrades necessary to meaningfully use the system.

Shaping efforts that would also help providers meet federal requirements such as Meaningful Use would be an important consideration, as well as any population data-driven payment initiatives from local commercial payers.

This initiative assumes that, at present, DHSS lacks the staffing for advanced data analytics and would need to engage a data analytics contractor to assist in assessing, planning, and pricing this solution before moving forward. This poses a challenge for covering the cost of the contract and for DHSS to manage the contractor's work to ensure the desired outcomes are achieved.

PROVIDER ROLES

This initiative creates the opportunity for the Alaska Primary Care Association, Alaska Behavioral Health Association, Alaska State Hospital and Nursing Home Association, Tribal health system partners, AeHN, and DHSS to engage and identify the information and tools that would best assist providers with managing the health of their Medicaid enrollees. This is a provider-focused initiative and requires active participation by physical and behavioral health practices, clinics and hospitals. Helping providers be successful and minimizing administrative burden is critical. Linking to practice standards or guidelines

[121] For more about Epic: https://www.epic.com/software-community.php

through electronic tools can save time for a busy practitioner and ensure the right care is delivered at the right time and place, contributing to provider satisfaction and improved outcomes for the patient.

OPPORTUNITIES FOR COLLABORATION WITH OTHER PAYERS

This initiative could be a first step in broader alignment and data sharing across payers and could support the development of an All-Payer Claims Database. All-Payer Claims Databases exist or are in development in a number of states. These data systems aggregate medical claims data from entities that pay for medical services to provide necessary information to improve health care cost, quality, and outcomes.[122] This initiative can construct the framework to which additional lines of coverage could be added. This would allow for statewide quality metrics to be examined with the broader partnerships of other payers, and have a greater influence on changing prescribing and care practices. This has been demonstrated by efforts of multiple communities across the country under the Robert Wood Johnson Foundation's Aligning Forces for Quality initiative.[123] Additionally, with greater attention to alternative payment approaches nationwide, a multi-stakeholder approach can be valuable to fulfill commercial or Medicare health plan requirements.

PROJECTED TIMELINE AND STATE RESOURCE REQUIREMENTS

Building the infrastructure and data analytic capacity would likely require three to five years of concerted focus and efforts and substantial investment by DHSS and providers.

In State Fiscal Year (SFY) 2017, DHSS would:

a) Continue the onboarding of Medicaid providers to the HIE. This may include DHSS exploring regulation changes to make participation mandatory for Medicaid providers.

b) Complete DHSS's current efforts, using HITECH funding, to populate the HIE clinical data repository with Medicaid claims data.

c) Secure federal and state funding and develop a Request for Proposals for a data analytics vendor to assess DHSS current capacity, and develop a scope of work and cost estimate for implementing necessary data analytics support. South Dakota is currently pursuing a similar effort and could potentially share their Request for Proposals with Alaska DHSS.

d) Secure funding to implement the most cost effective option for collecting required behavioral health data from providers, as determined by the Division of Behavioral Health.

e) Develop a planning document to integrate the Prescription Drug Monitoring Program into the HIE. Determine costs and potential solutions, and secure necessary funding.

f) Complete planning and feasibility analysis to identify the optimal solution to connect Emergency Departments with each other, with primary care and behavioral health providers, and with the Prescription Drug Monitoring Program. Analyze existing vendors to determine if the HIE can provide the needed functionality. If it cannot, an off-the-shelf software package such as the Emergency Department Information Exchange (EDIE) would supplement this functionality. Determine costs and requirements, and work with Alaska State Hospital and Nursing Home Association to secure necessary funding.

[122] Alaska Health Care Commission, Policy Brief: All-Payer Claims Database, December 2014. For more about APCD, see https://www.apcdcouncil.org/

[123] Robert Wood Johnson Foundation, Aligning Forces for Quality: http://www.rwjf.org/en/library/collections/af4q.html

In SFY 2018, DHSS would begin implementation of activities based on the results of the planning steps described above. This includes:

a) Continue onboarding Medicaid providers to the HIE.

b) Implement solution to connect Emergency Departments with each other, with primary care and behavioral health providers, and with the Prescription Drug Monitoring Program. Implementing this solution will require access to robust Medicaid enrollee data making this contingent on the timeline for implementation of Medicaid provider onboarding to the HIE, and enrollee selection of and assignment to Primary Care Providers, as described in the Primary Care Improvement Initiative.

c) Complete the integration of the Prescription Drug Monitoring Program into the HIE.

d) Secure federal and state funding and release Request for Proposal to secure an advanced data analytics contractor to fulfil the scope of work identified in the task above including the infrastructure to enable a two-way communications platform, provider dashboards and population management tools between Medicaid providers and DHSS.

In SFY 2019 and beyond, DHSS would:

a) Monitor and manage data analytics contractor and implementation of provider communications platforms, population management tools and continue to enhance internal data collection and analysis capabilities.

b) Continue to manage the Emergency Care Initiative and ensure as broad participation as possible among hospitals, Primary Care Providers and behavioral health providers.

c) Continue to pursue any available federal or other funding opportunities to support enhanced data collection and analytics among Medicaid providers.

The proposed timeline (Figure 6) does not factor in resource constraints or the time required for DHSS to secure budgetary resources and authority to implement the initiative, but rather assumes availability of DHSS resources and is based on the anticipated effort and timing of steps associated with obtaining federal approval. If the decision is made to move forward with the recommended reforms, DHSS would then determine the resources and time required to implement the initiative.

Figure 6. Phased Approach for Data Analytics and Information Technology Infrastructure Initiative



Phase 1: Reforms Underway SFY 2014 - 2016	Phase 2: Foundation for Transformation SFY 2017	Phase 3: Towards Paying for Value SFY 2018	Phase 4: High Value, High Functioning System SFY 2019 and Beyond
• Infrastructure development of the HIE • EHR Incentive Program • Outreach and onboarding of providers to HIE • DHSS effort to populate the HIE clinical data repository with Medicaid claims data	• Continue onboarding Medicaid providers to the HIE • Explore regulation changes to make HIE participation mandatory for Medicaid providers • Complete effort to populate the HIE clinical data repository with Medicaid claims data • Secure funding and develop a Request for Proposals for a data analytics vendor to assess DHSS current capacity, and develop a scope of work and cost estimate for implementing necessary data analytics support • Secure funding to implement the most cost effective option for collecting required behavioral health data • Develop a planning document to integrate the Prescription Drug Monitoring Program into the HIE • Complete planning and feasibility analysis to support the Emergency Care initiative	• Continue onboarding Medicaid providers to the HIE • Implement solution to support the Emergency Care initiative • Complete the integration of the Prescription Drug Monitoring Program into the HIE • Secure federal and state funding and release Request for Proposal to secure an advanced data analytics contractor to fulfil the scope of work, including the infrastructure to enable a two-way communications platform, provider dashboards and population management tools between Medicaid providers and DHSS	• Monitor and manage data analytics contractor and implementation of provider communications platforms, population management tools and continue to enhance internal data collection and analysis capabilities • Continue to manage the Emergency Care Initiative and ensure as broad participation as possible • Continue to pursue any available federal or other funding opportunities to support enhanced data collection and analytics among Medicaid providers

B. PAYING FOR VALUE: PILOT INITIATIVES

INITIATIVE 4. EMERGENCY CARE INITIATIVE

This initiative proposes that hospital Emergency Departments would access necessary Medicaid enrollee patient data to improve patient care, reduce preventable Emergency Department use, facilitate follow up with primary care and behavioral health providers, and improve prescription monitoring, to reduce opioid misuse.

DESCRIPTION

This initiative is a private-public partnership between Alaska's Department of Health and Social Services (DHSS), the Alaska State Hospital and Nursing Home Association and the Alaska Chapter of the American College of Emergency Physicians (ACEP). The initiative relies on the Information Technology (IT) 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. While it is anticipated that Initiative 5 in this report (Accountable Care Organizations) is expected to reduce use of Emergency Departments as part of its overall impact, this initiative targets individuals who are frequent users of emergency care in order to improve health and support appropriate use of care.

KEY FEATURES

a) Emergency Department providers would use Alaska's Health Information Exchange (HIE), or a commercially available software package, to access utilization and other medical information for Medicaid enrollees.[124] The software would provide the capacity to enter and share patient information in near-real time in order to provide appropriate health services and to connect enrollees with necessary follow-up care. Emergency Department providers would use the system to access necessary patient information about recent visits to other facilities, health issues, results from diagnostic tests and other relevant clinical data, including identifying high utilizers of emergency services.

b) As described in Initiative 3, the Prescription Drug Monitoring Program would be integrated into the HIE, which would provide Emergency Department providers improved access to the database used to control prescription drug use in the state. [125] Under this initiative the contract team also proposes that DHSS work with the Alaska State Hospital and Nursing Home Association and ACEP to develop statewide narcotics guidelines.

c) As described in the Primary Care Improvement Initiative, Emergency Departments would be able to refer high utilizers of emergency services to their Primary Care Providers and, for those who are eligible, to Section 2703 Health Homes, to receive appropriate care from primary care, behavioral health and coordination of community supports, such as supportive housing.

d) DHSS would develop a shared savings model to reward participating Emergency Departments for their efforts to improve care and reduce Medicaid program costs.

[124] As described in Initiative 3, DHSS would assess the functionality of the HIE to determine if it can provide adequate support for this initiative and, if it cannot, an off-the-shelf software package such as the Emergency Department Information Exchange (EDIE) would supplement this functionality.

[125] Alaska's Prescription Drug Monitoring Program is a statewide electronic database that collects data on pharmaceuticals dispensed in the state. The database allows data to be accessed by individuals who are authorized by state law to receive the information in order to facilitate the safe, effective utilization of such medications by Alaskans.

TRIBAL PARTICIPATION

Both Tribal and non-Tribal Emergency Departments and hospitals may participate in this initiative.

SPECIAL POPULATIONS

This initiative does not have any particular requirements related to special populations.

RELATED PROJECTS

The Primary Care Improvement Initiative includes a description of the Alaska Medicaid Coordinated Care pilot program. This initiative will extend the reach of this pilot program.

The Emergency Care Initiative will improve provider access to the Prescription Drug Monitoring Database through the Health Information Exchange to facilitate near real-time access to the database, as described in Initiative 3.

ANTICIPATED IMPROVEMENTS TO SERVICE DELIVERY

Connecting Emergency Department providers with necessary patient information would help to reduce inappropriate use of the Emergency Department and contain costs for the Medicaid program. This initiative, coupled with the other initiatives proposed in this report, would increase follow up with primary care and behavioral health providers to connect enrollees to care in appropriate settings. Near real-time access to the Prescription Drug Monitoring Program database would reduce misuse of prescription medications, especially opioids.

ANTICIPATED IMPROVEMENTS TO OUTCOMES AND ACCESS

This initiative provides information and direct links between providers, with the goal of improving access to appropriate care and improving health outcomes.

PROJECTED COSTS AND SAVINGS

Appropriate utilization of health services and care settings improves patient outcomes and reduces overall Medicaid program costs. 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 timelines reflected in the actuarial analysis correspond with the proposed timeline for this initiative.

The Emergency Care Initiative relies on a shared savings model to incentivize hospitals to participate and is expected to produce immediate and increasing cost savings (Table 8). Milliman projects greater reductions in Emergency Department visits each year as providers gain experience with the new practices and tools implemented through this initiative. For this analysis, Milliman replaced half of the avoided Emergency Department visits with an office visit. The resulting office visits were assumed to be distributed as follows: 50 percent to a primary care physician, 25 percent to a specialist, and 25 percent

to outpatient psychiatric visits. Milliman assumed 30 percent of resulting savings would be shared with the hospitals. See Appendix I for further details of Milliman's analysis.

Table 8. Actuarial Results for the Emergency Care Initiative

MEDICAID REDESIGN INITIATIVES: EMERGENCY CARE INITIATIVE VALUES IN $MILLIONS*					
SERVICE CATEGORY	**FY17**	**FY18**	**FY19**	**FY20**	**FY21**
Facility Inpatient	$0.0	$0.0	$0.0	$0.0	$0.0
Facility Outpatient	($4.6)	($9.7)	($12.4)	($14.6)	($17.1)
Professional	($0.5)	($0.8)	($0.8)	($0.9)	($1.1)
Pharmacy Drugs	$0.0	$0.0	$0.0	$0.0	$0.0
PCCM Fee	$0.0	$0.0	$0.0	$0.0	$0.0
Capitation	$0.0	$0.0	$0.0	$0.0	$0.0
Other	$0.0	$0.0	$0.0	$0.0	$0.0
TOTAL MEDICAL COST	**($5.0)**	**($10.5)**	**($13.1)**	**($15.5)**	**($18.2)**
ASO Fees	$0.0	$0.0	$0.0	$0.0	$0.0
TOTAL EXPENDITURE CHANGE	**($5.0)**	**($10.5)**	**($13.1)**	**($15.5)**	**($18.2)**
After Shared Savings	($3.5)	($7.3)	($9.2)	($10.9)	($12.7)
FMAP Share	($2.2)	($4.7)	($5.8)	($6.8)	($7.9)
NET ALASKA COST (SAVINGS)	**($1.3)**	**($2.7)**	**($3.4)**	**($4.1)**	**($4.8)**

** 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.*

The Information Technology and Data Analytics Initiative describes the technology infrastructure necessary to support this initiative, which includes the ability to share client data across hospitals and providers as well as streamlined access to the Prescription Drug Monitoring Database. In addition to anticipated technology costs, DHSS will need to secure approval from Centers for Medicare and Medicaid Services (CMS), execute a State Plan Amendment, negotiate the terms of the shared savings with hospitals, and establish the capabilities to identify shared savings attributable to these efforts.

FEDERAL REQUIREMENTS FOR IMPLEMENTATION

Under its current authority, DHSS spending on implementation for this initiative can be supported with federal Medicaid funds. Federal approval of a State Plan Amendment is needed for a shared savings payment to be implemented.

STATE STATUTORY AND/OR REGULATORY CHANGES

Review of the Prescription Drug Monitoring Program statute (AS 08.80.030) may be required, including considerations for any needed revisions to privacy and confidentiality limitations on data sharing. Initiative 3 includes a description of this effort.

RATE STRUCTURES AND PAYMENT MECHANISMS

This initiative proposes a shared savings payment to offset some of the revenue lost by Emergency Departments and hospitals as Emergency Department use is reduced. DHSS would work with the Alaska State Hospital and Nursing Home Association and participating providers to develop the shared savings model. DHSS could propose a structure that sets a threshold, up to which all per member Medicaid savings associated with reduced emergency care utilization accrue to DHSS. Once the threshold is reached, additional savings would be shared between DHSS and its partners. The formula used for sharing savings will reward providers who have changed practices and systems, which resulted in reduced expenditures for Emergency Department services. Actuarial analysis for this initiative assumed that DHSS would share 30 percent of the savings from this initiative with participating providers.

This approach uses shared savings as an incentive for providers who operate within a fee-for-service system that rewards volume of services provided. Emergency Departments that coordinate care to reduce utilization and divert enrollees to lower level and less expensive care settings will see a financial benefit. The goal of this approach is to reduce low acuity, non-emergent utilization of emergency services while improving health outcomes for enrollees. If DHSS cannot incentivize providers to help change these high-cost utilization patterns, the alternative may be to reduce payments or service access to find savings for emergency care.

MONITORING AND REPORTING REQUIREMENTS

Federal monitoring is not required for this initiative. DHSS monitoring of Emergency Department costs and utilization of other service settings will be required in order to determine savings to DHSS to calculate shared savings payments.

EXPERIENCE OF OTHER STATES

The initiative is modeled on collaborative efforts in Washington to reduce emergency visits and coordinate patient care.[126] Both Washington and Oregon implemented voluntary Emergency Department Information Exchange (EDIE) programs in collaboration with leadership from private health care partners.

In Washington, this project was a joint effort by the Washington State Hospital Association, Washington State Medical Association and Washington Chapter of the American College of Emergency Physicians. In the first year of implementation in Washington (FY 2013), Medicaid Emergency Department costs dropped by $33.6 million.[127] Medicaid enrollee Emergency Department visits were reduced by nearly 10 percent, with visit rates by high utilizers (5 or more visits/year) declining by approximately 11 percent. For less serious conditions, the rate went down by more than 14 percent over the year.

In 2013, the Oregon Health Leadership Council (OHLC) formed a voluntary partnership with the Oregon Health Authority (OHA, the State's Medicaid agency), the Oregon Association of Hospitals and Health Systems (OAHHS), the Oregon Chapter of the American College of Emergency Physicians (OCEP) and the

[126] http://www.wsha.org/quality-safety/projects/er-is-for-emergencies/ and https://www.wsma.org/wcm/For_Patients/ER_is_for_Emergencies/wcm/Patients/Know_Your_Choices/ER_is_for_Emergencies_Home.aspx?hkey=30298295-d65b-4804-b8a1-8a79d40e3207

[127] "Emergency Department Utilization: Update on Assumed Savings from Best Practices Implementation." Report to the Legislature. Washington Health Care Authority. March 20, 2014.

OHLC health plans to implement EDIE and build the technical infrastructure to share clinical information across care sites for the purpose of provider/care team notification. OHA, OHLC and the OHLC member plans sponsored the first year costs. The group expanded data collection to include care guidelines and all inpatient admissions, discharges and transfers. Oregon began implementation in summer 2015 and has universal adoption by all non-VA hospitals across the state, as well as strong participation by Medicaid managed care plans. Initial implementation costs were $500,000 and operational costs are $570,000 for three years, with the State funding half and the private sector coordinating financial participation for the other half. Medicaid administrative funds (50 percent) support the state share. In establishing costs in Alaska, the partners will need to take into account the significantly smaller Medicaid program, as well as information about scalable versus fixed program costs. In Washington and Oregon, the fees charged for EDIE cover the cost of the utility and data transfers.

POTENTIAL CHALLENGES

As a collaborative effort, this project requires participation by a range of hospital Emergency Departments and other providers. Some hospitals may have concerns about implementing reforms that could result in reduced revenues; however, the shared savings program with DHSS will offset some lost revenue. Implementing the technology required for this project to succeed will require financial resources and expertise, as described in Initiative 3.

PROVIDER ROLES

This is a provider-focused reform and requires active participation by Emergency Department and hospital staff, as well as primary care and behavioral health providers, for design and implementation. In Alaska, the Alaska State Hospital and Nursing Home Association has worked with the Alaska Chapter of the American College of Emergency Physicians, hospitalist physicians and some larger hospitals. There is now an opportunity for DHSS to strengthen its partnership with these private organizations, to focus on improving health and reducing costs for Medicaid enrollees.

OPPORTUNITIES FOR COLLABORATION WITH OTHER PAYERS

While DHSS has a specific interest in improving appropriate access to and use of care for Medicaid enrollees, other payers can participate as well. This includes private market payers and the Alaska Department of Administration, Division of Retirement and Benefits, which oversees health benefits for State of Alaska employees and retirees. As individuals gain and lose Medicaid eligibility over time, they cross systems and payers. Allowing providers to appropriately access patient information without regard to payer improves long-term outcomes. Other payers can participate in program development and should engage in supporting the development and operation costs.

PROJECTED TIMELINE AND STATE RESOURCE REQUIREMENTS

Initial DHSS investment can be limited, other than the investment in the HIE and integrating the Prescription Drug Monitoring Program database, as described in Initiative 3. Shared savings payments to provider organizations would be paid out of savings that accrue to DHSS from changes in service utilization and setting. Some DHSS resources will be required during program development, and to manage the assessment of savings and payments to participating providers, but this should be fundable through savings.

Significant work is involved in developing the infrastructure and capacity required for near real-time access to client data across sites. As described in Initiative 3, it will take two to three years to build the maturity of and linkages to the HIE, integrate prescription monitoring infrastructure and make near real-time data available to providers.

a) In State Fiscal Year (SFY) 2017, DHSS, the Alaska State Hospital and Nursing Home Association and ACEP would determine the parameters for a shared savings program that incentivizes provider participation, while allowing DHSS to retain savings and maintain services. During this time, the partners would collaborate to develop statewide narcotics guidelines and determine the process to adopt them. DHSS would secure necessary federal approval for the shared savings payments through a Medicaid State Plan Amendment.

b) Once the necessary infrastructure is in place and providers are connected to it, as described in Initiative 3, program implementation can begin. This could occur as a regional pilot or statewide.

c) DHSS will monitor the outcomes of the pilot, both in terms of service and setting utilization, patient outcomes and cost savings. As savings accrue to DHSS, and the threshold is met, shared savings payments will be made to providers.

The proposed timeline (Figure 7) does not factor in resource constraints or the time required for DHSS to secure budgetary resources and authority to implement the initiative, but rather assumes availability of DHSS resources and is based on the anticipated effort and timing of steps associated with obtaining federal approval. If the decision is made to move forward with the recommended reforms, DHSS would then determine the resources and time required to implement the initiative.

Figure 7. Phased Approach for Emergency Care Pilot



Phase 1: Reforms Underway SFY 2014 - 2016	Phase 2: Foundation for Transformation SFY 2017 - 2018	Phase 3: Towards Paying for Value SFY 2019 - 2020	Phase 4: High Value, High Functioning System Beyond SFY 2020
• Alaska Medicaid Coordinated Care pilot program	• Collaborate with ASHNHA, ACEP and other partners to develop program and design shared savings payments • Solicit federal approval and develop DHSS capabilities to support shared savings model • Expand State HIE capacity and infrastructure while private partners develop capacity and connect to HIE (explore alternative technology solutions, if needed)	• Continue to enhance technology and refine implementation efforts • Conduct program assessment activities, monitor and distribute savings	• Expand implementation and assess utilization changes, savings attributable to pilot

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

This initiative proposes that Alaska's Department of Health and Social Services (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.

DESCRIPTION

Accountable Care Organizations are groups of physicians, hospitals, and other health care providers, who come together to deliver coordinated high quality care to their patients. The ACO is designed to ensure that patients, especially those with chronic needs, get the right care at the right time. The coordination of providers helps avoid duplication of services and prevent errors. An ACO that delivers high quality care and controls costs can share in the savings it creates. The organizational structure of ACOs may vary, but most ACOs include primary care as the foundation and engage specialty care providers and hospitals in the greater accountability for improving health outcomes. A local group of providers or a commercial insurer working closely with providers can administer an ACO.

There are two general payment mechanisms for ACOs:[128]

- *Shared savings/shared losses model*: In this model, the state continues to pay providers directly. The state establishes a benchmark target for the total cost of care and the ACO is then eligible for a portion of the savings if it meets that cost benchmark, as well as quality targets; or conversely, is responsible for a portion of the overrun.

- *Capitated per member per month or global payment model*: In this model, the ACO is responsible for paying providers and receives a per member per month or upfront lump sum intended to cover the risk adjusted total cost of care for the patient population. If a Medicaid ACO chooses, or is required, to pay claims and assume risk, there are usually similar types of requirements, often less stringent, as those in the commercial marketplace, primarily related to ensuring the organization has enough capital reserves to cover the costs of claims. In Alaska, DHSS would have authority to require ACOs to meet additional requirements, if it expected the ACOs to be responsible for paying claims.[129]

This initiative proposes using a shared savings/shared losses model to promote local engagement and ease the transition to engaging providers in risk. A shared savings/shared losses model could offer Alaska's providers an incentive to collaborate on patient care without requiring them to take on a level of risk not commonly used in the state.

---

[128] 2015 Medicaid Health Care Purchasing Compendium. National Governor's Association.

[129] Alaska Title 21 (Insurance), AS 21.03.021. *Application of title.* [...] (b) Except as otherwise provided in this title, a person that provides coverage for the cost of medical care in this state is subject to this title unless the person shows that, while providing coverage for medical care, the person is subject to the jurisdiction of another agency of this state or of the federal government by providing the director with the appropriate certificate, license, or other document issued by the other governmental agency that permits or qualifies the person to provide coverage for medical care. (f) If an insurer is not required to obtain a certificate of authority in this state under AS 21.09.020(5), the provisions of this title do not apply to policies or contracts issued by the insurer.

KEY FEATURES

a) DHSS would work with interested providers to pilot the shared savings/shared losses ACO model in up to three communities or regions.

b) The services the ACOs would provide include primary and acute physical care, behavioral health care, post-acute care, and pharmacy (with the exception of high-cost specialty drugs); Long-term Services and Supports would not be included, at least at the outset of the pilot project.

c) Care management would be shared across the providers in the ACO.

d) DHSS would assign Medicaid enrollees to the ACOs; assignment could be based on claims and utilization patterns in the year prior to the start year. Enrollees would not be able to opt out of enrollment in an ACO (based on the program as designed in DHSS's waiver application).

e) DHSS would continue to make regular fee-for-service payments to each provider in the ACO group for Medicaid covered services and benefits.

f) ACOs would work across their provider networks to align efforts to improve the delivery of care and achieve the desired and required quality outcome goals and cost-saving targets.

g) Individual providers in each ACO would be expected to coordinate care for their shared patients to enhance quality and efficiency, and reduce the total costs of care for their assigned enrollees. DHSS would determine the targeted savings amount for each ACO as a percentage of the total costs of care of the entire similar fee-for-service Medicaid population. Savings would be split 60/40 between DHSS (60 percent) and the ACOs (40 percent) that meet the threshold quality metrics set by DHSS. ACOs that achieved higher quality targets could be eligible for a greater percentage of the savings, up to 55 percent. Each ACO would determine how the savings payout would be distributed among the providers in the ACO network and would be required to include that information in its application to DHSS.

h) DHSS would require providers to meet a set of quality indicators; providers who achieve expected cost savings but fail to meet the minimum threshold of quality standards would not receive shared savings payments. In addition, providers would be required to track and report a variety of quality measures.

i) To solicit interest from provider groups that would like to become Medicaid ACOs, DHSS could release a Request for Information (RFI). The RFI would require, at a minimum, each proposed ACO to submit the following information:

- Participating providers in the ACO network (list of specific provider entities and individual providers). ACOs could choose to include providers of Long-term Services and Supports in their governance structure so that they can share clinical information and align financial incentives that would improve transitions of care and help to reduce potentially avoidable Emergency Department and inpatient services.

- A description of the governance structure, including mechanisms for clinical and financial integration and how representation will be determined within that structure. DHSS would determine if it wants ACOs to be distinct corporate entities and if enrollee representation of some kind is required as part of the governance structure.

- A description of organizational capabilities, and leadership and management structure.
- A description of data and analytic capacity.
- The geographic area that the ACO would serve.
- The current estimated eligible Medicaid enrollees that would be served by the proposed ACO providers. It is recommended that there be a minimum of 7,500 enrollees per ACO to ensure a large enough patient population to mitigate the effects of large cost disparities and make a large enough savings impact to be of value to DHSS.
- DHSS would review the ACO proposal and contract with any it deemed viable. Each ACO would be accountable for a set of services for an assigned group of Medicaid enrollees in the specific geographic area.

j) In rural areas, the model would be regional. In more populated areas, the ACO would be a subset of Medicaid providers in a geographic area.

TRIBAL PARTICIPATION

For modeling purposes, the ACO pilot described in this initiative is focused solely on non-Tribal providers and non-Tribal enrollees assigned to the ACOs. During planning, DHSS and Tribal providers could explore Tribal interest in participating in an ACO pilot. For example, in the pilot areas, Tribal providers could be permitted to create ACOs. They could choose to develop ACOs among Tribal providers only, or in partnership with non-Tribal providers, depending on the needs of their communities and willingness of providers to participate.

SPECIAL POPULATIONS

Medicaid enrollees in an institution (skilled nursing facility or Institute for Mental Diseases) for more than 30 days would not be assigned to an ACO or continue enrollment in an ACO once they have entered an institution.

Enrollees receiving other Long-term Services and Supports could be enrolled in an ACO; however, these services would not be included in total costs of care benchmark calculations for purposes of shared savings or losses (as noted above), at least not for the first few years. These enrollees are primarily in eligibility categories that have been excluded from this ACO model design and actuarial analysis. Because it will require significant effort for both providers and DHSS to develop and implement successful ACOs and because Long-term Services and Supports are complicated to manage, it is not recommended that these benefits be included at this time. As the ACO pilots show stability and achieve savings, DHSS could work with providers to determine if, when and how to incorporate Long-term Services and Supports providers and benefits into the ACO model. This will likely be driven individually by the ACOs and how ready and able they are to include Long-term Services and Supports, as well as the needs of their specific communities.

RELATED PROJECTS

There are not any current projects that are related specifically to this initiative.

ANTICIPATED IMPROVEMENTS TO SERVICE DELIVERY

This model is built on the strengths of the providers, plans, hospitals, or other partners that come together to create an ACO. Bridging across primary and acute physical care, behavioral health care and pharmacy, ACOs can align providers to focus on managing their enrollees on a population basis, as well as ensuring care coordination and management for complex, high-needs enrollees. ACOs establish a solid foundation focused on patient-centered, team-based primary care to manage patients across the continuum of needs and strengthen connections with community services that can improve population health and lower costs. Potential shared savings creates the incentive for the ACO providers to work together to meet quality and cost goals.

Building high performing, cross-functional teams in which all partners have well-defined roles and responsibilities and work closely with the primary care team is an essential aspect of an ACO. The umbrella of the ACO structure can provide access to data and patient population analysis to assist providers in focusing on patients who need to be proactively engaged. Targeted efforts for complex case management and alignment with local organizations to link enrollees with social services can align with the clinical expertise of the providers to improve the quality and effectiveness of care for individuals and their families.

Developing ACOs requires a process of building primary care networks and creating technical assistance and data analytical tools for clinical level support. Having the ACO act as an umbrella can relieve smaller, unsupported rural or urban clinical practices from coordinating efforts by themselves. The ACO model keeps the care management within the clinical relationship as much as possible. In Alaska, the ACOs could support care coordination tasks for providers, such as travel coordination, securing pre-authorizations, scheduling referrals and processing required forms.

Alignment with the ACO infrastructure also can help small regional hospitals to communicate with outpatient providers and enhance the continuity and transitions of care, which otherwise can often result in redundant lab, imaging or Emergency Department visits, re-admissions or poor handoffs. Having incentives to smooth the process for the individual patients and their families increases both the quality of care as well as the efficiency of care, with evidence of improvement in metrics and reduction of health care cost trends.

ANTICIPATED IMPROVEMENTS TO OUTCOMES AND ACCESS

ACOs are designed to give providers incentives to coordinate care more effectively.[130] ACO enrollees are expected to have fewer inpatient admissions and readmissions, their use of primary care should increase, and there should be improvements in their utilization of medications (both overutilization and underutilization) through better medication management, and their use of hospital Emergency Departments for non-emergent care should decrease. The integration of physical and behavioral health providers into a single ACO entity also can provide significant benefit in coordinating care across systems that have traditionally operated more in siloes than collaboratively. As Medicaid ACOs are fairly new, programs are just starting to get data on savings and quality measures. As described in the state experience section, in its first year Oregon's Coordinated Care Organizations had decreased inpatient and outpatient costs compared to the period before the program was adopted.[131]

[130] CMS maintains a list of ACO information for Medicare, including a list of websites with enrollment, spending and savings information. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/MSSP-ACO-data.pdf

[131] "Oregon's Health System Transformation: 2014 Final Report." Oregon Health Authority. June 24, 2015.

As the Medicare program has been using ACOs for several years, much of the information on savings comes from that system. In August 2015, Centers for Medicare and Medicaid Services (CMS) issued 2014 quality and financial performance results that indicated that Medicare ACOs were slowing cost growth while providing improved care.[132] The 20 early adopter "Pioneer" ACOs and 333 Medicare Shared Savings Program ACOs generated total savings of more than $411 million in 2014, which is net of all ACOs' savings and losses. CMS found that overall savings increased from prior years. On an individual program basis, ACOs with more experience generated greater savings than newer ACOs.

The ACO partnership can bring improved access to specialty care using innovative approaches that connect enrollees with primary care and new models of care that align behavioral health and physical health. In addition to cost savings, DHSS should tie any shared savings an ACO could earn to meeting a minimum threshold of quality metrics. These might include standard Healthcare Effectiveness Data and Information Set (HEDIS) quality measures,[133] specific metrics that track with DHSS's overall Medicaid quality goals (e.g., inpatient readmissions, Emergency Department utilization, medication management, etc.), and utilization management criteria. ACOs also have an incentive to ensure enrollees have timely access to care with the appropriate providers. This model creates financial incentives that align entities across a community and a patient population.

PROJECTED COSTS AND SAVINGS

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 timelines reflected in the actuarial analysis correspond with the proposed timeline for this initiative.

The actuarial analysis for the Accountable Care Organizations initiative assumes a pilot program beginning in State Fiscal Year (SFY) 2019. Milliman assumed that primary care and behavioral health care services are included in the pilot while dental services are carved out. The initiative relies on a shared savings model to incentivize providers to participate and is expected to produce immediate and increasing cost savings (Table 9). Milliman assumed that utilization of preventive services would increase while utilization of a range of other services would decrease. Participating Accountable Care Organizations would receive 40 percent of the savings generated over the baseline projection on an annual basis. For this analysis, Milliman excluded Tribal members and managed care optional[134] enrollees and assumed 32.5 percent of the remaining eligible enrollee population would participate in an Accountable Care Organization pilot. The analysis is based on 285,000 member months or participation of approximately 23,750 enrollees. If enrollees are allowed to opt out, Milliman estimates that up to 50 percent of the eligible population could elect not to participate based on experience in other states. See Appendix I for further details of Milliman's analysis.

[132] "Fact Sheet: Medicare ACOs Provide Improved Care While Slowing Cost Growth in 2014." August 25, 2015. https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-08-25.html

[133] Healthcare Effectiveness Data and Information Set (HEDIS) - See more at: http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures.aspx#sthash.fzGspgpB.dpuf

[134] The eligibility categories that are managed care optional include foster care children, Title IV-E subsidized adoption children, and juveniles court ordered into state custody.

Table 9. Actuarial Results for the Accountable Care Organizations Initiative

MEDICAID REDESIGN INITIATIVES: ACCOUNTABLE CARE ORGANIZATIONS VALUES IN $MILLIONS*					
SERVICE CATEGORY	**FY17**	**FY18**	**FY19**	**FY20**	**FY21**
Facility Inpatient	$0.0	$0.0	($0.9)	($1.8)	($3.6)
Facility Outpatient	$0.0	$0.0	($1.8)	($3.2)	($6.8)
Professional	$0.0	$0.0	($0.9)	($2.2)	($4.5)
Pharmacy Drugs	$0.0	$0.0	($0.7)	($1.6)	($3.4)
PCCM Fee	$0.0	$0.0	$0.0	$0.0	$0.0
Capitation	$0.0	$0.0	$0.0	$0.0	$0.0
Other	$0.0	$0.0	($0.1)	($0.2)	($0.3)
TOTAL MEDICAL COST	**$0.0**	**$0.0**	**($4.5)**	**($8.9)**	**($18.6)**
ASO Fees	$0.0	$0.0	$0.0	$0.0	$0.0
TOTAL EXPENDITURE CHANGE	**$0.0**	**$0.0**	**($4.5)**	**($8.9)**	**($18.6)**
After Shared Savings	$0.0	$0.0	($2.7)	($5.3)	($11.2)
FMAP Share	$0.0	$0.0	($1.7)	($3.3)	($6.9)
NET ALASKA COST (SAVINGS)	**$0.0**	**$0.0**	**($1.0)**	**($2.0)**	**($4.2)**

** 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.*

Launching an Accountable Care Organizations pilot will require an investment by DHSS and participating entities. If successful, this pilot could pave the way for the development of Accountable Care Organizations in other regions. In addition to investing in the capabilities described in the Information Technology and Data Analytics Initiative, costs will be associated with DHSS efforts to design, manage, and evaluate the pilot; secure approval from the Centers for Medicare and Medicaid Services (CMS), possibly through an 1115 waiver application; negotiate the terms of the shared savings with pilot participants; establish the capabilities to identify shared savings attributable to these efforts; and develop improved reporting capacity to meet federal reporting requirements.

FEDERAL REQUIREMENTS FOR IMPLEMENTATION

The CMS State Medicaid Director letter from February 2012, describes policy considerations and relevant statutory authorities for creating Integrated Care Models in state Medicaid programs.[135] ACOs are considered a subgroup of Integrated Care Models along with ACO-like models and other "arrangements that emphasize person-centered, continuous, coordinated, and comprehensive care." Depending on how Alaska chooses to structure the ACO organizational design, payment mechanism, and shared savings/shared losses structure, a change to the Medicaid State Plan through an Amendment could be sufficient; however, a Section 1115 demonstration waiver may be necessary to achieve maximum flexibility.[136]

[135] State Medicaid Director letter 2012 letter outlining ICMs: www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-001.pdf and www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-002.pdf

[136] CMS State Medicaid Director letters: #12-001 (RE: Integrated Care Models. July 10, 2012); #12-002 (RE: Policy Considerations for Integrated Care Models. July 10, 2012); #13-005 (RE: Shared Savings Methodologies. August 30, 2013); and #13-007 (RE: Quality Considerations for Medicaid and CHIP Programs. November 22, 2013).

In the subsequent CMS State Medicaid Director letter dated July 10, 2012, CMS provides further guidance on implementing Integrated Care Models through State Plans. This letter outlines the statutory options to allow Integrated Care Models to furnish services authorized under Sections 1905(a)(25) and, by reference, 1905(t)(1) of the Social Security Act, through a State Plan Amendment (SPA). These models are consistent with the statutory description of optional Medicaid State Plan Primary Care Case Management services. States may use the authority provided under 1905(t)(1) using a State Plan Amendment to offer coordinating, locating, and monitoring activities broadly, create incentive payments for providers who demonstrate program savings, and share savings with participating providers either directly or through umbrella provider network arrangements, also known as "shared savings" programs.

DHSS will need to discuss with CMS specific financing issues, such as the distribution of shared savings with the ACOs. If DHSS should choose to pursue a Section 1115 waiver, it would need to demonstrate how it would meet actuarial soundness requirements, as the ACO payments may need to meet similar requirements for managed care rates, depending on the risk management and claims payment arrangement DHSS designs. States that are using the Integrated Care Models State Plan Amendment option to pay for quality improvement and shared program savings may offer these payments as the base reimbursement methodology for the Integrated Care Models provider, or as deferred compensation to a care coordination base rate.

If DHSS pursues ACO pilots, regardless of whether it chooses to implement through a SPA or Section 1115 waiver, CMS will expect DHSS to, at minimum:

- Comprehensively describe the assignment of enrollees and how DHSS will ensure they have adequate choice of providers.
- Explain the specific method that will be used to calculate payments to ACO entities and providers, the method that will be used to calculate losses (if using that model), and the timeframe and method to distribute payments or collect loss payments.
- Explain any eligibility restrictions for providers to receive shared savings payments (such as meeting quality measure thresholds).
- Describe how incentives do not discourage the provision for medically necessary care.

STATE STATUTORY AND/OR REGULATORY CHANGES

Current Alaska statute (AS 47.07.036) allows DHSS to make changes to Medicaid if current cost saving measures are insufficient to stay within the program's authorized budget.

DHSS has the authority under AS 47.07.030 (Medical Services to Be Provided) to establish a Primary Care Case Management system or a Managed Care Organization contract in which certain eligible individuals are required to enroll and seek approval from a case manager or the managed care organization before receiving certain services. DHSS has the authority and responsibility to establish enrollment criteria and determine eligibility for services consistent with federal and State law.

Depending on how broadly the Department of Commerce, Community and Economic Development, Division of Insurance interprets the application of insurance law, an ACO with shared losses could trigger insurance regulations.

This model could require exemptions under Alaska State laws that govern antitrust issues. Federal ACO and Shared Savings entities serving Medicare have had explicit exemptions to ensure this was not a barrier. Alaska should have a legal review of its statutes, particularly any implications of Title 23, Chapter 50 Collective Negotiation by Physicians, Section 23.50.020: Collective action by competing physicians. However, the model would appear to align with the following language related to working with a health benefit plan:

> *(a) . . . Competing physicians may meet and communicate concerning . . . (6) the formulation and application of reimbursement methodology; (7) quality assurance programs; (8) health service utilization review procedures. . . .*

RATE STRUCTURES AND PAYMENT MECHANISMS

ACOs can have a variety of rate structures, depending on state and provider preferences and their willingness and ability to assess and accept financial risk associated with covering costs for health care provision for a specific population. For Alaska, the following are recommendations for building an ACO reimbursement model:

a) Providers in an ACO would receive a portion of the shared savings as "payment" for their additional care management and care coordination efforts. DHSS could use this as the only incentive, if the possible savings payouts are significant enough to be of value to providers; or, DHSS could add an up-front payment to help ACOs build care management capacities and factor that in to the savings calculation. Alternatively, DHSS could pay an additional per member per month to providers for care coordination services. As noted above, if providers in the ACO are also Primary Care Providers in the Primary Care Improvement Initiative, presumably they would be getting a per member per month for care coordination. Such a payment would be considered separate from any ACO initiative payment structure.

b) DHSS would continue to make regular fee-for-service payments to each provider in the ACO group for Medicaid covered services and benefits. If DHSS chose to have the ACOs assume claims payments, this would require a slightly different approach and program design, as well as require that the ACOs would have the administrative structure to bill on behalf of providers and meet any other requirements DHSS may impose to ensure that providers were paid appropriately under the ACO structure.

c) The total cost of care baseline for ACOs would be based on the fee-for-service costs of care for a similar population of Medicaid enrollees statewide for similar covered physical care and behavioral care services (including post-acute care services), covered pharmacy benefits, with the exception of high-cost specialty drugs.

d) Effective design is key to ensuring that savings targets are properly aligned; a well-designed approach might look like:

    1. Year one savings target is two percent reduction to the baseline, net of any efficiency factors or variance expectations, based on a minimum of 7,500 enrollees per ACO.

    2. Year two through year five savings would be measured against the Medicaid fee-for-service trend factor, in order to ensure that the ACO continues to maintain lower costs compared to the fee-for-service Medicaid system.

e) Savings would be split between DHSS and ACOs on a 60/40 basis: 60 percent would accrue to DHSS, 40 percent to the ACOs. ACOs would need to meet the minimum quality threshold measures set by DHSS to be eligible for any shared savings. DHSS could also allow ACOs to earn up to 55 percent of the savings by achieving higher quality targets, as an additional incentive.

f) After two years, the financial arrangements with ACOs would include shared losses agreements.

MONITORING AND REPORTING REQUIREMENTS

CMS would specify quarterly financial and quality reporting depending on the specific design and reimbursement mechanisms of Alaska's ACO pilots. If DHSS used a Section 1115 waiver, CMS also may expect it to maintain and/or improve quality metrics throughout the waiver demonstration period. Additionally, Section 1115 waivers will require an extensive mid-term and full waiver external evaluation. Regardless of which ACO model or mechanisms DHSS chooses, CMS expects all states to have a transparent process in place to review evidence that practice transformation will have a positive impact on the overall care provided to the Medicaid enrollees. This can include regular reviews of quality measure results, possible provider reporting systems or audits of related claims in order to establish accountability of provider activities.

EXPERIENCE OF OTHER STATES

Some states that are pursuing ACOs for Medicaid enrollees are building on existing care delivery programs that already involve some degree of coordination among providers. These states also may have developed key Information Technology (IT) infrastructure and capacity necessary to facilitate coordination among ACO providers. States may also use different terminology in their Medicaid ACO initiatives, such as Coordinated Care Organizations (CCOs) in Oregon, Regional Care Collaborative Organizations (RCCOs) in Colorado, and Integrated Health Care Delivery Systems (IHCDS) in Minnesota.

The Accountable Care Collaborative (ACC) is Colorado Medicaid's primary health care program. Medicaid clients in the ACC receive the regular Medicaid benefit package and belong to the RCCO for the area where they reside. ACC clients also choose a Primary Care Medical Provider. Colorado pays Primary Care Medical Providers fee-for-service rates plus a small per member per month payment for "medical home" services. It pays the RCCOs a per member per month rate for a specified set of care coordination and performance metric functions. Both the RCCOs and Primary Care Medical Providers are able to participate in a shared savings program, funded by a withhold from the per member per month amount. Colorado reported statewide net savings of $29 to $33 million during FY 2014, its third year of operation;[137] however, in the past state fiscal year, no savings were achieved to allow payments to the Primary Care Medical Providers or the RCCOs. There is work underway to adjust the model to increase the leverage of the RCCOs and Primary Care Medical Providers to improve this going forward. Colorado also is preparing for Phase 2 of its Accountable Care Collaborative model, in which the State will combine two currently separate systems for physical and behavioral health under one entity in its next iteration of the RCCOs, to be called Regional Accountable Entities (or RAEs).

In Minnesota, both integrated and non-integrated systems can apply to become an ACO, resulting in a regional set of safety net providers now acting as an ACO. To support ACO adoption among providers

[137] Colorado Accountable Care collaborative, 2014 Annual Report. Available at: https://www.colorado.gov/pacific/sites/default/files/Accountable%20Care%20Collaborative%202014%20Annual%20Report.pdf

with a range of capabilities, Minnesota's Health Care Delivery Systems demonstration (HCDS) includes two options within managed care and fee-for-service. For integrated provider delivery systems, the integrated HCDS option includes symmetrical two-way risk sharing in both gains and losses. Providers who are not part of an integrated delivery system are eligible for the Virtual HCDS option, which allows organizations to participate in one-way gain sharing with the state. Both models include the use of a Minimum Performance Threshold, a two percent minimum that must be met in either direction prior to any gain or loss sharing.

Oregon has 16 CCOs that began operating in 2012. Each one is unique to its region, including one in Eastern Oregon that has brought together providers, Critical Access Hospitals, social workers and community service providers together with 12 very remote and isolated counties where previously there had not been managed care. Each county has an engaged community advisory committee that are represented across the CCO on its governing board. They have seen steady improvement in the majority of quality metrics, including improvement after adding newly eligible adults through Expansion. Oregon's statute requires Medicaid CCOs include a Primary Care Provider and a behavioral health provider on their governing boards, to ensure active participation across both communities of providers, as the two Medicaid funding streams are blended into the CCO.

Oregon has seen a reduction in outpatient and inpatient costs.[138] Thirteen CCOs reduced all cause hospital readmission and statewide Emergency Department use continues to decline. There was a 60 percent reduction in hospital admissions for adults with chronic obstructive pulmonary disease and almost 27 percent reduction in admissions for diabetics. Primary care has been a foundation for the coordinated care organizations, with a 56 percent increase in adoption of patient centered primary care homes. Avoidable Emergency Department utilization declined by almost half since 2011, with newly enrolled Expansion adults having fewer avoidable emergency room visits than other members. The state has maintained its promise to CMS to reduce cost trends by two percent and is holding at less than the 3.4 percent trend rate as it enters the fourth year of Oregon's Section 1115 waiver. The quality measures tied to incentive payments are tracked by plan, and 13 of the 16 CCOs earned 100 percent of their 2014 performance and quality pool funds.

With the goal to drive change across the delivery system for all Oregonians, Oregon has repurchased its state employee benefits using the same framework of accountability and quality improvement used in their Medicaid CCO program. While not asking for specific organizational re-structuring, the commercial health plans are being held to the same metrics and same cost trends as the CCOs. One CCO has become a health plan choice for state employees, and two of the health plans available for both state employees and school district employees are partners in the Medicaid CCOs. This has resulted in state savings that translated back to both fill funding gaps, and contribute to recent pay increases for state employees.

The Oregon Legislature asked its Department of Justice to examine antitrust laws as they were finalizing their CCO concept, with a review of existing Oregon statutes.[139] The review identified exceptions to Stark law[140] related to payment incentives, found no Oregon statutes in conflict and it was believed to not be a barrier to proceeding.

---

[138] Oregon Health Authority, "Oregon's Health System Transformation: 2014 Final Report." June 24, 2015. http://www.oregon.gov/oha/Metrics/Documents/2014%20Final%20Report%20-%20June%202015.pdf

[139] Oregon's 2012 Stark Law and Related Limitations on Financial Interests in Health Care Reimbursement is available at: www.oregon.gov/oha/OHPR/docs/medliab_starklegalanalysis.pdf

[140] Section 1877 of the Social Security Act (the Act) (42 U.S.C. 1395nn), also known as the physician self-referral law and commonly referred to as the "Stark Law": Prohibits a physician from making referrals for certain designated health services (DHS) payable by

Vermont developed a shared savings program for Medicaid, echoing the federal Medicare shared savings approach already successfully being used by health system ACOs in the state. Phasing into its Medicaid ACO program over the first three years, the ACOs are responsible for core physical health services in year one, optional to add in behavioral health, Long-term Services and Supports, and pharmacy benefits in year two, but required to add the non-physical health services in year three. An ACO's performance must reach a certain point for it to be considered for shared savings (the "Gate"); to then retain a greater portion of the potential savings, the ACO must reach a series of higher performance levels (the "Ladder"). The program launched in 2014 and reported savings of $14.6 million in its first year.[141]

Arkansas' Episodes of Care alternative payment State Plan Amendment requires providers "to pass" a set of quality indicators which differ for each episode type; providers who achieve commendable average per-episode costs but fail to achieve these standards will not receive shared savings payments. In addition, providers are required "to track" a separate set of quality indicators. Providers have access to individualized quarterly performance reports through a Provider Portal. Performance reports are produced by the State, through a vendor, that include data on quality across episodes, cost effectiveness relative to cost thresholds and other providers, and the provider's utilization patterns and cost drivers. Reports available through the Provider Portal draw on claims data as well as clinical data entered into the Portal by the providers. Providers have access to quarterly reports during the initial preparatory period to gain comfort with this system and assess current performance, and the portal provides the State with adequate monitoring and documentation to share with CMS.

POTENTIAL CHALLENGES

Harnessing the benefits of both collaboration and competition of the ACO model is important, but difficult. It is critical to assess local market dynamics to understand if ACOs could stimulate provider competition (to improve quality and reduce costs) or create consolidation of market power, which could increase costs. This has been a concern for the Medicare and commercial ACOs in their development in other parts of the country with competing systems of care. Due to low reimbursement in Medicaid, and most communities having only one health care hospital system, states with ACO models have not seen this so far. For Alaska, fostering collaboration among providers will be more critical to success than attempting to prevent anti-competitive behavior. Collaboration across a community of providers can be very cost-effective with the Medicaid population, which often faces underlying issues related to unmet health and social needs. Discussions among Alaska providers have raised concerns that many will not be ready for this type of initiative. Providers have identified a number of challenges to forming ACOs to serve Medicaid enrollees including lack of incentives to work together, lack of infrastructure to share data and communications efficiently and securely, concern about increased administrative burden to providers and a lack of Primary Care Providers.

Simply delegating greater decision-making to a group of providers is not sufficient in and of itself to achieve clinical innovation, and therefore improved quality and reduced costs. ACOs need support from DHSS for technical assistance, learning collaboratives, project management, and other formal oversight

Medicare to an entity with which he or she (or an immediate family member) has a financial relationship (ownership, investment, or compensation), unless an exception applies; prohibits the entity from presenting or causing to be presented claims to Medicare (or billing another individual, entity, or third party payer) for those referred services; and, establishes a number of specific exceptions and grants the Secretary the authority to create regulatory exceptions for financial relationships that do not pose a risk of program or patient abuse.

[141] Medicaid Share Savings Programs Helped Avoid $14.6 Million in Costs in 2014" Vermont Governor's Office. September 8, 2015. Available at http://governor.vermont.gov/node/2474.

mechanisms. In turn, ACOs need to be able to provide similar support for their participating providers. For example, ACOs using quality improvement advisors to help practice teams reconfigure care delivery to serve patients more efficiently, or providing grants for practice-led projects.

Primary care provider shortages in some communities may present a barrier to ACO formation; additionally, stakeholders voiced concern that primary and behavioral health care providers may not have equal bargaining power with specialists and hospitals. Recent looks at Medicare ACOs revealed:

> *. . . Almost one-third of the ACOs participating in the Shared Savings Program that launched in 2012 or 2013 said specifically that they pass along a share of their reward to primary-care doctors, in some cases as much as 80 percent. Some ACOs said only that they distribute shares to physicians generally. But the ones that disclosed detailed breakdowns of how they allocate those bonuses said 46 percent on average would go to primary-care doctors. Among ACOs whose disclosures singled out specialists and hospitals for Medicare bonus shares, the average shares were lower: 20 percent and 27 percent, respectively..*[142]

PROVIDER ROLES

Both the physical and behavioral health provider communities are integral to the success of the ACO initiative. An ACO can help to bring the disparate funding streams of physical and behavioral health together through one entity to help move providers toward innovative approaches to whole person care. A strong Primary Care Provider community includes, either on site or virtually, behavioral health providers to integrate the care around individual patients and their families.

There is opportunity to engage a variety of provider types in the Alaska model, including hospitals, primary care physicians and practitioners, specialists, behavioral health providers, and even Long-term Services and Supports providers. Although the cost of Long-term Services and Supports will not be included in the cost of care for the ACO, it will be beneficial to coordinate these services for enrollees who need them. The broader the participation of providers, the more opportunity for coordinated care management across sectors. However, the broader the participation of providers, the more complex the ACO structure. Especially in the early stages, it will be critical for DHSS to engage providers in a robust dialogue about the kind of ACO model(s) that are most likely to succeed the most quickly.

Alaska providers may not be sufficiently prepared to collaborate and coordinate to the level required to achieve savings. ACOs by definition are provider organizations, and if providers are not fully on board with the ACO model, the opportunity for both improved quality of care and reimbursement, then the ACO is not likely to succeed.

While some level of enthusiasm exists for a model that would empower regions and providers, providers frequently expressed the need to focus on essential reform initiatives before embarking on this next leg of the reform journey.

OPPORTUNITIES FOR COLLABORATION WITH OTHER PAYERS

CMS is moving toward increased provider accountability to improve quality and reduce costs and the national Medicare Pioneer ACO initiative has now been operating for several years. Because of these national trends, ACOs could be a good option for Alaska. As noted earlier, the U.S. Department of Health

[142] http://www.modernhealthcare.com/article/20150829/MAGAZINE/308299961

and Human Service's goal is to have 80 percent of all payments in Medicare made through alternative payment mechanisms. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) included, as it was repealing the current Sustainable Growth Rate formula, language in Section 101 on moving forward on new approaches to payment in Medicare such as shared savings. Many commercial health plans are also pursuing shared savings models.

Efforts underway in other states across the country include some of the commercial plans that operate in Alaska. For example, Moda Health has experience with accountable care models as leads of the very rural Eastern Oregon CCO in Oregon and may be willing to participate in similar initiatives in Alaska. This is also true for Providence Health System, which participates both as a provider in several CCOs, and as a health plan with Oregon's state employees now under an accountable contract with the State.

Per a recent Center for Health Care Strategies survey, through an ACO model, a state such as Alaska could, "leverage its purchasing power to stimulate new, innovative and integrated care models for Medicaid beneficiaries."[143] Multi-payer alignment is a key element to consider for providers to change their models of care. Conversations with the other payers in the state could be important as DHSS develops an ACO model, particularly around alignment of metrics providers must meet for various payers. The more DHSS can require providers to be accountable and share in incentives across all payers, the more willing providers will be to adopt more efficient delivery systems across all their patient populations.

PROJECTED TIMELINE AND STATE RESOURCE REQUIREMENTS

The Center for Health Care Strategies identified key areas for states to define and standardize regarding ACOs, which include:

- Data sharing
- Analytic support
- Technical assistance
- Performance measurement
- Role of the ACO entity in providing these results

In order to develop accurate estimates for the timeline and resources required by DHSS for planning and implementing this initiative, an assessment of the following will be needed:

a) Current staff structure and capabilities;

b) Current IT systems and capabilities for data collection and analytics;

c) Current capability to oversee the quality program design and measures or financial design and measures; and,

d) The number of pilot ACOs and providers involved in them, which would affect the volume of provider outreach and assistance, reporting, and other requirements.

[143] McGinnis, T., & Small, D. M. (2012). Accountable care organizations in Medicaid: emerging practices to guide program design. Center for Health Care Strategies, Inc. Recent interviews with a set of states in various stages of implementing accountable care in Medicaid reported that rather than rigorously delineating specific ACO structures and processes, states should set key goals, outcomes and milestones, and let the ACOs develop locally-tailored strategies to meet those objectives. Payment has to be clearly tied to achieving those results. www.chcs.org/media/Creating_ACOs_in_Medicaid.pdf

To augment its current capacity, DHSS may need to add both infrastructure and staff or vendors to:

- Support providers with technical assistance and to monitor each ACO, based on the specific agreement it develops with DHSS.
- Identify and enroll individuals in each ACO, as well as track and manage their ongoing enrollment over time, especially as they may gain or lose Medicaid eligibility, or become ineligible for ACO enrollment.
- Collect and analyze all data reported by the ACOs, including all required quality and financial metrics from individual participating providers, as well as the ACO entities.
- Create reporting and analytics to share with ACOs about their specific enrollees individually and collectively.
- Develop the financial benchmarks and shared savings/shared losses model and required reporting to accurately pay providers or collect from providers, as appropriate.

DHSS must be able to manage enrollment in ACOs, as well as track claims associated with ACO enrollees and any quality or performance metrics assigned to the ACOs. This initiative would require significant work with and among participating providers to ensure the appropriate/optimal legal structures, data and analytics infrastructure for both DHSS and ACOs, and agreement on the shared savings/losses calculation methodology.

DHSS currently does not have experience with supporting forms of managed care, which it would need to develop or procure in order to support an ACO pilot. DHSS would need, at a minimum, to build provider outreach and technical support and program monitoring; be able to manage eligibility and enrollment in each specific ACO; collect and analyze all required and desired reporting, including for quality and financial management, as well as reporting to CMS; and, establish and manage the payment mechanisms accurately and in a timely fashion.

DHSS could identify staff who could take on some of the initial planning and development work, such as stakeholder engagement, design of basic program structure, and design of the shared savings model; however, it is not known what level of experience or expertise current DHSS staff have, or whether there are enough staff to fully support the development of this initiative. Therefore, it is recommended that DHSS either hire a contractor to support this effort, or hire staff with the specific skills DHSS currently does not have to support this effort, based on the minimum required activities noted below.

General activities and timeframe required to implement this initiative, assuming a July 1, 2016 start date for planning and development, include:

a) **Phase 1: Planning (SFY 2017-2018)**. Activities in this phase need to occur simultaneously, as each component helps to inform design and development of the overall program.

   Provider Engagement (SFY 2017-2018). Engage with providers to determine the interest and potential capabilities of those who may wish to participate in an ACO, an appropriate governance structure for Alaska ACOs, appropriate quality metrics and shared savings opportunities. This should include informal and formal meetings and discussions with potential ACO providers across the state, and should be ongoing as program details are developed so providers have the opportunity to offer feedback and DHSS can build provider buy-in. This also could include discussions with other payers who may be interested in partnering with Medicaid to create multi-payer ACOs.

Early Program Design (SFY 2017). To begin program design, DHSS should create an internal team to oversee and be accountable for all aspects of the ACO program design and development. This team would be responsible for identifying other staff and resources (whether internal or external) needed to support the ACO effort and for communicating project status to DHSS leadership and stakeholders. This team should include at least one full-time staff dedicated to the ACO pilot project.

Once formed, this team could begin development of the Section 1115 waiver application to CMS, including:

- Overall program structure: the type of ACO entities, the regions, how enrollees will be assigned, and other program requirements.
- Quality metrics and minimum quality achievement thresholds to participate in shared savings opportunities.
- The shared savings model, including total cost of care benchmarks, any risk corridors, any other expected payments, such as investment in care coordination build up or per member per month care coordination payments, and the timeframes for measures and payments. DHSS also should begin to develop what it expects shared losses parameters to be, and timeframes for measures and mechanisms for collecting payments.
- Begin building data and analytics capabilities to support expected ACO model requirements. Some of the required infrastructure to support this initiative could be provided by implementing Initiative 3.
- DHSS should incorporate frequent conversations with CMS about the design and development of an ACO pilot. Getting CMS input and buy-in early will help to ensure a smooth process for the waiver application. CMS also can give DHSS technical assistance to help with the actual waiver application development and any possible funding that might be available to support the planning effort.

Final Program Design (SFY 2018). Based on work to date on program structure, quality metrics and financial modeling, as well as input from providers on all these aspects:

- Finalize program structure design, including governance structure of ACO entities, locations, enrollee assignment process and estimated numbers of enrollees. This could include release of a Request for Information (RFI) to providers, to gather final input on the program to include in the waiver application and ultimately a Request for Proposal (RFP).
- Assess and make changes to the Medicaid Management Information System (MMIS) and other current DHSS IT systems as needed to support requirements for assigning and tracking ACO enrollees, as well as providers. (This can start earlier, but DHSS will need enough detail of the final program design to fully vet its systems capacities and capabilities to meet those needs.)
- Submit the Section 1115 waiver application to CMS. As noted above, CMS is likely to approve the waiver application more quickly if DHSS has engaged with CMS throughout the development of the program and application. DHSS should include in its application at least a draft RFP document.
- Ensure necessary infrastructure supports will be in place to support the ACOs. This includes reviewing systems, staff and other resources and identifying any potential challenges that may arise during final implementation.

b) **Phase 2: Implementation (SFY 2019-2020)**. Once the program is designed and after securing approval from CMS for its Section 1115 waiver application, DHSS would be positioned to release an RFP for formation of one or more ACOs in early SFY 2019. DHSS would then select the applicant(s) and engage in final negotiations and contracting with the entities. Concurrently, DHSS would need to complete implementation of systems changes, filling staffing and resource needs, and putting in place any other internal infrastructure necessary to fully support the ACOs when launched.

c) **Phase 3: Ongoing Operations and Evaluation (SFY 2020 and beyond)**. Once operational, DHSS would continue to engage in the following activities:

- Ongoing management of ACO contracts, as well as providing or or procuring technical assistance for ACOs and ACO providers.
- Measurement of quality and other performance metrics, to validate program impacts and any savings.
- Payment of any shared savings, recoupment of any shared losses, as appropriate based on each ACO's performance against established benchmarks.
- Ongoing reporting and communications with CMS about ACO operations and impacts.

The proposed timeline (Figure 8) does not factor in resource constraints or the time required for DHSS to secure budgetary resources and authority to implement the initiative, but rather assumes availability of DHSS resources and is based on the anticipated effort and timing of steps associated with obtaining federal approval. If the decision is made to move forward with the recommended reforms, DHSS would then determine the resources and time required to implement the initiative.

Figure 8. Phased Approach for Accountable Care Organizations Pilot



Phase 1: Reforms Underway SFY 2014 - 2016	Phase 2: Foundation for Transformation SFY 2017 - 2018	Phase 3: Towards Paying for Value SFY 2019 - 2020	Phase 4: High Value, High Functioning System Beyond SFY 2020
	• Stakeholder engagement to develop conceptual design and structure • Basic program design and structure, development of Section 1115 waiver application • Basic design of shared savings/losses model and quality parameters • Assessment and updates to IT systems, data analytics capacity, identification of additional staffing needs • Finalization and submission of Section 1115 waiver application to CMS	• Development and release of ACO RFP, selection of participating provider groups • ACOs form and develop systems so that all participating providers are able to share information about enrollees in a timely manner	• ACOs work toward collective improvements in quality measures and care coordination • ACOs share in savings and losses, and begin to transform the way care is provided • Evaluation of ACOs

C. WORKGROUPS TO SUPPORT REFORM EFFORTS

Health care reform presents a complex set of interrelated issues. Focusing on Medicaid Redesign necessarily narrows the scope of this project's efforts, but the process of exploring potential reforms has brought up other areas that require further stakeholder engagement and development before being presented as reform initiatives at a future date. While all of the initiatives presented in this report have benefitted, and continue to benefit, from stakeholder input, the topics below cannot move forward at this time without significant collaboration between the Alaska Department of Health and Social Services (DHSS) and interested stakeholders. DHSS would need to commit resources to coordinate and manage continued stakeholder engagement. The desired results of this investment would be improved engagement with providers who serve Medicaid enrollees and improvements in service delivery to improve health outcomes and decrease costs. The actuarial analysis completed for this project estimated a significant cost savings particularly from expanded use of telemedicine in Alaska (Table 10).

The following three topics are proposed to each be the scope of a workgroup composed of DHSS staff and relevant stakeholders (which may include providers, administrators, and reform advocates) collectively tasked with identifying one or more specific recommendations within that scope. The primary purpose of each workgroup is to develop future reforms for the state's Medicaid program, but may include recommendations pertinent to other aspects of the health care system in Alaska. The workgroups would focus on:

- *Define appropriate use of telemedicine and expand utilization.* Currently, Medicaid provides reimbursement for a variety of telemedicine services. Discussions of how and by whom telemedicine should be delivered in the state predate the Medicaid reform project, and these larger questions require additional work to develop appropriate solutions.

- *Medicaid business process improvements.* As the name suggests, this topic area may include a variety of specific process reforms that would potentially improve the performance of or reduce the administrative burdens associated with the Medicaid program. While DHSS has identified several improvements, more work remains to vet these proposals with stakeholders and to identify additional opportunities to reduce the administrative burden on providers who serve Medicaid enrollees.

- *Ongoing Medicaid Redesign key partner engagement.* This workgroup would build on the momentum and artnership developed between DHSS and interested stakeholders who are committed to ongoing collaboration on the subject of redesigning the Medicaid program to increase value through controlling costs and improving health outcomes. AK Health Reform is a collaborative organization that is a leader in this dialogue in Alaska, which provides an excellent vehicle for this ongoing engagement.

This section includes information gathered to date and an outline of reform needs in each topic area.

WORKGROUP 1. DEFINE AND EXPAND APPROPRIATE USE OF TELEMEDICINE

This initiative seeks to address barriers and improve supports for the expanded use of telemedicine and telehealth in Alaska;[144] specifically, the workgroup formed would be tasked with addressing barriers related to licensure, reimbursement and coordination of telehealth providers and equipment. The purpose of increasing the use of telemedicine and telehealth is to increase access to behavioral health, primary care, and specialty care services that are not otherwise available in or near the patient's home community. Particular opportunities exist for expansion in the areas of care coordination and ongoing monitoring of chronic conditions. Telemedicine extends health services and, in some cases, can replace in-person visits, which can help to control costs and improve appropriate utilization. This has been particularly effective with behavioral health services where clients can avoid the stigma sometimes associated with accessing services, and, for those in small communities with few local providers, clients can access services in a more confidential setting.[145]

The potential cost savings associated with telemedicine could be significant for Alaska. As part of the actuarial analysis completed for this report, Milliman projected the potential impact of DHSS launching a Telemedicine Initiative starting in State Fiscal Year (SFY) 2018 (Table 10). Milliman's projections are based on analysis of Alaska Medicaid utilization rates and the changes in utilization patterns and resulting cost savings that Milliman has observed in states that have implemented successful telemedicine programs. See Appendix I for details of Milliman's analysis.

[144] *Telemedicine* means the delivery of clinical health care services by means of real time, two-way electronic audio-visual communications, including the application of secure videoconferencing or store and forward technology to provide or support healthcare delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, care management and self-management of a patient's health care while such patient is at an originating site and the health care provider is at a distant site. *Telehealth* means delivering health care services by means of information and communications technologies consisting of telephones, remote patient monitoring devices or other electronic means which facilitate the assessment, diagnosis, consultation, treatment, education, care management and self-management of a patient's health care while such patient is at the originating site and the health care provider is at the distant site. (American Medical Association, Advocacy Resource Center, 2014.)

[145] The Mat-Su Behavioral Health Environmental Scan Report 2 - The System of Care, prepared by Mat-Su Health Foundation and the Western Interstate Commission on Higher Education, reports data from the 2002-2011 National Survey on Drug Use and Health (NSDUH) which asked Mat-Su respondents reasons for not seeking care when they felt they needed it. The most common reasons stated for not seeking mental health treatment were cost (63%); not knowing where to go (18%); concerns about confidentiality (6%) and not enough insurance coverage (15%). The most common reasons for not seeking substance abuse care were cost (63%), not ready to stop use (20%), and worry about concern about stigma (36%). Residents and provider interviews also reinforced these findings.

Table 10. Actuarial Results for Telemedicine

MEDICAID REDESIGN INITIATIVES: TELEMEDICINE VALUES IN $MILLIONS*					
SERVICE CATEGORY	**FY17**	**FY18**	**FY19**	**FY20**	**FY21**
Facility Inpatient	$0.0	($0.5)	($1.0)	($1.5)	($2.0)
Facility Outpatient	$0.0	($2.2)	($4.5)	($7.2)	($10.1)
Professional	$0.0	($8.7)	($18.1)	($28.2)	($37.5)
Pharmacy Drugs	$0.0	$4.2	$7.8	$12.0	$15.0
PCCM Fee	$0.0	$0.0	$0.0	$0.0	$0.0
Capitation	$0.0	$0.0	$0.0	$0.0	$0.0
Other	$0.0	($0.0)	($0.1)	($0.1)	($0.1)
TOTAL MEDICAL COST	**$0.0**	**($7.1)**	**($15.9)**	**($25.0)**	**($34.8)**
ASO Fees	$0.0	$0.0	$0.0	$0.0	$0.0
TOTAL EXPENDITURE CHANGE	**$0.0**	**($7.1)**	**($15.9)**	**($25.0)**	**($34.8)**
After Shared Savings	$0.0	($7.1)	($15.9)	($25.0)	($34.8)
FMAP Share	$0.0	($4.5)	($10.1)	($15.7)	($21.6)
NET ALASKA COST (SAVINGS)	**$0.0**	**($2.6)**	**($5.8)**	**($9.4)**	**($13.2)**

** 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.*

Telemedicine generally falls into four broad categories:

1. *Store-and-Forward* (asynchronous): generally used for the evaluation of recorded patient information, such as results from imaging, where the provider and the patient are not simultaneously present;
2. *Real-time Interaction* (synchronous): includes live, two-way interaction using audiovisual communication technology where the patient and the provider are simultaneously present;
3. *Remote Monitoring*: includes the electronic collection of health and medical data in one location and transmittal to a provider through electronic communication technology; and,
4. *Mobile Health* (eHealth): includes patient support through mobile communication such as texting and public health alerts.

Alaska has a long history of using telemedicine successfully. Alaska's Tribal health system has incorporated telemedicine into a range of health services and uses it routinely. This success was greatly aided by the development of the Alaska Federal Health Care Access Network; 99 percent of telehealth events on this system originated within the Indian Health Service-funded healthcare delivery system.[146] The non-Tribal health system in Alaska has also collaborated to increase adoption of telemedicine in Alaska, including efforts by individual providers and support from the Alaska State Hospital and Nursing Home Association (ASHNHA). Barriers to increased adoption include the lack of a single organization with a focus on statewide telehealth development, reimbursement and regulatory issues, and issues

[146] Evolution & Summative Evaluation of the Alaska Federal Health Care Access Network Telemedicine Project, University of Alaska Statewide Health Programs, November 2004.

related to technology and coordination, among others.[147] Providers are making advances with telemedicine, but these are often limited to a specific health system.[148] Stakeholders have identified physician licensure as an issue that must be resolved in order for telemedicine to advance in the non-tribal system. It would require a collaborative process that involves a range of stakeholders to identify agreeable solutions to this and other barriers. Some telemedicine services are currently covered by the state's Medicaid program (Table 11).

Telemedicine and telehealth in Alaska should support collaborative care as a virtual component of the patient's medical home; it could also assist with self-monitoring for chronic conditions and provide electronic monitoring for people receiving Home and Community-based Services.

Table 11. Status of Telemedicine in Alaska's Medicaid Program

CRITERIA FOR ALASKA MEDICAID TO COVER SERVICES FURNISHED THROUGH TELEMEDICINE	TELEMEDICINE SERVICES COVERED BY ALASKA MEDICAID
• Covered under traditional, non-telemedicine methods • Provided by a treating, consulting, presenting, or referring provider • Appropriate for provision via telemedicine	• An initial visit • One follow-up visit • A consultation to confirm a diagnosis • Diagnostic, therapeutic or interpretive services • A psychiatric or substance abuse assessment • Psychotherapy • Pharmacological management services on an individual enrollee basis
TYPES OF SERVICE DELIVERY CURRENTLY COVERED	**TELEMEDICINE COSTS CURRENTLY *NOT* COVERED BY MEDICAID**
• Interactive method: Provider and patient interact in "real time" using video/camera and/or dedicated audio conference equipment. • Store-and-forward method: The provider sends digital images, sounds, or previously recorded video to a consulting provider at a different location. The consulting provider reviews the information and reports back his or her analysis. • Self-monitoring method: The patient is monitored in his or her home via a telemedicine application, with the provider indirectly involved from another location.	• Use of telemedicine equipment and systems • Services delivered by telephone when not part of a dedicated audio conference system • Services delivered by facsimile • The following services provided by telemedicine application: o Direct entry midwife o Durable medical equipment (DME) o End-stage renal disease o Home and community-based waiver o Personal care assistant o Pharmacy o Private duty nursing o Transportation and accommodation o Vision (includes visual care, dispensing, or optician services)[149]

[147] Telehealth in Alaska's Hospitals- Identified Issues, Needs and Opportunities, October 2014. A collaborative effort between the Alaska State Hospital and Nursing Home Association, DHSS and the Denali Commission.

[148] For example, Providence Alaska Health Systems uses a web-based telemedicine system that allows the consulting neurologist to evaluate stroke patients in multiple locations around Alaska within ten minutes. With the use of the new Web-based telemedicine service, Remote Evaluation of Acute isCHemic stroke (REACH), a doctor specialized in stroke medicine is always on-call and ready within seconds to quickly and remotely evaluate, diagnose and recommend treatment for stroke patients. (http://alaska.providence.org/locations/pamc/services/stroke/Pages/emergencystroke.aspx, accessed October 25, 2015)

[149] http://manuals.medicaidalaska.com/physician/physician.htm#prof_ii/Section_ii_professional_claims_management.htm (Accessed October 25, 2015)

SCOPE FOR WORKGROUP EFFORT

To identify and remove barriers to the increased use of telemedicine, DHSS would convene a workgroup that brings together stakeholders including providers and administrators from the Tribal and non-Tribal health systems, both physical and behavioral health; medical provider associations, both physician and nursing; behavioral health provider associations and advisory groups; health care system leaders, associations and payers; and, the Alaska Medical Board. The American Medical Association has drafted model bills and other policy tools to assist states with expanding telemedicine coverage.

This workgroup should be guided by lessons learned through evaluations of existing telemedicine programs in Alaska, by the issue briefing developed by ASHNHA and DHSS in 2014,[150] and by the results of pilot projects, such as the recent initiative piloted in the Mat-Su Borough by Set Free Alaska. This pilot project has achieved results in reducing substance use, client satisfaction with mode of treatment, and in decreasing the no-show rate for appointments; however, it identified issues with Medicaid reimbursement and State licensure that hamper implementation.[151]

a) Review and update regulations and/or consider drafting legislation to ensure the safe and appropriate practice of telemedicine and to increase appropriate utilization. This would include:

    1. Clarifying existing Medicaid-covered services and identifying changes or additions to these services.

    2. Resolving issues related to professional licensure and prescribing authority for providers who do not reside in Alaska, but who deliver health services through telemedicine.

b) Identify an accessible platform and an entity to compile and maintain a directory of telehealth providers, telehealth equipment addresses, a platform for scheduling sessions for providers and equipment, and the facilitation of network communications for telehealth services. Consider the Alaska e-Health Network (AeHN) and the Health Information Exchange (HIE) for this activity, if feasible, or, if not, identify a separate entity.

c) Identify solutions to other barriers identified by the group to increase appropriate utilization of telehealth in Alaska.

PROJECTED TIMELINE AND STATE RESOURCE REQUIREMENTS

This workgroup could convene in SFY 2017 to develop actionable recommendations regarding licensure and regulatory changes if DHSS and interested stakeholders identify telemedicine as a priority.

[150] *Telehealth in Alaska's Hospitals: Identified Issues, Needs and Opportunities*, October 2014. A collaborative effort between the Alaska State Hospital and Nursing Home Association, DHSS and the Denali Commission.

[151] Mat-Su Behavioral Health Environmental Scan Report 2 - The System of Care, prepared by Mat-Su Health Foundation and the Western Interstate Commission on Higher Education, September 2015.

WORKGROUP 2. MEDICAID BUSINESS PROCESS IMPROVEMENTS

While there are always opportunities for improvements in Medicaid business processes, it is particularly true when there are significant regulatory, policy and/or program changes. The Patient Protection and Affordable Care Act has accelerated changes in Medicaid programs across the country and states have had to respond to a multitude of major changes in a very short time period, while also maintaining current program operations and serving enrollees, providers and other stakeholders. DHSS, like its counterparts in all other states and U.S. Territories, faces a number of challenges in trying to both implement these many changes and work toward continuous quality improvement of complex policies and procedures.

Additionally, across every sector of the health care system, Alaska providers have called out the administrative complexity and burden associated with caring for Medicaid enrollees. Providers expressed frustration with the administrative costs associated with adhering to a variety of often duplicative Medicaid policies and practices.

This topic area would build on this project's redesign efforts, which identified several specific improvements that DHSS views as priorities and a variety of possible improvements recommended by stakeholders. To carry this work forward and identify priority improvements based on shared efficiency gains or particular problem areas, DHSS would convene a workgroup of Medicaid providers and administrators, representing physical, behavioral, long-term care and Home and Community-based Services. The goal of the workgroup is to review and prioritize improvements in Medicaid business processes that would gain efficiencies, reduce overall costs, and improve satisfaction of providers, enrollees and other stakeholders. As DHSS implements further Medicaid Redesign initiatives, providers and administrators would need to be at the table with DHSS to ensure that the standards, criteria and requirements that are developed:

1. Reduce administrative burden and are reasonable for providers to meet;
2. Support high-quality care;
3. Avoid unintended consequences that could negatively impact enrollees or providers; and,
4. Create State and provider accountability to the system.

It also would be very important to engage enrollees and ensure that they understand the impacts that some of these business process improvements would have on them and how they use Medicaid services. Providers, advocacy groups, and community organizations can be partners in communicating with enrollees and helping them understand system changes.

Engaging with other entities in the health care system would also bring several benefits. Tribal providers should be part of the process, both to contribute overall to the efforts, but specifically to ensure that standards and criteria developed as part of each business process improvement are appropriate to the Tribal health system. There are opportunities for all providers to learn through these efforts and to help set statewide standards of care, as well as help enrollees more effectively use the health care system. The private sector and DHSS could both learn from better understanding the processes and protocols used by each, and to promote statewide standards, where appropriate. In addition, as primary care and behavioral health become further integrated, the documentation systems required by each sector must be aligned.

SCOPE FOR WORKGROUP EFFORT

The workgroup would be tasked with reviewing, identifying and prioritizing business process improvements. As specific improvements are prioritized, separate workgroups could be formed to focus on design and implementation efforts associated with each improvement. DHSS has already initiated a number of workgroups to focus on the System of Care for behavioral health services. The workgroup organized under this initiative should coordinate its work with the System of Care workgroups in order to identify opportunities for additional cross-sector coordination and avoid duplication of efforts.

a) Establish a structured Utilization Management program that uses evidence-based care guidelines, supports improved quality of care and consists of standard processes.

b) Establish standards and criteria for use of non-emergency medical transportation services.

c) Develop a DHSS Fraud, Waste and Abuse plan built on standardized data analytics, best practice and consistent audit criteria, coordinated audit schedules and reviews, and timely notification.

d) Coordinate with the Division of Behavioral Health (DBH) Streamlining Initiative, which includes changes to reporting requirements for DBH Treatment and Recovery grantees and alignment of state-level quality assurance activities with National Accreditation reviews and activities.

PROJECTED TIMELINE AND STATE RESOURCE REQUIREMENTS

Recommended process improvements would be developed with a set of standards that can be applied to each prioritized process improvement. These standards can also serve as a foundational structure for how to develop, implement, and communicate subsequent business process improvements.

Each improvement area would need to include the following:

a) Specific criteria, standards, requirements, measures and/or expectations providers must meet to be considered compliant and to be reimbursed for services delivered.

b) Written policies and procedures or plans that include these criteria, standards, requirements, measures and/or expectations; regular and standard protocols for reviewing and updating policies and procedures with new information and clearly noted review/approval dates on each document so it is clear when the policies and procedures went into effect.

c) Staff training on all relevant policies and procedures or plans; common accessible location of all policies and procedures or plans so staff can easily find and reference them as needed; includes internal coordination and communication steps to ensure that all DHSS divisions that may be impacted or have a role are part of the training and consistently applying the policies and procedures or plans.

d) Communication of policies and procedures to all relevant providers and stakeholders well in advance of implementation; a common accessible location on the DHSS website for providers, stakeholders and enrollees to see the policies and procedures and related criteria, standards, requirements, measures and/or expectations they must meet.

e) Notifications to all relevant providers and stakeholders in advance of any changes to current policies and procedures or new policies and procedures.

WORKGROUP 3. ONGOING MEDICAID REDESIGN KEY PARTNER ENGAGEMENT

The project's stakeholder engagement process was designed to seek guidance, input and feedback using an iterative process to develop and refine the recommendations in this report. Groups engaged in thoughtful dialogue about each topic in a variety of settings including key partner work sessions, webinars, sector-specific stakeholder meetings, membership and constituency meetings and other presentations. In addition to the valuable contributions key partners and stakeholders made to the deliverables of this process, there is a shared recognition of the value of further engagement and collaboration between DHSS and other health system partners who have an interest in a high-functioning, effective Medicaid program. As noted elsewhere in this report, reform and redesign are ongoing processes, and, in particular, the larger shift from fee-for-service to value-based payments will require a long-term approach with a clear sequence of incremental changes. Ongoing stakeholder engagement and collaboration is critical to the success of these current and future efforts.

The project team recommends that DHSS convene a workgroup focused on future Medicaid redesign to continue the work begun in this process. This workgroup can provide structure for dialogue on system improvements, leadership to champion future recommendations, and multi-sector support for implementing meaningful change.

D. INITIATIVE CONSIDERED BUT NOT RECOMMENDED

The consultant team analyzed an initiative to implement full-risk managed care in Alaska, assessing its feasibility and identifying the potential for cost savings and improved health outcomes. The initiative was presented to the Department of Health and Social Services (DHSS) and key partners and stakeholders at each engagement. After thorough consideration and feedback from many stakeholders, it became clear that a shift to full-risk managed care is not feasible at this time without considerable intermediate changes in infrastructure, payment mechanisms, and clear definition of the area(s) in which it could be successful. As such, the consultant team does not recommend full-risk managed care at this time (Table 12).

Table 12. Status and Rationale for Full-Risk Managed Care Initiative

INITIATIVE	STATUS	RATIONALE
Full-Risk Managed Care Initiative	*Analyzed but not recommended at this time*	• Alaska, with large rural areas and sparse population, presents significant difficulties for Managed Care Organizations (MCO) to achieve typical economies of scale and adequate provider networks. Anchorage and Fairbanks have sizeable populations, but high provider costs even in these areas would likely mean that MCOs would want robust rates to ensure they could make at least a small margin. • Current research is mixed on the extent to which full-risk managed care improves quality and saves money for Medicaid enrollees, particularly in rural areas where limited plan competition and provider participation present challenges. • Lack of experience among Alaska providers with alternative reimbursement methodologies, limited data sharing capabilities, and the quality and performance monitoring typically required of providers in managed care plan networks may reduce participation, which would make it difficult for an MCO to meet network adequacy standards and result in high out-of-network costs. • Lack of full-risk managed care in the commercial health care market in Alaska makes the learning curve steeper for providers and DHSS. • Other similarly situated Medicaid programs have struggled to implement full-risk managed care by MCOs, and DHSS does not currently have the operational infrastructure and capacity to support full-risk managed care, which comes with extensive federal requirements. • Actuarial analysis does not project cost savings.

FULL-RISK MANAGED CARE INITIATIVE

This initiative would implement a full-risk, capitated managed care model, with all Medicaid services delivered to enrollees through Managed Care Organizations (MCOs); it would be launched in the largest population areas of the state.

DESCRIPTION

This analysis specifically reviews a full-risk managed care model that delivers care through Managed Care Organizations. Managed Care Organizations (MCOs) are insurance plans that are regulated by state divisions of insurance and have met all the requirements for capital reserves to cover incurred claims. In this model, the MCOs would be reimbursed at a per member per month capitated rate for a specific set of benefits and services delivered to specific Medicaid enrollees noted in the contract, as designed by DHSS. In Alaska, MCOs would be concentrated in the areas of the state with enough enrollees to ensure the MCO's viability. Rural areas of the state do not have the number of enrollees, and would present problems for MCOs to develop adequate provider networks to meet network adequacy requirements. It is difficult for MCOs to achieve sufficent financial margins to stay in business in rural areas.

KEY FEATURES

a) Managed care contracts for enrollees in large population areas such as Anchorage, Mat-Su Borough, Fairbanks, Kenai Peninsula, and Juneau.

b) Based on requirements from CMS, all Medicaid enrollees in an area would be required to participate in managed care, except:

   1. Those receiving Long-term Services and Supports (skilled nursing facility or Home and Community-based).

   2. Dually eligible enrollees who do not have full Medicaid (e.g., Qualified Medicare Beneficiaries and Specified Low Income Medicare Beneficiaries).

   3. American Indian/Alaska Native enrollees who meet enrollment criteria could voluntarily enroll in managed care, but would not be required to enroll.

   4. If an area had only one MCO, enrollees in that area would be allowed the option of choosing to receive care through the MCO or through the traditional fee-for-service delivery system.

c) Benefits would include all general Medicaid State Plan physical health and behavioral health services for all Medicaid enrollees required to participate in managed care, including Substance Use Disorder treatment, all vision and dental benefits available to the specified enrollees, and all emergency and non-emergency transportation benefits. Given the much more complex nature of administering Long-term Services and Supports through managed care and the lack of both DHSS and Alaska providers' experience with full-risk managed care, the consultant team does not recommend that Long-term Services and Supports (including Home and Community-based Services) be included in a full-risk managed care model at this time.

TRIBAL PARTICIPATION

American Indian/Alaska Native enrollees who meet the enrollment criteria could voluntarily enroll in managed care, but, by federal law, these enrollees cannot be required to do so. Additionally, Tribal health organizations could form MCOs, if they chose to do so.

SPECIAL POPULATIONS

An MCO enrollee population would not include certain populations, including:

a) Those receiving Long-term Services and Supports (skilled nursing facility or Home and Community-based).

b) Dually eligible enrollees who do not have full Medicaid (e.g., Qualified Medicare Beneficiaries and Specified Low Income Medicare Beneficiaries).

RELATED PROJECTS

There are not currently any other projects in Alaska Medicaid that are similar to full-risk managed care.

ANTICIPATED IMPROVEMENTS TO SERVICE DELIVERY

MCOs have an incentive to provide high-quality care to meet contractual performance metrics within the capitated rate they are paid. The flexibility of this payment arrangement is how they typically achieve improvements in care and services; they often are able to identify and respond to enrollee needs more quickly and systematically than traditional Medicaid. For example, they can offer services that are not generally available in a typical fee-for-service Medicaid program, such as enhanced care coordination, or better eyeglasses or dental care, and non-traditional care like acupuncture or chiropractic. MCOs can expand states' ability to reach enrollees and provide a greater level of customer service and support through 24/7 call centers to facilitate access to crisis services, Primary Care Providers, specialists and specialty care, transportation, interpretation for multiple languages, and even assistance with Medicaid eligibility and enrollment issues.

Increasingly, MCOs are implementing provider pay-for-performance and bonus payment programs tied to providers meeting specific Healthcare Effectiveness Data and Information Set (HEDIS) or other quality measures.[152] Most MCOs also offer providers in their networks a variety of practice and patient-level data, such as the number of patients who have not received recommended screenings, or who have not had a check-up in the last twelve months, or diabetic patients who are due for an updated A1C test. Additionally, MCOs often support data sharing through common provider and patient portals or systems that keep all the providers on a patient's care team connected and informed of the care that a patient is receiving. These supports and monitoring efforts can help providers improve the quality of their care and their patients' health outcomes and, across enough providers, can have significant impacts on Medicaid programs overall.

In Alaska, however, it would be difficult for managed care organizations to achieve the necessary economies of scale and adequate provider networks to achieve these improvements in service delivery, given large frontier areas and sparse populations. MCOs must meet specific network adequacy requirements and ensure that enrollees have timely access to Medicaid covered services and benefits. In

[152] Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service, which makes it possible to compare the performance of health plans on an "apples-to-apples" basis. HEDIS measures address a broad range of important health issues. Among them are Asthma Medication Use, Persistence of Beta-Blocker Treatment after a Heart Attack, Controlling High Blood Pressure, Comprehensive Diabetes Care, Breast Cancer Screening, Antidepressant Medication Management, Childhood and Adolescent Immunization Status, Childhood and Adult Weight/BMI Assessment. http://www.ncqa.org/HEDISQualityMeasurement/WhatisHEDIS.aspx

addition, high provider costs even in more urban areas would likely mean that MCOs would want robust rates to ensure they could make at least a small profit margin.

Providers in Alaska are not experienced with reimbursement methodologies other than fee-for-service and do not have compelling incentives to participate in a Medicaid MCO. There is currently no full-risk managed care in the commercial health care market in Alaska, which would make the learning curve even steeper for providers and DHSS. In addition, the current lack of data collection and sharing capabilities and experience with the type of quality and performance monitoring that are typically required of providers in managed care plan networks would create additional barriers. If the MCOs could not get enough providers to participate, they might not be able to meet network adequacy standards and end up with high out-of-network costs.

ANTICIPATED IMPROVEMENTS TO OUTCOMES AND ACCESS

Like state Medicaid programs that aggressively manage their enrollees' health, high functioning managed care organizations can improve overall quality of care. For example, MCOs often have programs that specifically target key HEDIS measures such as childhood immunization rates, breast and cervical cancer screening rates, diabetes and asthma management rates and others. MCOs can and do often bring other kinds of innovations to Medicaid programs through programs or services that:

- Contract with local trusted organizations that provide social services supports such as housing and food security.
- Support network providers with more timely information about their patients if they make Emergency Department visits or are admitted into the hospital.
- Help Primary Care Providers connect patients to hard-to-find specialists or get access to specialized care and treatments.
- Pay for supports and services Medicaid does not traditionally cover, but that can offer significant benefits to individuals that positively affect their overall health, such as patient navigators, health technology tools, childcare and transportation.

In Alaska, it would be difficult for MCOs to achieve these improvements in outcomes and access because of the challenges to improving service delivery described in the previous section.

PROJECTED COSTS AND SAVINGS

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 actuarial analysis for this initiative assumes implementation of full-risk managed care beginning in State Fiscal Year (SFY) 2020. Milliman projects net costs for each year modeled (Table 13). Milliman assumes that utilization of preventive services would increase while utilization of a range of other services would decrease. Milliman's utilization projections are based on analysis of Alaska Medicaid utilization rates and medical cost savings achieved by similar programs in other states. Savings associated with reduced utilization are offset by administrative and margin allowances, insurer taxes, and projected increases in unit costs based on typical contractual agreements between providers and

Managed Care Organizations. For this analysis, Milliman assumes 75 percent of the eligible enrollee population, excluding Tribal and managed care optional[153] enrollees, would be enrolled in full-risk managed care. See Appendix I for further details of Milliman's analysis.

Table 13. Actuarial Results for the Full-Risk Managed Care Initiative

MEDICAID REDESIGN INITIATIVES: FULL-RISK MANAGED CARE VALUES IN $MILLIONS*					
SERVICE CATEGORY	**FY17**	**FY18**	**FY19**	**FY20**	**FY21**
Facility Inpatient	$0.0	$0.0	$0.0	($14.8)	($13.3)
Facility Outpatient	$0.0	$0.0	$0.0	($17.9)	($23.2)
Professional	$0.0	$0.0	$0.0	($14.3)	($20.3)
Pharmacy Drugs	$0.0	$0.0	$0.0	($11.5)	($18.9)
PCCM Fee	$0.0	$0.0	$0.0	$0.0	$0.0
Net Capitation Expenses	$0.0	$0.0	$0.0	$77.4	$96.3
Other	$0.0	$0.0	$0.0	$0.3	($0.6)
TOTAL MEDICAL COST	**$0.0**	**$0.0**	**$0.0**	**$19.3**	**$20.0**
ASO Fees	$0.0	$0.0	$0.0	$0.0	$0.0
TOTAL EXPENDITURE CHANGE	**$0.0**	**$0.0**	**$0.0**	**$19.3**	**$20.0**
After Shared Savings	$0.0	$0.0	$0.0	$19.3	$20.0
FMAP Share	$0.0	$0.0	$0.0	$12.1	$12.4
NET ALASKA COST (SAVINGS)	**$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.*

In addition to the costs projected by Milliman, DHSS resources will be required to secure approval from the Centers for Medicare and Medicaid Services (CMS); prepare and evaluate a Request for Proposal; establish actuarially sound capitation rates; negotiate contract(s) with managed care organization(s); develop data analytics and reporting capacity specific to federal managed care reporting requirements; administer managed care contracts; develop and manage quality assurance programs and grievance and appeals processes; and, conduct provider relations and education.

FEDERAL REQUIREMENTS FOR IMPLEMENTATION

States can choose how they want to approach both delivery system and reimbursement under Medicaid Managed Care based on regulations in 42 CFR 438 and various federal authorities. Medicaid managed care requires states to develop and implement a regulatory structure to oversee managed care organizations, including quality and access standards defined by CMS, as well as state requirements. States must apply for approval from CMS to implement managed care for Medicaid through three basic types of federal authorities, or combinations of them. These authorities essentially allow states to waive certain aspects of Section 1902 of the Social Security Act (SSA), the key Section of the Medicaid statute that specifies the requirements a state Medicaid agency must include in its state Medicaid plan. Specifically, these authorities allow states to apply for waivers from Section 1902 requirements for:

[153] The eligibility categories that are managed care optional include foster care children, Title IV-E subsidized adoption children, and juveniles court ordered into state custody.

- *Statewideness.* States can request to implement a managed care delivery system in specific areas (generally counties) as opposed to the whole state. This would be especially important for Alaska because so much of the state is remote and has such small populations that, in some areas, it would not be feasible for MCOs to operate.

- *Comparability of Services.* States can ask for waivers to provide different benefits to enrollees in managed care than in the traditional Medicaid program.

- *Freedom of Choice.* States can request the ability to require enrollees to receive their Medicaid services from a managed care plan, as long as there are at least two MCOs to choose from. If only one managed care plan is available in an area, states must allow enrollees in that area to opt out and get care through the traditional Medicaid program.

1932(A) STATE PLAN AUTHORITY

States can submit to CMS through a State Plan Amendment information such as the types of entities that would be used and which groups of enrollees would be enrolled in their managed care programs. Once a state plan amendment is approved, a state can run its managed care program without needing periodic renewals from CMS. However, this authority does not allow states to require dual eligible individuals, American Indian/Alaska Native enrollees, or children with special health care needs to enroll in a managed care program.[154] The 1932(a) State Plan authority does not require the State to show comparability of service, freedom of choice, or statewideness.[155]

1915(A) AUTHORITY

States can implement a voluntary managed care program by executing contracts with companies procured using a competitive procurement process. CMS must approve the contracts before the state can make payments to the organizations. Thirteen states and Puerto Rico currently use 1915(a) contracts to administer voluntary managed care programs. This authority does not allow states to require a Medicaid enrollee to participate in the managed care program. Under 1915(a), states can authorize voluntary managed care on a statewide basis or in limited geographic areas.

1915(B) WAIVER

There are four types of 1915(b) waivers that states can use to implement a managed care program:

1. (b)(1) Freedom of Choice – Allows states to implement a managed care delivery system that restricts the types of providers that enrollees can use to access Medicaid benefits.

2. (b)(2) Enrollment Broker - Allows a county or local government to act as a choice counselor or enrollment broker in order to help enrollees choose a managed care plan.

3. (b)(3) Non-Medicaid Services Waiver – Allows states to use the savings that it accrues from a managed care delivery system to provide additional services under the plan.

4. (b)(4) Selective Contracting Waiver – Allows states to restrict the number or type of providers who can provide specific Medicaid services (such as disease management or transportation).

[154] See Appendix C for the criteria for dual eligibility for Medicaid and Medicare.

[155] https://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/At-a-glance-medicaid-Authorities.pdf

The biggest differences between a 1915(b) waiver program and a 1932(a) State Plan program are that using a 1915(b) waiver, states are able to require dual eligible individuals, American Indian/Alaska Native enrollees, and children with special health care needs to enroll in managed care. States must demonstrate that their managed care program is cost-effective, efficient and consistent with the principles of the Medicaid program. Approval for the 1915(b) waiver program is for two years, with options to renew. The state must show the waiver is "cost effective" and how the waiver will not substantially impair enrollee access to medically necessary services of adequate quality. The 1915(b) waivers do not require states to meet statewideness, comparability of services or freedom of choice provisions. CMS has begun the process of "modularizing" its current 1915(b) waiver application to separate the various statutory authorities. First in this process is a streamlined application for states to selectively contract with providers under their fee-for-service delivery system. It simplifies the process for documenting the cost-effectiveness of the waiver but requires that states demonstrate maintenance of beneficiary access.

SECTION 1115 DEMONSTRATION WAIVER

Although a more involved application process, Section 1115 give states flexibility to try "experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP programs" for a five-year period. States can create managed care programs which:

a) Expand eligibility to individuals who are not otherwise Medicaid or CHIP eligible;

b) Provide services not typically covered by Medicaid;

c) Use innovative service delivery systems that improve care, increase efficiency, and reduce costs. For example, require MCOs to establish Patient Centered Medical Homes or Health Homes, or develop ACOs, or use Community Health Workers as part of the care coordination team.

STATE STATUTORY AND/OR REGULATORY CHANGES

Section 47.07.030(d) of the Alaska State Statutes notes that DHSS may offer optional services that include primary care case management and coverage under a contract with a managed care organization.[156] Under such an arrangement, certain eligible individuals can be required to enroll and seek approval from a case manager or the managed care organization before receiving certain services. The section gives DHSS the authority to establish enrollment criteria and other rules for coverage provided through managed care. As managed care contracts are not now in place, implementation would require the implementation of regulations in this area.

In addition, the Alaska Administrative Code Title 21. Insurance, Chapter 7 (Regulation of Managed Care Insurance Plans) provide statutory authority to engage in managed care contracts, and regulate provisions such as the relationship between the managed care plan and providers and patients, confidentiality of information, appeals and grievances, and limitations on liability of medical reviewers.[157]

Implementing full-risk managed care in Alaska would likely require development of more insurance regulations. Medicaid managed care requires states to develop and implement a regulatory structure to

[156] http://www.akleg.gov/basis/statutes.asp#47.07.030

[157] The regulations are at: http://www.touchngo.com/lglcntr/akstats/Statutes/Title21/Chapter07.htm.

oversee managed care organizations, including for quality and access standards approved by CMS, as well as the state. The level of effort required for this would need to be assessed as part of the planning and implementation for this initiative.

RATE STRUCTURES AND PAYMENT MECHANISMS

Full-risk capitation rates must be certified as actuarially sound, and typically are adjusted for age, sex, existence of Medicare or other third party insurance, and Medicaid eligibility category. The proposed Medicaid MCO rules published by CMS in May 2015, substantially change what constitutes "actuarially sound" rates. The regulations further propose more stringent requirements regarding timely, accurate encounter data from both managed care organizations and states to ensure compliance with quality assurance and utilization measures, enrollee satisfaction standards, and to improve the accuracy of capitation rates.[158]

Establishing full-risk capitation requires that states have staff with the specific skills and expertise to develop actuarially sound rates and that they have access to sound data to support their enrollment, cost, and utilization assumptions. Even if states work with actuarial firms to handle rate development, they still must have enough expertise in the underlying rate development process and be able to ensure that their actuaries have considered all the relevant factors in establishing rates. Rates that are too high waste state money; yet, rates that are too low can encourage Managed Care Organizations to cut corners and/or reduce reimbursements to providers. If Managed Care Organizations cannot make a minimum margin of profit, they will not participate in Medicaid. Risk adjusting rates can help to mitigate some of these issues. For example, tying higher rates to enrollees with higher health care costs, either through risk cohorts (such as children ages zero to two, children ages three to six, pregnant women, adults ages 55 to 64) or by risk stratifying individual enrollees and paying rates based on their acuity level or risk score.

It is also important for states to be deliberate about which fee schedule they will use to build their capitated rates. For many states, access to complete and accurate enrollee data may not be available. If capitation rates are based on existing Medicaid fee-for-service payments, states must factor in any current access issues that could change under a managed care model.

MONITORING AND REPORTING REQUIREMENTS

Regardless of how states choose to pursue Medicaid managed care, there are considerable federal regulations that govern managed care delivery systems that they must meet. These requirements include that Managed Care Organizations have quality programs, provide appeal and grievance rights for all enrollees, meet provider network adequacy and reasonable access to provider standards, and the right to choose and change managed care plans. There are a variety of reporting requirements such as collection of quality and access to care information, provider network adequacy, and financial reporting. These reporting challenges become greater when states lack substantive managed care experience and can create a danger that states become overly reliant on guidance from the MCOs themselves, creating potential conflicts of interest.

[158] The proposed managed care rules published by CMS in May of 2015, lay out additional requirements related to ensuring actuarially sound rates. While not yet final, states should look to these rules to validate that they are aligned with CMS as they develop their MCO rates over the next year. The proposed rules can be found at https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-26-05.html.

Although MCOs are responsible for paying provider claims and submitting encounter data to the states, states must include the encounter data as part of their quarterly CMS Medicaid Statistical Information System (MSIS) reports. As CMS moves to the next iteration of MSIS, Transformed MSIS (TMSIS), states need to be prepared to meet a variety of new reporting requirements, including more robust encounter data reporting. All MSIS reports must be submitted quarterly. It is expected that because DHSS does not process any encounter data today, it is assumed that it would need to modify its IT systems and data processing capabilities to consume MCO encounter data and validate it before reporting it to CMS.

Timely, accurate and clean encounter data are critical for states to ensure that their MCOs are complying with contract requirements such as quality assurance and utilization measures, and to be able to set accurate capitation rates for MCOs. The proposed managed care rules have new requirements related to encounter data reporting by both MCOs and states.[159] A July 2015 Office of Inspector General report recommended that CMS begin withholding payments from states that do not report their managed care encounter data accurately or in a timely manner.[160]

The proposed federal managed care regulations also indicate CMS is continuing to support more robust quality measurement requirements and improvement efforts in managed care by focusing on transparency, alignment with other systems, and consumer and stakeholder engagement. CMS is proposing authority to specify standardized performance measures and topics for performance-improvement projects for MCOs. Additionally, CMS is proposing that states would be required to develop and implement a Medicaid managed care quality rating system based on three summary indicators: clinical quality management; member experience; and, plan efficiency, affordability, and management. Finally, the proposed rule would also amend Medicaid provisions requiring a state comprehensive quality strategy, applicable to all state Medicaid programs, including fee-for-service Medicaid programs. States would be required to update their state comprehensive quality strategy at least every three years and to post their quality strategy on the state's Medicaid website.

EXPERIENCE OF OTHER STATES

To date, 38 states and the District of Columbia have full-risk, capitated managed care programs for some or nearly all of their Medicaid enrollees and for some or nearly all benefits and services.[161] Medicaid MCOs deliver a set of Medicaid benefits to a specific Medicaid population in exchange for a capitated per member per month rate. Historically, full-risk contracts were limited to children and pregnant women; many states now employ full-risk contracts that include or are specifically designed for complex enrollees such as aged/blind/disabled individuals and those with severe behavioral health needs.[162]

Full-risk managed care has historically been an attractive option for many states because it provides expenditure predictability for budgeting purposes. Also, full-risk managed care provides the incentive to health plans to ensure enrollees access primary care to prevent the occurrence of more serious (and costly) conditions, and to coordinate primary and specialty care, furthering potential to reduce costs.

---

[159] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-26-05.html.

[160] Dept. of Health and Human Services, Office of Inspector General, *Not All States Reported Medicaid Managed Care Encounter Data As Required*, Suzanne Murrin, Deputy Inspector General for Evaluations and Inspections, OEI-07-13-00120 July 2015.

[161] Kaiser Family Foundation, Medicaid Managed Care Market Tracker, http://kff.org/data-collection/medicaid-managed-care-market-tracker/

162 Kaiser Family Foundation, Julia Paradise Associate Director, Kaiser Commission on Medicaid and the Uninsured and the Council of State Governments Washington, DC, September 15, 2014:Medicaid Managed Care A Primer and National Overview, http://knowledgecenter.csg.org/kc/system/files/Paradise%202014.pdf

On the national level, there is debate about how much MCOs can actually save state Medicaid programs. Only one researcher found overall cost savings, while most others conclude managed care is either cost-neutral or even more costly than fee-for-service programs.[163] Studies conducted by consulting firms on behalf of managed care companies or industry trade groups do find savings, primarily resulting from reduced inpatient utilization. One of these reports concluded that savings in rural areas are about half what they are in more urban regions.[164] Another study found that depending on the fee-for-service rates a state already pays providers, there may not be much savings. If states pay high fee-for-service rates and MCOs can reduce those rates, there could be savings. However, if providers feel they cannot get adequate payment from MCOs, they may choose not to participate in their networks, which can result in much higher costs or lack of provider access in some areas.[165]

Some states are now including nearly all services and populations in one comprehensive program, while others have risk-based managed care only for certain populations, specific regions, or particular services. Table 14 shows the various managed care structures of several states with different kinds of full-risk managed care models.

Table 14. Examples of States' Full-Risk Managed Care Programs

STATE	FULL-RISK MANAGED CARE MODEL HIGHLIGHTS
California	California has had managed care for many years for children, young women and pregnant women. However, children with special needs and the aged/blind/disabled were "carved out" and covered under separate fee-for-service programs. California's system includes county-based health plans (owned and operated by the counties) and private MCOs. Each county has a different type of managed care structure, and many of the counties in the more rural areas of California had no managed care for any of their Medicaid enrollees. In the last few years, California has expanded managed care statewide to include all the counties, and has moved all of its aged/blind/disabled enrollees into health plans.
Missouri	Missouri Medicaid contracts with MCOs to provide health care services for a monthly capitation payment for each enrollee. Participation in MO HealthNet Managed Care is mandatory for certain eligibility groups within the three regions with managed care: Eastern, Western and Central.[166] There are still some rural counties in Missouri where HealthNet is not available; in these areas, Medicaid remains all fee-for-service. However, the State is looking to move to MCOs across the entire state.
New Mexico	New Mexico has one of the longest histories of the study states with full-risk managed care and over the past 15 years the program has undergone many changes. Prior to January, 2014, New Mexico operated three full-risk managed care programs: Salud! for acute/physical care. A separate, full-risk capitated program for behavioral health care (which has been carved in, carved out, and then spun off to be a separate state agency). A full-risk capitated program for long-term care services called Coordination of Long-Term Services (CoLTS).

[163] Lewin Group, "Report for America's Health Insurance Plans: Medicaid Managed Care Cost Savings - A Synthesis of 24 Studies : Final Report," March 2009. http://thehill.com/images/stories/blogs/ahipcostsavings.pdf.

[164] "Medicaid Capitation Expansion's Potential Cost Savings" developed for the Association for Community Affiliated Plans and Medicaid Health Plans of America, 2006, The Lewin Group.

[165] Medicaid Managed Care Costs, Access and Quality of Care, The Robert Wood Johnson Foundation, Michael Sparer, The Mailman School of Public Health, Columbia University, Research Synthesis Report Number 23, September 2012, http://www.rwjf.org/en/library/research/2012/09/medicaid-managed-care.html

[166] Missouri Department of Social Services website, "Populations" http://dss.mo.gov/mhd/mc/pages/population.htm and "Regions" http://dss.mo.gov/mhd/mc/pages/regions.htm

STATE	FULL-RISK MANAGED CARE MODEL HIGHLIGHTS
New Mexico (cont.d)	In 2014, the State launched Centennial Care, an integrated, comprehensive managed care program. It contracts with four MCOs, each providing services statewide. Nearly all Medicaid enrollees are mandatorily enrolled and receive all services through the program. There are two exceptions: Because of an existing lawsuit, the Intellectually/Developmentally Disabled (I/DD) population receives their waiver services outside of Centennial Care; although, they receive other Medicaid benefits and services through the Centennial Care health plans. Native Americans who meet long-term care level of care or are not dually eligible for Medicare and Medicaid are mandatorily enrolled. All other Native Americans may opt-in to Centennial Care. This compromise is a result of extensive negotiations between the New Mexico Medicaid agency, CMS and the many Tribes located in the state.
Washington	Washington State Health Care Authority (WSHCA) operates full-risk contracts with five health plans. Additionally, the Washington Medicaid Integration Partnership (WMIP) is managed care for Supplemental Security Insurance (SSI) or SSI-related Medicaid enrollees in Snohomish County. One health plan covers medical, mental health, chemical dependency treatment services, and long-term care services for this pilot project. The pilot, started in 2005, has demonstrated some success, specifically in lowering growth in prescriptions filled for mental illness,[167] and the State is considering expanding the project to other geographic areas.

Full-risk managed care does provide states with an opportunity to use outside expertise to build and manage provider networks, conduct enrollee education and outreach, ensure care coordination and collaboration among providers and handle claims payments. However, as Washington discovered through an audit of two of its largest managed care organizations, use of managed care organizations to handle these program elements is not always successful.[168] The audit found that the plans may have significantly overpaid providers, which in turn may have resulted in higher than appropriate payments to the MCOs. To avoid such issues, Alaska would have to provide strong oversight of and insight into the activities of any managed care partners.

POTENTIAL CHALLENGES

Full-risk managed care would be difficult for Alaska to pursue at this time for a variety of reasons:

a) The difficulties for managed care organizations to achieve typical economies of scale and adequate provider networks in a state with such large frontier areas and sparse populations. There are sizeable populations in areas such as Anchorage and Fairbanks, but high provider costs even in those areas would likely mean that MCOs would want robust rates to ensure they could make at least a small margin.

b) DHSS lacks the experience required to develop and manage oversight requirements to successfully launch full-risk managed care for Medicaid (e.g., development of rates, contract management of managed care plans, reporting and monitoring capabilities).

[167] Davis Mancuso, Melissa Ford Shah, Barbara Felver, Daniel Nordlund. "Washington Medicaid Integration Partnership: Medical Care, Behavioral Health, Criminal Justice, and Mortality Outcomes for Disabled Clients Enrolled in Managed Care," December 2010. https://www.dshs.wa.gov/sites/default/files/SESA/rda/documents/research-9-100.pdf

[168] Ostrom, Carol, "State Medicaid audit suggests $17.5 million overpaid: An audit of the state Health Care Authority says the overpayments may have gone to contracted managed-care organizations to care providers," *Seattle Times*, April 15, 2014.

c) The lack of experience providers in Alaska have with reimbursement methodologies other than fee-for-service and their lack of data collection and sharing capabilities and experience with the type of quality and performance monitoring that are typically required of providers in managed care plan networks. If the MCOs could not get enough providers to participate, they might not be able to meet network adequacy standards and end up with high out-of-network costs.

d) The lack of full-risk managed care in the commercial health care market in Alaska, which would make the learning curve even steeper for providers and DHSS.

Additionally, it would require significant effort for DHSS to build the necessary structures to support full-risk managed care. This includes staff with the requisite skill sets to develop or oversee actuarially sound rate development, managed care contractual requirements and oversight, membership management and financial and member reconciliations, and data reporting and analytics specific to managed care.

PROVIDER COMMUNITY ROLES

It is vital to have strong provider engagement prior to implementation of full-risk managed care, particularly if providers do not have previous experience with full-risk managed care. Without provider buy-in or at least agreement not to openly oppose full-risk managed care, it is very difficult for MCOs to build provider networks that meet network adequacy standards and requirements. Providers need to know they have adequate protections with Managed Care Organizations particularly regarding reimbursement structures and rates, quality expectations and utilization review processes.

Moving providers to working under an MCO umbrella, which can encompass very different ways of being paid, monitored and assigned patients than what they experience under a traditional fee-for-service relationship with DHSS would require a significant investment in provider relations. MCOs often require providers to meet more rigorous quality and performance metrics. While it would be the responsibility of the MCOs to engage with providers, Alaska Medicaid would want to embark on a robust stakeholder engagement process to ensure adequate buy-in from providers or it could risk a situation where many providers would choose not to participate in Medicaid.

OPPORTUNITIES FOR COLLABORATION WITH OTHER PAYERS

Given the vast geographic expanse of the state, and sparse population in many areas, it could be difficult to find MCOs willing to participate in Medicaid outside of the main population centers such as Anchorage and Fairbanks. Even for non-profit health plans, full-risk managed care requires a high enough membership to spread the risk and make capitation rates work to achieve enough of a margin to stay in business. However, there may be insurance carriers currently in Alaska that could grow their business through partnerships with Medicaid in a capitated model that would guarantee sufficient revenue and covered lives. For example, the two primary commercial insurers in Alaska, Premera and Moda Health might be interested in partnering with Medicaid to build up qualified health plans they have in the Federally Facilitated Marketplace, or look at opportunities to pool Medicaid enrollees with State of Alaska employees.

PROJECTED TIMELINE AND STATE RESOURCE REQUIREMENTS

Because Alaska currently has no managed care products, even in the commercial health insurance markets, there is limited experience and expertise available to help establish a strong oversight structure within DHSS. CMS requires both states and MCOs to meet a high level of management and oversight, encounter reporting and financial reconciliation, grievance and appeals and customer service, and the requirements will only increase with the new proposed managed care rules. DHSS does not have entities or structures in place today with a similar level of administrative or operational responsibilities. It would require a significant investment of time and resources for DHSS to build the necessary internal support structures to ensure adequate oversight of a full-risk managed care program. This would include staff with experience and expertise in:

- Administering managed care contracts.
- Developing capitation rates that are actuarially sound and do not have a negative impact on Alaska's upper payment limit.
- Data analytics and reporting specific to CMS managed care reporting requirements, including encounter reporting from the Managed Care Organizations.
- Developing and managing quality assurance programs and Performance Improvement Plans with each Managed Care Organization.
- Conducting provider relations and education.
- Ensuring adequate and timely access to grievance and appeals for enrollees' managed care-related issues.

Building these competencies through hiring new staff and training existing staff would take time. To build a full-risk managed care program from the ground up would take Alaska Medicaid at minimum three years, depending on how easily or quickly qualified staff can be recruited and hired and DHSS can gain approval from CMS, as well as work through any statutory issues.

DHSS would have to make significant modifications to its existing IT systems to ensure the ability to capture, validate and report encounter data. It also likely would need to make both data and analytic improvements to be able to track required MCO quality and performance measures. Initiative 3, also outlined and recommended in this report, could support at least some of this needed IT infrastructure.

The proposed timeline does not factor in resource constraints or the time required for DHSS to secure budgetary resources and authority to implement the initiative, but rather assumes availability of DHSS resources and is based on the anticipated effort and timing of steps associated with obtaining federal approval. If the decision is made to move forward with the recommended reforms, DHSS would then determine the resources and time required to implement the initiative.

4. POTENTIAL EXPANSION COVERAGE MODELS

On September 1, 2015, under the leadership of Governor Bill Walker, Alaska Medicaid expanded eligibility to include adults between ages 19 to 64, whose incomes are at or below 138 percent of the federal poverty level (FPL) and are not eligible for another type of Medicaid or Medicare. This effectively opened Medicaid to an additional 42,000 newly eligible Alaskans who otherwise had no affordable or even available coverage options. Alaska's Medicaid Expansion is expected to bring the State of Alaska nearly $145 million in federal revenue in its first year.[169] The Governor anticipates savings gained by using federal funds to provide medical services previously funded exclusively by State General Funds.

Alaska's small and dispersed population poses challenges for service delivery when many people who require health care services lack coverage. This results in individuals seeking care in emergency settings where, by federal law, they cannot be refused care.[170] It also results in individuals not seeking care for conditions at an early stage when care can be provided at a lower cost, driving the need for care for more advanced conditions at a higher cost. To replace emergency care with more appropriate primary care and behavioral health services in non-emergency settings, individuals must have health care coverage to procure the services. Expansion of Medicaid coverage to a broader range of low-income individuals provides a sustainable base for providers to develop and offer services in more appropriate and cost-effective settings.

Most of the individuals expected to enroll through the Expansion are uninsured prior to their enrollment in Medicaid. Individuals without insurance coverage have lower access to services and poorer health compared to individuals enrolled in coverage.[171] While coverage alone is not the only factor affecting individuals' health and access to care, it plays a significant role, particularly for low-income individuals for whom the cost of care is a significant barrier.

As the Alaska Department of Health and Social Services (DHSS) implements Medicaid reforms, service delivery improvements will affect those enrolled through Expansion, extending the impact of Medicaid reform to a broader group of low-income Alaskans. By extending health coverage to this group, Medicaid will be able to better coordinate care and to increase access to needed primary care and behavioral health services, to improve health and contain costs over time. At the time of this writing, 30 states and the District of Columbia have expanded Medicaid;[172] while each program has been implemented differently, early evidence suggests that states that have expanded Medicaid have seen improved health outcomes and reduced mortality in the newly-covered population.[173]

---

[169] Alaska Department of Health and Social Services, *Healthy Alaska Plan: A Catalyst for Reform.* February 2015. (http://dhss.alaska.gov/HealthyAlaska/Documents/Healthy_Alaska_Plan_FINAL.pdf).

[170] In 1986, Congress enacted the Emergency Medical Treatment & Labor Act (EMTALA) to ensure public access to emergency services regardless of ability to pay. Section 1867 of the Social Security Act imposes specific obligations on Medicare-participating hospitals that offer emergency services to provide a medical screening examination (MSE) when a request is made for examination or treatment for an emergency medical condition (EMC), including active labor, regardless of an individual's ability to pay. Hospitals are then required to provide stabilizing treatment for patients with EMCs. If a hospital is unable to stabilize a patient within its capability, or if the patient requests, an appropriate transfer should be implemented.

[171] Kaiser Family Foundation, "Medicaid's Impact on Access to Health Care" http://kff.org/report-Section/what-is-medicaids-impact-on-access-to-care-health-outcomes-and-quality-of-care-setting-the-record-straight-on-the-evidence-issue-brief/

[172] http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/

[173] Kaiser Family Foundation, "The Effects of the Medicaid Expansion on State Budgets: An Early Look in Select States" (March 2015) http://files.kff.org/attachment/issue-brief-the-effects-of-the-medicaid-expansion-on-state-budgets-an-early-look-in-select-states

DHSS expanded eligibility for Medicaid using a State Plan Amendment that provides the same benefits and services to the Expansion population as is currently provided to existing Medicaid enrollees. The coverage models considered through this project (Table 15) begin with the option currently in place, and then analyze two other coverage models: one based on the commercially available benchmark plan, administered by DHSS; and, the other, the same benchmark plan, purchased from a private insurer.

Table 15. 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.[174] Providers expressed significant concern about the additional administrative burden that would be associated with implementing an additional 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 with Qualified Health Plans through the Federally Facilitated Marketplace. Medicaid would pay premiums and co-payments directly to the private insurer and would continue to directly fund 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.

Harvard School of Public Health, "Expanding Medicaid to low-income adults leads to improved health, fewer deaths" (July 2012) http://www.hsph.harvard.edu/news/press-releases/medicaid-expansion-lower-mortality/

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

EXPANSION MODEL 1. CURRENT ALTERNATIVE BENEFIT PLAN

Expansion enrollees would continue to receive coverage under the current Alternative Benefit Plan that includes the same benefits and services provided to existing Medicaid enrollees. The consultant team recommends Option 1 because it offers a comprehensive benefit package that includes dental benefits for relatively little additional expense, and because a single benefit package is simpler and less costly to administer for DHSS and providers.

DESCRIPTION

This Expansion coverage model analyzes the current approach, which would maintain the standard Alaska Medicaid benefit plan for individuals covered by Expansion. This model has the advantage of keeping all Medicaid enrollees on one benefit plan, which is administratively simpler for DHSS, providers and enrollees. While this option does not specifically include delivery system changes for the Expansion group, the reforms proposed in this report and other reforms DHSS is undertaking would apply to the Expansion group who would receive the same benefits as other Medicaid enrollees. This benefit plan includes the behavioral health services currently available to Medicaid enrollees, which supports the other reforms proposed through this project to increase access to behavioral health services for Alaskans who need them.

KEY FEATURES

a) Individuals eligible for Medicaid under Alaska's Expansion are covered under an Alternative Benefit Plan that is defined as the standard benefits offered to other Medicaid eligible individuals in the state.[175]

b) Co-payments are the same as those for the non-Expansion enrollee population.[176]

TRIBAL PARTICIPATION

American Indian/Alaska Native individuals would continue to be eligible for Medicaid and would continue to access services as they currently do. Expanding Medicaid eligibility increases opportunities for DHSS to work closely with CMS and Tribal Health Organizations to maximize the Tribal health system's ability to serve American Indian/Alaska Native enrollees and capture the 100% FMAP rate for all Medicaid enrollees. This rate will remain at 100% federal participation even as the rate for non-American Indian/Alaska Native enrollees is reduced to 90% by 2020.

SPECIAL POPULATIONS

This proposal does not affect programs or other activities for special populations.

RELATED PROJECTS

This proposal relates to the Expansion of Medicaid eligibility that went into effect September 1, 2015.

[175] See Appendix E for a full description of current Alaska Medicaid benefit plan.

[176] See Appendix G: *Healthy Alaska Plan: Environmental Assessment Appendices, Appendix E* for a full description of current cost-sharing requirements.

ANTICIPATED IMPROVEMENTS TO SERVICE DELIVERY

This proposal does not make any specific changes to service delivery from the current system. In comparison to the two other coverage models for the Expansion population, this option would be simplest for DHSS, providers and enrollees to administer and manage. Maintaining the current approach, which offers the same benefit plan to all enrollees, offers simplicity and predictability to providers of needed services and incentivizes them to participate in the Medicaid program.

ANTICIPATED IMPROVEMENTS TO OUTCOMES AND ACCESS

This benefit structure is the baseline against which the other alternative coverage models for the Expansion population are compared. The anticipated improvements to outcomes and access are primarily the result of gaining health care coverage through Medicaid.

Maintaining the current benefits for all enrollees avoids administrative complexity for DHSS staff, providers and consumers. Providers would not have to conduct checks to determine the appropriate coverage by eligibility group. Limiting complexity helps to maintain provider participation in the Medicaid program. It would also allow all Medicaid enrollees to benefit from reforms to Medicaid service delivery as they are implemented, and to ensure that enrollees can access the full array of services, including behavioral health services, for which there is a significant documented need among individuals in the Expansion population.[177]

PROJECTED COSTS AND SAVINGS

In analyzing the alternative Medicaid Expansion options, Milliman reviewed Evergreen Economics memorandum "Projected Population, Enrollment, Service Costs and Demographics of Medicaid Expansion Beginning in FY2016" for reasonableness. Generally, Milliman found the assumptions that Evergreen Economics used to be reasonable.

Expansion Option 1, the Current Alternative Benefit Package (Table 16), is estimated to cost the state $4.9 million in State Fiscal Year (SFY) 2017 increasing to $23.9 million in SFY 2021 as federal match declines.

Table 16. Actuarial Results for Expansion Option 1: Current Alternative Benefit Package

EXPANSION OPTION 1: CURRENT ALTERNATIVE BENEFIT PACKAGE*					
	FY17	**FY18**	**FY19**	**FY20**	**FY21**
Newly Eligible Adults	41,980	42,050	42,120	42,190	42,260
Take-Up Rate	55.4%	63.0%	63.0%	63.0%	63.0%
New Enrollees	23,273	26,492	26,535	26,580	26,623
COST PER ENROLLEE	**$7,913**	**$8,275**	**$8,658**	**$9,062**	**$9,489**
Medical	$7,854	$8,213	$8,593	$8,994	$9,418
Admin	$59	$62	$65	$68	$71
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**

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

[177] 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/

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 further details of Milliman's analysis.

FEDERAL REQUIREMENTS FOR IMPLEMENTATION

The Affordable Care Act authorizes states to expand eligibility to adults with incomes effectively up to 138 of the federal poverty level. Alaska's recent eligibility Expansion was undertaken using a State Plan Amendment. The Alternative Benefit Plan was defined as the benefits in the existing Medicaid program. No additional updates are required.

STATE STATUTORY AND/OR REGULATORY CHANGES

The Medicaid State Plan was amended to include eligibility for the Expansion population. State regulation refers to the State Plan; regulation is updated by reference when the State Plan is changed.

RATE STRUCTURES AND PAYMENT MECHANISMS

The current rates and fee-for-service payment structure is maintained, along with current enrollee co-payment requirements.

MONITORING AND REPORTING REQUIREMENTS

Existing Medicaid reporting is maintained for all populations.

EXPERIENCE OF OTHER STATES

Thirty states and the District of Columbia have expanded Medicaid under the ACA authority. In all but six states, Expansions began on January 1, 2014. While seven states applied for and received federal approval for Section 1115 waivers to establish coverage for Expansion populations, the remaining state programs expanded coverage consistent with their existing Medicaid benefits.

Because states expanded their Medicaid programs on or after January 1, 2014, analysis of year one data is limited. However, in a recent study of hospital discharge data in 16 states, states that expanded Medicaid using the ACA authority saw declines in the number of hospital discharges for uninsured patients.[178] This change in payer mix was seen across the country, both for hospital discharges in general, and for specific diagnoses such as asthma or mental health. Interviews with providers serving homeless patients in five states indicate that Medicaid Expansion has increased coverage for homeless individuals and is contributing to improved access for this population. The providers also indicated that improved access to care has led to improved health and supported homeless individuals' ability to work, gain and maintain stable housing. [179]

POTENTIAL CHALLENGES

Because DHSS has already expanded eligibility to the Alaska Medicaid program using the Alternative Benefit Plan that would be maintained in this option, this option does not include any additional challenges to current practice.

---

[178] "Issue Brief: New Analysis Shows States with Medicaid Expansion Experienced Declines in Uninsured Hospital Discharges," Robin Rudowitz and Rachel Garfield. September 2015. The Kaiser Commission on Medicaid and the Uninsured.

[179] "Issue Brief: Early Impacts of the Medicaid Expansion for the Homeless Population," Barbara DiPietro, Samantha Artiga, and Alexandra Gates. November 2014. The Kaiser Commission on Medicaid and the Uninsured.

PROVIDER COMMUNITY ROLES

Providers would continue to participate in the Medicaid program on an opt-in basis.

OPPORTUNITIES FOR COLLABORATION WITH OTHER PAYERS

This option does not provide specific opportunities for other payers to engage in collaboration.

PROJECTED TIMELINE AND STATE RESOURCE REQUIREMENTS

Currently, all Medicaid enrollees have access to this benefit and payment structure. No additional resources are needed to implement this program beyond those already planned.

EXPANSION MODEL 2. ALTERNATIVE BENEFIT PLAN BASED ON QUALIFIED HEALTH PLAN

Expansion enrollees would receive coverage administered by Alaska Medicaid under an Alternative Benefit Plan that would include the same benefits and services as the commercial plan with the largest insured commercial, non-Medicaid enrollment in the state. DHSS would be required to manage a separate benefit package for the Expansion population in addition to the benefit package it currently provides.

The consultant team does not recommend Option 2 for the following reasons:

- 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.
- Providers expressed significant concern about the additional administrative burden that would be associated with implementing a separate Medicaid benefit plan for the Expansion population.
- 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.

DESCRIPTION

Under this Alternative Benefit Plan coverage model, Alaska would adopt a new benchmark equivalent of the plan with the largest insured commercial, non-Medicaid enrollment in the state. In Alaska, this is the Premera Blue Cross Blue Shield Alaska Heritage Select Envoy plan. With this option, DHSS would continue to administer the benefit plan.

The Alternative Benefit Plan is a package of benefits that can differ from those offered under traditional Medicaid, or it can be similar to or the same as the traditional Medicaid benefit package. The Affordable Care Act requires that Expansion population enrollees be covered with an Alternative Benefit Plan (it may also be used for other populations, including children ages six and over). For the Expansion population, Alternative Benefit Plan coverage must either be equal to a specified benchmark plan or a federally-approved coverage option, and provide both mandatory state plan services and the Essential Health Benefits. These benefits are ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. The benchmark plan for this Alternative Benefit Plan provides these and some additional benefits such as acupuncture, chiropractic, and naturopathic services. The Alternative Benefit Plan must be actuarially equivalent to a specified benchmark.[180]

[180] State Medicaid Director Letter #12-003, CMS. November 20, 2012.

KEY FEATURES

a) This Alternative Benefit Plan would provide the ten federally mandated Essential Health Benefits and Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for enrollees under age 21. It would comply with the Mental Health Parity and Addiction Equity Act, cover non-emergency medical transportation and offer access to federally qualified and rural health center services. Benefit reductions and eliminations follow:

1. Dental services are not covered, compared to the current Medicaid Benefit of $1,150 in annual preventative care;
2. Vision care benefits are limited to an annual eye examinations and a pair of lenses annually, one pair of frames every two calendar years;
3. Hearing aids and hearing exams are one per every three years with an $800 cap on hardware per three calendar years;
4. Additional limits would be applied to the amount and duration of services, including some services contained in the Essential Health Benefits such as Rehabilitation and Hospice.[181]

b) Co-payments would be required of all Expansion population enrollees at the level allowed for those with incomes up to 100 percent of the federal poverty level, up to the maximum cost-sharing contribution of 5 percent of household income.[182] There would be no co-payment for Emergency Department use or primary care. Co-payments for narcotics, other specified prescriptions and some specialty care would be increased to incentivize enrollees to seek lower cost alternatives.

c) For enrollees with incomes at or above 100 percent of federal poverty level, providers would be able to withhold services if the required co-payment was not paid at time of service. Even with this requirement in place, a significant proportion of Alaska's Medicaid enrollees would be exempt from cost sharing requirements. Most co-payments are not allowed for American Indian/Alaska Native enrollees or for individuals considered medically frail.[183]

TRIBAL PARTICIPATION

American Indian/Alaska Native enrollees in the Expansion population would receive the same Alternative Benefit Plan as other Expansion enrollees, and would be exempt from most cost sharing.

Option 2 would create a negative fiscal impact on Tribal Health Organizations because some services currently included in the Medicaid benefit plan for all enrollees, including the Expansion population, are not included in this Alternative Benefit Plan. These services (e.g., dental services) are reimbursed by Medicaid with 100% federal match, but would not be reimbursed by Medicaid if Option 2 were selected.

SPECIAL POPULATIONS

The medically frail would be given the option to opt out of this Alternative Benefit Plan and receive services through fee-for-service Medicaid.[184]

---

[181] See Appendix F for the full list of benefits and limits of the Qualified Health Plan.

[182] As used in this document, the term "co-payment" means enrollee cost sharing that includes set per visit or event costs as well as payments set as a percent of total charges or other methods.

[183] See Appendix C for description of exemptions related to Special Populations.

[184] According to federal regulations, state definitions of medically frail or individuals who otherwise have special medical needs include children with serious emotional disturbances, individuals with disabling mental disorders (including chronic substance abuse disorders), individuals with serious and complex medical conditions, individuals with physical and/or mental disabilities that significantly impair their ability to perform one or more activities of daily living, and children with special needs defined under §438.50(d)(3) 42 CFR 440.315.

ANTICIPATED IMPROVEMENTS TO SERVICE DELIVERY

Providers have indicated that they often are not able to collect co-payments, so a reduced co-payment schedule would mean an increased state payment for primary care, effectively increasing provider reimbursement for these services.

This benefit plan aligns with a common commercial package, reducing issues related to churn between commercial and Medicaid benefits. "Churn" refers to changes in coverage that lead to disruptions in provider access or treatment continuity. Maintaining the same coverage across payer changes avoids such disruptions and helps enrollees maintain provider relationships.

ANTICIPATED IMPROVEMENTS TO OUTCOMES AND ACCESS

Reduced cost sharing for primary care and prevention encourages enrollees to utilize care in appropriate settings and to take steps to improve or maintain health.

PROJECTED COSTS AND SAVINGS

Under Expansion Option 2, Expansion enrollees are covered under a benefit package that differs from the current Medicaid benefit package. Actuarial analysis indicates that Expansion Option 2 would result in a cost reduction of approximately four percent in State Fiscal Years (SFY 2020) and beyond compared to the projected expenditures for Expansion Option 1 (Table 17). This variance is 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. In SFY 2017, State costs would actually increase due to administrative costs associated with implementing Expansion Option 2.

Table 17. Actuarial Results for Expansion Option 2: Alternative Benefit Plan based on a Qualified Health Plan

EXPANSION OPTION 2: ALTERNATIVE BENEFIT PLAN (ABP) BASED ON QUALIFIED HEALTH PLAN (QHP)*					
	FY17	**FY18**	**FY19**	**FY20**	**FY21**
Newly Eligible Adults	41,980	42,050	42,120	42,190	42,260
Take-Up Rate	55.4%	63.0%	63.0%	63.0%	63.0%
New Enrollees	23,273	26,492	26,535	26,580	26,623
COST PER ENROLLEE	**$7,418**	**$7,770**	**$8,141**	**$8,534**	**$8,950**
Medical	$7,326	$7,672	$8,039	$8,427	$8,838
Admin	$93	$97	$102	$107	$112
TOTAL COST	**$172,648,000**	**$205,831,000**	**$216,021,000**	**$226,831,000**	**$238,266,000**
Federal Cost	$167,699,000	$194,394,000	$202,076,000	$208,115,000	$215,396,000
STATE COST	**$4,949,000**	**$11,437,000**	**$13,945,000**	**$18,716,000**	**$22,870,000**
COMPARISON TO EXPANSION OPTION 1					
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)**

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

FEDERAL REQUIREMENTS FOR IMPLEMENTATION

Changing the Alternative Benefit Plan requires an amendment to the Medicaid State Plan. DHSS would need to submit Medicaid State Plan Amendments to update the Medicaid Alternative Benefit Plan from the current Secretary-approved option to the Largest State Commercial Health Plan option. As Alaska already has an Alternative Benefit Plan defined for this population, DHSS would need to complete CMS State Plan templates ABP-2a, ABP-3, ABP-4, and ABP-5, and submit them as State Plan Amendments. CMS approval of these amendments is needed prior to the adoption of a new Alternative Benefit Plan. The timeframe for federal approval of a State Plan Amendment varies, typically 60 to 120 days.

Current Expansion population members would experience a reduction in services from their currently approved Medicaid Alternative Benefit Plan. Since Alaska implemented its Medicaid Expansion using a Secretary-approved Alternative Benefit Plan equivalent to the Traditional Medicaid benefit plan, CMS would view changes that reduce services available to the Expansion population as a reduction in services. DHSS would be required to provide both public notice and conduct Tribal consultation in accordance with 42 CFR 431.408 and 42 CFR 431.408(b).

STATE STATUTORY AND/OR REGULATORY CHANGES

DHSS would need to update its Medicaid regulations and submit changes to its Medicaid State Plan to allow for changes in cost sharing for the Expansion population. Although changes to an Alternative Benefit Plan that do not affect cost sharing can be implemented using a State Plan Amendment, if DHSS decided to impose cost-sharing higher than the 5 percent level allowed by state plan, federal waiver approval would be required.

To implement programmatic elements that meet federal requirements, DHSS would need to ensure capacity to identify exempt populations, track member spending, and discontinue cost sharing when the individual or household reaches the cost-sharing maximum of 5 percent of household income. Current Alaska statute (AS 47.07.036) allows DHSS to make changes to Medicaid if current cost saving measures are insufficient to stay within the program's authorized budget. Changes to the benefits or other program elements can be made under this provision. The medically frail group is not specifically addressed in state statute or regulations, but would need to be addressed in regulations.

RATE STRUCTURES AND PAYMENT MECHANISMS

The current rates and fee-for-service payment structure would be maintained. Co-payments would be required of all enrollees in the Expansion population at the level allowed for those with incomes up to 100 percent of the federal poverty level, up to the maximum cost-sharing contribution of 5 percent of household income. There would be no co-payment for Emergency Department use or primary care. Co-payments for narcotics or other identified prescriptions and some specialty care would be increased to provide an incentive to seek alternatives.

MONITORING AND REPORTING REQUIREMENTS

DHSS would need to report and reconcile enrollment and expenditure information on the Expansion group through CMS forms 37 (Medicaid Program Budget Report) and 64 (Quarterly Expense Report). The information to complete these activities is similar to the information that CMS requires of other Medicaid Eligibility Groups.

EXPERIENCE OF OTHER STATES

Since 2014, 30 states and the District of Columbia have used the authority provided by the Affordable Care Act to expand Medicaid to low income adults.[185] Most of the states that have used an Alternative Benefit Plan for their Medicaid Expansion populations have done so using Secretary-approved coverage based on benefits provided in an approved Medicaid state plan. The benchmark plan used varies. Several states, including Arizona, Colorado and Iowa, made coverage available using a state employee benefit plan as the benchmark. Others, including larger population states like Illinois and Michigan and smaller states such as Hawaii and Washington, DC, use the largest small group plan as their benchmark. States that have implemented an Alternative Benefit Plan for their Expansion populations have the opportunity to make changes to the benefits or change benchmarks, providing significant flexibility in administration and ability to meet members' needs over time.

Because Medicaid Expansion only began in January 2014 (later in some states), there has not been significant analysis of the cost impact of benefit plan changes for this population. The first full year of data ended in December 2014, but as enrollment in Medicaid occurred throughout 2014 and beyond, most states are only just now in possession of enough data to analyze impacts. Cost analyses will be coming out in the next year that include information on the impact of Alternative Benefit Plans. States do have expectations about savings; in developing an Alternative Benefit Plan, states conducted analyses to identify the costs and benefits of different variants.[186]

In FY 2015 and 2016, only a few states reduced benefits that impacted Expansion enrollees and only Arkansas has a change with a potentially large monetary impact:[187]

- Arkansas put limits on non-emergency medical transport for non-medically frail adults in their Expansion population.
- New York discontinued coverage for viscosupplementation of the knee, and limited DEXA scans for screening to once every two years for enrollees over a certain age.
- Oklahoma eliminated coverage for sleep studies.

In FY 2015, 24 states expanded covered Medicaid benefits, while only one state reduced benefits.[188] An additional 18 states are expanding benefits for FY 2016 and five are restricting them.

POTENTIAL CHALLENGES

Some benefits currently provided by the Medicaid benefit plan are not covered under the Alternative Benefit Plan based on the Qualified Health Plan benefit package. Some of these may be the services most needed by Medicaid enrollees. For example, while Medicaid covers dental services, the Qualified Health Plan does not. The major findings of the "Oral Health in America: A Report of the Surgeon General" highlight the importance of dental care, particularly for vulnerable populations, and recommends extending dental coverage to reduce disparities.[189]

---

[185] Status of State Action on the Medicaid Expansion Decision" Henry J. Kaiser Family Foundation, State Health Facts. November 2, 2015.

[186] Washington State released a strawman scenario for its ABP analyses:
https://www.statereforum.org/sites/default/files/alternative_benefit_plan_strawman020713.pdf;
New York looked at the four ABP options for its Expansion:
https://www.statereforum.org/sites/default/files/ny_medicaid_benchmark_benefit_option_hma.pdf

[187] "Medicaid Reforms to Expand Coverage, Control Costs and Improve Care: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2015 and 2016" Health Management Associates for the Kaiser Family Foundation and National Association of Medicaid Directors. October 2015.

[188] Ibid.

[189] The National Institute of Dental and Craniofacial Research, September 2000.

If the duration and level of service provided by the benefit plan is limited, Medicaid enrollees may continue to require behavioral health and substance abuse treatment services funded by State grant programs. As individuals enter Medicaid through Expansion, some of the State-grant funded services would be re-financed through Medicaid, which is supported by a 100 percent federal match through 2016, phasing down to a still robust 90 percent match by 2020. In order to ensure this occurs successfully, the benefit plan for the Expansion population should provide the full range of behavioral health services currently provided by Medicaid.

Federal ambulatory service coverage requirements and mental health parity rules, along with coverage for the ten essential health benefits may mean that this Alternative Benefit Plan option may not provide a lower-cost alternative to the current plan. If this option does provide cost savings, the cost difference would come from changes in the benefit structure. Some consumer and provider stakeholders may oppose limitations on benefits for a population that includes individuals with significant needs. Reductions in some benefits could lead to other service use that could reduce or eliminate the savings associated with the change.

Managing multiple Medicaid benefit plans can increase administrative complexity for DHSS and providers, and may cause confusion for enrollees who may have household members on different plans.

Providers indicated that they routinely do not collect enrollee co-payments, as collecting the small fee amount is not worth their effort. It is unclear whether providers would turn away patients with whom they have ongoing relationships when the patient fails to make a co-payment. Additionally, providers opposed reforms that add administrative complexity. Having some individuals who are exempt from mandatory co-payments (those under 100 percent federal poverty level) and others subject to the requirements would mean additional work for providers, who would need to identify which category patients fall into.

PROVIDER COMMUNITY ROLES

Providers would be expected to track benefits for the two groups of Medicaid beneficiaries. This adds complexity for provider practices and makes it more likely that providers would respond by either failing to collect co-payments or deciding that the burden of participation is greater than the benefit of taking Medicaid enrollees as patients.

OPPORTUNITIES FOR COLLABORATION WITH OTHER PAYERS

The benefit plan would be closely aligned with a common benefit plan in the commercial market. To the extent that private payers push for delivery system changes, this could support DHSS's efforts to implement such changes as well.

PROJECTED TIMELINE AND STATE RESOURCE REQUIREMENTS

This initiative would take one to three years to implement. Although changes to an Alternative Benefit Plan that do not affect cost sharing can be implemented using a State Plan Amendment, if DHSS decided to impose cost sharing higher than the five percent level allowed under the State Plan, federal waiver approval would be required.

Implementation includes the following activities, some of which can occur simultaneously and some, such as Information Technology (IT) changes and provider training, will require new DHSS resources:

a) State Plan Amendment process (3 to 6 months)

   1. Update the State Plan to reflect program changes
   2. CMS review, including DHSS conversations with CMS

b) IT updates (6 to 12 months)

   1. Identify changes to the Medicaid Management Information System (MMIS) and other relevant systems
   2. Implement changes: the timing of this implementation would depend on whether this is done in house or requires a contract for assistance

c) Develop monitoring program (3 months) including data collection and analysis plan, to ensure changes do not negatively impact access or quality of care

d) Provider and Enrollee education (3 months) to develop and distribute materials and training for both audiences

e) Enroll Expansion eligible individuals in the updated Alternative Benefit Plan (ongoing)

EXPANSION MODEL 3. PRIVATE COVERAGE OPTION BASED ON QUALIFIED HEALTH PLAN

To pursue this model, DHSS would use Medicaid funds to pay for Expansion enrollees to purchase Qualified Health Plans through the Federally Facilitated Marketplace. Alaska Medicaid would pay premiums and co-payments directly to the private insurer.[190] The consultant team does not recommend Option 3 because the cost of pursuing the private coverage option is significantly higher than administering the program through DHSS.

DESCRIPTION

In this model, commonly referred to as "the private option," DHSS would require the Expansion population, excluding American Indian/ Alaska Native enrollees and the medically frail, to choose a Qualified Health Plan through the Federally Facilitated Marketplace, placing this population in commercial insurance rather than public coverage. Medicaid funds would pay for enrollee premiums and any co-payments that exceed the federally allowable limit of five percent of income. The commercial insurer would be responsible for delivering mandatory Medicaid benefits to the enrollee and the enrollee's principal relationship would be with the insurer rather than the Medicaid agency. DHSS would pay for mandatory Medicaid services not covered by the commercial plan.

The private option could also be limited to those Medicaid enrollees eligible for employer-sponsored insurance, as is currently the case in Alaska. This option would expand on Alaska's existing Health Insurance Premium Payment program for Medicaid and Denali KidCare enrollees. DHSS should first evaluate the existing program's administrative and programmatic costs and benefits before choosing to expand the Health Insurance Premium Payment program through education and outreach efforts. DHSS has stated that the current program is resource intensive to administer.

As is the case with Expansion Model 2, this option uses an Alternative Benefit Plan to cover the Expansion population. Alternative Benefit Plans must be actuarially equivalent to the Medicaid benefit plan and conform to Medicaid Requirements of Section 1937 of the Social Security Act by providing the ten federally mandated Essential Health Benefits.

KEY FEATURES

a) Medicaid funds would cover member premiums and any co-payments that exceed the federally allowable limit of five percent of income.

b) Enrollment would be mandatory for most Expansion enrollees. Some enrollees, including American Indian/Alaska Native enrollees and medically frail persons, would be able to opt out and be served through the traditional Medicaid program.[191]

[190] As used in this document, the term "co-payment" means enrollee cost sharing that includes set per visit or event costs as well as payments set as a percent of total charges or other methods.

[191] The definition of medically frail is codified in federal regulations finalized in July 2013 § 440.315(f)). The definition includes individuals with chronic Substance Use Disorders (SUD). This means that individuals with chronic SUD, along with individuals otherwise included in the federal definition of medically frail, could choose whether to enroll in the private coverage option or stay in fee-for-service Medicaid. If a large number of newly eligible individuals are diagnosed with a chronic SUD, the number of mandatory enrollees could be reduced significantly.

c) Federal rules require enrollee choice of plan in order to implement private coverage on a mandatory basis. The exception to this requirement is that in rural areas where choice is not possible, eligible individuals may be enrolled on a mandatory basis without offering plan choice. This could affect large parts of Alaska where the rural setting makes participation by multiple insurers significantly less likely than in urban centers.[192]

d) Where choice was available, individuals would be given a choice of plan. Individuals who do not act would be auto-assigned to a plan.

e) DHSS would pay for mandatory benefits not provided through the private plan on a fee-for-service basis. DHSS would not need to provide optional benefits, such as vision or most adult dental, currently available to Medicaid enrollees.

f) While commercial coverage must cover the 10 federally mandated Essential Health Benefits listed above, there can be visit and other coverage limits. This distinguishes the coverage from what is currently offered through Medicaid, where very few services or benefits are subject to coverage limitations. Because chronic Substance Use Disorder, persistent mental health conditions and children with severe emotional disturbance are included within the definition of 'medically frail', individuals with these conditions would be able to opt out of the private option and continue to be served by the traditional Medicaid program.

g) As one way to encourage private coverage for low income Alaskans, DHSS may want to consider building on its existing Health Insurance Premium Payment program. This program uses Medicaid funds to support private group coverage for individuals with access to cost effective employer-sponsored insurance or COBRA benefits. Across the country, the model used by the Health Insurance Premium Payment program is the most prevalent type of Medicaid-funded private coverage program. The existing program can be used as a first step to developing a larger private coverage model, or be expanded.[193] As with the private coverage model more generally, the Health Insurance Premium Payment program requires DHSS to provide wraparound benefits that are not offered through the enrollee's group plan.

h) Private Coverage can be implemented incrementally, as follows:

   1. Expand the Health Insurance Premium Payment program by making participation mandatory for Expansion individuals with access to cost effective employer-sponsored insurance. Medicaid would continue to pay for both enrollees' premiums and co-payments, up to current Medicaid cost-sharing requirements.

   2. Apply for a Section1115 waiver in order to enroll other Expansion enrollees in Qualified Health Plans for the 2017 plan year (on an optional or mandatory basis, depending on availability of multiple Qualified Health Plans).

TRIBAL PARTICIPATION

American Indian/Alaska Native enrollees would be given the option to opt out of private coverage and receive services through the fee-for-service Medicaid program.

[192] § 438.52(b) Choice of MCOs, PIHPs, PAHPs, and PCCMs, Exception for rural area residents. Implementation of this exception requires an approved 1115, 1915(b), or 1932(a) waiver.

[193] As described in the Federal Authority Section, Health Insurance Premium Payment program are requested using a Section 1906 authority to amend the Medicaid State Plan.

SPECIAL POPULATIONS

Medically frail individuals would be given the option to opt out of private coverage and receive services through fee-for-service Medicaid.

RELATED PROJECTS

Payment of private coverage premiums and co-payments using Medicaid funds already exists under the Alaska Health Insurance Premium Payment program for Medicaid and Denali KidCare enrollees. The program currently enrolls 262 Medicaid eligible persons and an additional 47 non-Medicaid eligible family members.[194] Expanding private coverage to other Expansion enrollees could start with promoting enrollment in this existing program.

ANTICIPATED IMPROVEMENTS TO SERVICE DELIVERY

Service delivery in this model is determined by the participating health plans available to consumers in the Alaska market. Any improvements in service delivery would be driven by the private insurance market or by providers. In the fee-for-service Alaska market, the move between public and private coverage may not significantly affect Medicaid's underlying cost structure, and in some cases Medicaid's costs are lower than those paid by commercial plans.[195] Evaluation of the existing Health Insurance Premium Payment program would inform DHSS of the costs and benefits of expanding this approach to more enrollees.

ANTICIPATED IMPROVEMENTS TO OUTCOMES AND ACCESS

Utilizing private insurance coverage can reduce the effects of churn for enrollees moving between Medicaid and marketplace plans.

The private coverage model also increases enrollment in the private health insurance marketplace in Alaska. Increased enrollment may bring more healthy lives into the market and could stabilize or lower premium prices for all populations. This is particularly relevant for the Health Insurance Premium Payment program, as the enrollee is keeping the same coverage as their income changes, with either Medicaid or the enrollee paying the premiums and co-payments. Where the employee is eligible for high value group coverage, maintaining continuity as their incomes increase helps increase continuity of care. The consultant team recommends additional evaluation of the existing program to understand how many Medicaid eligible individuals could potentially benefit.

In some states considering a private coverage model, it is anticipated to expand provider options for Medicaid enrollees. This is less relevant in Alaska, where Medicaid provider participation is strong.

[194] The program enrolls the whole family, as a child has access to employer-sponsored insurance only if the employed parent is enrolled, and occasionally that parent is not Medicaid-eligible.

[195] Alaska Department of Health and Social Services, October 2015. DHSS pays significantly less for medical transportation by helicopter than private insurers pay for the same service.

PROJECTED COSTS AND SAVINGS

Under Expansion Option 3, Expansion enrollees purchase coverage through the Federally Facilitated Marketplace. Medicaid pays premiums and co-payment amounts directly to the private insurer and pays for any required Medicaid services not provided through the Qualified Health Plan. For this analysis, Milliman assumed the Medicaid program would be responsible for premiums, co-payment amounts in excess of five percent of member income, and the cost of non-emergency transportation at a level similar to current Medicaid coverage. Although DHSS's administrative role and, thus, costs are reduced under this option, DHSS would be responsible for ensuring that the enrollee does not experience costs beyond the allowed Medicaid limits, paying for services not covered by the private coverage benefit plan, and paying co-payments for services paid by the insurer.

As shown in Table 18, Expansion Option 3, the Private Coverage Option, would result in increased State and federal expenditures of between 30 percent and 40 percent, depending on fiscal year, over projected State and federal Medicaid Expansion expenditures under Expansion Option 1. However, the federal government will not fund expenditures greater than those projected in the baseline. Therefore, the cost to the State from implementing Option 3 increases substantially over the projected cost to the State to implement Option 1.

Table 18. Actuarial Results for Expansion Option 3: Private Option based on a Qualified Health Plan

EXPANSION OPTION 3: PRIVATE OPTION BASED ON A QUALIFIED HEALTH PLAN (QHP)*					
	FY17	**FY18**	**FY19**	**FY20**	**FY21**
Newly Eligible Adults	41,980	42,050	42,120	42,190	42,260
Take-Up Rate	55.4%	63.0%	63.0%	63.0%	63.0%
New Enrollees	23,273	26,492	26,535	26,580	26,623
COST PER ENROLLEE	**$10,387**	**$11,010**	**$11,673**	**$12,380**	**$13,134**
Medical	$10,288	$10,904	$11,561	$12,262	$13,009
Admin	$99	$105	$112	$118	$126
TOTAL COST	**$241,747,000**	**$291,668,000**	**$309,741,000**	**$329,062,000**	**$349,671,000**
Federal Cost	$179,294,000	$207,471,000	$215,331,000	$221,394,000	$228,761,000
STATE COST	**$62,453,000**	**$84,197,000**	**$94,410,000**	**$107,668,000**	**$120,910,000**
COMPARISON TO EXPANSION OPTION 1					
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.*

The actuarial findings are in line with a 2014 report by the federal Government Accounting Office (GAO), which noted, "payments to physicians under Medicaid fee-for-service and managed care for 26 evaluation and management services that the GAO reviewed, such as office visits and emergency care, were generally lower than private insurance."[196]

[196] Medicaid Payment: Comparisons of Selected Services under Fee-for-Service, Managed Care, and Private Insurance. GAO-14-533. July 15, 2014. http://www.gao.gov/products/GAO-14-533

FEDERAL REQUIREMENTS FOR IMPLEMENTATION

A voluntary private option program that maintains all Medicaid benefits and co-payment protections could be achieved with a State Plan Amendment under Section 1905(a) authority. However, states do not frequently use this authority for a private coverage program aimed at the general Medicaid population because states often seek to provide an alternative set of benefits and/or different co-payment amounts.

Alaska implemented its Health Insurance Premium Payment program using a State Plan Amendment under Section 1906 authority. The program allows Medicaid eligible persons with access to employer-sponsored coverage to have their coverage subsidized by Medicaid dollars rather than enroll in Medicaid coverage. This authority requires that each participant's private employer-sponsored insurance be reviewed and deemed cost effective by DHSS. The program, which can be made mandatory for individuals with access to employer-sponsored insurance, retains all benefits and co-payment protections provided through the Medicaid State Plan for other enrollees.

To implement a private option program with mandatory enrollment and/or pared down benefits requires a Social Security Act Section 1115 waiver.[197] To gain federal approval, the state must demonstrate federal cost neutrality compared to a traditional Medicaid program. To date, CMS has approved Section 1115 waivers in the three states that applied to use this authority to expand Medicaid using private coverage. In addition, if the state seeks to implement cost-sharing amounts greater than those allowed under traditional Medicaid, this authority can be sought through a 1916 (f) State Plan Amendment.

In its agreements with the states that have established alternative coverage models, CMS has permitted a provision that will allow a state to revisit the budget neutrality targets if the state cost of serving the newly eligible population is higher than anticipated. This provision was established because it is very difficult to reliably set a budget neutrality baseline for a population the states have not historically covered.

In developing a Section 1115 waiver, the state must show it is doing something it could not do otherwise, such as engaging in coverage that improves care, increasing efficiency and reducing costs. CMS assesses state Medicaid program objectives against criteria including whether the proposed program will:

a) Increase and strengthen coverage for low-income individuals in the state;

b) Increase access to, stabilize, and strengthen providers and provider networks serving Medicaid and low-income populations;

c) Improve health outcomes for Medicaid and other low-income populations; or

d) Increase the efficiency and quality of care for Medicaid and other low-income populations through initiatives to transform service delivery networks.[198]

[197] Mandatory enrollment for individuals who do not have a federal regulatory right to opt out such as American Indian/Alaska Native enrollees and the medically frail.

[198] http://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/Section-1115-demonstrations.html.

STATE STATUTORY AND/OR REGULATORY CHANGES

DHSS has clear statutory authority to engage in managed care contracts and has authority to operate its Health Insurance Premium Payment program. To develop a more expansive private option program, will require additional regulations, requiring a significant level of effort for DHSS.

As with any program change, Alaska would need to amend its Medicaid State Plan as part of obtaining federal approval to use a full private coverage program or to alter significantly its current Health Insurance Premium Payment program.

RATE STRUCTURES AND PAYMENT MECHANISMS

To obtain CMS approval to implement the private option coverage, DHSS would be required to demonstrate that the private option would be budget neutral for the federal government compared to coverage under the current Medicaid program. DHSS would need to conduct significant, detailed analysis to identify the appropriate per member per month rate for the Expansion population. DHSS would negotiate this rate with CMS and, if the private option were implemented and actual costs exceeded this rate, the State would be responsible for paying the difference to the federal government. Therefore, the rate would be designed with the following considerations:

a) The need to remain under the federal budget neutrality cap to avoid financial responsibility for costs above the cap.

b) Total costs would include a per member per month rate that covers needed services for the population, fee-for-service costs of paying for additional services required but not included in the private plan benefits, and administrative costs associated with developing actuarially sound rates and other program administration costs.

c) The rate must be sufficient to attract one or more insurers to participate.[199]

MONITORING AND REPORTING REQUIREMENTS

DHSS would be subject to all the financial requirements to which it is currently obligated under Title XIX (Medicaid), along with additional reporting requirements related to monitoring budget neutrality.

CMS would require DHSS to provide quarterly reports that include information on implementation progress; documentation of key operational and other challenges; underlying causes of challenges; how challenges are being addressed; key achievements; and to what the conditions and efforts successes can be attributed. CMS would review and approve performance metric reporting templates.

Quarterly financial reports include Medicaid expenditure reports that separate out expenditures for services provided through the demonstration. Expenditures must be reported through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System.

For projects undertaken using Section 1115 authority, an annual report on the demonstration would include: a summary of quarterly report information regarding operations and activities from the quarterly reports; total annual expenditures for the demonstration population for the demonstration year (with administrative costs reported separately); yearly enrollment reports with member months

[199] For a mandatory program, at least two plans must be offered, except where a rural exemption is employed.

identified. The draft report is due by 90 days after the end of the demonstration year. Once CMS comments are received by the state, the final report is then due within 30 days. At the end of the demonstration, a final demonstration report is due to CMS within 120 days.

DHSS would participate in monitoring activities with CMS, including periodic monitoring calls between CMS and DHSS staff, at which point they would discuss any significant actual or anticipated developments affecting the Section 1115 demonstration.

EXPERIENCE OF OTHER STATES

The private coverage model is sometimes called the "Arkansas model;" it has also been implemented in Iowa and New Hampshire. These states' models are being used to study impacts of enrolling Medicaid enrollees in private insurance on provider access and churn, as well as related care discontinuities.

Arkansas, which enrolls parents with incomes between 17 and 138 percent of the federal poverty level and childless adults with incomes between 0 and 138 percent of the federal poverty level, has covered over 200,000 low-income individuals through the program. Iowa includes all Expansion eligible individuals with incomes between 101 and 138 percent of the federal poverty level. The Iowa program was intended to be mandatory, however the state had only one Qualified Health Plan available in 2015 and CMS requires a choice of plans for mandatory enrollment. As a result, enrollees in Iowa are allowed to opt-out of the Qualified Health Plan into a Medicaid managed care plan.

Initially, spending on the private option in Arkansas was higher than the projections the State submitted to CMS for its waiver. More recently, Arkansas appears to be exceeding its budget neutrality targets. The waiver under which Arkansas operates allows it to calculate cost-effectiveness differently from the methods generally allowed. This alternative calculation includes the program's impact on coverage, access to care, Marketplace competitiveness, and reduced churn between Medicaid and Marketplace coverage. So far, the program is calculated to be saving over $88 million in FY 2015, and generating new revenue of $29.7 million.[200]

Arkansas's outgoing governor has proposed program changes, including a premium of 2 percent of income for participants with income at or above 100 percent of the federal poverty level, and moving the lowest-income individuals out of the program and into the state's traditional Medicaid program.[201]

New Hampshire engaged in a phased approach starting with premium support for individuals with access to employer-sponsored insurance. Starting January 1, 2016, the state would begin enrolling the newly eligible in a mandatory Qualified Health Plan premium assistance program, with Medicaid paying enrollee premiums and co-payments. This includes parents with income as low as 38 to 138 percent of the federal poverty level and childless adults with incomes up to 138 percent of the federal poverty level. Copayments are limited to the amounts already allowed by Medicaid (capped at five percent of household income), and members with income under 100 percent of the federal poverty level are not subject to cost sharing requirements. To promote continuity of coverage in the final phase, New Hampshire would strive to enroll current Managed Care Organization members into a Qualified Health Plan offered by the same insurer.

[200] "Issue Brief: A Look at the Private Option in Arkansas," Jocelyn Guyer, Naomi Shine, Marybeth Musumeci and Robin Rudowitz. Kaiser Commission on Medicaid and the Uninsured. August 2, 2015.

[201] "Arkansas Governor Wants to Keep Medicaid Expansion, but With Changes." Abby Goodnough. New York Times, August 19, 2015.

Pennsylvania had a program for newly eligible individuals with incomes between 101 and 138 percent of the federal poverty level in Qualified Health Plans, but the current governor has returned the program to traditional Medicaid benefits and administration. The move away from private coverage was taken to simplify the program and reduce administrative complexity.

Employer Sponsored Insurance Variant. CMS has approved Health Insurance Premium Payment programs or similar premium assistance programs in Alaska and other states. Prior to passage of the Affordable Care Act, thirty-nine states ran at least one employer-sponsored insurance program for Medicaid and/or CHIP-eligible individuals. A majority of the programs were voluntary; the rest required enrollment for Medicaid eligible individuals with access to cost-effective employer-sponsored insurance. In 2014, Iowa and New Hampshire added employer-sponsored, insurance-specific private coverage programs.

Most premium assistance programs are small compared to the size of each state's overall Medicaid programs.[202] Programs tend to be limited in scope, as many employer plans do not meet the cost effectiveness test. This is becoming increasingly difficult due to the decline in availability of employer-sponsored insurance and the increase in high deductible plans. Administrators also highlight challenges with providing outreach and education to beneficiaries, providers, employers and caseworkers. The programs seem to be most successful when they engage directly with eligible individuals, rather than requiring employers to participate in the process.

Member Co-payments. Indiana received authority under Section 1916(f) to implement co-payments that exceeds the eight dollar maximum for non-emergency services. Arkansas and Michigan have Section 1115 waivers in which the participant co-payments are paid into a member savings account that is used for health expenditures, but the amounts are consistent with what would have been allowed under traditional Medicaid rules.

POTENTIAL CHALLENGES

Current state programs are relatively new, and it is not yet clear whether states will find promised savings from the private coverage option. Federal cost neutrality may be difficult to achieve due to the cost of member premiums and expenses related to program administration. This could be a particular challenge in Alaska, where commercial insurance premiums are higher than average, and even at full participation in the program, administering the reimbursements to insurers would be challenging.

A 2015 federal Government Accountability Office (GAO) report indicated that in initial implementation, Arkansas' spending limit of $4 billion set under its Private Option Section 1115 waiver is $778 million more than the cost of paying for the population under a traditional Medicaid program. In addition to the cost of private insurance premiums, Arkansas is required by CMS to pay directly for required Medicaid benefits not provided by the private plan. These services, including Non-Emergency Medical Transportation, applicable Early and Periodic Screening, Diagnostic and Treatment and some dental services, are included in the calculation of costs for a private coverage program.

Like other states expanding Medicaid, Alaska does not have significant experience covering the Expansion population, which consists of low-income adults who are not parent/caretaker relatives or individuals with disabilities. This lack of information on likely service needs and costs makes it difficult to estimate the baseline costs of how much DHSS would have spent on this population if it were to provide coverage through the traditional Medicaid benefit plan, rather than through the private option.

[202] "Issue Brief - Premium Assistance in Medicaid and CHIP: An Overview of Current Options and Implications of the Affordable Care Act", Kaiser Commission on Medicaid and the Uninsured. March 2013

In addition, in a state with a small and dispersed population, the fixed costs of administering the program may be higher than is sustainable. For example, DHSS would pay insurers for enrollees' premiums, and also be responsible for reimbursing insurers for member co-payments. Currently DHSS imposes co-payments up to a limit of five percent of income, and must track member costs to determine when they meet the limit. To make these determinations under private coverage would require DHSS to work with the insurer to reconcile spending and reimburse the insurer for member co-payments over the limit. DHSS would incur costs associated with implementing the technology and other tools required to conduct the work given the small Medicaid population may have a higher per capita fixed costs than can be borne by the program.

However, when covering individuals with access to employer-sponsored insurance, DHSS would only pay the enrollee's portion of premiums, as the employer would pay the rest of the premium. In this case, there may be potential savings from moving enrollees into Medicaid-subsidized private employer-sponsored insurance.

In the states where CMS has approved the private option, American Indian/Alaska Native enrollees are voluntary enrollees; in Arkansas and New Hampshire, they may opt out, and in Iowa, they are not enrolled automatically but may opt in if they choose to participate. Forty percent of Alaska's Medicaid population are American Indian/Alaska Native, which means that DHSS would need to continue administering its traditional program to a significant number of enrollees, while also contracting with Qualified Health Plans for other participants.

Although the private option could possibly expand access for enrollees to more providers, this may not be true in Alaska, where Medicaid provider participation may in fact be greater than in the private market. For example, many DHSS-funded behavioral health providers currently bill Medicaid but do not have systems in place to bill third party insurance.

It may be difficult to secure insurer participation statewide, given the areas of low population and provider shortages across Alaska. A program with mandatory enrollment for eligible individuals requires that enrollees have a choice of plans; if one of the two insurers on the Federally Facilitated Marketplace exits the state's market, DHSS would be required to allow enrollees to choose between private coverage and the traditional Medicaid program. There are other challenges:

- Using private coverage significantly reduces DHSS's ability to influence care models and provider behavior due to the lower proportion of Medicaid enrollees in DHSS-administered coverage.
- A private option may be administratively more complex for DHSS.
- It may be more cost effective to limit private coverage to paying the enrollee portion of employer-sponsored insurance, when available to the enrollee through his or her workplace.

For the employer-sponsored insurance variant of the private coverage model, there are administrative challenges related to identifying offers of employer-sponsored insurance, as well as determining eligibility for employer-sponsored insurance and benefit cost-effectiveness compared to the Medicaid benefit. DHSS should evaluate the existing private option program before determining whether it would be feasible to include Medicaid Expansion enrollees.

PROVIDER COMMUNITY ROLES

If the private option were implemented, the provider community would interact directly with the private insurer to submit and receive payments for care to patients. Providers who bill third party insurers regularly have expressed concerns about private insurer coverage denials. Behavioral health providers that do not already bill third party insurance would need to establish relationships and processes for billing third party insurers.

OPPORTUNITIES FOR COLLABORATION WITH OTHER PAYERS

A private option does not support collaboration with other payers. Medicaid would be ceding delivery system decisions to contracted insurers, and would have very limited opportunity to affect how providers are paid or how care is structured.

PROJECTED TIMELINE AND STATE RESOURCE REQUIREMENTS

The Private Option model could take two to three years to implement, as a Section 1115 waiver request is a significant undertaking. The federal waiver approval process requires time for drafting the request (three to six months, depending on the resources DHSS can bring to bear on the effort), and up to six months for CMS review and negotiations.

To implement the private option, DHSS would need to invest significant staff or contractual resources to construct a Request for Proposals, which must follow state procurement laws, for insurer participation, contracting, enrollment and follow up/evaluation. To implement programmatic elements that meet federal requirements, DHSS would need to build capacity to identify exempt populations, track obligations and discontinue co-payments when the individual/household reaches the maximum co-payment contribution of five percent of household income.

To administer the program, DHSS would develop a mechanism for transmitting enrollment information to the insurer, define and enforce reporting requirements, and track enrollment, outcomes and other measures to ensure that enrollees are receiving needed services and are not adversely affected by the program. Non-Qualified Health Plan contracted services may include the provision of Non-Emergency Medical Transportation, applicable Early and Periodic Screening, Diagnostic and Treatment to eligible individuals and some behavioral health, dental, vision and other excluded specialty services. This can be a significant effort, but may be partially or fully offset by reduced efforts to administer the traditional state program. However, DHSS could not eliminate traditional Medicaid, as there would be Medicaid eligible individuals who cannot be enrolled in a private option plan or who can opt out.

5. LIST OF APPENDICES

Appendix A. Table of Acronyms and Abbreviations A-1

Appendix B. Stakeholder Engagement B-1

Appendix C. Rules for Medicaid Populations by Program Type C-1

Appendix D. Behavioral Health Continuum of Care D-1

Appendix E. Current Alaska Medicaid Benefits E-1

Appendix F. Qualified Health Plan, Benefits and Limits F-1

Appendix G. Healthy Alaska Plan: Medicaid Redesign and Expansion Environmental Assessment (separate document available at dhss.alaska.gov/healthyalaska)

Appendix H. Estimated Financial Impact of Medicaid Expansion Coverage Options on the Alaska Medicaid Budget (separate document available at dhss.alaska.gov/healthyalaska)

Appendix I. Estimated Financial Impact of Medicaid Redesign Initiatives on the Alaska Medicaid Budget (separate document available at dhss.alaska.gov/healthyalaska)

APPENDIX A. TABLE OF ACRONYMS AND ABBREVIATIONS

The Medicaid Redesign and Expansion project is one of several initiatives the Department of Health and Social Services has undertaken to improve Alaska's health care delivery system. As with any complex topic, there are a great deal of acronyms, abbreviations, jargon and technical language associated with Medicaid and the health care system. Table A is a working list of acronyms and abbreviations stakeholders may encounter throughout the project, ranging from Medicaid and the national health care system to institutions or concepts specific to Alaska.

Table A. Table of Acronyms and Abbreviations, Updated December 2015

ABP	Alternative Benefit Package or Plan	**CMS**	Centers for Medicare & Medicaid Services
ACA / PPACA	Patient Protection and Affordable Care Act ("Affordable Care Act")	**DBH**	Division of Behavioral Health (DHSS)
ACO	Accountable Care Organization	**DES/DET**	Designated Evaluation and Stabilization/ Designated Evaluation and Treatment (hospitals)
ADL	Activity of Daily Living	**DHAT**	Dental Health Aide Therapist (provider within Tribal system)
AEHN	Alaska E-Health Network (the state's Health Information Exchange)	**DHHS**	(U.S.) Department of Health and Human Services
AHRQ	Agency for Healthcare Research and Quality	**DHSS**	Department of Health and Social Services
AI/AN	American Indian and Alaska Native	**DJJ**	Division of Juvenile Justice
AMHTA	Alaska Mental Health Trust Authority	**DME**	Durable Medical Equipment
ANP	Advanced Nurse Practitioner	**DOC**	Department of Corrections
API	Alaska Psychiatric Institute	**DRG**	Diagnosis-Related Group (payment method)
ASAM	American Society of Addiction Medicine (levels 0.5 to 4)	**DSH**	Disproportionate Share Hospital
ASAP	Alcohol Safety Action Program	**DSM(-5)**	Diagnostic and Statistical Manual of Mental Disorders
ASO	Administrative Services Organization	**DSRIP**	Delivery System Reform Incentive Pool
BH	Behavioral Health (includes substance use and mental health)	**ED / ER**	Emergency Department (may also be referred to as Emergency Room)
BHA/P	Behavioral Health Aide/Practitioner	**EHB**	Essential Health Benefits (10)
BPCI	Bundled Payments for Care Improvement	**EHR**	Electronic Health Record
CBHC	Certified Behavioral Health Center	**EPSDT**	Early and Periodic Screening, Diagnosis and Treatment
CHA/P	Community Health Aide/Practitioner (provider within Tribal system)	**FFS**	Fee for Service (payment model)
CHC	Community Health Center	**FMAP**	Federal Medical Assistance Percentage

FPL	Federal Poverty Level	**PCCM**	Primary Care Case Management
FQHC	Federally Qualified Health Center	**PCMH**	Patient Centered Medical Home
GPRA	Government Performance and Results Act	**PFP**	Pay for Performance
HCBS	Home and Community Based Services	**PIHP**	Prepaid Inpatient Health Plan
HCC	Health Care Commission	**PMPM**	Per Member, Per Month (payment)
HCS	Division of Health Care Services (DHSS)	**QHP**	Qualified Health Plan
HIE	Health Information Exchange	**QI**	Quality Improvement
HMIS	Health Management Information System	**RCCO**	Regional Care Collaborative Organization
HRA	Health Risk Assessment	**SAMHSA**	Substance Abuse and Mental Health Services Administration
HRSA	Health Resources and Services Administration	**SBIRT**	Screening, Brief Intervention, and Referral to Treatment (behavioral health screening)
HSA	Health Savings Account	**SDS**	Division of Senior and Disabilities Services (DHSS)
IMD	Institutions for Mental Diseases	**SED**	Severe Emotional Disturbance (youth)
LTC	Long Term Care	**SMI**	Serious Mental Illness (adult)
LTSS	Long Term Services and Supports	**SOA**	State of Alaska
MCO	Managed Care Organization	**SPA**	State Plan Amendment
MMIS	Medicaid Management Information System	**SSA**	Social Security Act
NICU	Neonatal Intensive Care Unit	**SUD**	Substance Use Disorder (adult)
OB/GYN	Obstetrics and Gynecology	**THO**	Tribal Health Organization
OCS	Office of Children's Services	**UCR**	Usual, Customary and Reasonable (charges: the amount paid for a medical service in a geographic area based on what providers in the area usually charge for the service)

APPENDIX B. STAKEHOLDER ENGAGEMENT

Throughout the project, the consultant team worked closely with DHSS to conduct a wide-reaching stakeholder engagement process to inform and solicit input from a broad cross-section of stakeholders across the state about the vision for reform and specific reform options being considered. As the team worked to develop the package of reforms put forward in this report, the consultants and DHSS leadership met with a set of key partners representing several constituencies who interact with the Medicaid system. The group of representatives was tasked with bringing information and soliciting further feedback from their membership or constituencies throughout the process. This approach was intended to maximize the project's resources and the time available to reach a broad audience.

STAKEHOLDER ENGAGEMENT PLAN COMPONENTS

The project team created a stakeholder engagement plan at the beginning of the process, outlining several ways in which stakeholders could remain informed and provide input during the development of the recommendations presented. Stakeholders had opportunities to provide input at several points in the iterative process of research, analysis, discussion and decision-making. A list of organizations engaged and meetings attended by the consultant team are included in this appendix.

- *Key Partner and DHSS Work Sessions on August 18, October 9 and November 10, 2015.* DHSS leadership and a group of key partners met to review the analysis of the contract team and provide feedback. Meetings provided key partners an overview of project findings to date, the key findings or recommendations from the preceding round of analysis, and provided opportunities to weigh the feasibility of these options with the group.

- *Project update webinars held on July 27, September 2, October 21, November 19, 2015*; a final webinar is tentatively scheduled for January 2016 following publication of this report. Each webinar presented the information from the preceding Key Partner and DHSS Work Session, lasted one hour, included a Q&A session for attendees to ask questions of the team, and allowed for live participation, as well as a recording of the session for later viewing.

- *"Road Show" of presentations and meetings by DHSS.* Throughout fall 2015, there were opportunities to engage with various constituencies about the project at member meetings, conferences, special gatherings, and committee meetings. These sessions were led by DHSS staff, most scheduled at the request of stakeholders. DHSS staff are continuing presentations and updates to organizations in 2016.

- *Additional meetings with sector-specific stakeholder groups.* Recognizing that some of the proposed initiatives would benefit from more detailed engagement from stakeholders, Agnew::Beck, with DHSS staff, conducted six additional meetings with sector groups convened by DHSS, including behavioral health providers; long term services and supports (LTSS) providers and advocates; physicians; Tribal providers; hospital and nursing home administrators and providers; and, Community Health Centers.

- *"Meeting in a Box" tool for additional stakeholder engagement.* The DHSS project team and consultant team had limited resources to conduct meetings with each constituent group, and wanted to ensure that the information and project status was communicated consistently with each group. Agnew::Beck created a "meeting in a box," a set of materials designed to help others conduct meetings to engage with their own constituents and provide feedback. The materials included an agenda, invitation, facilitator's guide, PowerPoint presentation, handouts and worksheets to guide discussion, and a follow-up online survey to gather responses directly from participants in those meetings.

- *Healthy Alaska Plan, Medicaid Redesign web page, listserv and e-mail address for online communication.* DHSS managed an informative web page (http://dhss.alaska.gov/healthyalaska) for materials related to the project, as well as sending periodic updates through the Medicaid Redesign e-mail listserv, such as announcements inviting recipients to the webinars. In addition, DHSS received feedback and requests for presentations through its dedicated inbox, medicaid.redesign@alaska.gov, throughout the process.

- *Testimony in legislative hearings during the 2016 Legislative Session.* When the report is transmitted to legislators for deliberation, stakeholders will have additional opportunities to participate in the process through legislative committee hearings as they are scheduled in the Alaska House and Senate.

STAKEHOLDER PARTICIPATION

Table B below indicates the number and affiliation(s) of stakeholders represented at the several events in this process. Individuals and organizations contributed through participation in key partner meetings, stakeholder meetings or presentations with DHSS and the consultant team, and webinars providing updates on the project. The list is illustrative but not exhaustive, as several events (including webinars, virtual meetings, and conference presentations) do not have a complete record of attendees by name.

Table B. Stakeholders Engaged During Medicaid Redesign and Expansion Technical Assistance Project, 2015

INDIVIDUAL(S)	ORGANIZATION
Mike Easterday	Aetna Insurance
Karl Garber Connie Sipe	AGENet: Alaska Geriatric Exchange Network
Rosalie Nadeau Jim Sellers	Akeela, Inc.
Barb Doty	Alaska Academy of Family Physicians
Kim Champney Lizette Stiehr Trish Walter	Alaska Association on Developmental Disabilities
[unspecified]	Alaska Bar Association, Elder Law Section
Tom Chard	Alaska Behavioral Health Association
Anne Dennis-Choi	Alaska Child and Family

INDIVIDUAL(S)	ORGANIZATION
Andy Elsberg Ben Shelton Anne Zink	Alaska College of Emergency Physicians
Jane Erickson Kristin Mitchell	Alaska College of Physicians
Denise Daniello	Alaska Commission on Aging
[unspecified]	Alaska Community and Public Transportation Advisory Board
Kelsey Beer David Logan Jon McNeil	Alaska Dental Society
L. Diane Casto	Alaska Department of Corrections
Zoya Ponomareva	Alaska EHR Alliance
Ilona Farr	Alaska Family Medical Care
Donn Bennice	Alaska Family Services
[unspecified]	Alaska Food Coalition
Rilene Ann	Alaska Housing Finance Corporation
Jocelyn Pemberton	Alaska Innovative Medicine
Mark Walker	Alaska Island Community Services
Kate Burkhart	Alaska Mental Health Board Advisory Board on Alcoholism and Drug Abuse
Katie Baldwin-Johnson Jeff Jessee Amanda Lofgren Mary Jane Michael Russ Webb	Alaska Mental Health Trust Authority
Verné Boerner Eric Jordan Alberta Unok	Alaska Native Health Board
Matt Hirschfeld	Alaska Native Medical Center
Garvin Federenko Roald Helgesen Jerry Moses Emily Read Lorena Skonberg Charlene Walker	Alaska Native Tribal Health Consortium
Mo Hillstrand	Alaska Nurse Practitioner Association
Arlene Brisco Donna Phillips	Alaska Nurses Association
[unspecified]	Alaska Osteopathic Medical Association (invited)
Allison Lee	Alaska Personal Care Assistant (PCA) Association
Molly Gray	Alaska Pharmacists Association

INDIVIDUAL(S)	ORGANIZATION
David D'Amato Marie Jackman Patty Linduska Nancy Merriman Suzanne Niemi Tom Taylor	Alaska Primary Care Association
Melissa Ring	Alaska Psychiatric Institute
Mike Sobocinski	Alaska Psychological Association
Annie Feidt	Alaska Public Radio Network
Charlie Miller Ross Tanner Julie Taylor Mary Totten	Alaska Regional Hospital
Connie Beemer Becky Hultberg Jeannie Monk	Alaska State Hospital and Nursing Home Association
Anita Halterman Rep. Dave Talerico Rep. Louise Stutes Rep. Paul Seaton	Alaska State Legislature
Graham Glass Melinda M. Rathkopf	Alaska State Medical Association
Paul Cornils	Alaska Youth and Family Network
Heather Davis	Alaskan AIDS Assistance Association
John C. Laux Ward Hurlburt	Alaskan Center for Sustainable Healthcare
Lillian Ford	Aleutian Pribilof Island Association, Inc.
Tamar Ben-Yosef	All Alaska Pediatric Partnership
Don Black	Allanivik Hotel
Mario Lanza	Alyeska Family Medicine
[unspecified]	American Academy of Pediatrics (invited)
Jerry Jenkins	Anchorage Community Mental Health Services
Jenny Love	Anchorage Neighborhood Health Center
[unspecified]	Anchorage Senior Advisory Commission
Luke Welles	Arctic Slope Native Association
Leslee Orebaugh Sherry Mettler	Assisted Living Association
Becky Bohrer	Associated Press
Chuck Bill Alan Ulrich	Bartlett Regional Hospital
Pam Miller	Behavioral Health Compliance Solutions, LLC
LaTesia Guinn	Bethel Family Clinic

INDIVIDUAL(S)	ORGANIZATION
Stephen Herting	Camai Community Health Center
Erin Walker Trollis	Catholic Community Service
Lisa D.H. Aquino	Catholic Social Services
Shari Conner Rick Davis Bruce Richards	Central Peninsula Hospital
Bill Sorrells	Christian Health Associates
[unspecified]	Commonwealth North
Sandra Heffern	Community Care Coalition
Bettina Brentano	Community Connections
Erik McFerrin	Copper River Native Association
Kelly Fields Melinda L. Peter	Council of Athabascan Tribal Governments
Joel Medendorp	Cross Road Medical Center
[unspecified]	Dahl Memorial Clinic
Clinton Lasley Claire Schleder	Department Health of Social Services
Cheley Grigsby	DHSS, Breast and Cervical Health Program
Christy Lawton	DHSS, Office of Children's Services
Beth Davidson	DHSS, State Health Information Technology Coordinator, Health Information Exchange (HIE)
Brita Bishop Randall Burns Holly Byrnes Kathleen Carls Sara Clark Daniel Collison Lynn Eldridge George Girod Joan Houlihan Valerie Kenny Teri Keklak Jim McLaughlin Ingrid Stevens Joni Stumpe Stacy Toner Albert Wall Sean Wilhelm	DHSS, Division of Behavioral Health
Margaret Brodie Lori Campbell Naomi (Harris) Davidson Susan Dunkin Renee Gayhart	DHSS, Division of Health Care Services

INDIVIDUAL(S)	ORGANIZATION
Gennifer Moreau Erin Narus Jane Urbanovsky Linda Walsh	DHSS, Division of Health Care Services (cont.d)
Rob Wood	DHSS, Division of Juvenile Justice
Monica Mitchell Sean O'Brien	DHSS, Division of Public Assistance
Jay Butler Jean Findley Janice Gray Sherrell Holtshouser Jill Lewis Gail Stolz Tim Struna Julia Thorsness Rebecca Topol Brad Whistler Sharon Whytal Stephanie Wrightman-Birch	DHSS, Division of Public Health
Deb Etheridge Duane Mayes Angela Salerno Summer Wheeler Jetta Whittaker	DHSS, Division of Senior and Disabilities Services
Sarah Woods	DHSS, Financial and Management Services
Pat Carr	DHSS, Health Planning and Systems Development
Judy Helgeson Doug Jones	DHSS, Medicaid Integrity Program
Jared Kosin	DHSS, Office of Medicaid Rate Review
Valerie Davidson Sana Efird Karen Forrest Tony Newman Jon Sherwood	DHSS, Office of the Commissioner
Susan Bailey Esther Bennett Jennifer Harrison Danita Koehler Trisha Patton	Eastern Aleutian Tribes
Violet Rice	Eklutna Village Clinic
Jennifer Glorioso	Fairbanks School District
Jeff Vereide	Full Circle Counseling Solutions
Ashley Aemmer	Gastineau Human Services

INDIVIDUAL(S)	ORGANIZATION
Brittany Howell Patrick Reinhart	Governor's Council on Disabilities and Special Education
Eileen Scott	Iluiluik Family and Health Services
Terri Ulrich	ImProTRAC, LLC
Noel Rea	Innovative Solutions of Alaska
Anna Nelson	Interior AIDS Association
Cheryl Kilgore	Interior Community Health Center
Heidi Young	Island Care Services
[unspecified]	Juneau Alliance for Mental Health Inc.
Jaylene Peterson Nyren	Kenaitze Indian Tribe
[unspecified]	Mat-Su Aging and Disability Resource Center
Michael Alter	Mat-Su Emergency Physicians
Melissa Kemberling Elizabeth Ripley	Mat-Su Health Foundation
Kevin Munson	Mat-Su Health Services
Jesse Atwood Sue Dean Addy Kelly John Lee	Mat-Su Regional Medical Center
Rachel Greenberg	Mat-Su Senior Services
Susan Garner Jean Kincaid	Mat-Su Services for Children and Adults
[unspecified]	Medicaid Medical Care Advisory Committee
[unspecified]	Medicaid Task Force (Tribal Health System)
Lorilyn Swanson	Medical Care Advisory Committee
Poornima Singh	Menges Group
Ann Lovejoy	Mountain Pacific Quality Health, Alaska
Eldon Mulder	Mulder Company
Natasha Pineda	Municipality of Anchorage, Health and Human Services (formerly Trust)
Tanya Davids David Levy Carla Wright	Municipality of Anchorage, Aging and Disabilities Resource Center
Marie J. Lavigne	Municipality of Anchorage, Senior Services
Emily Kane	Naturopath practitioner
Jennifer Miller	Ninilchik Community Clinic
[unspecified]	Ninilchik Traditional Council
Andy Mayo	North Star Behavioral Health
Heath McAnally	Northern Anesthesia and Pain Medicine
Angie Gorn Kim Knutson	Norton Sound Health Corporation
Teresa Holt	Office of Long-term Care Ombudsman

INDIVIDUAL(S)	ORGANIZATION
Freddie Olin	Office of Lt. Gov. Mallott
Tyson Gallagher	Office of Rep. Gattis, Alaska State Legislature
Paulyn Swanson	Office of Rep. Hawker, Alaska State Legislature
Taneeka Hanson	Office of Rep. Seton, Alaska State Legislature
Jane Conway	Office of Sen. Giessel, Alaska State Legislature
Patricia Walker	Office of Sen. Hoffman, Alaska State Legislature
Heather Shadduck	Office of Sen. Kelly, Alaska State Legislature
Melissa Kookesh	Office of Sen. Stedman, Alaska State Legislature
Jeff Goldberg	Optum Insight
Monica Adams	Peninsula Community Health Services of Alaska
Elizabeth Woodyard	Petersburg Medical Center
Paul Mattfeld Melanie Matthews	Prestige Care
Hilary Hardwick	Production Plus
Kathleen Hollis Bruce Lamoureux Richard Mandsager Anne E. Musser	Providence Alaska Medical Center
Monica Anderson Christine Barrington Cindy Gough Tiffany Hall LeeAnn Horn	Providence Health and Services Alaska
Harold Johnston	Providence Medical Group
Joe Fong	Providence Seward Medical Center
Joella Beard	Rehab and Sports Medicine, U.S. Veterans Administration
[unspecified]	Rockne S. Wilson, Wilson & Wilson, CPAs
Tolani Finley	Salvation Army, Clitheroe Center
[unspecified]	SeaView Community Services
Carolyn Heyman-Layne	Sedor, Wendlandt, Evans and Filippi
Dave Donley	Former Senator, Alaska State Legislature
Phillip Licht Cassi Sheppard	Set Free Alaska
Patrick Linton Ross Van Camp	Seward Community Health Center
Rob Allen Patrick Williams	Sitka Community Hospital
Kerry Tomlinson	Sitka Counseling
Myra Munson	Sonosky, Chambers, Sachse, Endreson & Perry
Kris S. Johnston	Sound Alternatives, Cordova

INDIVIDUAL(S)	ORGANIZATION
Dave Branding	South Peninsula Behavioral Health Services
Bob Letson	South Peninsula Hospital
Chris Bragg Doug Eby Fred Kopacz Laura Kotelman April Kyle Jim Lamb Michelle Tierney	Southcentral Foundation
Michael Lang Dan Neumeister Mary Teachout	Southeast Regional Health Consortium (SEARHC)
Marianne Mills	Southeast Senior Services
Andrew Principe	Starling Advisors
Heidi Frost	Statewide Independent Living Council (SILC)
[unspecified]	Summit Family Practice
Melody West	Sunshine Community Health Center
Jacoline Bergstrom Crystal Stordahl	Tanana Chiefs Conference
James Shill	Tanana Valley Clinic
Theresa Welton	Trinion Quality Care Services, Inc.
Kimber Jackson	Trust Training Cooperative
Susan Johnson	U.S. Department of Health and Human Services
Karina Gonzales Bill Hogan	University of Alaska Anchorage
Rosyland Frazier	University of Alaska Anchorage, Institute of Social and Economic Research (ISER)
Sue Brogan Randi Sweet	United Way of Anchorage
Carma Reed	US Department of Housing + Urband Development
Carolyn Brown	Wellspring, Juneau
[unspecified]	White's Pharmacy
Robert Rang Marla Sanger	Wrangell Medical Center
Diana M Murat	Yukon-Kuskokwim Health Corporation
Grace Abbott	[organization(s) not specified]
Renae Axelson	
Sarah Bailey	
Tammy Bailey	
Lois Barger	
Michael Becker	
Barbara Berner	

INDIVIDUAL(S)	ORGANIZATION
Ginger Blaisdell	[organization(s) not specified]
Jacquelyn Boyer	
David Boyle	
Tony Braden Jr.	
Lisa Brown	
JoLynn Cagle	
Kathryn Carssow	
Lori Chikoyak	
Liz Clement	
Jessica Cler	
Terry Connolly	
Rebecca Contreras	
Christina Cross	
Alyson Currey	
Brenda Dee	
Sheli DeLaney	
Leigh Dickey	
Michael Dickey	
Jan Dodds	
Michael Engelhard	
Karla Evarts	
Donna Faeo	
Amanda Faulkner	
Teri Firor	
Andrew Ford	
Debra Foster	
Chandra Genacta	
Angie Gerken	
Becky Gonzales	
Kay Gouwens	
Jane Griffith	
Dee Ellen Grubbs	
Chris Gunderson	
Marion Hagen	
Amber Halsey	
Liz Handy	
Jan Harris	
P.J. Hatfield-Bauer	
Karel Hauser	
Nacole Heslep	

INDIVIDUAL(S)	ORGANIZATION
Geppe Hernandez	[organization(s) not specified]
Amberly Hobbs	
Lisa Humes-Schulz	
Brittany Hutchison	
Carol Jensen	
Jane Johnson	
Ruth Johnson	
Lorraine Jones	
Kelly Keeter	
Keren Kelley	
Dorothy Khan	
Kelly Kikuchi	
Vickie Knapp	
Steve Krall	
Kim Laird	
Jamie Lang	
Jeanne Larson	
Jacob Lauten	
Tami Lawson-Churchill	
Dane Lenaker	
John Limm	
Laura Lucas	
Juli Lucky	
Robin Lutz	
Mary McEwen	
Rosa McCabe	
Colleen McNulty	
Walter Majoris	
Tom Martin	
Carla Meitler	
Jessie Menkens	
Elliott Milhollin	
Mark Miller	
Scott Mitchell	
Lanny Mommsen	
Dan Monahan	
David Morgan	
Brenda Moore Beyers	
Martha Moore	
Rynnieva Moss	

INDIVIDUAL(S)	ORGANIZATION
Barbara Murray	[organization(s) not specified]
Wandee Murray	
Richard Nault	
Kristine Nelsen	
Ric Nelson	
Brenda Newburn	
Teresa O'Connor	
Lee Olson	
Paul Ortner	
Linnea Osborne	
Sierra Palmer	
Katie Jo Parrott	
Dorothy Pickles	
Laura Pierre	
Jeri Powers	
Kenni Psenak Linden	
Margaret Quinn	
Mark Regan	
Jerrine Regester	
Linda Reimer	
Judith Renwick	
Paul Richards	
Melissa Robbins	
Jennifer Roberts	
Michelle Rork	
Ryan Ruggles	
Cecelia Russell	
Tina Russell	
Amanda Ryder	
Karen Samuelson	
Laura Sanbei	
Gregg Schomaker	
Barb Seibel	
Jean Selk	
Erin Shine	
Jody Simpson	
Kim Skipper	
Paul Smith	
Emily Splinter-Felton	
Christiann Stapf	

INDIVIDUAL(S)	ORGANIZATION
Rachael Stark	[organization(s) not specified]
Emily Stevens	
Elizabeth Streifel	
Eric Swanson	
Sheela Tallman	
Laura Thiesen	
Christophe Ticarro	
Jerry Troshynski	
Erika Van Flein	
Kristin Vandagriff	
Shelly Vendetti-Vuckovich	
Jennifer Watkins	
Lisa Watson	
Pam Watts	
Amy Westfall	
Pam White	
Andra Woodard	
Treva Wornath	
Karla Wright	
Peggy Sue Wright	

APPENDIX C. RULES FOR MEDICAID POPULATIONS BY PROGRAM TYPE

Table C provides an overview of the rules and allowances related to program design elements specific Medicaid sub-groups as defined by the Center for Medicaid and Medicare Services (CMS).[1]

Table C. Rules for Medicaid Populations by Program Type

	CATEGORICALLY ELIGIBLE GROUPS (PRE-AFFORDABLE CARE ACT)[2,3]	ADULT EXPANSION POPULATION[4]	AMERICAN INDIAN/ ALASKA NATIVE	MEDICALLY FRAIL[5]
Enrollee Premiums	• Allowed for individuals with income over 150% FPL up to aggregate cap of 5% of family income for all premiums and cost sharing • Waiver needed to use with people at lower income • Not allowed for exempt groups: o Children under 18 o Pregnant women under 150% FPL o Individuals living in institutions who must contribute their income to costs of care o Individuals in hospice care o Women in breast and cervical cancer treatment program o Individuals getting home & community based services who pay for cost of care	Allowed for individuals with income over 150% FPL, up to aggregate cap of 5% of family income for all premiums and cost sharing Imposing cost-sharing for people at lower income requires a waiver	Premiums are not allowed for American Indian/Alaska Native enrollees who are eligible to receive services from an Indian Health Service provider	Allowed for individuals with income over 150% FPL, up to aggregate cap of 5% of family income for all premiums and cost sharing Imposing cost-sharing for people at lower income requires a waiver

[1] Provided to DHSS by The Curie Group: Long-term Performance of the Pennsylvania Medicaid Behavioral Health Program, Compass Health Analytics, Inc., December 2010.

[2] This includes the groups eligible for Medicaid benefits prior to the passage of the Affordable Care Act: children through age 18 with family income up to 203% of the federal poverty level (FPL); pregnant women up to 200% FPL (children and pregnant women are covered as Denali KidCare); other adult parents/caretaker relatives up to 128% FPL (Family Medicaid); individuals determined to be aged, blind or disabled up to 250% FPL. Some disabled groups including those with Medicare who are eligible for Medicaid on a spend-down basis are eligible at lower income levels.

3 Dual eligible (Medicare/Medicaid) beneficiaries are not included in this discussion due to the rules around what and how Medicaid pays for care for this population. For more information on dual eligible beneficiaries, see the last page of this document.

4 Childless adults ages 19 to 64 with income up to 133% FPL.

5 "Medically frail" is federally defined but is not a Medicaid eligibility category. Some individuals who fit this definition qualify for Medicaid as disabled. Within federal guidelines, states may further define medically frail and individual with special medical needs. At minimum, this includes children with serious emotional disturbances, children in certain other circumstances such as those in foster care or receiving adoption assistance, individuals with disabling mental disorders, individuals with serious and complex medical conditions, individuals with physical or mental disabilities that significantly impair their ability to perform one or more activities of daily living, and individuals with chronic substance use disorders.

	CATEGORICALLY ELIGIBLE GROUPS (PRE-AFFORDABLE CARE ACT)[2,3]	ADULT EXPANSION POPULATION[4]	AMERICAN INDIAN/ ALASKA NATIVE	MEDICALLY FRAIL[5]

Enrollee Cost Sharing (e.g., Co-payments)	• Allowed for parents, childless adults, aged/blind/disabled with some exceptions
	• Pregnant women over 150% FPL can be subject to co-payments for non-pregnancy services
	• Not allowed for exempt groups (*see above*)
	• Services for which co-pays are allowed:
	  ○ Allowed up to federal limits[6]
	  ○ Allowed for inpatient, outpatient, non-emergency ED, prescriptions
	  ○ Not allowed for emergency, family planning, pregnancy-related or children's preventive services
	• Amounts vary with income, are based on state's payment for service
	• Waiver required to impose higher cost sharing
	• Services cannot be withheld for failure to pay, but enrollees can be liable for unpaid copayments
	• States may establish alternative out of pocket costs for certain Medicaid enrollees with income above 100% FPL. Alternative out of pocket costs may be higher than nominal but are still subject to cap of 5% of family income. State may deny services for non-payment of alternative copayments.
		Allowed up to federal limits (*see above*)	• Exempt from most cost sharing
			• AI/AN who are eligible to receive services from an Indian Health Service provider but have never done so can be charged co-payments.
			• State may choose to charge co-payments for non-preferred drugs or non-emergency ED use (services cannot be withheld for non-payment)[7]
				Exempt from cost sharing

Wellness Incentives	• Applies to all enrollee categories • Subject to CMS approval • Allowed as long as the program rewards participants, does not penalize non-participation			

[6] States must ensure that the total cost of Medicaid premiums and cost-sharing for a family does not exceed 5 percent of the family's income on a quarterly or monthly basis.

[7] Indian Health Care Provider means a health care program, including CHS, operated by the Indian Health Service or by an Indian Tribe, Tribal Organization, or Urban Indian Organization, as defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

	CATEGORICALLY ELIGIBLE GROUPS (PRE-AFFORDABLE CARE ACT)[2,3]	ADULT EXPANSION POPULATION[4]	AMERICAN INDIAN/ ALASKA NATIVE	MEDICALLY FRAIL[5]
Alternative Benefit Plans[8]	Allowed for general population (state discretion regarding whether to impose)	Required; Alternative Benefit Package may mirror benefit package for pre-expansion groups, or be a separate package for this population	Required for adult expansion group, allowed for others	Adult expansion group: can choose ABP defined using essential health benefits or defined in Medicaid state plan; for others, voluntary.
Private Coverage Option	• Unknown whether CMS would approve for this group • Would likely require use of wraparound for certain services	Requires a waiver, can be mandatory enrollment if there is choice of plan	Voluntary (exempt in Arkansas; may opt out in Iowa and New Hampshire)	Voluntary (some states use health risk assessment to identify for coverage)
Primary Care Case Management, Assignment to Provider	State can require participation	State can require participation through State Plan or a waiver authority	State can require participation through State Plan or a waiver authority	State can require participation through State Plan or a waiver authority
Accountable Care Organizations	• States can require participation • May require waiver to implement if ACO is at risk, similar to MCO	State can require participation	Voluntary	States can require enrollees to use if only providing care management (not taking risk)
Managed Care Organizations[9]	• State can require enrollees receive services from Managed Care Plan if there are at least two MCOs. • If there is only one MCO, enrollment is optional unless choice in rural area is waived under 1115 or 1915(b)[10]	State may require (see categorically eligible description)	With 1915(b) waiver, State may require enrollment of AI/AN, dual eligible, children with special health care needs If required to enroll, can receive services from a Tribal provider (including non-network)	Voluntary enrollment

[8] States have the option to provide alternative benefits specifically tailored to meet the needs of certain Medicaid population groups, target residents in certain areas of the state, or provide services through specific delivery systems instead of following the traditional Medicaid benefit plan. http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/alternative-benefit-plans.html

[9] http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-site.html

[10] 42 CFR 438.52(b)

MEDICARE AND MEDICARE/MEDICAID "DUAL ELIGIBILITY"[11]

The following people are eligible for Medicare:

- Individuals age 65 and older
- Individuals under age 65 with certain disabilities
- Individuals with end stage renal disease.

An individual must also meet the following criteria:

- A U.S. citizen or a permanent legal resident; and
- Self or spouse has worked long enough to be eligible for Social Security or railroad retirement benefits, usually having earned 40 credits from about 10 years of work, even if the individual or spouse is not yet receiving these benefits; or
- Self or spouse is a government employee or retiree who has not paid into Social Security, but paid Medicare payroll taxes while working

Individuals who are eligible for Medicaid and Medicare are known as "dual eligible" persons. Dual eligible individuals have one of the following kinds of eligibility for Medicaid:

- Full Medicaid
- Medicaid savings programs, which includes:
    - Qualified Medicare Beneficiary (QMB) Program
    - Specified Low-Income Medicare Beneficiary (SLMB) Program
    - Qualifying Individual (QI) Program
    - Qualified Disabled Working Individual (QDWI) Program.

Full Medicaid for Medicare beneficiaries pays for Medicare premiums and some cost sharing for medical expenses, as well as services not covered by Medicare, such as including nursing facility care beyond the 100-day Medicare limit, eyeglasses, and hearing aids. Medicaid savings programs help enrollees pay for premiums and in some cases out-of-pocket expenses and Medicaid services not covered by Medicare.

For all eligible groups, Medicaid is the payer of last resort, so Medicare pays claims first. Only when the Medicaid payment rate is higher than the Medicare allowed amount does Medicaid pay for Medicare covered services. As Medicare generally pays more than Medicaid, Medicare generally pays for a given covered service to a level that would not make the recipient subject to a Medicaid co-payment. As Medicare has the control over the beneficiary's benefit package, most states exempt this population from care management programs, up to and including managed care plan enrollment.

[11] For additional information on the Medicare dual eligible program requirements and eligibility factors, see the following November 2014 CMS presentation: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Medicare_Beneficiaries_Dual_Eligibles_At_a_Glance.pdf

APPENDIX D. BEHAVIORAL HEALTH CONTINUUM OF CARE

Table D. Behavioral Health Continuum of Care, as Defined by the Substance Abuse and Mental Health Services Administration (SAMHSA)
Reproduced from Substance Abuse and Mental Health Services Administration, "Good and Modern Addiction and Mental Health Service System" (2011)

HEALTHCARE HOME AND PHYSICAL HEALTH	PREVENTION (INCLUDING PROMOTION)	ENGAGEMENT SERVICES	OUTPATIENT SERVICES	MEDICATION SERVICES	COMMUNITY SUPPORT (REHABILITATIVE)	OTHER SUPPORTS (HABILITATIVE)	INTENSIVE SUPPORT SERVICES	OUT-OF-HOME RESIDENTIAL SERVICES	ACUTE INTENSIVE SERVICES	RECOVERY SUPPORTS
General and specialized outpatient medical services Acute primary care General health screens, tests and immunization Comprehensive care management Care coordination and health promotion Comprehensive transitional care Individual and family support Referral to community services	Screening, Brief Intervention and Referral to Treatment (SBIRT) Brief motivational interviews Screening and brief intervention for tobacco cessation Parent training Facilitated referrals Relapse prevention and wellness recovery support Warm line	Assessment Specialized evaluations (psychological, neurological) Service planning (including crisis planning) Consumer and family education Outreach	Individual evidenced-based therapies Group therapy Family therapy Multi-family therapy Consultation to caregivers	Medication management Pharmacotherapy (including Medication Assisted Treatment) Laboratory services	Parent/caregiver support Skill building (social, daily living, cognitive) Case management Behavioral management Supported employment Permanent supported housing Recovery housing Therapeutic mentoring Traditional healing services	Personal care Homemaker respite Supported education Transportation Assisted living services Recreational services Interactive communication technology devices Trained behavioral health interpreters	Substance abuse intensive outpatient services Partial hospital Assertive Community Treatment Intensive home based treatment Multi-systemic therapy Intensive Case Management	Crisis residential and stabilization Clinically managed 24-hour care Clinically managed medium intensity care Adult mental health residential Children's mental health residential services Youth substance abuse residential services Therapeutic foster care	Mobile crisis services Medically monitored intensive inpatient Peer based crisis services Urgent care services 23 hour crisis stabilization service 24/7 crisis hotline services	Peer Support Recovery support coaching Recovery support center services Supports for self-directed care Continuing care for substance use disorders

APPENDIX E. CURRENT ALASKA MEDICAID BENEFITS

Table E lists current Medicaid benefits, how many U.S. states and territories include or exclude each benefit, and whether or not they are included in Alaska's current benefit plan.

Table E. Table of Medicaid Benefits and Coverage in Alaska, U.S. States and Territories

BENEFIT	COVERED *(ALL STATES + TERR)*			COVERED
	YES	*NO*	*N/A*	(ALASKA)
INSTITUTIONAL AND CLINIC SERVICES				
Freestanding Ambulatory Surgery Center (Not in Hospital)	51	5	-	**Yes**
Federally Qualified Health Center (FQHC) Services	54	2	-	**Yes**
Freestanding Birth Centers	33	19	4	**Yes**
Inpatient Hospital Services (except IMD)	56	0	-	**Yes**
Outpatient Hospital Services	56	0	-	**Yes**
Physical or Mental Health Clinic (Not in Hospital)	54	2	-	**Yes**
Rehabilitation Services, Mental Health or Substance Abuse	53	3	-	**Yes**
Rural Health Clinic Services	48	8	-	**Yes**
PRACTITIONER SERVICES				
Certified Registered Nurse Anesthetist	42	14	-	**Yes**
Chiropractor	27	29	-	**No**
Dental Services	53	3	-	**Yes**
Medical/Surgical Services by Dentist	56	0	-	**Yes**
Nurse-Midwife	52	4	-	**Yes**
Nurse Practitioner	55	1	-	**Yes**
Optometrist	56	0	-	**Yes**
Physician	56	0	-	**Yes**
Podiatrist	48	8	-	**No**
Psychologist	38	18	-	**Yes**
PRESCRIPTION DRUGS				
Prescription Drugs	56	0	-	**Yes**
THERAPY SERVICES				
Occupational Therapy Services	36	20	-	**Yes**
Physical Therapy Services	39	17	-	**Yes**
Therapy Services for Speech, Language, Hearing Disorders	40	16	-	**Yes**
PRODUCTS AND SERVICES				
Dentures	37	19	-	**Yes**
Eyeglasses	46	10	-	**Yes**
Hearing Aids	34	22	-	**Yes**
Medical Equipment and Supplies	56	0	-	**Yes**
Prosthetics and Orthotics	54	2	-	**Yes**
TRANSPORTATION SERVICES				
Ambulance	56	0	-	**Yes**
Non-Emergency Transportation	56	0	-	**Yes**
OTHER SERVICES				
Diagnosis, Screening, Prevention	48	8	-	**Yes**
Lab, X-Ray (Non-Hospital or Clinic)	56	0	-	**Yes**
Targeted Case Management	50	6	-	**Yes**
Tobacco Cessation for Pregnant Women	50	6	-	**Yes**
LONG TERM CARE: HOME AND COMMUNITY BASED SERVICES				
Home and Community Based Services Waiver	47	9	-	**Yes**

BENEFIT	COVERED *(ALL STATES + TERR)*			COVERED
	YES	*NO*	*N/A*	(ALASKA)
Home Health (Nursing Services, Home Health Aides, Medical Supplies and Equipment)	55	1	-	**Yes**
Hospice	42	14	-	**Yes**
Personal Care	31	25	-	**Yes**
Private Duty Nursing	23	33	-	**No**
LONG TERM CARE: INSTITUTIONAL CARE				
Inpatient Hospital and Nursing Facility Services In Institutions for Mental Diseases, Age 65 and Older	46	10	-	**Yes**
Inpatient Psychiatric, under Age 21	52	4	-	**Yes**
Intermediate Care Facility for Intellectual and/or Developmental Disabilities	48	8	-	**Yes**
Skilled Nursing Facility (Except IMD)	54	2	-	**Yes**
Religious Non-Medical Healthcare Institution or Practitioner	9	47	-	**No**

APPENDIX F. QUALIFIED HEALTH PLAN, BENEFITS AND LIMITS

Table F outlines the 2017 benchmark Qualified Health Plan for Alaska, the Alaska Heritage Select Envoy plan (silver) provided by Premera Blue Cross Blue Shield of Alaska.

Table F. Premera Alaska Heritage Select Envoy Plan, Benefits and Limits (2017)
Source: Centers for Medicare and Medicaid Services (CMS), published December 7, 2015[1]

BENEFIT	EHB	BENEFIT COVERED?	QUANTITIVE LIMIT ON SERVICE?	LIMIT QUANTITY	LIMIT UNIT	EXCLUSIONS	EXPLANATIONS
Primary Care Visit to Treat an Injury or Illness	Yes	Covered	No				
Specialist Visit	Yes	Covered	No				
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	Covered	No				Covered only when the provider is licensed to practice where the care is provided, is providing a service within the scope of that license, is providing a service or supply for which benefits are specified in this plan, and when benefits would be payable if the services were provided by a physician.
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Covered	No				
Outpatient Surgery Physician/Surgical Services	Yes	Covered	No				
Hospice Services	Yes	Covered	Yes	6	Month(s) per Lifetime	Charges in excess of the average wholesale price shown in the "Pharmacist's Red Book" for prescription drugs, insulin, and intravenous drugs and solutions, Over-the- counter drugs, solutions and nutritional supplements, Drugs and solutions received while you're an inpatient, except for covered inpatient hospice care, Services provided to someone other than	Inpatient hospice care up to a maximum of 10 days. Respite care, up to a maximum of 240 hours, to relieve anyone who lives with and cares for the terminally ill member.

[1] Table reproduced from original plan documentation: https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2017-Benchmark-Summary_AK.zip

BENEFIT	EHB	BENEFIT COVERED?	QUANTITIVE LIMIT ON SERVICE?	LIMIT QUANTITY	LIMIT UNIT	EXCLUSIONS	EXPLANATIONS
						the ill or injured member, Services of family members or volunteers, Services, supplies or providers not in the written plan of care or not named as covered in this benefit, Custodial care, except for hospice care services, Non-medical services, such as spiritual, bereavement, legal or financial counseling, Normal living expenses, such as food, clothing, and household supplies; housekeeping services except for those of a home health aide as prescribed by the plan of care; and transportation services, Dietary assistance, such as "meals on Wheels," or nutritional guidance.	
Routine Dental Services (Adult)	No	Not Covered	No				
Infertility Treatment	No	Not Covered	No				
Long-Term/Custodial Nursing Home Care	No	Not Covered	No				
Private-Duty Nursing	No	Not Covered	No				
Routine Eye Exam (Adult)	No	Covered	No				
Urgent Care Centers or Facilities	Yes	Covered	No				
Home Health Care Services	Yes	Covered	Yes	130	Visit(s) per Year	Services, supplies or providers not in the written plan of care or not named as covered benefit. Services provided to someone other than the ill or injured member. Custodial care, except for hospice care services. Non-medical services. Normal living expenses; and transportation services. Dietary assistance, such	130 visits per applies to home visits of a home health care provider or one or more: registered nurse; a licensed practical nurse; a licensed physical therapist or occupational therapist; a certified respiratory therapist; a speech therapist certified by the American Speech, Language, and Hearing Association; a home

BENEFIT	EHB	BENEFIT COVERED?	QUANTITIVE LIMIT ON SERVICE?	LIMIT QUANTITY	LIMIT UNIT	EXCLUSIONS	EXPLANATIONS
						as "Meals on Wheels," or nutritional guidance.	health aide directly supervised by one of the above providers; and a person with a master's degree in social work.
Emergency Room Services	Yes	Covered	No			Treatment of chemical dependency/substance abuse, except treatment of medically necessary detoxification services provided on same basis as any other emergency medical condition.	
Emergency Transportation/Ambulance	Yes	Covered	No			Air and Ground transpottation: Services that aren't sudden and life-endangering, Transport by taxi, bus, private car or rental car, Meals and lodging.	Air and Ground transpiration benefit is limited to medical emergency. Ambulance services is separate benefit, covers both medical emergency transport and non-emergent transport.
Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Covered	No			Hospital admissions for diagnostic purposes only, unless the services can't be provided without the use of inpatient hospital facilities, or unless the medical condition makes inpatient care medically necessary. Any days of inpatient care that exceed the length of stay that is medically necessary to treat the condition.	
Inpatient Physician and Surgical Services	Yes	Covered	No				
Bariatric Surgery	No	Not Covered	No				
Cosmetic Surgery	No	Not Covered	No				Exceptions to no coverage for cosmetic surgery: Repair of a defect that's the direct result of an accidental injury, providing such repair is started within 12 months of the date of the accident. Repair of a dependent child's congenital anomaly. Reconstructive breast surgery in connection with a mastectomy as

BENEFIT	EHB	BENEFIT COVERED?	QUANTITIVE LIMIT ON SERVICE?	LIMIT QUANTITY	LIMIT UNIT	EXCLUSIONS	EXPLANATIONS
							provided under the Mastectomy and Breast Reconstruction Services benefit. Correction of functional disorders (not including removal of excess skin and/or fat related to weight loss surgery or the use of obesity drugs), upon our review and approval.
Skilled Nursing Facility	Yes	Covered	Yes	60	Day(s) per Year	Custodial care. Care that is primarily for senile deterioration, mental deficiency or retardation or the treatment of chemical dependency.	
Prenatal and Postnatal Care	Yes	Covered	No				
Delivery and All Inpatient Services for Maternity Care	Yes	Covered	No				
Mental/Behavioral Health Outpatient Services	Yes	Covered	No			Dementia and sleep disorders. Biofeedback services for psychiatric conditions other than generalized anxiety disorder. Family and marital counseling, and family and marital psychotherapy, except when medically necessary to treat the diagnosed psychiatric condition or conditions of a member. Therapeutic or group homes, foster homes, nursing homes, boarding homes or schools, military academies, and child welfare facilities. Telephonic services, except for crisis/emergency evaluations, or when the member is temporarily confined to bed for medical reasons. Telehealth services that do not utilize real-time video or audio services. Mental health evaluations for purposes other than evaluating the presence of or planning treatment for covered mental health disorders. Treatment of	

BENEFIT	EHB	BENEFIT COVERED?	QUANTITIVE LIMIT ON SERVICE?	LIMIT QUANTITY	LIMIT UNIT	EXCLUSIONS	EXPLANATIONS
						sexual dysfunctions, such as impotence. All medical services provided in preparation for or after gender reassignment surgery, also including the surgery medical counseling and hormone therapy, regardless of age.	
Mental/Behavioral Health Inpatient Services	Yes	Covered	No				
Substance Abuse Disorder Outpatient Services	Yes	Covered	No			Treatment of non-dependent alcohol or drug use or abuse. Voluntary support groups, such as Alanon or Alcoholics Anonymous. Court-ordered services, services related to deferred prosecution, deferred or suspended sentencing, or to driving rights, unless such services are medically necessary. Halfway houses, quarter way houses, recovery houses, and other sober living residences. Residential treatment programs or facilities that are not units of legally operated hospitals, or that are not state licensed or approved facilities for the provision of residential chemical dependency treatment. Residential detoxification.	
Substance Abuse Disorder Inpatient Services	Yes	Covered	No			Treatment of non-dependent alcohol or drug use or abuse. Voluntary support groups, such as Alanon or Alcoholics Anonymous. Court-ordered services, services related to deferred prosecution, deferred or suspended sentencing, or to driving rights, unless such services are medically necessary. Halfway houses, quarter way houses, recovery houses, and other sober living residences. Residential treatment programs or facilities that are not units of legally operated hospitals, or that are not state	

BENEFIT	EHB	BENEFIT COVERED?	QUANTITIVE LIMIT ON SERVICE?	LIMIT QUANTITY	LIMIT UNIT	EXCLUSIONS	EXPLANATIONS
						licensed or approved facilities for the provision of residential chemical dependency treatment. Residential detoxification.	
Generic Drugs	Yes	Covered	No				
Preferred Brand Drugs	Yes	Covered	No				
Non-Preferred Brand Drugs	Yes	Covered	No				
Specialty Drugs	Yes	Covered	No				
Outpatient Rehabilitation Services	Yes	Covered	Yes	45	Visit(s) per Year	Recreational, vocational or educational therapy. Exercise or maintenance-level programs. Social or cultural therapy. Treatment that is not actively engaged in by the ill, injured or impaired member. Gym or swim therapy. Custodial care. Inpatient rehabilitation received more than 24 months from the date of onset of the member's accidental injury or illness or from the date of the member's surgery that made the rehabilitation necessary.	A "visit" is a session of treatment for each type of therapy. Each type of therapy combined accrues toward the above visit maximum. Multiple therapy sessions on the same day will be counted as 1 visit, unless provided by different health care providers.
Habilitation Services	Yes	Covered	Yes	45	Visit(s) per Year	Habilitative, education, or training services or supplies for dyslexia, for attention deficit disorders, and for disorders or delays in the development of a child's language, cognitive, motor or social skills, including evaluations thereof.	Habilitative services is only covered in the context of autism spectrum disorders services, including ABA, counseling and treatment programs necessary to develop, maintain, or restore the functioning of an individual.
Chiropractic Care	Yes	Covered	Yes	12	Visit(s) per Year		
Durable Medical Equipment	Yes	Covered	No			Supplies or equipment not primarily intended for medical use, Special or extra-cost convenience features, exercise equipment or weights, orthopedic appliances for use in sports, recreation or similar activities, penile prostheses, whirlpools, sauna baths, massage	

BENEFIT	EHB	BENEFIT COVERED?	QUANTITIVE LIMIT ON SERVICE?	LIMIT QUANTITY	LIMIT UNIT	EXCLUSIONS	EXPLANATIONS
						devices, structural modifications to home or vehicle.	
Hearing Aids	No	Not Covered	No				
Imaging (CT/PET Scans, MRIs)	Yes	Covered	No			Diagnostic surgeries and scope insertion procedures, such as colonoscopy or endoscopy, Allergy Testing, Covered inpatient diagnostic services furnished and billed by inpatient facility, covered outpatient diagnostic services billed by outpatient facility or emergency room and received in combination with other hospital or emergency room services, services relating to testing, diagnosis, or treatment of infertility, mammography services.	
Preventive Care/ Screening/Immunization	Yes	Covered	No				
Routine Foot Care	Yes	Covered	No				Routine foot care when the member is a diabetic.
Acupuncture	Yes	Covered	Yes	12	Visit(s) per Year		Services must be medically necessary to relieve pain, induce surgical anesthesia, or to treat a covered illness, injury or condition.
Weight Loss Programs	No	Not Covered	No				
Routine Eye Exam for Children	Yes	Covered	No				
Eye Glasses for Children	Yes	Covered	No				
Dental Check-Up for Children	Yes	Covered	No				
Rehabilitative Speech Therapy	Yes	Covered	Yes	45	Visit(s) per Year		Visit limit for physical, speech, and occupational therapy services combined.
Rehabilitative Occupational	Yes	Covered	Yes	45	Visit(s) per Year		Visit limit for physical, speech, and occupational

BENEFIT	EHB	BENEFIT COVERED?	QUANTITIVE LIMIT ON SERVICE?	LIMIT QUANTITY	LIMIT UNIT	EXCLUSIONS	EXPLANATIONS
and Rehabilitative Physical Therapy							therapy services combined.
Well Baby Visits and Care	Yes	Covered	No				
Laboratory Outpatient and Professional Services	Yes	Covered	No				
X-rays and Diagnostic Imaging	Yes	Covered	No				
Basic Dental Care - Child	Yes	Covered	No				
Orthodontia - Child	Yes	Covered	No				
Major Dental Care - Child	Yes	Covered	No				
Basic Dental Care - Adult	No	Covered	No				
Orthodontia - Adult	No	Not Covered	No				
Major Dental Care – Adult	No	Covered	No				
Abortion for Which Public Funding is Prohibited	No	Covered	No				
Transplant	Yes	Covered	Yes	75,000	Dollar(s) per Lifetime	Organ, bone marrow and stem cell transplants, including any direct or indirect complications and after effects thereof, except as specifically stated under the Transplants benefit. Donor costs for a solid organ transplant, or bone marrow or stem cell reinfusion not specified as covered under the Transplants benefit. Non-human or mechanical organs, unless they aren't "experimental or investigational services." Transplants or related services from a provider not approved by us. Services that will be paid by any government foundation or charitable grant. This includes services performed on	Quantitative limit on Donor costs only. The types of solid organ transplants and bone marrow/stem cell reinfusion procedures that currently meet the plan's criteria for coverage are: Heart, Heart/double lung, single lung, Double lung, Liver, Kidney, Pancreas, Pancreas with kidney, Bone marrow (autologous and allogenic), Stem cell (autologous and allogeneic).

BENEFIT	EHB	BENEFIT COVERED?	QUANTITIVE LIMIT ON SERVICE?	LIMIT QUANTITY	LIMIT UNIT	EXCLUSIONS	EXPLANATIONS
						potential or actual living donors or recipients and on cadavers. Planned blood storage for more than 12 months for possible future use.	
Accidental Dental	Yes	Covered	No			Services must be completed within 12 months unless an extension is granted.	
Dialysis	Yes	Covered	No				
Allergy Testing	Yes	Covered	No				
Chemotherapy	Yes	Covered	No				
Radiation	Yes	Covered	No				
Diabetes Education	Yes	Covered	No				
Prosthetic Devices	Yes	Covered	No				Benefit limited to initial purchase of prosthetic; does not cover replacement unless the existing device can't be repaired, or replacement is prescribed by a physician because of a change in your physical condition.
Infusion Therapy	Yes	Covered	No			Charges in excess of the average wholesale price shown in the "Pharmacist's Red Book" for drugs and solutions. Over-the-counter drugs, solutions and nutritional supplements. Drugs and solutions received while you're an inpatient in a hospital or other medical facility.	
Treatment for Temporomandibular Joint Disorders	No	Not Covered	No				
Nutritional Counseling	Yes	Covered	No			"Nutritional therapy services that meet the federal guidelines designated as preventive care will be subject to applicable frequency limits."	
Reconstructive Surgery	Yes	Covered	No				Breast reconstruction allowed.

Milliman Client Report

Milliman

Estimated Financial Impact of Medicaid Expansion Coverage Options on the Alaska Medicaid Budget

Prepared for:
Alaska Department of Health and Social Services

Prepared by:
Milliman, Inc.

Susan E. Pantely, FSA, MAAA
Principal and Consulting Actuary

650 California Street, 17th Floor
San Francisco, California
94108-2702
USA

Tel +1 415 403 1333
Fax +1 415 403 1334

milliman.com

January 19, 2016

Table of Contents

I. BACKGROUND 1

Description of Coverage Options for Expansion Population 1

II. FISCAL IMPACT SUMMARY 1

III. METHODOLOGY AND ASSUMPTIONS 3

Expansion Option 1: Current Alternative Benefit Package 3
Expansion Option 2: ABP Based on a QHP 4
Expansion Option 3: Private Option Based on a QHP 4
Assumptions 5

IV. OTHER IMPACTS NOT MODELED 7

V. DATA RELIANCE AND IMPORTANT CAVEATS 8

I. BACKGROUND

The Alaska Department of Health and Social Services (AK DHSS) is exploring various health system reform initiatives through its Medicaid Redesign and Expansion Project. In June 2015, the Alaska Department of Health and Social Services contracted with Agnew::Beck Consulting, Health Management Associates, and Milliman, Inc. to provide technical assistance for the Department's Medicaid Redesign and Expansion Project. As part of this engagement, Milliman was asked to estimate the financial impact to the state Medicaid medical expenditures, including the incremental administrative cost, of these reform initiatives. We have not included costs that require a capital investment such as an investment in Information Technology (IT) Infrastructure that may be required to administer the proposed Expansion Options. We have not analyzed the fiscal impact to the state's economy, uninsured population health care costs, or other residual economic impacts in this report. This report contains our findings related to the options for the Medicaid expansion population.

Description of Coverage Options for Expansion Population

Agnew::Beck worked closely with AK DHSS to design the project approach and stakeholder engagement process. The HMA team completed an Environmental Assessment and shared the findings with key partners. Throughout the process, HMA shared policy expertise and national experience. Milliman attended all key partner work sessions, provided feedback on potential actuarial impact, and reviewed draft analyses throughout each round of the project. Medicaid expansion options were identified based on stakeholder feedback, other states' experiences, and an understanding of Alaska's current Medicaid system. Upon completion of this process, Milliman was asked to estimate expenditures for the following options:

Expansion Option 1: **Current Alternative Benefit Plan (ABP)**. On September 1, 2015, Alaska Medicaid expanded eligibility to include adults between ages 19 to 64, who have income at or below 138 percent of the Federal Poverty Level (FPL) and who are not eligible for another type of coverage under Medicaid or Medicare. Individuals eligible for Medicaid under Alaska's expansion are covered under an ABP that is defined as the standard benefits offered to other Medicaid eligible individuals in the state. Expansion Option 1 assumes expansion enrollees continue to receive coverage under the current Alternative Benefit Plan that includes the same benefits and services provided to existing Medicaid enrollees.

Expansion Option 2: **Alternative Benefit Plan (ABP) based on a Qualified Health Plan (QHP)**. Under Expansion Option 2, expansion enrollees are covered under a benefit package based on an ABP that differs from the current Medicaid benefit package.

Expansion Option 3: Private Option based on a Qualified Health Plan (QHP). Expansion enrollees purchase coverage through the Federally Facilitated Marketplace. Medicaid pays premiums and co-payment amounts directly to the private insurer and pays for any required Medicaid services not provided through the QHP.

II. FISCAL IMPACT SUMMARY

Alaska Medicaid expanded eligibility on September 1, 2015. In order to avoid showing a partial year during the ramp up period of Medicaid expansion, we did not include state fiscal year 2016 in our analysis. Although any changes to the current expansion population coverage could not occur until at least state fiscal year 2018, our analysis analyzes the five-year period beginning with state fiscal year 2017. The tables below summarize the projected state and federal expenditures for the Medicaid expansion enrollees by state fiscal year for each coverage option.

This report assumes that the reader is familiar with the State of Alaska's Medicaid program and its benefits. The report was prepared solely to provide assistance to AK DHSS to determine which, if any, modifications to make to the program. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

Expansion Option 1: Current Alternative Benefit Package*

	FY2017	FY2018	FY2019	FY2020	FY2021
Newly Eligible Adults	41,980	42,050	42,120	42,190	42,260
Take-Up Rate	55.4%	63.0%	63.0%	63.0%	63.0%
New Enrollees	23,273	26,492	26,535	26,580	26,623
Cost Per Enrollee					
Medical	$7,854	$8,213	$8,593	$8,994	$9,418
Admin	$59	$62	$65	$68	$71
Total	$7,913	$8,275	$8,658	$9,062	$9,489
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**

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

Expansion Option 2: Alternative Benefit Plan (ABP) based on a Qualified Health Plan (QHP)**

	FY2017	FY2018	FY2019	FY2020	FY2021
Newly Eligible Adults	41,980	42,050	42,120	42,190	42,260
Take-Up Rate	55.4%	63.0%	63.0%	63.0%	63.0%
New Enrollees	23,273	26,492	26,535	26,580	26,623
Cost Per Enrollee					
Medical	$7,326	$7,672	$8,039	$8,427	$8,838
Admin	$93	$97	$102	$107	$112
Total	$7,418	$7,770	$8,141	$8,534	$8,950
Total Cost	**$172,648,000**	**$205,831,000**	**$216,021,000**	**$226,831,000**	**$238,266,000**
Federal Cost	**$167,699,000**	**$194,394,000**	**$202,076,000**	**$208,115,000**	**$215,396,000**
State Cost	**$4,949,000**	**$11,437,000**	**$13,945,000**	**$18,716,000**	**$22,870,000**
Comparison to Expansion Option 1					
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)

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

For state fiscal years 2020 and later, we estimate that Expansion Option 2 would result in a cost reduction of approximately 4% in comparison to the Expansion Option 1 projected state and federal Medicaid expansion expenditures. This is primarily driven by the removal of dental benefits for these members. For state fiscal year 2017, we estimate an increase in state cost under Expansion Option 2. The state's share of increase in administrative cost would be greater than the state's share of decrease in medical cost, resulting in the increase of state cost in total. We assumed the same Medicaid enrollment take-up rates for all three options. Therefore, we did not measure any change in participation that may occur based on the option implemented. However, take-up rates may be lower for Expansion Option 2 due to the

This report assumes that the reader is familiar with the State of Alaska's Medicaid program and its benefits. The report was prepared solely to provide assistance to AK DHSS to determine which, if any, modifications to make to the program. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

removal of dental benefits. In particular, younger, healthier eligibles may find the dental coverage more valuable than the medical coverage and have less incentive to enroll under Expansion Option 2.

Coverage Option 3: Private Option based on a Qualified Health Plan (QHP)***

	FY2017	FY2018	FY2019	FY2020	FY2021
Newly Eligible Adults	41,980	42,050	42,120	42,190	42,260
Take-Up Rate	55.4%	63.0%	63.0%	63.0%	63.0%
New Enrollees	23,273	26,492	26,535	26,580	26,623
Cost Per Enrollee					
Medical	$10,288	$10,904	$11,561	$12,262	$13,009
Admin	$99	$105	$112	$118	$126
Total	$10,387	$11,010	$11,673	$12,380	$13,134
Total Cost	**$241,747,000**	**$291,668,000**	**$309,741,000**	**$329,062,000**	**$349,671,000**
Federal Cost	**$179,294,000**	**$207,471,000**	**$215,331,000**	**$221,394,000**	**$228,761,000**
State Cost	**$62,453,000**	**$84,197,000**	**$94,410,000**	**$107,668,000**	**$120,910,000**
Comparison to Expansion Option 1					
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.

We estimate that the Expansion Option 3 would result in increased state and federal expenditures of between 30% and 40%, depending on fiscal year, over Expansion Option 1 projected state and federal Medicaid expansion expenditures. However, the federal government will not fund expenditures greater than those projected in the baseline. Therefore, the cost to the state would increase substantially over the projected expenditures for the state in the Expansion Option 1. As noted above, we assumed the same take-up rates for all three options, and did not measure any change in participation that may occur based on the option implemented. However, the perception of a commercial plan having greater access, desirability, and ease of maintaining coverage with income fluctuations may lead to higher take-up rates for Expansion Option 3.

Note that we have provided point estimates for both costs and enrollment. Actual results will vary from our projections for many reasons, including differences from assumptions regarding take up rates, projected members by FPL levels, cost trends, and future FMAP rates, as well as other random and non-random factors. Experience should continue to be monitored on a regular basis, with modifications to projections as necessary.

III. METHODOLOGY AND ASSUMPTIONS

Expansion Option 1: Current Alternative Benefit Package

Previously, the AK DHSS engaged Evergreen Economics to estimate the cost of the Medicaid expansion enrollees. In order not to duplicate effort, it was requested that we rely on the Evergreen report to the extent possible. We reviewed the Evergreen Economics memorandum "Projected Population, Enrollment, Service Costs and Demographics of Medicaid Expansion Beginning in FY2016" for reasonableness. Generally, we found the assumptions that Evergreen Economics used to be reasonable. We made the following modifications to the Evergreen Economics estimates to produce the expected expenditures for Expansion Option 1.

This report assumes that the reader is familiar with the State of Alaska's Medicaid program and its benefits. The report was prepared solely to provide assistance to AK DHSS to determine which, if any, modifications to make to the program. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

- We used calendar year 2014 eligibility and claims experience for Alaska Medicaid enrollees 19-64 years of age, excluding enrollees classified as Old Age Assistance and Aid to the Blind or Disabled. We adjusted the historical experience to reflect the expected demographics of the expansion population and removed medical expenses related to pregnancy. The data identified tribal health facilities. We assumed the Alaska Native expansion enrollees will use the same proportion of services at tribal health facilities as the enrollees in the experience data. Calendar year 2014 data was not available when Evergreen's report was produced. We believe it is appropriate to use the most up-to-date claims experience data.

- We included costs related to administrative activities in our estimate of the total cost of Medicaid expansion. There will be incremental costs associated with the administration of the additional members and we believe it is appropriate to include them in the expenditures associated with the expansion population. We assumed administrative costs would be 0.75% of expected total expenses, consistent with estimates used in the report "The Healthy Alaska Plan: A Catalyst for Reform."

We used the same take-up rate assumptions as the Evergreen report for consistency. Take-up rates observed in other states have been higher. However, the take-up rates for the expansion population in other states are below the take-up rates for the children populations in those states. Without further analysis, we believe the take-up rates assumed Alaska's expansion population have a similar relationship to the children take-up rates that are observed in Alaska.

Expansion Option 2: ABP Based on a QHP

We adjusted baseline projections for the expected impact of the benefit changes. The benefit changes included:

- Removal of dental benefits
- Removal of hearing aid benefits
- Increased coverage for services such as chiropractic and acupuncture
- Reduction in vision benefits

Based on our interpretation of the benefits, the other benefit changes were assumed not to have a material impact on the results. The medically frail population must be provided the option of receiving traditional Medicaid benefits. We assumed that all medically frail Medicaid expansion enrollees would remain in the traditional Medicaid benefit package.

We increased emergency room utilization by 2% due to the removal of dental coverage. We assumed administrative expenses are 1.25% of total expenses due to the increased administrative effort associated with administering two benefit packages. We estimate that Expansion Option 2 would reduce state and federal Medicaid expenditures for the expansion population by approximately 4% in state fiscal years 2020 and later in comparison to Expansion Option 1. The primary driver of the difference in expenditures is the removal of the dental benefit. If all medically frail Medicaid expansion enrollees moved to the ABP based on a QHP, the reduction in state and federal Medicaid expenditures for the expansion population would be approximately 5% in state fiscal years 2020 and later.

Expansion Option 3: Private Option Based on a QHP

The medically frail population is not required to enroll in the private option; therefore, we have assumed that all of the medically frail expansion enrollees will remain in traditional fee-for-service Medicaid. Based on observations from other states, we have estimated that approximately 10% of the expansion population will qualify as medically frail, with an average morbidity factor of 2.5 times the average expansion population morbidity, except for dental services where we assumed an average morbidity factor of 1.35. For the population who will enroll in the private option, the Medicaid program will be responsible for the following medical costs:

- Premium for coverage purchased from the individual marketplace
- Cost sharing amounts in excess of 5% of member income
- Cost of non-emergency transportation at a level similar to current Medicaid coverage

This report assumes that the reader is familiar with the State of Alaska's Medicaid program and its benefits. The report was prepared solely to provide assistance to AK DHSS to determine which, if any, modifications to make to the program. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

We estimated the required revenue for the expansion population as the expected members multiplied by baseline Medicaid PMPM adjusted by the following factors:

- 1.25 factor to reflect increased provider fees associated with products offered on the Exchange
- 0.90 factor to reflect a shift from Medicaid fee-for-service to a more managed environment
- 30% silver plan cost-sharing
- 15% administrative load, typical of the administrative load included for commercial premiums

We estimated the required revenue for the individuals on the Exchange by multiplying the number of enrollees by the premium for 2016 second-lowest silver plan. We then solved for the premium adjustment needed to produce the estimated required revenue for both the expansion and individual Exchange members based on the demographics of the combined membership.

We estimate that the Expansion Option 3 would result in increased expenditures of between 30% and 40%, depending on fiscal year, over Expansion Option 1 projected state and federal Medicaid expansion expenditures. However, the federal government will not fund expenditures greater than those projected in the baseline. Therefore, the cost to the State of Alaska would increase substantially over the projected expenditures for the State in the Expansion Option 1.

The Alaska Exchange market has seen high rate increases the past two years and continues to evolve. It is difficult to project the future premium increase or decrease given the volatility of the individual market in the Alaska Exchange without a robust analysis of the underlying claims data. The estimates for Expansion Option 3 are highly dependent on the future premiums for individual coverage on the Alaska Exchange. To the extent the premiums are higher or lower than projected, the federal and state expenditures projected above may vary significantly.

Expansion Option 3 assumes all non-medically frail expansion eligibles receive coverage through the Alaska exchange. However, certain states have used split enrollment models where the lower FPL eligible receive traditional Medicaid and the higher FPL eligibles receive coverage through the Private Option. The split enrollment scenario may meet budget neutrality requirements resulting in a more favorable federal matching rate.

Assumptions

The following assumptions were used in all of the expansion option projections unless otherwise noted below.

Expansion Population

The primary enrollees of Medicaid expansion are working-age adults 21–64 years of age who are not caring for dependent children, are not disabled or pregnant, and who are at or below 138 percent of Federal Poverty Level (FPL). The income eligibility threshold is 133% FPL with a 5% income disregard, making the threshold effectively 138% of FPL. In addition, Medicaid expansion affects a small number of other adults, 18–64 years of age, who do not meet current income limits for Medicaid eligibility. Specifically, Medicaid expansion will include Non-disabled individuals, ages 19-20, between 123% and 138% of FPL, and Disabled individuals, ages 18-64, between 102% and 138% of FPL, who do not receive Medicare.

Rebates and Third Party Liability

Pharmacy rebates and recoveries from third party liability have not been included in the projections and will reduce the projected costs in our analysis.

Pent-up Demand for Services

We did not include an adjustment for pent-up demand for services. Individuals who are currently uninsured may have pent-up demand for health care services; however, other sources were available to obtain financial assistance for medical care prior to Medicaid expansion in Alaska. For example, one program is the Chronic & Acute Medical Assistance (CAMA) program, a state-only program administered through the DHSS Division of Health Care Services that provides financial assistance to Alaskans who need medical care but do not qualify for the state Medicaid program. Additionally,

This report assumes that the reader is familiar with the State of Alaska's Medicaid program and its benefits. The report was prepared solely to provide assistance to AK DHSS to determine which, if any, modifications to make to the program. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

an analysis of new enrollees to the Alaska Medicaid program over the last several years who were previously uninsured adults did not show increased utilization of services during the first few months of enrollment into the program.

Additionally, since there is a nine month time period lapse between the expansion implementation date and the start date of our projections, most pent-up demand will have occurred prior to our projection period. Based on these factors, we believe it is reasonable to not include an explicit adjustment for pent-up demand.

Utilization Trend

Certain utilization trends were applied to the calendar year 2014 base data by category of service to reflect the expectation of utilization differences between the base data and the baseline projection period. Trend rates were estimated based on industry experience for comparable programs and actuarial judgment. Table 1 illustrates the annual growth rates used to trend the base data to the midpoint of each fiscal year. The calendar year 2014 data has been adjusted before trending to reflect an explicit adjustment for emerging calendar year 2015 experience that primarily reflects increased utilization of recent break-through therapies such as those associated with hemophilia and Hepatitis C. Table 1a illustrates the adjustment made to the pharmacy data.

Table 1
Alaska Department of Health and Social Services
Medicaid Redesign Initiatives
Utilization Trend

Category	1H15*	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021
Average Utilization – IP	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Average Utilization – OP	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%
Average Utilization – Prof	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%
Average Utilization – Rx	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%
Average Utilization – Other	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%

* *Annualized trend shown*

Table 1a
Alaska Department of Health and Social Services
Medicaid Redesign Initiatives
Pharmacy Adjustment

	One-Time Adjustment 2015
Break-Through Therapy	5%

Allowed Charge Trend

We made an adjustment for the following items that are expected to impact the historical allowed charge:

- Expected rate rebasing
- Expected rate schedule increases and/or decreases
- Average allowed charge trend reflecting shift to higher acuity services

The assumed trend rate by category of service for average allowed charge that is attributed to these changes is outlined in Table 2.

This report assumes that the reader is familiar with the State of Alaska's Medicaid program and its benefits. The report was prepared solely to provide assistance to AK DHSS to determine which, if any, modifications to make to the program. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

Table 2 Alaska Department of Health and Social Services Medicaid Redesign Initiatives Allowed Charge Trend							
Category	**1H2015***	**FY2016**	**FY2017**	**FY2018**	**FY2019**	**FY2020**	**FY2021**
Average Allowed Charge - IP	3.00%	3.00%	1.00%	1.00%	1.00%	1.00%	1.00%
Average Allowed Charge - OP	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%
Average Allowed Charge - Prof	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%
Average Allowed Charge - Rx	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%
Average Allowed Charge - Other	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%

* *Annualized trend shown*

For Expansion Option 3, we assumed that average charge trends for service categories other than prescription drugs would be higher than the trends assumed for Expansion Options 1 and 2 due to the coverage being provided in the commercial market. We assumed that average charge trends for these service categories would be 2% higher on an annual basis in Expansion Option 3 than the trends assumed for Expansion Options 1 and 2.

Medicaid Provider Reimbursement

We assumed there would be no change in Medicaid provider reimbursement rates specific to the expansion population, except as noted under the Expansion Option 3. Each state establishes the reimbursement rate that will be paid to hospitals, physicians, pharmacies and other healthcare providers. Medicaid reimbursement rates are typically lower than those paid by Medicare and commercial health insurance carriers. In order to ensure access to the expansion population, some states have chosen to increase the Medicaid reimbursement rates. Alaska has historically paid Medicaid reimbursement rates that are higher than those for Medicare. Therefore, we believe it is reasonable to assume that the Medicaid reimbursement rates for the entire Medicaid program will remain consistent with current methodology.

Federal Medical Assistance Percentage

Table 3 below shows the Federal Medical Assistance Percentages (FMAPs) used to determine the federal share of the projected expenditures for the expansion population. Medical expenses for Alaska Natives receiving services at a tribal facility are eligible for 100% FMAP. Alaska Natives were identified based on their status in the enrollment data. We were also provided a list of Tribal Health Facilities to identify the facilities eligible for 100% FMAP. The combination of enrollment data and Tribal Health Facilities enabled us to project the FMAP separately for this population.

Table 3 Alaska Department of Health and Social Services Medicaid Redesign Initiatives Federal Medical Assistance Percentage (FMAP)						
Category	**SFY2016**	**SFY2017**	**SFY2018**	**SFY2019**	**SFY2020**	**SFY2021**
Medical	100.00%	97.50%	94.50%	93.50%	91.50%	90.00%
Medical - Alaska Native at Tribal Health Facility	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Admin	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%

IV. OTHER IMPACTS NOT MODELED

The following outlines additional financial impacts related to Medicaid expansion. The issues highlighted below ***have not*** been included in the financial projections shown in our analysis.

This report assumes that the reader is familiar with the State of Alaska's Medicaid program and its benefits. The report was prepared solely to provide assistance to AK DHSS to determine which, if any, modifications to make to the program. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

- **Reductions in DSH Allotments**: Medicaid Disproportionate Share (DSH) funding will be reduced starting in 2018 depending on the characteristics of each state. Changes to DSH funding are not part of our estimates. The dollar reductions in DSH allotments would be consistent for each scenario modeled.

- **Impact on Other State Programs**: We did not consider the impact of Medicaid expansion on any other Alaska state programs. We would expect that many individuals currently receiving care in state-funded or subsidized programs will become eligible and enroll in the Medicaid expansion. This will produce savings for Alaska as the costs of these programs are reduced or eliminated. These savings are not incorporated into the scenarios above. For example, Chronic & Acute Medical Assistance (CAMA) program, a 100% state-funded program administered through the DHSS Division of Health Care Services that provides financial assistance to Alaskans who need medical care but do not qualify for the state Medicaid program, medical services paid for by the Department of Corrections, and Behavioral Health Grants may all be reduced. DHSS projects annual savings for these programs with Medicaid expansion will range from $13 million to $25 million from state fiscal year 2017 through 2021. Another example would be state employees who have health coverage though the State but who have incomes below 138 percent of FPL. These individuals may become eligible for the Medicaid expansion and enroll in the program.

- **Economic Ripple Effect or Multiplier**: We did not consider the multiplied impact of the additional state and federal dollars spent in the state.

- **Implementation Cost**: We did not consider the cost of implementation of the options in our analysis.

V. DATA RELIANCE AND IMPORTANT CAVEATS

We used fee-for-service data, encounter data, and eligibility data provided by the AK DHSS. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

Differences between the projected and actual experience will depend on the extent that future experience conforms to the assumptions made in the projections. It is certain that actual experience will not conform exactly to the assumptions used. Actual amounts will differ from projected amounts to the extent that actual experience is better or worse than expected.

This report has been prepared solely for the internal business use of and is only to be relied upon by the management of AK DHSS. Milliman does not intend to benefit or create a legal duty to any third party recipient of its work. It should only be reviewed in its entirety.

The results of this report are technical in nature and are dependent upon specific assumptions and methods. No party should rely on these results without a thorough understanding of those assumptions and methods. Such an understanding may require consultation with qualified professionals.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The author of this report is a member of the American Academy of Actuaries, and meets the qualifications for performing the analyses in this report.

The terms of Agnew::Beck's contract with the Alaska Department of Health and Social Services effective June 1, 2015 apply to this report and its use.

This report assumes that the reader is familiar with the State of Alaska's Medicaid program and its benefits. The report was prepared solely to provide assistance to AK DHSS to determine which, if any, modifications to make to the program. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

Milliman Client Report

Milliman

Estimated Financial Impact of Medicaid Redesign Initiatives on the Alaska Medicaid Budget

Prepared for:
Alaska Department of Health and Social Services

Prepared by:
Milliman, Inc.

Susan E. Pantely, FSA, MAAA
Principal and Consulting Actuary

650 California Street, 17th Floor
San Francisco, California
94108-2702
USA

Tel +1 415 403 1333
Fax +1 415 403 1334

milliman.com

January 19, 2016

Table of Contents

I. BACKGROUND 1

Description of Medicaid Redesign Initiatives 1

II. FISCAL IMPACT SUMMARY 2

III. OVERVIEW OF FINANCIAL PROJECTIONS 7

IV. DATA AND ACTUARIAL MODELS 7

Data 7
Actuarial Models 7
Overview 7
Populations Modeled 7
Categories of Service 8

V. DEVELOPMENT OF BASELINE PROJECTION 9

Completion Factor Adjustment 9
Benefit Changes 9
Utilization Trend 9
Average Allowed Charge Trend 10
Enrollment 10
Federal Medicaid Assistance Percentage (FMAP) 11

VI. INITIATIVE ADJUSTMENTS 12

Primary Care Improvement Adjustments 12
Behavioral Health Access Adjustments 13
Emergency Room Adjustments 14
Accountable Care Organization (ACO) Adjustments 15
Telemedicine Adjustments 15
Full Risk Managed Care Adjustments 16
Data Reliance and Important Caveats 18

Appendix A Calendar Year 2014 Data by Population and Category of Service 20

This report assumes that the reader is familiar with the State of Alaska's Medicaid program and its benefits. The report was prepared solely to provide assistance to AK DHSS to determine which, if any, modifications to make to the program. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

I. BACKGROUND

The Alaska Department of Health and Social Services (AK DHSS) is exploring various health system reform initiatives through its Medicaid Redesign and Expansion Project. In June 2015, the Alaska Department of Health and Social Services contracted with Agnew::Beck Consulting, Health Management Associates, and Milliman, Inc. to provide technical assistance for the Department's Medicaid Redesign and Expansion Project. As part of this engagement, Milliman was asked to estimate the financial impact of these reform initiatives.

Description of Medicaid Redesign Initiatives

Agnew::Beck worked closely with AK DHSS to design the project approach and stakeholder engagement process. The HMA team completed an Environmental Assessment and shared the findings with key partners. Throughout the process, HMA shared policy expertise and national experience. Milliman attended all key partner work sessions, provided feedback on potential actuarial impact, and reviewed draft analyses throughout each round of the project. Medicaid redesign initiatives were identified based on stakeholder feedback, other states' experiences, and an understanding of Alaska's current Medicaid system. Upon completion of this process, Milliman was asked to estimate expenditures for the following options:

Initiative 1: Primary Care Improvement Initiative. This initiative proposes a Primary Care Case Management (PCCM) model, in which primary care providers contract with the State to furnish case management services. Providers will be paid fee for service for medical services rendered plus a monthly case management fee. Enrollees will be connected to a Section 2703 Health Homes program, if they meet the specified Health Home chronic condition criteria. Enrollees who require higher levels of support but do not meet the Section 2703 Health Home criteria will receive Targeted Case management or be enrolled in the Alaska Medicaid Coordinated Care Initiative.

Initiative 2: Behavioral Health Access Initiative. This initiative addresses key gaps in the behavioral health continuum of care to improve access to the right services at the right time, ideally before crisis occurs. This initiative also proposes contracting with an administrative service organization (ASO) to increase capacity and manage a coordinated behavioral health care system.

Initiative 3: Data Analytics and Information Technology Infrastructure Initiative. Through this initiative, Alaska's Department of Health and Social Services (DHSS) would increase its capacity to appropriately collect and share health information among providers and analyze health data to improve outcomes and decrease costs. No actuarial analysis was performed on this initiative.

Initiative 4: Emergency Care Initiative. Hospital Emergency Departments will use electronic data sharing, patient education and post-emergency department/hospital follow up to reduce preventable ED use and improve healthcare for enrollees with high ED utilization, including opioid users, homeless persons and people with chronic behavioral health conditions.

Initiative 5: Accountable Care Organizations (ACO) Pilot: Shared Savings/Shared Losses Model. The state and providers would create Accountable Care Organization (ACO) pilots designed to improve care management of assigned enrollees across a group of providers who agree to share responsibility for the cost and quality of health care for their patient population. These providers would be more accountable for improving health outcomes of this population and would share in any savings or losses it creates.

Workgroup 1: Define Appropriate Use of Telemedicine and Increase Utilization. A workgroup will be formed to address barriers and improve supports for the expanded use of telemedicine and telehealth in Alaska; specifically, the workgroup formed will be tasked with addressing barriers related to licensure, reimbursement and coordination of telehealth providers and equipment.

Initiative 6: Full Risk Managed Care Model. This initiative would be a full-risk, capitated managed care model, with all Medicaid services delivered to enrollees through managed care organizations (MCOs); it would be implemented in the large population areas of the state.

This report assumes that the reader is familiar with the State of Alaska's Medicaid program and its benefits. The report was prepared solely to provide assistance to AK DHSS to determine which, if any, modifications to make to the program. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

II. FISCAL IMPACT SUMMARY

Table 1 below compares the fiscal impact by state fiscal year (SFY) of each initiative. Tables 1a through 1g below show the estimated State and Federal expenditures assuming the current system is unchanged (baseline) and for each initiative as well as the savings/cost over the baseline.

The initiatives below are not mutually exclusive. Therefore, the fiscal implementation of all, or a subset, of the initiatives below will not equal the sum of those estimates.

Note that the baseline projection is not representative of total State and Federal expenditures for the Alaska Medicaid program. The populations modeled reflect a subset of the Alaska Medicaid enrollees. Waiver enrollees, chronic and acute medical assistance enrollees, Institutionalized enrollees, long term care and nursing home eligible enrollees, dual eligible, and Part B only enrollees are excluded from our projections. Details on the populations modeled are included under "Populations Modeled" in Section IV of this report.

Additionally, prescription drug rebates and AK DHSS administrative expenses have been excluded from the projections in this report.

Given these items, the total estimated AK DHSS expenditures will differ significantly from these projections.

Table 1
Medicaid Redesign Initiatives
Net Program Initiative Costs (Savings) to Alaska
Values in $Millions

Initiative	SFY17	SFY18	SFY19	SFY20	SFY21
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 Room	($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

This report assumes that the reader is familiar with the State of Alaska's Medicaid program and its benefits. The report was prepared solely to provide assistance to AK DHSS to determine which, if any, modifications to make to the program. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

Table 1a Alaska Department of Health and Social Services Medicaid Redesign Initiatives Baseline Projections (Values in $Millions)					
Category of Service	**SFY17**	**SFY18**	**SFY19**	**SFY20**	**SFY21**
Facility Inpatient	$270.0	$275.9	$283.0	$288.7	$294.5
Facility Outpatient	$189.8	$209.8	$221.1	$236.6	$253.2
Professional	$537.7	$574.5	$603.5	$633.9	$665.8
Pharmacy Drugs	$124.7	$140.4	$153.1	$167.0	$182.2
PCCM Fee	$0.0	$0.0	$0.0	$0.0	$0.0
Capitation	$0.0	$0.0	$0.0	$0.0	$0.0
Other	$215.5	$228.6	$237.7	$247.2	$257.1
Total Medical Cost	**$1,337.6**	**$1,429.2**	**$1,498.4**	**$1,573.4**	**$1,652.9**
FMAP Share	$847.5	$908.0	$949.1	$983.8	$1,026.6
Net Alaska Cost	**$490.2**	**$521.2**	**$549.3**	**$589.6**	**$626.3**

Table 1b Alaska Department of Health and Social Services Medicaid Redesign Initiatives Primary Care Improvement Initiative (Values in $Millions)					
Category of Service	**SFY17**	**SFY18**	**SFY19**	**SFY20**	**SFY21**
Facility Inpatient	($0.4)	($1.6)	($9.8)	($10.8)	($11.8)
Facility Outpatient	($0.9)	($3.4)	($10.0)	($12.4)	($15.2)
Professional	($0.2)	($0.9)	($4.6)	($5.0)	($5.4)
Pharmacy Drugs	($0.2)	($1.1)	($4.4)	($5.7)	($7.2)
PCCM Fee	$1.1	$3.1	$4.6	$4.7	$4.7
Capitation	$0.0	$0.0	$0.0	$0.0	$0.0
Other	($0.0)	($0.1)	($0.5)	($0.6)	($0.7)
Total Change in Medical Cost	**($0.7)**	**($4.0)**	**($24.6)**	**($29.8)**	**($35.5)**
ASO Fees	$7.0	$17.5	$26.2	$27.7	$29.2
Total Expenditure Change	$6.3	$13.5	$1.5	($2.2)	($6.3)
After Shared Savings	$6.3	$13.5	$1.5	($2.2)	($6.3)
FMAP Share	$3.9	$8.4	$1.0	($1.4)	($3.8)
Net Alaska Cost (Savings)	**$2.4**	**$5.0**	**$0.5**	**($0.8)**	**($2.4)**

This report assumes that the reader is familiar with the State of Alaska's Medicaid program and its benefits. The report was prepared solely to provide assistance to AK DHSS to determine which, if any, modifications to make to the program. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

Table 1c Alaska Department of Health and Social Services Medicaid Redesign Initiatives Behavioral Health Initiative (Values in $Millions)					
Category of Service	**SFY17**	**SFY18**	**SFY19**	**SFY20**	**SFY21**
Facility Inpatient	$0.0	($0.2)	($0.5)	($0.9)	($1.5)
Facility Outpatient	$0.0	$0.0	$0.1	$0.1	$0.2
Professional	$0.0	$1.2	$5.0	$9.4	$14.3
Pharmacy Drugs	$0.0	$0.0	$0.1	$0.1	$0.2
PCCM Fee	$0.0	$0.0	$0.0	$0.0	$0.0
Capitation	$0.0	$0.0	$0.0	$0.0	$0.0
Other	$0.0	$0.0	$0.0	$0.0	$0.0
Total Change in Medical Cost	**$0.0**	**$1.1**	**$4.6**	**$8.7**	**$13.2**
ASO Fees	$0.0	$3.5	$5.3	$5.5	$5.8
Total Expenditure Change	$0.0	$4.6	$9.9	$14.2	$19.1
After Shared Savings	$0.0	$4.6	$9.9	$14.2	$19.1
FMAP Share	$0.0	$2.9	$6.3	$8.9	$11.8
Net Alaska Cost (Savings)	**$0.0**	**$1.7**	**$3.6**	**$5.3**	**$7.2**

Table 1d Alaska Department of Health and Social Services Medicaid Redesign Initiatives Emergency Care Initiative (Values in $Millions)					
Category of Service	**SFY17**	**SFY18**	**SFY19**	**SFY20**	**SFY21**
Facility Inpatient	$0.0	$0.0	$0.0	$0.0	$0.0
Facility Outpatient	($4.6)	($9.7)	($12.4)	($14.6)	($17.1)
Professional	($0.5)	($0.8)	($0.8)	($0.9)	($1.1)
Pharmacy Drugs	$0.0	$0.0	$0.0	$0.0	$0.0
PCCM Fee	$0.0	$0.0	$0.0	$0.0	$0.0
Capitation	$0.0	$0.0	$0.0	$0.0	$0.0
Other	$0.0	$0.0	$0.0	$0.0	$0.0
Total Medical Cost	**($5.0)**	**($10.5)**	**($13.1)**	**($15.5)**	**($18.2)**
ASO Fees	$0.0	$0.0	$0.0	$0.0	$0.0
Total Expenditure Change	($5.0)	($10.5)	($13.1)	($15.5)	($18.2)
After Shared Savings	($3.5)	($7.3)	($9.2)	($10.9)	($12.7)
FMAP Share	($2.2)	($4.7)	($5.8)	($6.8)	($7.9)
Net Alaska Cost (Savings)	**($1.3)**	**($2.7)**	**($3.4)**	**($4.1)**	**($4.8)**

This report assumes that the reader is familiar with the State of Alaska's Medicaid program and its benefits. The report was prepared solely to provide assistance to AK DHSS to determine which, if any, modifications to make to the program. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

Table 1e Alaska Department of Health and Social Services Medicaid Redesign Initiatives ACO Initiative (Values in $Millions)					
Category of Service	**SFY17**	**SFY18**	**SFY19**	**SFY20**	**SFY21**
Facility Inpatient	$0.0	$0.0	($0.9)	($1.8)	($3.6)
Facility Outpatient	$0.0	$0.0	($1.8)	($3.2)	($6.8)
Professional	$0.0	$0.0	($0.9)	($2.2)	($4.5)
Pharmacy Drugs	$0.0	$0.0	($0.7)	($1.6)	($3.4)
PCCM Fee	$0.0	$0.0	$0.0	$0.0	$0.0
Capitation	$0.0	$0.0	$0.0	$0.0	$0.0
Other	$0.0	$0.0	($0.1)	($0.2)	($0.3)
Total Medical Cost	**$0.0**	**$0.0**	**($4.5)**	**($8.9)**	**($18.6)**
ASO Fees	$0.0	$0.0	$0.0	$0.0	$0.0
Total Expenditure Change	$0.0	$0.0	($4.5)	($8.9)	($18.6)
After Shared Savings	$0.0	$0.0	($2.7)	($5.3)	($11.2)
FMAP Share	$0.0	$0.0	($1.7)	($3.3)	($6.9)
Net Alaska Cost (Savings)	**$0.0**	**$0.0**	**($1.0)**	**($2.0)**	**($4.2)**

Table 1f Alaska Department of Health and Social Services Medicaid Redesign Initiatives Telemedicine Initiative (Values in $Millions)					
Category of Service	**SFY17**	**SFY18**	**SFY19**	**SFY20**	**SFY21**
Facility Inpatient	$0.0	($0.5)	($1.0)	($1.5)	($2.0)
Facility Outpatient	$0.0	($2.2)	($4.5)	($7.2)	($10.1)
Professional	$0.0	($8.7)	($18.1)	($28.2)	($37.5)
Pharmacy Drugs	$0.0	$4.2	$7.8	$12.0	$15.0
PCCM Fee	$0.0	$0.0	$0.0	$0.0	$0.0
Capitation	$0.0	$0.0	$0.0	$0.0	$0.0
Other	$0.0	($0.0)	($0.1)	($0.1)	($0.1)
Total Medical Cost	**$0.0**	**($7.1)**	**($15.9)**	**($25.0)**	**($34.8)**
ASO Fees	$0.0	$0.0	$0.0	$0.0	$0.0
Total Expenditure Change	$0.0	($7.1)	($15.9)	($25.0)	($34.8)
After Shared Savings	$0.0	($7.1)	($15.9)	($25.0)	($34.8)
FMAP Share	$0.0	($4.5)	($10.1)	($15.7)	($21.6)
Net Alaska Cost (Savings)	**$0.0**	**($2.6)**	**($5.8)**	**($9.4)**	**($13.2)**

This report assumes that the reader is familiar with the State of Alaska's Medicaid program and its benefits. The report was prepared solely to provide assistance to AK DHSS to determine which, if any, modifications to make to the program. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

Table 1g Alaska Department of Health and Social Services Medicaid Redesign Initiatives Full Risk Managed Care Initiative (Values in $Millions)					
Category of Service	**SFY17**	**SFY18**	**SFY19**	**SFY20**	**SFY21**
Facility Inpatient	$0.0	$0.0	$0.0	($14.8)	($13.3)
Facility Outpatient	$0.0	$0.0	$0.0	($17.9)	($23.2)
Professional	$0.0	$0.0	$0.0	($14.3)	($20.3)
Pharmacy Drugs	$0.0	$0.0	$0.0	($11.5)	($18.9)
PCCM Fee	$0.0	$0.0	$0.0	$0.0	$0.0
Net Capitation Expenses	$0.0	$0.0	$0.0	$77.4	$96.3
Other	$0.0	$0.0	$0.0	$0.3	($0.6)
Total Medical Cost	**$0.0**	**$0.0**	**$0.0**	**$19.3**	**$20.0**
ASO Fees	$0.0	$0.0	$0.0	$0.0	$0.0
Total Expenditure Change	$0.0	$0.0	$0.0	$19.3	$20.0
After Shared Savings	**$0.0**	**$0.0**	**$0.0**	**$19.3**	**$20.0**
FMAP Share	$0.0	$0.0	$0.0	$12.1	$12.4
Net Alaska Cost (Savings)	**$0.0**	**$0.0**	**$0.0**	**$7.2**	**$7.6**

The full risk managed care initiative projections include Alaska's premium tax on Medicaid Managed Care Organizations (MCOs) and would generate income for the state's General Revenue Fund. That amount would allow the state to draw down federal Medicaid matching funds that can be used to meet program expenses. MCOs are held harmless from the tax through higher capitation payments, so the net gain to the state is the federal match amount, less the amount of tax remitted to counties. The net gain to the state from the premium tax is not included in the above projection.

Note that we have provided point estimates for the projected costs and savings. Actual results will vary from our projections for many reasons, including differences from assumptions regarding take up rates, projected members by FPL levels, cost trends, utilization trends, and future FMAP rates, as well as other random and non-random factors. Experience should continue to be monitored on a regular basis, with modifications to projections as necessary.

This report assumes that the reader is familiar with the State of Alaska's Medicaid program and its benefits. The report was prepared solely to provide assistance to AK DHSS to determine which, if any, modifications to make to the program. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

III. OVERVIEW OF FINANCIAL PROJECTIONS

The following sections of this report contain the documentation related to the actuarial models, populations modeled, covered services, base data adjustments, and development of financial projections.

Appendix A summarizes calendar year 2014 experience for the Alaska Medicaid population that will be eligible for the initiatives modeled. These data summaries use unadjusted claims and encounter data. Adjustments made to these summaries are described in the "Adjustments to Base Data" section.

IV. DATA AND ACTUARIAL MODELS

Data

The base data used for the projections is comprised of calendar year 2014 experience for the Alaska Medicaid population. Data includes claims for services incurred during this time period and paid through September 30, 2015. The membership, encounter and claims experience were provided to Milliman by the Alaska Department of Health and Social Services. The data has been adjusted for certain factors as described in Section V.

Historical cost and utilization has been stratified by category of service for each population. All actuarial models illustrate costs at Medicaid reimbursement. Pharmacy expenditures are illustrated before reduction for rebates received from manufacturers.

Actuarial Models

Overview

Experience data was stratified by population and category of services. Populations and categories of service are further described in the "Population" and "Categories of Service" sections. The actuarial models are comprised of the following data elements:

Member Months: This value represents the number of enrollee months in each population group during the experience period.

Annual Utilization per 1,000: This value represents annual utilization per 1,000 members for each type of service. The value was developed by dividing total units for each service by member months and multiplying by 12 times 1,000.

Average Cost per Service: This value represents the average amount that was paid per unit for the service provided.

Cost per Member per Month (PMPM): This value represents the net benefit cost for each type of service. It was developed by multiplying the annual utilization per 1,000 and the average cost per service, then dividing by 12,000.

Populations Modeled

We created actuarial models for the populations expected to be covered under the initiatives. We eliminated members with an eligibility code related to a waiver program from our analysis. We also eliminated members who are institutionalized in a long term care facility. We stratified the population in order to analyze the utilization patterns for a homogenous group. The following populations were modeled:

- **Medicaid – Adult**: This category includes all members over age 18 with program code AF not included above.
- **Aid to the Blind / Aid to the Permanently Disabled**: These members were identified by program codes AB and AD.

This report assumes that the reader is familiar with the State of Alaska's Medicaid program and its benefits. The report was prepared solely to provide assistance to AK DHSS to determine which, if any, modifications to make to the program. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

- **Old Age Assistance**: These members were identified by program code OA.
- **Pregnant Women**: These members were identified by program code AF and eligibility subtype PB, PC, PR, or PX. Additionally, members with program code AF, eligibility code 11, and eligibility subtype AF, H1, S1, SU, T1, or TO were included in this category.
- **Medicaid – Child**: This category includes all members age 18 and younger with program code AF not included above.
- **Managed Care Optional**: These members were identified by program code AF and eligibility subtype FC, FF, IV, or JC.
- **SCHIP**: These members were identified by program code AF and eligibility subtype CP, H2, or S2.
- **Expansion**: The model for the expansion population was created based on the Medicaid – Adult model calibrated to the estimated PMPM cost for the expansion population.

Appendix A contains three actuarial models for each of the populations above: one for non-Tribal individuals, one for Tribal individuals receiving services from Tribal providers, and one for Tribal individuals receiving services from non-Tribal providers. For purposes of Appendix A, the Medicaid – Adult, Aid to the Blind / Aid to the Permanently Disabled, Old Age Assistance, and Pregnant Women populations were combined into a single "Adult" population. The Expansion population is not shown separately in Appendix A.

Categories of Service

Table 2 illustrates the units and classification basis used for each broad category of service in the actuarial models. The data we received did not include Diagnosis-Related Group codes for inpatient claims. We assigned DRGs based on the diagnoses codes associated with each inpatient admission.

Table 2
Alaska Department of Health and Social Services
Medicaid Redesign Initiatives
Categories of Service

Category of Service	Units	Classification Basis
Facility Inpatient	Admits/Days	DRG
Facility Outpatient	Visits	Revenue Code, Procedure Code
Facility Outpatient Pharmacy	Scripts	National Drug Code
Professional	Procedures or Visits	Procedure Code, Procedure Code Modifier
Prescription Drugs	Scripts	National Drug Code
Private Duty Nursing/Home Health	Visits	Procedure Code
Ambulance	Visits	Procedure Code
DME and Supplies; Prosthetics	Procedures	Procedure Code
Glasses/Contacts	Visits	Procedure Code

This report assumes that the reader is familiar with the State of Alaska's Medicaid program and its benefits. The report was prepared solely to provide assistance to AK DHSS to determine which, if any, modifications to make to the program. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

V. DEVELOPMENT OF BASELINE PROJECTION

The fiscal year 2016 (SFY16) through fiscal year 2021 (SFY21) baseline financial projections were developed by applying a series of adjustments to the calendar year 2014 base data included in Appendix A. The following sections describe the adjustments that were made.

Completion Factor Adjustment

Data summarized in this report includes all claims for services provided to enrollees during calendar year 2014, as submitted by September 30, 2015.

Medical claims were multiplied by a completion factor to reflect unpaid claims incurred in calendar year 2014. We based our completion factor on the reported but not paid claim report as of September 30, 2015 and prior year incurred but not paid claim estimates. Table 3 illustrates the completion factor used. Prescription drug claims were assumed to be complete.

Table 3 Alaska Department of Health and Social Services Medicaid Redesign Initiatives Adjustment for Claims Incurred but not Reported (IBNR)	
Completion Factor – Medical Claims	1.0102

Benefit Changes

Applied Behavioral Analysis (ABA) will become a covered benefit beginning July 1, 2016. We increased the child PMPM claim cost by $27.59 PMPM for ABA services in fiscal year 2017 based on estimates provided by AK DHSS. Thereafter, we assumed the PMPM increases by the same utilization and average allowed charge trend as other benefits.

Utilization Trend

Certain utilization trends were applied to the calendar year 2014 base data by category of service to reflect the expectation of utilization differences between the base data and the baseline projection period. Trend rates were estimated based on industry experience for comparable programs and actuarial judgment. Table 4 illustrates the trend rates used to trend the base data to the midpoint of each fiscal year.

Table 4 Alaska Department of Health and Social Services Medicaid Redesign Initiatives Utilization Trend	
Category	**SFY15-SFY21***
Utilization – IP	0.00%
Utilization – OP	2.00%
Utilization - Prof	3.00%
Utilization – Rx	3.00%
Utilization - Other	1.00%

* *Annualized trend shown*

This report assumes that the reader is familiar with the State of Alaska's Medicaid program and its benefits. The report was prepared solely to provide assistance to AK DHSS to determine which, if any, modifications to make to the program. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

The calendar year 2014 data has been adjusted before trending to reflect an explicit utilization adjustment for increased utilization of Hepatitis C and hemophilia drugs based on emerging calendar year 2015 experience. Table 4a illustrates the one-time adjustments made to the pharmacy data.

Table 4a
Alaska Department of Health and Social Services
Medicaid Redesign Initiatives
Pharmacy Adjustments

Condition	Adjustment
Hemophilia	1.3% - All
Hepatitis C	14.4% - Adult Only

Average Allowed Charge Trend

We made an adjustment for the following items that are expected to impact the historical allowed charge:

- Expected rate rebasing
- Expected rate schedule increases and/or decreases
- Average allowed charge trend reflecting shift to higher acuity services

The estimated effect of these changes to the average allowed charge is outlined in Table 5.

Table 5
Alaska Department of Health and Social Services
Medicaid Redesign Initiatives
Allowed Charge Trend

Category	SFY15-SFY16	SFY17-SFY21
Average Allowed Charge - IP	3.00%	1.00%
Average Allowed Charge - OP	4.00%	4.00%
Average Allowed Charge - Prof	1.00%	1.00%
Average Allowed Charge - Rx	5.00%	5.00%
Average Allowed Charge - Other	2.00%	2.00%

** Annualized trend shown*

Enrollment

We assumed enrollment increases of 1.1% annually for the non-expansion population. For the expansion population, we projected the enrollment based on the expected number of newly eligible adults and the expected take-up rate for the newly eligible population. Table 6 summarizes the cumulative enrollment projections for the expansion population.

Table 6
Alaska Department of Health and Social Services
Medicaid Redesign Initiatives
Expansion Projected Enrollment

	SFY17	SFY18	SFY19	SFY20	SFY21
Newly Eligible Adults	41,980	42,050	42,120	42,190	42,260
Take-Up Rate	55.4%	63.0%	63.0%	63.3%	63.0%
New Enrollees	23,273	26,492	26,535	26,580	26,623

This report assumes that the reader is familiar with the State of Alaska's Medicaid program and its benefits. The report was prepared solely to provide assistance to AK DHSS to determine which, if any, modifications to make to the program. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

Federal Medicaid Assistance Percentage (FMAP)

We assumed the Federal Medicaid Assistance Percentages (FMAP) by population as outlined in Table 7.

Table 7
Alaska Department of Health and Social Services
Medicaid Redesign Initiatives
Federal Medicaid Assistance Percentage (FMAP)

	SFY17	SFY18	SFY19	SFY20	SFY21
Medicaid	50.00%	50.00%	50.00%	50.00%	50.00%
SCHIP*	88.00%	88.00%	88.00%	70.75%	65.00%
Expansion**	97.50%	94.50%	93.50%	91.50%	90.00%
Tribal Members at Tribal Providers^	100.00%	100.00%	100.00%	100.00%	100.00%
Administrative	50.00%	50.00%	50.00%	50.00%	50.00%

Source: http://aspe.hhs.gov/basic-report/fy2016-federal-medical-assistance-percentages

** SCHIP is 88% for October 1, 2015 - September 30, 2019, then 65% thereafter.*

***The Federal Medical Assistance Percentage (FMAP) rates for the ACA expansion are as follows: CY2015 – CY2020 are as follows: 100%, 100%, 95%, 94%, 93%, 90%.*

^Tribal members receiving service at Tribal providers always receive 100% FMAP.

This report assumes that the reader is familiar with the State of Alaska's Medicaid program and its benefits. The report was prepared solely to provide assistance to AK DHSS to determine which, if any, modifications to make to the program. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

VI. INITIATIVE ADJUSTMENTS

This section describes the adjustments made to the projected base data for each initiative.

Primary Care Improvement Adjustments

Implementation Date

We assumed that this initiative begins in fiscal year 2017.

Population

We excluded managed care optional eligibles from this analysis. Of the remaining eligible, we assumed that 30% of eligibles are enrolled in this initiative in fiscal year 2017, 70% of eligibles are enrolled in this initiative in fiscal year 2018, and all eligibles are enrolled in fiscal years 2019 and later. Tribal members are required to have the option to opt-out. Therefore, we assumed that 50% of Tribal members will opt-out and remain in traditional fee-for-service.

Additional Expenses

We assumed the Administrative Service Organization (ASO) would receive fees of 2.5% of projected professional and pharmacy cost for their services. We assumed that non-Tribal primary care physicians (PCPs) receive $5 PMPM for the additional responsibilities under this initiative. Additionally, we assumed that the level 3 Health Home providers would receive $15 PMPM for each member enrolled in the Health Home.

Utilization Adjustments

The utilization adjustments reflect the expected impact on medical utilization for this initiative as compared to the baseline. We developed the utilization adjustments based on our analysis of historical Alaska Medicaid utilization rates, medical cost savings achieved by similar programs in other states, and other information. For example, assume we estimated 1,100 emergency room visits per 1,000 in fiscal year 2019 in the baseline projection. The fiscal year 2019 emergency room visits per 1,000 for this initiative would be estimated as 1,018 (1,100 x .925). As displayed in Table 8a below, we expect the impact of the initiative to increase over time. Table 8a summarizes the utilization adjustments for the Primary Care Improvement initiative.

Table 8a
Alaska Department of Health and Social Services
Medicaid Redesign Initiatives
Primary Care Initiative Utilization Adjustment Factors

	UTILIZATION ADJUSTMENT FACTORS									
	SFY17		SFY18		SFY19		SFY20		SFY21	
Benefit	Adult	Child	Adult	Child	Adult	Child	Adult	Child	Adult	Child
Hospital Inpatient Services	0.994	0.996	0.988	0.991	0.975	0.982	0.963	0.972	0.950	0.963
Hospital Maternity	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Hospital Outpatient Services (non-ER)	0.994	0.996	0.988	0.991	0.975	0.982	0.963	0.972	0.950	0.963
Hosp OP ER and Prof ER	0.949	0.961	0.938	0.941	0.925	0.932	0.913	0.922	0.900	0.913
Professional Services - Primary Care	1.013	1.019	1.016	1.008	1.032	1.016	1.047	1.024	1.063	1.032
Professional Services (Non-Maternity)	0.997	0.999	0.994	0.997	0.988	0.994	0.981	0.991	0.975	0.988
Professional Services (Maternity)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Preventive Services	1.016	1.008	1.031	1.016	1.063	1.032	1.094	1.047	1.125	1.063
Prescription Drugs	0.996	0.998	0.992	0.995	0.984	0.990	0.976	0.985	0.968	0.980
Other Services	0.994	0.996	0.988	0.991	0.975	0.982	0.963	0.972	0.950	0.963

This report assumes that the reader is familiar with the State of Alaska's Medicaid program and its benefits. The report was prepared solely to provide assistance to AK DHSS to determine which, if any, modifications to make to the program. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

Table 8b summarizes the utilization adjustments for the Health Homes initiative.

Table 8b Alaska Department of Health and Social Services Medicaid Redesign Initiatives Health Homes Utilization Adjustment Factors		
	SFY19-SFY21	
Benefit	Adult	Child
Hospital Inpatient Services	0.800	0.850
Hospital Maternity	0.950	0.950
Hospital Outpatient Services	0.800	0.850
Hosp OP ER and Prof ER	0.750	0.800
Professional Services (Non-Maternity)	0.900	0.950
Professional Services (Maternity)	1.000	1.000
Preventive Services	1.500	1.250
Prescription Drugs	0.870	0.930
Other Services	0.800	0.850

Behavioral Health Access Adjustments

Implementation Date

We assumed that this initiative begins in fiscal year 2018.

Additional Expenses

We assumed the Administrative Service Organization (ASO) would receive fees of 3.5% of projected behavioral health professional and pharmacy costs for their services.

Utilization Adjustments

The Behavioral Health Access initiative increases access to behavioral health and provides care at the most appropriate level. Certain services, such as outpatient psychiatric visits, are expected to increase due to increased access associated with new provider types being reimbursed by Medicaid. The increase in access is modeled using utilization adjustment factors greater than 1.000. The utilization adjustments are summarized in Table 9.

This report assumes that the reader is familiar with the State of Alaska's Medicaid program and its benefits. The report was prepared solely to provide assistance to AK DHSS to determine which, if any, modifications to make to the program. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

Table 9 Alaska Department of Health and Social Services Medicaid Redesign Initiatives Behavioral Health Adjustment Factors								
	UTILIZATION ADJUSTMENT FACTORS							
	SFY18		SFY19		SFY20		SFY21	
Benefit	Adult	Child	Adult	Child	Adult	Child	Adult	Child
Hospital Inpatient Services	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Hospital and Residential Psychiatric, Alcohol & Drug Abuse	0.940	0.975	0.920	0.965	0.900	0.955	0.880	0.945
Hospital Maternity	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Hospital Outpatient Services	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Hosp OP ER and Prof ER	0.970	0.970	0.960	0.960	0.950	0.950	0.940	0.940
Prof OP Psychiatric, Alcohol & Drug Abuse	1.040	1.020	1.050	1.030	1.060	1.040	1.065	1.050
Prof Office / Home Visits - PCP	0.962	0.980	0.952	0.971	0.943	0.962	0.939	0.952
Professional Services (Other Non-Maternity)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Professional Services (Maternity)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Preventive Services	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Prescription Drugs	1.020	1.020	1.030	1.030	1.040	1.040	1.050	1.050
Other Services	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000

Emergency Room Adjustments

Implementation Date

We assumed that this initiative begins in fiscal year 2017.

Population

We included all eligibles in this initiative.

Utilization Adjustments

The utilization adjustment reflects the expected impact on medical utilization for this initiative. We developed the utilization adjustments based on our analysis of historical Alaska Medicaid utilization rates, medical cost savings achieved by similar programs in other states, and other information. Table 10 summarizes the utilization adjustments applied to facility and physician services associate with the emergency room.

Table 10 Alaska Department of Health and Social Services Medicaid Redesign Initiatives Emergency Room Utilization Adjustment Factors					
Benefit	SFY17	SFY18	SFY19	SFY20	SFY21
Hosp OP ER and Prof ER	0.930	0.865	0.839	0.822	0.806
PCP Office Visits	1.007	1.014	1.016	1.018	1.019
Spec Office Visits	1.003	1.006	1.007	1.007	1.008
OP Psychiatric Visits	1.001	1.002	1.002	1.003	1.003

We replaced 50% of the avoided emergency room visits with an office visit. The resulting office visits were assumed to be distributed as follows: 50% to a primary care physician, 25% to a specialist, and 25% to outpatient psychiatric visits.

This report assumes that the reader is familiar with the State of Alaska's Medicaid program and its benefits. The report was prepared solely to provide assistance to AK DHSS to determine which, if any, modifications to make to the program. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

In order to incentivize the hospital to participate, we have assumed 30% of the resulting savings will be shared with the hospitals.

Accountable Care Organization (ACO) Adjustments

Implementation Date

We assumed that this initiative will begin in fiscal year 2019.

Population

Tribal members and managed care optional members are not included in the ACO initiative. The ACO initiative is a pilot program and ACOs will not be available in all regions. We assumed that 32.5% of the remaining population is eligible for an ACO.

ACO Structure

We assumed dental services are carved out of the ACO. We assumed that behavioral health services are included in the ACO.

We also assumed that the ACO receives 40% of savings generated over the baseline projection on an annual basis.

Utilization Adjustments

The utilization savings adjustment reflects the medical cost savings generated through the ACO's care management activities. We developed the utilization savings adjustments based on our analysis of historical Alaska Medicaid utilization rates, medical cost savings achieved by similar programs in other states, and other information. The estimated utilization adjustment factors for the adult and child populations are shown in Table 11.

Table 11
Alaska Department of Health and Social Services
Medicaid Redesign Initiatives
Accountable Care Organization (ACO) Factors

	UTILIZATION ADJUSTMENT FACTORS					
	SFY19		SFY20		SFY21	
Benefit	Adult	Child	Adult	Child	Adult	Child
Hospital Inpatient Services	0.967	0.975	0.933	0.950	0.900	0.925
Hospital Maternity	0.990	1.000	0.980	1.000	0.970	1.000
Hospital Outpatient Services (non-ER)	0.967	0.975	0.933	0.950	0.900	0.925
Hosp OP ER and Prof ER	0.917	0.925	0.883	0.900	0.850	0.875
Professional Services (Non-Maternity)	0.983	0.992	0.967	0.983	0.950	0.970
Professional Services (Maternity)	1.000	1.000	1.000	1.000	1.000	1.000
Preventive Services	1.083	1.042	1.167	1.083	1.250	1.125
Prescription Drugs	0.978	0.987	0.957	0.973	0.935	0.960
Other Services	0.967	0.975	0.933	0.950	0.900	0.925

Telemedicine Adjustments

Implementation Date

We assumed that this initiative will begin in fiscal year 2018.

This report assumes that the reader is familiar with the State of Alaska's Medicaid program and its benefits. The report was prepared solely to provide assistance to AK DHSS to determine which, if any, modifications to make to the program. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

Telemedicine Coverage

This initiative is proposed as a workgroup to better define which telemedicine services will be covered, how they will be reimbursed, and other specifications. Our projections are based on the changes in utilization patterns we have observed that have implemented successful telemedicine programs.

Population

All eligibles are included in this initiative.

Utilization Adjustments

The utilization adjustment reflects the expected impact on medical utilization for this initiative. We developed the utilization adjustments based on our analysis of historical Alaska Medicaid utilization rates, medical cost savings achieved by similar programs in other states, and other information. We have observed mixed results for change in non-emergency transportation utilization associated with implementation of telemedicine coverage. Some programs have seen non-emergency transportation utilization decrease as services shift from office visits to telemedicine visits. However, other programs have seen non-emergency transportation utilization increase as the telemedicine visits led to more office visits. We assumed no change to non-emergency transportation utilization in our projection given the lack of information on which to base this assumption. Given the rural composition of Alaska, it is possible non-emergency transportation utilization will decrease. To the extent non-emergency room utilization decreases, the savings associated with this initiative will be higher than projected. Table 12 summarizes the utilization adjustments used in our projections.

Table 12
Alaska Department of Health and Social Services
Medicaid Redesign Initiatives
Telemedicine Utilization Adjustment Factors

Benefit	SFY18	SFY19	SFY20	SFY21
Hosp OP ER and Prof ER	0.970	0.941	0.913	0.885
Facility IP Medical Days	0.990	0.980	0.970	0.961
PCP Office Visits	0.919	0.891	0.861	0.827
Spec Office Visits	0.919	0.891	0.861	0.827
Telemedicine (PCP)	--	1.373	1.768	2.185
Telemedicine (Spec)	--	1.373	1.768	2.185
Prescription Drugs	1.030	1.051	1.072	1.082

Full Risk Managed Care Adjustments

Implementation Date

Given the time required to prepare a request for proposal, the evaluation of the proposals, and the contracting process with the managed care organizations, we have assumed that full risk managed care will be implemented beginning fiscal year 2020.

Population

Federal law requires that Tribal enrollees be given the ability to opt-out of full risk managed care. Federal law also requires that certain other eligibility categories be given the ability to opt-out of full risk managed care. The eligibility categories that are managed care optional include foster care children, Title IV-E subsidized adoption children, and juveniles court ordered into state custody. We have assumed that all Tribal and managed care optional enrollees opt-out of full risk managed care.

This report assumes that the reader is familiar with the State of Alaska's Medicaid program and its benefits. The report was prepared solely to provide assistance to AK DHSS to determine which, if any, modifications to make to the program. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

Of the remaining population, some enrollees may live in areas too rural to make managed care enrollment feasible. We assumed that 75% of the population (excluding Tribal and managed care optional members) are enrolled in full risk managed care.

Utilization Adjustments

The utilization savings adjustment reflects the medical cost savings generated through MCO care management activities. We developed the utilization savings adjustments based on our analysis of historical Alaska Medicaid utilization rates, medical cost savings achieved by similar programs in other states, and other information. The estimated utilization adjustment factors for the adult and child populations are shown in Table 13.

Table 13
Alaska Department of Health and Social Services
Medicaid Redesign Initiatives
Full Risk Utilization Adjustment Factors

	SFY20-SFY21	
Benefit	**Adult**	**Child**
Hospital Inpatient Services	0.800	0.850
Hospital Maternity	0.950	0.950
Hospital Outpatient Services	0.800	0.850
Hosp OP ER and Prof ER	0.750	0.800
Professional Services (Non-Maternity)	0.900	0.950
Professional Services (Maternity)	1.000	1.000
Preventive Services	1.500	1.250
Prescription Drugs	0.870	0.930
Other Services	0.800	0.850

Managed Care Contracting Adjustments

We made adjustments to reflect typical contractual arrangements between MCOs and providers. MCOs expect to contract with providers at a rate greater than the FFS reimbursement for medical services to establish networks that provide adequate access to medical services for the Medicaid enrollees. However, MCOs typically have slightly more favorable discounts on ingredient cost and dispensing fees from PBMs than states can usually obtain.

Table 14 shows the MCO reimbursement adjustment by type of service.

Table 14
Alaska Department of Health and Social Services
Medicaid Redesign Initiatives
Full Risk Managed Care Organization (MCO) Reimbursement Adjustment

Category	MCO Reimbursement Adjustment - % Change Unit Cost
Hospital Inpatient	2%
Hospital Outpatient	1%
Professional Services	1%
Prescription Drugs	-1%
Other	1%

This report assumes that the reader is familiar with the State of Alaska's Medicaid program and its benefits. The report was prepared solely to provide assistance to AK DHSS to determine which, if any, modifications to make to the program. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

Administration and Margin Allowance

Table 15 shows the MCO administration / margin allowance by eligibility category as a percentage of capitation revenue. The total administration / margin allowance is set as a percentage of the final benefit cost based on managed care industry experience and MCO administrative cost data.

Table 15
Alaska Department of Health and Social Services
Medicaid Redesign Initiatives
Full Risk Managed Care Organization (MCO) Administrative/Margin Allowance

Category	MCO Administrative/Margin Allowance (as % of Revenue)
Aid to Blind / Aid to Disabled	8.5%
Old Age Assistance	6.8%
Managed Care Optional	11.1%
SCHIP	11.1%
Pregnant Women	11.1%
Medicaid - Adult	11.1%
Medicaid - Child	11.1%
Expansion	11.1%

ACA Health Insurer Assessment Fee

The ACA placed an annual fee on the health insurance industry starting in CY 2014. The fee will be allocated to qualifying health insurers based on their respective market share of premium revenue in the previous year (e.g., the 2016 health insurer fee will be based on 2015 premium revenue). Market share is based on commercial, Medicare, and Medicaid revenue. CMS regulations require Medicaid managed care rates to include allowances for taxes like the ACA insurer fee because they are an unavoidable cost of doing business for Medicaid MCOs. We have assumed a health insurer assessment fee of 2.5%.[*]

Premium Tax

The projected capitation rates include an allowance for the 2.7% premium tax collected by the Alaska Insurance Department.

Trend

We have assumed the fiscal year 2021 capitation rates increase 3% over the fiscal year 2020 capitation rates.

Data Reliance and Important Caveats

We used Fee for Service (FFS) cost and eligibility data for January 2014 through December 2014, historical and projected reimbursement information, Third Party Liability (TPL) recoveries, current fee schedules, and other DHSS information to calculate the projections in this report. This data was provided by AK DHSS. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

[*] Doucet, M. & Yahnke, J., *ACA Health Insurer Fee: Estimated Impact on the US Health Insurance Industry*, Milliman Research Report, April 2013.

This report assumes that the reader is familiar with the State of Alaska's Medicaid program and its benefits. The report was prepared solely to provide assistance to AK DHSS to determine which, if any, modifications to make to the program. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

In order to provide the information requested by AK DHSS we constructed several projection models. Differences between the projections in this report and actual experience will depend on the extent to which future experience conforms to the assumptions made in our projections. It is certain that actual experience will not conform exactly to the assumptions used. Actual amounts will differ from projected amounts to the extent that actual experience is higher or lower than expected.

Milliman prepared this report for the specific purpose of evaluating changes to the current Medicaid system. This report should not be used for any other purpose. This report has been prepared solely for the internal business use of and is only to be relied upon by the management of AK DHSS. Milliman does not intend to benefit or create a legal duty to any third party recipient of its work. This report should only be reviewed in its entirety.

The results of this report are technical in nature and are dependent upon specific assumptions and methods. No party should rely on these results without a thorough understanding of those assumptions and methods. Such an understanding may require consultation with qualified professionals. The author of this report is a consulting actuary for Milliman, member of the American Academy of Actuaries, and meets the Qualification Standards of the Academy to perform the analysis contained herein. To the best of my knowledge and belief, this report is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices.

The terms of Milliman's contract with Agnew::Beck Consulting, LLC effective June 1, 2015 apply to this report and its use.

This report assumes that the reader is familiar with the State of Alaska's Medicaid program and its benefits. The report was prepared solely to provide assistance to AK DHSS to determine which, if any, modifications to make to the program. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

Appendix A
Calendar Year 2014 Data
by Population and Category of Service

This report assumes that the reader is familiar with the State of Alaska's Medicaid program and its benefits. The report was prepared solely to provide assistance to AK DHSS to determine which, if any, modifications to make to the program. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

NON-TRIBAL ADULT POPULATION
257,909 Member Months

Alaska Department of Health and Social Services
Medicaid Redesign Initiatives
Claims Incurred 1/2014 through 12/2014, Paid through 9/2015
Summary of Experience Data: All Claims and Encounters

								COB PMPM:	$38.08
Benefit	Annual Admits Per 1,000	Average Length of Stay	Annual Utilization Per 1,000	Average Allowed Per Service	Allowed PMPM	Patient Pay Utilization Per 1,000	Average Patient Pay	Patient Pay PMPM	Paid PMPM
Inpatient									
Medical/Surgical	84.4	5.38	454.6 days	$2,668.00	$101.08	-	$0.00	$0.00	$101.08
Newborn	0.0	1.00	0.0 days	$3,678.34	$0.01	-	$0.00	$0.00	$0.01
Psychiatric	11.9	18.06	215.1 days	978.86	17.55	-	0.00	0.00	17.55
Alcohol & Drug Abuse	1.5	4.91	7.5 days	2,117.17	1.33	-	0.00	0.00	1.33
Mother - Deliveries	98.3	2.64	260.0 days	$2,692.00	$58.32	-	$0.00	$0.00	$58.32
Non-Deliveries	9.8	2.97	29.1 days	2,614.33	6.35	-	0.00	0.00	6.35
SNF	17.4	65.05	1,131.9 days	606.22	57.18	-	0.00	0.00	57.18
Subtotal	223.5	9.39	2,098.3 days	$1,382.89	$241.81	-	$0.00	$0.00	$241.81
Outpatient									
Observation			26.7 visits	$3,166.31	$7.03	1.3	$21.74	$0.00	$7.03
Emergency Room			1,004.4 visits	709.97	59.42	13.1	10.77	0.01	59.41
Surgery			197.3 visits	2,374.42	39.04	92.3	39.84	0.31	38.73
Radiology			366.0 visits	517.32	15.78	247.8	19.54	0.40	15.38
Pathology/Lab			768.9 visits	94.58	6.06	520.5	1.41	0.06	6.00
Pharmacy			219.1 visits	591.31	10.80	106.5	15.10	0.13	10.66
Cardiovascular			45.6 visits	282.38	1.07	33.8	11.10	0.03	1.04
PT/OT/ST			120.3 visits	520.61	5.22	73.9	18.24	0.11	5.11
Psychiatric			58.8 visits	203.03	0.99	1.0	19.31	0.00	0.99
Alcohol & Drug Abuse			22.9 visits	95.63	0.18	0.4	18.80	0.00	0.18
Preventive			173.0 visits	123.27	1.78	87.2	1.54	0.01	1.77
Other Outpatient Facility			694.0 visits	310.47	17.95	202.2	8.13	0.14	17.82
Subtotal					$165.33			$1.21	$164.12
Professional									
Inpatient/Outpatient Surgery			1,016.3 proced	494.62	41.89	430.3	2.63	0.09	39.26
Maternity			328.6 proced	915.01	25.06	25.4	3.25	0.01	21.81
Inpatient Visits			609.4 visits	248.57	12.62	286.8	5.36	0.13	12.50
Office/Home Visits			6,370.1 visits	145.03	76.99	2,113.6	3.03	0.53	76.45
Urgent Care Visits			61.1 visits	119.07	0.61	27.6	3.00	0.01	0.60
Office Administered Drugs/Allergy Testing			801.2 proced	219.01	14.62	107.7	1.47	0.01	14.61
Allergy Immunotherapy			16.0 visits	26.78	0.04	6.8	3.00	0.00	0.03
Miscellaneous Medical			590.7 proced	154.69	7.61	123.6	2.50	0.03	7.59
Preventive Exams			32.8 visits	196.64	0.54	5.8	3.00	0.00	0.54
Other Preventive			1,294.8 proced	74.32	8.02	127.3	2.14	0.02	8.00
ER Visits and Observation			1,082.2 visits	180.95	16.32	722.7	3.01	0.18	16.14
Vision, Hearing and Speech Exams			388.7 visits	171.57	5.56	28.0	3.04	0.01	5.55
Physical Therapy/Chiropractor			1,742.9 visits	159.44	23.16	18.3	3.05	0.00	23.15
Cardiovascular			404.0 proced	55.74	1.88	157.5	2.74	0.04	1.84
Radiology			2,815.6 proced	103.14	24.20	1,241.0	1.64	0.17	24.03
Pathology/Lab			7,972.8 proced	28.45	18.90	1,041.5	0.65	0.06	18.85
Outpatient Psychiatric			2,097.6 visits	250.93	43.86	34.2	3.19	0.01	43.85
Applied Behavioral Analysis			-	0.00	0.00	-	0.00	0.00	0.00
Outpatient Alcohol & Drug Abuse			477.0 visits	236.60	9.40	8.8	5.97	0.00	9.40
Subtotal					$331.27			$1.39	$329.89
Other									
Prescription Drugs			20,133.9 scripts	$79.53	$133.44	-	$0.00	$0.00	$133.44
Private Duty Nursing/Home Health			18.0 visits	1,543.54	2.32	-	0.00	0.00	2.32
Ambulance			157.0 visits	807.36	10.56	-	0.00	0.00	10.56
DME and Supplies			1,480.8 proced	91.89	11.34	5.1	2.62	0.00	11.34
Prosthetics			17.9 proced	630.77	0.94	-	0.00	0.00	0.94
Subtotal					$158.59			$0.00	$158.59
Additional Benefits									
Glasses/Contacts			455.0 visits	$35.70	$1.35	5.9	$3.00	$0.00	$1.35
Other - General			19.6 proced	8.35	0.01	0.1	3.00	0.00	0.01
Other - Hearing Aids			59.6 proced	337.14	1.68	-	0.00	0.00	1.68
Other - Dental			4,607.7 proced	157.79	60.59	-	0.00	0.00	60.59
Other - Acupuncture			- proced	0.00	0.00	-	0.00	0.00	0.00
Other - Reproductive Medicine			- proced	0.00	0.00	-	0.00	0.00	0.00
Other - Temporary Codes			12,777.1 proced	71.07	75.67	0.5	3.00	0.00	75.67
Other - Documentation/Unclassified			8.8 proced	2.97	0.00	-	0.00	0.00	0.00
Other - Non-Emergency Transportation			1,380.7 proced	145.38	16.73	-	0.00	0.00	16.73
Subtotal					$156.03			$0.00	$156.03
Total Medical Cost					$1,053.04			$2.61	$1,050.44

TRIBAL MEMBER, NON-TRIBAL PROVIDER ADULT POPULATION
180,518 Member Months

Alaska Department of Health and Social Services
Medicaid Redesign Initiatives
Claims Incurred 1/2014 through 12/2014, Paid through 9/2015
Summary of Experience Data: All Claims and Encounters

COB PMPM: $8.09

Benefit	Annual Admits Per 1,000	Average Length of Stay	Annual Utilization Per 1,000	Average Allowed Per Service	Allowed PMPM	Patient Pay Utilization Per 1,000	Average Patient Pay	Patient Pay PMPM	Paid PMPM
Inpatient									
Medical/Surgical	24.4	5.22	127.4 days	$2,754.62	$29.25	-	$0.00	$0.00	$29.25
Newborn	0.1	83.00	5.5 days	$995.97	$0.46	-	$0.00	$0.00	$0.46
Psychiatric	10.2	22.42	228.1 days	1,006.77	19.14	-	0.00	0.00	19.14
Alcohol & Drug Abuse	1.7	3.27	5.7 days	2,616.48	1.23	-	0.00	0.00	1.23
Mother - Deliveries	33.8	2.95	99.7 days	$2,811.42	$23.36	-	$0.00	$0.00	$23.36
Non-Deliveries	3.7	3.68	13.7 days	2,534.90	2.89	-	0.00	0.00	2.89
SNF	16.1	51.24	824.3 days	699.05	48.02	-	0.00	0.00	48.02
Subtotal	89.9	14.50	1,304.4 days	$1,144.00	$124.35	-	$0.00	$0.00	$124.35
Outpatient									
Observation			17.3 visits	$2,673.41	$3.85	1.5	$60.20	$0.01	$3.84
Emergency Room			459.7 visits	701.51	26.88	4.1	12.61	0.00	26.87
Surgery			46.6 visits	2,583.73	10.03	25.0	34.53	0.07	9.96
Radiology			135.8 visits	491.76	5.57	90.1	19.41	0.15	5.42
Pathology/Lab			199.7 visits	119.06	1.98	121.3	1.70	0.02	1.96
Pharmacy			49.1 visits	310.26	1.27	25.8	3.41	0.01	1.26
Cardiovascular			12.8 visits	352.62	0.38	9.7	14.03	0.01	0.37
PT/OT/ST			37.8 visits	540.84	1.70	27.2	15.61	0.04	1.67
Psychiatric			22.5 visits	203.28	0.38	0.1	3.00	0.00	0.38
Alcohol & Drug Abuse			12.1 visits	87.86	0.09	-	0.00	0.00	0.09
Preventive			48.5 visits	125.50	0.51	20.4	1.92	0.00	0.50
Other Outpatient Facility			195.8 visits	247.83	4.04	66.7	5.77	0.03	4.01
Subtotal					$56.68		$0.00	$0.34	$56.34
Professional									
Inpatient/Outpatient Surgery			533.5 proced	562.48	25.01	106.6	2.54	0.02	22.47
Maternity			327.4 proced	754.11	20.57	8.8	3.95	0.00	16.62
Inpatient Visits			507.2 visits	275.07	11.63	91.9	5.93	0.05	11.58
Office/Home Visits			5,225.6 visits	302.79	131.85	418.5	3.02	0.11	131.75
Urgent Care Visits			27.7 visits	130.10	0.30	12.6	3.00	0.00	0.30
Office Administered Drugs/Allergy Testing			310.3 proced	112.47	2.91	15.3	1.43	0.00	2.91
Allergy Immunotherapy			2.3 visits	57.76	0.01	0.5	3.00	0.00	0.01
Miscellaneous Medical			353.7 proced	121.12	3.57	27.2	2.35	0.01	3.56
Preventive Exams			23.1 visits	421.11	0.81	1.1	3.00	0.00	0.81
Other Preventive			700.0 proced	143.86	8.39	12.0	2.46	0.00	8.39
ER Visits and Observation			1,013.9 visits	166.70	14.08	312.6	3.01	0.08	14.01
Vision, Hearing and Speech Exams			371.9 visits	334.34	10.36	8.2	3.02	0.00	10.36
Physical Therapy/Chiropractor			540.4 visits	157.62	7.10	3.9	3.00	0.00	7.10
Cardiovascular			178.9 proced	71.14	1.06	38.9	2.64	0.01	1.05
Radiology			1,878.9 proced	102.98	16.12	405.0	1.46	0.05	16.07
Pathology/Lab			3,427.8 proced	46.78	13.36	411.9	0.47	0.02	13.35
Outpatient Psychiatric			1,042.5 visits	441.66	38.37	9.4	3.51	0.00	38.37
Applied Behavioral Analysis			-	0.00	0.00	-	0.00	0.00	0.00
Outpatient Alcohol & Drug Abuse			215.2 visits	502.41	9.01	10.7	4.04	0.00	9.01
Subtotal					$314.52		$0.00	$0.39	$314.14
Other									
Prescription Drugs			14,538.0 scripts	$68.47	$82.95	-	$0.00	$0.00	$82.95
Private Duty Nursing/Home Health			5.4 visits	1,606.23	0.72	-	0.00	0.00	0.72
Ambulance			230.3 visits	1,433.45	27.51	-	0.00	0.00	27.51
DME and Supplies			462.1 proced	118.79	4.57	0.9	3.00	0.00	4.57
Prosthetics			5.7 proced	704.27	0.34	-	0.00	0.00	0.34
Subtotal					$116.09		$0.00	$0.00	$116.09
Additional Benefits				0.00					
Glasses/Contacts			435.1 visits	$35.76	$1.30	2.1	$3.00	$0.00	$1.30
Other - General			1.5 proced	6.89	0.00	-	0.00	0.00	0.00
Other - Hearing Aids			16.0 proced	343.16	0.46	-	0.00	0.00	0.46
Other - Dental			2,713.7 proced	211.47	47.82	-	0.00	0.00	47.82
Other - Acupuncture			- proced	0.00	0.00	-	0.00	0.00	0.00
Other - Reproductive Medicine			- proced	0.00	0.00	-	0.00	0.00	0.00
Other - Temporary Codes			2,364.6 proced	70.08	13.81	0.1	3.00	0.00	13.81
Other - Documentation/Unclassified			1.3 proced	29.68	0.00	-	0.00	0.00	0.00
Other - Non-Emergency Transportation			8,408.4 proced	123.77	86.73	-	0.00	0.00	86.73
Subtotal					$150.11			$0.00	$150.11
Total Medical Cost					$761.76			$0.72	$761.03

TRIBAL MEMBER, TRIBAL PROVIDER ADULT POPULATION
180,518 Member Months

Alaska Department of Health and Social Services
Medicaid Redesign Initiatives
Claims Incurred 1/2014 through 12/2014, Paid through 9/2015
Summary of Experience Data: All Claims and Encounters

COB PMPM: $33.52

Benefit	Annual Admits Per 1,000	Average Length of Stay	Annual Utilization Per 1,000	Average Allowed Per Service	Allowed PMPM	Patient Pay Utilization Per 1,000	Average Patient Pay	Patient Pay PMPM	Paid PMPM
Inpatient									
Medical/Surgical	46.0	5.83	268.6 days	$2,379.43	$53.27	-	$0.00	$0.00	$53.27
Newborn	-	0.00	- days	$0.00	$0.00	-	$0.00	$0.00	$0.00
Psychiatric	1.9	2.21	4.2 days	4,066.99	1.44	-	0.00	0.00	1.44
Alcohol & Drug Abuse	1.1	4.59	5.2 days	2,737.21	1.18	-	0.00	0.00	1.18
Mother - Deliveries	74.9	2.49	186.8 days	$2,605.37	$40.55	-	$0.00	$0.00	$40.55
Non-Deliveries	8.3	3.75	31.3 days	1,960.67	5.11	-	0.00	0.00	5.11
SNF	7.8	7.80	60.5 days	1,363.68	6.87	-	0.00	0.00	6.87
Subtotal	140.0	3.97	556.5 days	$2,337.51	$108.41	-	$0.00	$0.00	$108.10
Outpatient									
Observation			27.3 visits	$1,070.62	$2.44	-	$0.00	$0.00	$2.42
Emergency Room			801.7 visits	542.03	36.21	0.7	13.06	0.00	35.85
Surgery			118.9 visits	842.95	8.35	0.1	36.19	0.00	8.34
Radiology			386.0 visits	444.82	14.31	0.5	19.58	0.00	14.31
Pathology/Lab			1,273.3 visits	167.88	17.81	0.9	8.96	0.00	17.68
Pharmacy			88.4 visits	266.96	1.97	0.1	1.53	0.00	1.96
Cardiovascular			34.4 visits	381.79	1.09	0.1	24.30	0.00	1.09
PT/OT/ST			121.7 visits	473.05	4.80	0.2	19.55	0.00	4.76
Psychiatric			43.0 visits	568.54	2.04	-	0.00	0.00	2.03
Alcohol & Drug Abuse			7.0 visits	556.65	0.33	-	0.00	0.00	0.33
Preventive			433.3 visits	163.84	5.92	0.1	0.82	0.00	5.88
Other Outpatient Facility			1,478.6 visits	366.69	45.18	1.8	19.79	0.00	44.89
Subtotal					$140.44			$0.01	$139.38
Professional									
Inpatient/Outpatient Surgery			26.2 proced	104.02	0.23	-	0.00	0.00	0.23
Maternity			25.9 proced	41.65	0.09	-	0.00	0.00	0.09
Inpatient Visits			0.1 visits	564.00	0.01	-	0.00	0.00	0.01
Office/Home Visits			72.3 visits	515.21	3.11	-	0.00	0.00	3.11
Urgent Care Visits			0.1 visits	564.00	0.01	-	0.00	0.00	0.01
Office Administered Drugs/Allergy Testing			0.3 proced	333.80	0.01	-	0.00	0.00	0.01
Allergy Immunotherapy			- visits	0.00	0.00	-	0.00	0.00	0.00
Miscellaneous Medical			4.8 proced	307.86	0.12	-	0.00	0.00	0.12
Preventive Exams			1.7 visits	564.00	0.08	-	0.00	0.00	0.08
Other Preventive			40.2 proced	303.80	1.02	-	0.00	0.00	1.02
ER Visits and Observation			32.3 visits	550.61	1.48	-	0.00	0.00	1.48
Vision, Hearing and Speech Exams			5.2 visits	493.75	0.22	-	0.00	0.00	0.22
Physical Therapy/Chiropractor			0.2 visits	564.00	0.01	-	0.00	0.00	0.01
Cardiovascular			1.4 proced	349.25	0.04	-	0.00	0.00	0.04
Radiology			11.5 proced	3.28	0.00	-	0.00	0.00	0.00
Pathology/Lab			1.2 proced	122.78	0.01	-	0.00	0.00	0.01
Outpatient Psychiatric			349.6 visits	828.13	24.13	-	0.00	0.00	23.99
Applied Behavioral Analysis									
Outpatient Alcohol & Drug Abuse			310.8 visits	806.51	20.89	-	0.00	0.00	20.86
Subtotal					$51.45			$0.00	$51.27
Other									
Prescription Drugs			- scripts	$0.00	$0.00	-	$0.00	$0.00	$0.00
Private Duty Nursing/Home Health			0.1 visits	61.95	0.00	-	0.00	0.00	0.00
Ambulance			12.0 visits	4,926.52	4.92	-	0.00	0.00	4.92
DME and Supplies			- proced	0.00	0.00	-	0.00	0.00	0.00
Prosthetics			- proced	0.00	0.00	-	0.00	0.00	0.00
Subtotal					$4.92			$0.00	$4.92
Additional Benefits									
Glasses/Contacts			1.1 visits	$564.00	$0.05	-	$0.00	$0.00	$0.05
Other - General			- proced	0.00	0.00	-	0.00	0.00	0.00
Other - Hearing Aids			- proced	0.00	0.00	-	0.00	0.00	0.00
Other - Dental			- proced	0.00	0.00	-	0.00	0.00	0.00
Other - Acupuncture			- proced	0.00	0.00	-	0.00	0.00	0.00
Other - Reproductive Medicine			- proced	0.00	0.00	-	0.00	0.00	0.00
Other - Temporary Codes			101.0 proced	354.41	2.98	-	0.00	0.00	2.98
Other - Documentation/Unclassified			- proced	0.00	0.00	-	0.00	0.00	0.00
Other - Non-Emergency Transportation			354.2 proced	148.94	4.40	-	0.00	0.00	4.40
Subtotal					$7.43			$0.00	$7.43
Total Medical Cost					$312.66			$0.01	$311.10

NON-TRIBAL MEDICAID-CHILD POPULATION
351,808 Member Months

Alaska Department of Health and Social Services
Medicaid Redesign Initiatives
Claims Incurred 1/2014 through 12/2014, Paid through 9/2015
Summary of Experience Data: All Claims and Encounters

								COB PMPM:	$13.01
Benefit	Annual Admits Per 1,000	Average Length of Stay	Annual Utilization Per 1,000	Average Allowed Per Service	Allowed PMPM	Patient Pay Utilization Per 1,000	Average Patient Pay	Patient Pay PMPM	Paid PMPM
Inpatient									
Medical/Surgical	21.2	4.26	90.4 days	$2,942.83	$22.17	-	$0.00	$0.00	$22.17
Newborn	83.6	4.00	334.4 days	$2,587.46	$72.11	-	$0.00	$0.00	$72.11
Psychiatric	11.2	41.25	461.4 days	515.01	19.80	-	0.00	0.00	19.80
Alcohol & Drug Abuse	0.1	10.00	1.0 days	1,049.52	0.09	-	0.00	0.00	0.09
Mother - Deliveries	0.6	3.00	1.9 days	$2,628.87	$0.43	-	$0.00	$0.00	$0.43
Non-Deliveries	0.3	2.38	0.6 days	2,688.70	0.15	-	0.00	0.00	0.15
SNF	11.1	99.49	1,102.7 days	316.33	29.07	-	0.00	0.00	29.07
Subtotal	128.2	15.55	1,992.6 days	$866.10	$143.81	-	$0.00	$0.00	$143.81
Outpatient									
Observation			5.8 visits	$2,991.32	$1.45	-	$0.00	$0.00	$1.45
Emergency Room			443.6 visits	428.08	15.83	0.3	8.88	0.00	15.83
Surgery			65.9 visits	2,316.12	12.71	1.2	31.20	0.00	12.71
Radiology			64.7 visits	279.86	1.51	2.9	14.16	0.00	1.51
Pathology/Lab			164.9 visits	72.70	1.00	7.6	1.13	0.00	1.00
Pharmacy			19.9 visits	1,547.09	2.57	1.1	1.76	0.00	2.57
Cardiovascular			5.3 visits	366.79	0.16	0.3	18.66	0.00	0.16
PT/OT/ST			28.7 visits	510.16	1.22	1.5	22.01	0.00	1.22
Psychiatric			15.6 visits	285.57	0.37	0.0	3.00	0.00	0.37
Alcohol & Drug Abuse			0.2 visits	271.14	0.01	-	0.00	0.00	0.01
Preventive			86.6 visits	34.37	0.25	4.1	0.38	0.00	0.25
Other Outpatient Facility			43.2 visits	230.40	0.83	2.0	5.72	0.00	0.83
Subtotal					$37.89			$0.01	$37.88
Professional									
Inpatient/Outpatient Surgery			261.4 proced	483.89	10.54	5.2	3.11	0.00	7.43
Maternity			2.8 proced	820.39	0.19	1.1	3.87	0.00	(3.68)
Inpatient Visits			365.6 visits	378.48	11.53	3.0	5.49	0.00	11.53
Office/Home Visits			2,231.8 visits	138.11	25.69	40.7	3.03	0.01	25.68
Urgent Care Visits			31.9 visits	119.71	0.32	0.9	3.00	0.00	0.32
Office Administered Drugs/Allergy Testing			85.3 proced	144.98	1.03	1.3	1.73	0.00	1.03
Allergy Immunotherapy			20.0 visits	29.81	0.05	0.7	3.00	0.00	0.05
Miscellaneous Medical			215.5 proced	198.63	3.57	1.4	2.33	0.00	3.57
Preventive Exams			1,015.6 visits	181.92	15.40	1.6	3.00	0.00	15.40
Other Preventive			1,770.1 proced	37.94	5.60	2.9	2.32	0.00	5.60
ER Visits and Observation			463.1 visits	148.38	5.73	19.7	3.02	0.00	5.72
Vision, Hearing and Speech Exams			266.0 visits	186.32	4.13	0.4	3.00	0.00	4.13
Physical Therapy/Chiropractor			756.0 visits	169.96	10.71	0.1	3.00	0.00	10.71
Cardiovascular			72.6 proced	81.04	0.49	1.4	2.20	0.00	0.49
Radiology			502.6 proced	53.51	2.24	19.6	2.39	0.00	2.24
Pathology/Lab			491.0 proced	20.15	0.82	4.1	1.99	0.00	0.82
Outpatient Psychiatric			2,113.3 visits	289.58	51.00	0.6	4.42	0.00	51.00
Applied Behavioral Analysis			-	0.00	0.00	-	0.00	0.00	0.00
Outpatient Alcohol & Drug Abuse			42.2 visits	731.02	2.57	0.0	3.00	0.00	2.57
Subtotal					$151.59			$0.03	$151.57
Other									
Prescription Drugs			3,245.2 scripts	$89.66	$24.25	-	$0.00	$0.00	$24.25
Private Duty Nursing/Home Health			2.5 visits	1,607.80	0.33	-	0.00	0.00	0.33
Ambulance			21.5 visits	1,416.41	2.54	-	0.00	0.00	2.54
DME and Supplies			254.3 proced	190.11	4.03	0.3	2.63	0.00	4.03
Prosthetics			0.8 proced	3,025.27	0.20	-	0.00	0.00	0.20
Subtotal					$31.35			$0.00	$31.35
Additional Benefits									
Glasses/Contacts			323.7 visits	$35.12	$0.95	0.3	$3.00	$0.00	$0.95
Other - General			0.2 proced	61.08	0.00	-	0.00	0.00	0.00
Other - Hearing Aids			7.6 proced	303.48	0.19	-	0.00	0.00	0.19
Other - Dental			5,523.6 proced	95.65	44.03	-	0.00	0.00	44.03
Other - Acupuncture			- proced	0.00	0.00	-	0.00	0.00	0.00
Other - Reproductive Medicine			- proced	0.00	0.00	-	0.00	0.00	0.00
Other - Temporary Codes			425.8 proced	88.19	3.13	-	0.00	0.00	3.13
Other - Documentation/Unclassified			0.2 proced	0.00	0.00	-	0.00	0.00	0.00
Other - Non-Emergency Transportation			338.0 proced	204.47	5.76	-	0.00	0.00	5.76
Subtotal					$54.06			$0.00	$54.06
Total Medical Cost					$418.71			$0.04	$418.67

TRIBAL MEMBER, NON-TRIBAL PROVIDER MEDICAID-CHILD POPULATION
310,289 Member Months

Alaska Department of Health and Social Services
Medicaid Redesign Initiatives
Claims Incurred 1/2014 through 12/2014, Paid through 9/2015
Summary of Experience Data: All Claims and Encounters

COB PMPM: $3.82

Benefit	Annual Admits Per 1,000	Average Length of Stay	Annual Utilization Per 1,000	Average Allowed Per Service	Allowed PMPM	Patient Pay Utilization Per 1,000	Average Patient Pay	Patient Pay PMPM	Paid PMPM
Inpatient									
Medical/Surgical	10.9	6.50	70.7 days	$3,306.54	$19.47	-	$0.00	$0.00	$19.47
Newborn	23.2	7.41	172.0 days	$2,689.08	$38.54	-	$0.00	$0.00	$38.54
Psychiatric	13.9	37.15	517.2 days	597.52	25.75	-	0.00	0.00	25.75
Alcohol & Drug Abuse	0.1	11.00	0.9 days	1,126.65	0.08	-	0.00	0.00	0.08
Mother - Deliveries	0.3	2.44	0.9 days	$2,691.16	$0.19	-	$0.00	$0.00	$0.19
Non-Deliveries	0.1	3.67	0.4 days	2,558.72	0.09	-	0.00	0.00	0.09
SNF	9.6	68.06	652.8 days	317.84	17.29	-	0.00	0.00	17.29
Subtotal	58.1	24.34	1,414.7 days	$860.20	$101.41	-	$0.00	$0.00	$101.41
Outpatient									
Observation			3.5 visits	$2,911.15	$0.84	-	$0.00	$0.00	$0.84
Emergency Room			173.4 visits	446.66	6.45	0.0	2.14	0.00	6.45
Surgery			55.0 visits	2,247.31	10.30	0.1	1.34	0.00	10.30
Radiology			29.1 visits	346.76	0.84	0.7	24.83	0.00	0.84
Pathology/Lab			64.3 visits	78.72	0.42	1.7	1.77	0.00	0.42
Pharmacy			16.5 visits	893.11	1.23	0.2	3.38	0.00	1.23
Cardiovascular			3.1 visits	375.18	0.10	0.2	13.95	0.00	0.10
PT/OT/ST			14.0 visits	409.96	0.48	0.1	18.75	0.00	0.48
Psychiatric			15.4 visits	223.48	0.29	-	0.00	0.00	0.29
Alcohol & Drug Abuse			0.1 visits	184.00	0.00	-	0.00	0.00	0.00
Preventive			36.1 visits	29.05	0.09	1.2	0.94	0.00	0.09
Other Outpatient Facility			26.9 visits	226.74	0.51	0.5	1.07	0.00	0.51
Subtotal					$21.54			$0.00	$21.54
Professional									
Inpatient/Outpatient Surgery			204.3 proced	674.51	11.48	0.7	3.53	0.00	7.95
Maternity			5.2 proced	699.85	0.30	0.2	3.00	0.00	(2.70)
Inpatient Visits			424.3 visits	403.88	14.28	1.7	7.47	0.00	14.28
Office/Home Visits			2,799.9 visits	261.81	61.09	6.1	3.00	0.00	61.08
Urgent Care Visits			16.4 visits	110.89	0.15	0.1	3.00	0.00	0.15
Office Administered Drugs/Allergy Testing			88.7 proced	93.76	0.69	0.2	1.80	0.00	0.69
Allergy Immunotherapy			3.5 visits	32.99	0.01	-	0.00	0.00	0.01
Miscellaneous Medical			248.6 proced	135.52	2.81	0.1	3.00	0.00	2.81
Preventive Exams			640.4 visits	332.52	17.75	2.0	3.00	0.00	17.74
Other Preventive			1,195.1 proced	91.33	9.10	0.6	2.60	0.00	9.10
ER Visits and Observation			428.0 visits	139.03	4.96	7.3	3.00	0.00	4.96
Vision, Hearing and Speech Exams			282.2 visits	364.88	8.58	0.1	3.00	0.00	8.58
Physical Therapy/Chiropractor			323.5 visits	175.16	4.72	-	0.00	0.00	4.72
Cardiovascular			91.4 proced	103.94	0.79	0.4	2.73	0.00	0.79
Radiology			412.2 proced	49.46	1.70	4.0	2.04	0.00	1.70
Pathology/Lab			389.0 proced	50.54	1.64	2.1	0.98	0.00	1.64
Outpatient Psychiatric			1,875.6 visits	307.38	48.04	0.3	4.00	0.00	48.04
Applied Behavioral Analysis			-	0.00	0.00	-	0.00	0.00	0.00
Outpatient Alcohol & Drug Abuse			31.7 visits	873.40	2.31	-	0.00	0.00	2.31
Subtotal					$190.40			$0.01	$190.39
Other									
Prescription Drugs			2,869.2 scripts	$70.24	$16.80	-	$0.00	$0.00	$16.80
Private Duty Nursing/Home Health			3.6 visits	2,053.91	0.62	-	0.00	0.00	0.62
Ambulance			61.2 visits	2,725.86	13.91	-	0.00	0.00	13.91
DME and Supplies			167.3 proced	188.99	2.63	0.2	2.40	0.00	2.63
Prosthetics			0.3 proced	1,027.09	0.03	-	0.00	0.00	0.03
Subtotal					$33.99			$0.00	$33.99
Additional Benefits									
Glasses/Contacts			296.3 visits	$34.28	$0.85	-	$0.00	$0.00	$0.85
Other - General			0.0 proced	46.96	0.00	-	0.00	0.00	0.00
Other - Hearing Aids			3.4 proced	350.20	0.10	-	0.00	0.00	0.10
Other - Dental			4,819.2 proced	145.14	58.29	-	0.00	0.00	58.29
Other - Acupuncture			- proced	0.00	0.00	-	0.00	0.00	0.00
Other - Reproductive Medicine			- proced	0.00	0.00	-	0.00	0.00	0.00
Other - Temporary Codes			300.9 proced	77.24	1.94	-	0.00	0.00	1.94
Other - Documentation/Unclassified			0.1 proced	0.00	0.00	-	0.00	0.00	0.00
Other - Non-Emergency Transportation			6,365.3 proced	127.25	67.50	-	0.00	0.00	67.50
Subtotal					$128.67			$0.00	$128.67
Total Medical Cost					$476.02			$0.01	$476.01

TRIBAL MEMBER, TRIBAL PROVIDER MEDICAID-CHILD POPULATION
310,289 Member Months

Alaska Department of Health and Social Services
Medicaid Redesign Initiatives
Claims Incurred 1/2014 through 12/2014, Paid through 9/2015
Summary of Experience Data: All Claims and Encounters

COB PMPM: $22.66

Benefit	Annual Admits Per 1,000	Average Length of Stay	Annual Utilization Per 1,000	Average Allowed Per Service	Allowed PMPM	Patient Pay Utilization Per 1,000	Average Patient Pay	Patient Pay PMPM	Paid PMPM
Inpatient									
Medical/Surgical	25.8	4.03	103.9 days	$2,699.18	$23.38	-	$0.00	$0.00	$23.38
Newborn	53.3	3.02	160.7 days	$2,645.40	$35.43	-	$0.00	$0.00	$35.43
Psychiatric	1.5	2.38	3.6 days	4,054.83	1.22	-	0.00	0.00	1.22
Alcohol & Drug Abuse	0.2	4.80	0.9 days	5,746.59	0.44	-	0.00	0.00	0.44
Mother - Deliveries	1.0	2.67	2.8 days	$2,567.91	$0.60	-	$0.00	$0.00	$0.60
Non-Deliveries	0.2	1.40	0.3 days	2,628.92	0.06	-	0.00	0.00	0.06
SNF	3.4	2.39	8.2 days	2,379.86	1.63	-	0.00	0.00	1.63
Subtotal	85.4	3.28	280.5 days	$2,685.08	$62.76	-	$0.00	$0.00	$62.65
Outpatient									
Observation			4.5 visits	$1,937.56	$0.72	-	$0.00	$0.00	$0.71
Emergency Room			494.4 visits	528.50	21.77	-	0.00	0.00	21.46
Surgery			51.1 visits	1,059.73	4.51	-	0.00	0.00	4.51
Radiology			63.1 visits	402.66	2.12	-	0.00	0.00	2.12
Pathology/Lab			301.5 visits	173.67	4.36	-	0.00	0.00	4.34
Pharmacy			15.9 visits	419.27	0.56	-	0.00	0.00	0.55
Cardiovascular			4.7 visits	316.67	0.12	-	0.00	0.00	0.12
PT/OT/ST			61.8 visits	460.37	2.37	-	0.00	0.00	2.34
Psychiatric			17.6 visits	575.43	0.85	-	0.00	0.00	0.83
Alcohol & Drug Abuse			0.7 visits	564.00	0.03	-	0.00	0.00	0.03
Preventive			144.3 visits	167.04	2.01	-	0.00	0.00	2.00
Other Outpatient Facility			433.2 visits	458.78	16.56	-	0.00	0.00	16.41
Subtotal					$55.99			$0.00	$55.40
Professional									
Inpatient/Outpatient Surgery			10.0 proced	60.71	0.05	-	0.00	0.00	0.05
Maternity			0.2 proced	225.60	0.00	-	0.00	0.00	0.00
Inpatient Visits			0.1 visits	564.00	0.00	-	0.00	0.00	0.00
Office/Home Visits			74.5 visits	563.21	3.50	-	0.00	0.00	3.50
Urgent Care Visits			0.0 visits	564.00	0.00	-	0.00	0.00	0.00
Office Administered Drugs/Allergy Testing			0.0 proced	564.00	0.00	-	0.00	0.00	0.00
Allergy Immunotherapy			- visits	0.00	0.00	-	0.00	0.00	0.00
Miscellaneous Medical			3.0 proced	190.62	0.05	-	0.00	0.00	0.05
Preventive Exams			18.7 visits	449.13	0.70	-	0.00	0.00	0.70
Other Preventive			48.1 proced	102.83	0.41	-	0.00	0.00	0.41
ER Visits and Observation			29.7 visits	564.00	1.39	-	0.00	0.00	1.39
Vision, Hearing and Speech Exams			3.1 visits	537.05	0.14	-	0.00	0.00	0.14
Physical Therapy/Chiropractor			0.3 visits	123.97	0.00	-	0.00	0.00	0.00
Cardiovascular			0.5 proced	241.71	0.01	-	0.00	0.00	0.01
Radiology			1.2 proced	0.00	0.00	-	0.00	0.00	0.00
Pathology/Lab			0.3 proced	322.29	0.01	-	0.00	0.00	0.01
Outpatient Psychiatric			221.8 visits	932.39	17.24	-	0.00	0.00	16.93
Applied Behavioral Analysis									
Outpatient Alcohol & Drug Abuse			89.8 visits	748.27	5.60	-	0.00	0.00	5.42
Subtotal					$29.10			$0.00	$28.61
Other									
Prescription Drugs			- scripts	$0.00	$0.00	-	$0.00	$0.00	$0.00
Private Duty Nursing/Home Health			0.3 visits	2,091.90	0.05	-	0.00	0.00	0.05
Ambulance			3.7 visits	4,639.15	1.42	-	0.00	0.00	1.42
DME and Supplies			- proced	0.00	0.00	-	0.00	0.00	0.00
Prosthetics			- proced	0.00	0.00	-	0.00	0.00	0.00
Subtotal					$1.47			$0.00	$1.47
Additional Benefits									
Glasses/Contacts			1.2 visits	$564.00	$0.06	-	$0.00	$0.00	$0.06
Other - General			- proced	0.00	0.00	-	0.00	0.00	0.00
Other - Hearing Aids			- proced	0.00	0.00	-	0.00	0.00	0.00
Other - Dental			0.4 proced	0.00	0.00	-	0.00	0.00	0.00
Other - Acupuncture			- proced	0.00	0.00	-	0.00	0.00	0.00
Other - Reproductive Medicine			- proced	0.00	0.00	-	0.00	0.00	0.00
Other - Temporary Codes			69.1 proced	331.31	1.91	-	0.00	0.00	1.91
Other - Documentation/Unclassified			- proced	0.00	0.00	-	0.00	0.00	0.00
Other - Non-Emergency Transportation			261.3 proced	57.59	1.25	-	0.00	0.00	1.25
Subtotal					$3.22			$0.00	$3.22
Total Medical Cost					$152.55			$0.00	$151.35

NON-TRIBAL MANAGED CARE OPTIONAL POPULATION
17,908 Member Months

Alaska Department of Health and Social Services
Medicaid Redesign Initiatives
Claims Incurred 1/2014 through 12/2014, Paid through 9/2015
Summary of Experience Data: All Claims and Encounters

								COB PMPM:	$18.88
Benefit	Annual Admits Per 1,000	Average Length of Stay	Annual Utilization Per 1,000	Average Allowed Per Service	Allowed PMPM	Patient Pay Utilization Per 1,000	Average Patient Pay	Patient Pay PMPM	Paid PMPM
Inpatient									
Medical/Surgical	15.4	2.65	40.9 days	$2,700.57	$9.20	-	$0.00	$0.00	$9.20
Newborn	12.1	10.17	122.6 days	$2,311.30	$23.62	-	$0.00	$0.00	$23.62
Psychiatric	57.0	49.44	2,815.7 days	471.60	110.66	-	0.00	0.00	110.66
Alcohol & Drug Abuse	-	0.00	- days	0.00	0.00	-	0.00	0.00	0.00
Mother - Deliveries	1.3	3.00	4.0 days	$2,661.85	$0.89	-	$0.00	$0.00	$0.89
Non-Deliveries	-	0.00	- days	0.00	0.00	-	0.00	0.00	0.00
SNF	43.6	142.42	6,203.0 days	306.35	158.36	-	0.00	0.00	158.36
Subtotal	129.3	71.03	9,186.3 days	$395.45	$302.73	-	$0.00	$0.00	$302.73
Outpatient									
Observation			4.7 visits	$3,552.59	$1.39	-	$0.00	$0.00	$1.39
Emergency Room			289.5 visits	503.90	12.16	-	0.00	0.00	12.16
Surgery			68.3 visits	2,454.28	13.98	0.7	1.01	0.00	13.98
Radiology			89.8 visits	244.41	1.83	1.3	34.28	0.00	1.82
Pathology/Lab			218.4 visits	86.08	1.57	2.7	0.89	0.00	1.57
Pharmacy			6.0 visits	79.06	0.04	-	0.00	0.00	0.04
Cardiovascular			8.7 visits	253.18	0.18	-	0.00	0.00	0.18
PT/OT/ST			71.7 visits	393.25	2.35	-	0.00	0.00	2.35
Psychiatric			115.9 visits	348.52	3.37	-	0.00	0.00	3.37
Alcohol & Drug Abuse			0.7 visits	46.00	0.00	-	0.00	0.00	0.00
Preventive			108.6 visits	35.08	0.32	0.7	0.60	0.00	0.32
Other Outpatient Facility			45.6 visits	253.44	0.96	1.3	2.25	0.00	0.96
Subtotal					$38.14			$0.00	$38.14
Professional									
Inpatient/Outpatient Surgery			245.3 proced	435.23	8.90	3.4	3.00	0.00	5.90
Maternity			4.0 proced	1,619.79	0.54	2.0	4.00	0.00	(3.46)
Inpatient Visits			631.2 visits	385.35	20.27	-	0.00	0.00	20.27
Office/Home Visits			2,809.0 visits	144.90	33.92	15.4	3.00	0.00	33.91
Urgent Care Visits			34.2 visits	133.25	0.38	-	0.00	0.00	0.38
Office Administered Drugs/Allergy Testing			94.5 proced	78.20	0.62	1.3	1.50	0.00	0.62
Allergy Immunotherapy			27.5 visits	13.51	0.03	4.7	3.00	0.00	0.03
Miscellaneous Medical			849.7 proced	271.56	19.23	0.7	3.00	0.00	19.23
Preventive Exams			743.1 visits	187.30	11.60	-	0.00	0.00	11.60
Other Preventive			1,675.2 proced	49.06	6.85	4.0	3.00	0.00	6.85
ER Visits and Observation			302.2 visits	153.35	3.86	5.4	3.00	0.00	3.86
Vision, Hearing and Speech Exams			497.9 visits	192.43	7.98	-	0.00	0.00	7.98
Physical Therapy/Chiropractor			2,507.5 visits	199.57	41.70	-	0.00	0.00	41.70
Cardiovascular			63.0 proced	99.15	0.52	-	0.00	0.00	0.52
Radiology			458.3 proced	50.46	1.93	2.7	3.00	0.00	1.93
Pathology/Lab			587.7 proced	21.42	1.05	1.3	3.00	0.00	1.05
Outpatient Psychiatric			13,342.2 visits	448.11	498.23	1.3	3.00	0.00	498.23
Applied Behavioral Analysis			-	0.00	0.00	-	0.00	0.00	0.00
Outpatient Alcohol & Drug Abuse			156.1 visits	886.67	11.54	-	0.00	0.00	11.54
Subtotal					$669.14			$0.01	$669.13
Other									
Prescription Drugs			6,786.7 scripts	$100.36	$56.76	-	$0.00	$0.00	$56.76
Private Duty Nursing/Home Health			- visits	0.00	0.00	-	0.00	0.00	0.00
Ambulance			18.1 visits	1,267.97	1.91	-	0.00	0.00	1.91
DME and Supplies			622.5 proced	138.73	7.20	0.7	3.00	0.00	7.20
Prosthetics			- proced	0.00	0.00	-	0.00	0.00	0.00
Subtotal					$65.87			$0.00	$65.87
Additional Benefits									
Glasses/Contacts			523.3 visits	$34.55	$1.51	-	$0.00	$0.00	$1.51
Other - General			- proced	0.00	0.00	-	0.00	0.00	0.00
Other - Hearing Aids			11.4 proced	555.75	0.53	-	0.00	0.00	0.53
Other - Dental			6,721.0 proced	92.42	51.76	-	0.00	0.00	51.76
Other - Acupuncture			- proced	0.00	0.00	-	0.00	0.00	0.00
Other - Reproductive Medicine			- proced	0.00	0.00	-	0.00	0.00	0.00
Other - Temporary Codes			3,447.6 proced	78.89	22.67	-	0.00	0.00	22.67
Other - Documentation/Unclassified			- proced	0.00	0.00	-	0.00	0.00	0.00
Other - Non-Emergency Transportation			686.2 proced	253.88	14.52	-	0.00	0.00	14.52
Subtotal					$90.98			$0.00	$90.98
Total Medical Cost					$1,166.86			$0.02	$1,166.84

TRIBAL MEMBER, NON-TRIBAL PROVIDER MANAGED CARE OPTIONAL POPULATION
26,432 Member Months

Alaska Department of Health and Social Services
Medicaid Redesign Initiatives
Claims Incurred 1/2014 through 12/2014, Paid through 9/2015
Summary of Experience Data: All Claims and Encounters

COB PMPM: $8.94

Benefit	Annual Admits Per 1,000	Average Length of Stay	Annual Utilization Per 1,000	Average Allowed Per Service	Allowed PMPM	Patient Pay Utilization Per 1,000	Average Patient Pay	Patient Pay PMPM	Paid PMPM
Inpatient									
Medical/Surgical	13.2	4.21	55.4 days	$3,229.39	$14.91	-	$0.00	$0.00	$14.91
Newborn	2.3	8.80	20.0 days	$1,705.36	$2.84	-	$0.00	$0.00	$2.84
Psychiatric	71.7	46.90	3,364.1 days	512.56	143.69	-	0.00	0.00	143.69
Alcohol & Drug Abuse	-	0.00	- days	0.00	0.00	-	0.00	0.00	0.00
Mother - Deliveries	0.5	4.00	1.8 days	$2,723.58	$0.41	-	$0.00	$0.00	$0.41
Non-Deliveries	-	0.00	- days	0.00	0.00	-	0.00	0.00	0.00
SNF	32.7	158.53	5,181.9 days	282.70	122.08	-	0.00	0.00	122.08
Subtotal	120.3	71.68	8,623.2 days	$395.11	$283.93	-	$0.00	$0.00	$283.93
Outpatient									
Observation			2.7 visits	$4,637.03	$1.05	-	$0.00	$0.00	$1.05
Emergency Room			197.5 visits	514.90	8.47	-	0.00	0.00	8.47
Surgery			53.1 visits	2,142.86	9.49	-	0.00	0.00	9.49
Radiology			54.0 visits	237.99	1.07	0.5	6.11	0.00	1.07
Pathology/Lab			157.5 visits	65.38	0.86	1.8	2.02	0.00	0.86
Pharmacy			28.1 visits	587.83	1.38	-	0.00	0.00	1.38
Cardiovascular			5.0 visits	290.10	0.12	-	0.00	0.00	0.12
PT/OT/ST			92.2 visits	431.85	3.32	0.5	11.66	0.00	3.32
Psychiatric			187.0 visits	594.16	9.26	-	0.00	0.00	9.26
Alcohol & Drug Abuse			0.5 visits	75.00	0.00	-	0.00	0.00	0.00
Preventive			118.5 visits	22.98	0.23	8.6	0.15	0.00	0.23
Other Outpatient Facility			68.6 visits	172.11	0.98	-	0.00	0.00	0.98
Subtotal					$36.23			$0.00	$36.23
Professional									
Inpatient/Outpatient Surgery			264.2 proced	532.20	11.72	-	0.00	0.00	11.72
Maternity			2.3 proced	1,450.77	0.27	-	0.00	0.00	0.27
Inpatient Visits			639.2 visits	400.04	21.31	1.8	5.25	0.00	21.31
Office/Home Visits			2,780.7 visits	264.52	61.30	9.1	3.00	0.00	61.30
Urgent Care Visits			12.7 visits	158.83	0.17	0.5	3.00	0.00	0.17
Office Administered Drugs/Allergy Testing			92.2 proced	92.62	0.71	-	0.00	0.00	0.71
Allergy Immunotherapy			- visits	0.00	0.00	-	0.00	0.00	0.00
Miscellaneous Medical			534.8 proced	354.24	15.79	-	0.00	0.00	15.79
Preventive Exams			560.7 visits	344.19	16.08	1.4	3.00	0.00	16.08
Other Preventive			1,100.0 proced	95.19	8.73	-	0.00	0.00	8.73
ER Visits and Observation			457.6 visits	148.88	5.68	1.8	3.00	0.00	5.68
Vision, Hearing and Speech Exams			509.8 visits	291.02	12.36	0.5	3.00	0.00	12.36
Physical Therapy/Chiropractor			2,296.8 visits	178.53	34.17	-	0.00	0.00	34.17
Cardiovascular			69.5 proced	111.38	0.64	-	0.00	0.00	0.64
Radiology			466.7 proced	55.12	2.14	1.8	2.25	0.00	2.14
Pathology/Lab			428.1 proced	38.52	1.37	-	0.00	0.00	1.37
Outpatient Psychiatric			14,072.9 visits	487.63	571.86	0.9	3.00	0.00	571.86
Applied Behavioral Analysis			-	0.00	0.00	-	0.00	0.00	0.00
Outpatient Alcohol & Drug Abuse			168.4 visits	1,180.75	16.57	-	0.00	0.00	16.57
Subtotal					$780.89			$0.00	$780.88
Other									
Prescription Drugs			5,580.5 scripts	$107.66	$50.07	-	$0.00	$0.00	$50.07
Private Duty Nursing/Home Health			0.9 visits	2,405.00	0.18	-	0.00	0.00	0.18
Ambulance			40.9 visits	981.46	3.34	-	0.00	0.00	3.34
DME and Supplies			306.4 proced	216.59	5.53	-	0.00	0.00	5.53
Prosthetics			0.9 proced	41.00	0.00	-	0.00	0.00	0.00
Subtotal					$59.13			$0.00	$59.13
Additional Benefits									
Glasses/Contacts			474.4 visits	$31.67	$1.25	0.5	$3.00	$0.00	$1.25
Other - General			- proced	0.00	0.00	-	0.00	0.00	0.00
Other - Hearing Aids			0.9 proced	70.00	0.01	-	0.00	0.00	0.01
Other - Dental			6,108.1 proced	126.21	64.24	-	0.00	0.00	64.24
Other - Acupuncture			- proced	0.00	0.00	-	0.00	0.00	0.00
Other - Reproductive Medicine			- proced	0.00	0.00	-	0.00	0.00	0.00
Other - Temporary Codes			2,786.6 proced	79.70	18.51	-	0.00	0.00	18.51
Other - Documentation/Unclassified			- proced	0.00	0.00	-	0.00	0.00	0.00
Other - Non-Emergency Transportation			3,587.0 proced	171.69	51.32	-	0.00	0.00	51.32
Subtotal					$135.32			$0.00	$135.32
Total Medical Cost					$1,295.50			$0.01	$1,295.49

TRIBAL MEMBER, TRIBAL PROVIDER MANAGED CARE OPTIONAL POPULATION
26,432 Member Months

Alaska Department of Health and Social Services
Medicaid Redesign Initiatives
Claims Incurred 1/2014 through 12/2014, Paid through 9/2015
Summary of Experience Data: All Claims and Encounters

								COB PMPM:	$15.89
Benefit	**Annual Admits Per 1,000**	**Average Length of Stay**	**Annual Utilization Per 1,000**	**Average Allowed Per Service**	**Allowed PMPM**	**Patient Pay Utilization Per 1,000**	**Average Patient Pay**	**Patient Pay PMPM**	**Paid PMPM**
Inpatient									
Medical/Surgical	17.2	3.79	65.4 days	$2,658.75	$14.48	-	$0.00	$0.00	$14.48
Newborn	0.5	2.00	0.9 days	$2,675.00	$0.20	-	$0.00	$0.00	$0.20
Psychiatric	2.7	2.00	5.4 days	3,096.46	1.41	-	0.00	0.00	1.41
Alcohol & Drug Abuse	-	0.00	- days	0.00	0.00	-	0.00	0.00	0.00
Mother - Deliveries	1.8	2.50	4.5 days	$2,625.15	$0.99	-	$0.00	$0.00	$0.99
Non-Deliveries	0.5	3.00	1.4 days	2,675.00	0.30	-	0.00	0.00	0.30
SNF	0.5	1.00	0.5 days	2,675.00	0.10	-	0.00	0.00	0.10
Subtotal	23.2	3.37	78.1 days	$2,687.90	$17.49	-	$0.00	$0.00	$17.29
Outpatient									
Observation			- visits	$0.00	$0.00	-	$0.00	$0.00	$0.00
Emergency Room			347.3 visits	514.88	14.90	0.5	24.30	0.00	14.85
Surgery			45.8 visits	1,261.44	4.82	-	0.00	0.00	4.82
Radiology			33.6 visits	428.26	1.20	-	0.00	0.00	1.20
Pathology/Lab			209.7 visits	132.60	2.32	0.9	2.61	0.00	2.30
Pharmacy			7.3 visits	255.03	0.15	-	0.00	0.00	0.15
Cardiovascular			2.7 visits	358.53	0.08	-	0.00	0.00	0.08
PT/OT/ST			113.9 visits	446.00	4.23	-	0.00	0.00	4.23
Psychiatric			32.7 visits	547.72	1.49	-	0.00	0.00	1.47
Alcohol & Drug Abuse			0.5 visits	564.00	0.02	-	0.00	0.00	0.02
Preventive			94.0 visits	164.33	1.29	0.5	0.34	0.00	1.26
Other Outpatient Facility			336.8 visits	441.51	12.39	-	0.00	0.00	12.32
Subtotal					$42.90			$0.00	$42.64
Professional									
Inpatient/Outpatient Surgery			9.5 proced	80.57	0.06	-	0.00	0.00	0.06
Maternity			0.5 proced	0.00	0.00	-	0.00	0.00	0.00
Inpatient Visits			- visits	0.00	0.00	-	0.00	0.00	0.00
Office/Home Visits			20.0 visits	562.95	0.94	-	0.00	0.00	0.94
Urgent Care Visits			- visits	0.00	0.00	-	0.00	0.00	0.00
Office Administered Drugs/Allergy Testing			- proced	0.00	0.00	-	0.00	0.00	0.00
Allergy Immunotherapy			- visits	0.00	0.00	-	0.00	0.00	0.00
Miscellaneous Medical			4.5 proced	398.02	0.15	-	0.00	0.00	0.15
Preventive Exams			10.0 visits	508.59	0.42	-	0.00	0.00	0.42
Other Preventive			34.0 proced	379.72	1.08	-	0.00	0.00	1.08
ER Visits and Observation			5.9 visits	564.00	0.28	-	0.00	0.00	0.28
Vision, Hearing and Speech Exams			3.2 visits	544.29	0.14	-	0.00	0.00	0.14
Physical Therapy/Chiropractor			0.5 visits	123.97	0.00	-	0.00	0.00	0.00
Cardiovascular			- proced	0.00	0.00	-	0.00	0.00	0.00
Radiology			1.4 proced	0.00	0.00	-	0.00	0.00	0.00
Pathology/Lab			- proced	0.00	0.00	-	0.00	0.00	0.00
Outpatient Psychiatric			1,215.7 visits	925.92	93.80	-	0.00	0.00	92.25
Applied Behavioral Analysis									
Outpatient Alcohol & Drug Abuse			399.5 visits	886.52	29.51	-	0.00	0.00	29.44
Subtotal					$126.39			$0.00	$124.76
Other									
Prescription Drugs			- scripts	$0.00	$0.00	-	$0.00	$0.00	$0.00
Private Duty Nursing/Home Health			- visits	0.00	0.00	-	0.00	0.00	0.00
Ambulance			5.0 visits	5,235.04	2.18	-	0.00	0.00	2.18
DME and Supplies			- proced	0.00	0.00	-	0.00	0.00	0.00
Prosthetics			- proced	0.00	0.00	-	0.00	0.00	0.00
Subtotal					$2.18			$0.00	$2.18
Additional Benefits									
Glasses/Contacts			0.5 visits	$564.00	$0.02	-	$0.00	$0.00	$0.02
Other - General			- proced	0.00	0.00	-	0.00	0.00	0.00
Other - Hearing Aids			- proced	0.00	0.00	-	0.00	0.00	0.00
Other - Dental			0.5 proced	0.00	0.00	-	0.00	0.00	0.00
Other - Acupuncture			- proced	0.00	0.00	-	0.00	0.00	0.00
Other - Reproductive Medicine			- proced	0.00	0.00	-	0.00	0.00	0.00
Other - Temporary Codes			222.0 proced	281.80	5.21	-	0.00	0.00	5.21
Other - Documentation/Unclassified			- proced	0.00	0.00	-	0.00	0.00	0.00
Other - Non-Emergency Transportation			96.2 proced	84.90	0.68	-	0.00	0.00	0.68
Subtotal					$5.91			$0.00	$5.91
Total Medical Cost					$194.87			$0.00	$192.78

NON-TRIBAL SCHIP POPULATION
65,264 Member Months

Alaska Department of Health and Social Services
Medicaid Redesign Initiatives
Claims Incurred 1/2014 through 12/2014, Paid through 9/2015
Summary of Experience Data: All Claims and Encounters

								COB PMPM:	$3.38
Benefit	Annual Admits Per 1,000	Average Length of Stay	Annual Utilization Per 1,000	Average Allowed Per Service	Allowed PMPM	Patient Pay Utilization Per 1,000	Average Patient Pay	Patient Pay PMPM	Paid PMPM
Inpatient									
Medical/Surgical	11.8	2.88	33.8 days	$3,079.00	$8.68	-	$0.00	$0.00	$8.68
Newborn	2.0	2.09	4.2 days	$2,652.06	$0.93	-	$0.00	$0.00	$0.93
Psychiatric	8.3	44.56	368.7 days	510.48	15.68	-	0.00	0.00	15.68
Alcohol & Drug Abuse	-	0.00	- days	0.00	0.00	-	0.00	0.00	0.00
Mother - Deliveries	0.6	3.33	1.8 days	$2,512.60	$0.38	-	$0.00	$0.00	$0.38
Non-Deliveries	-	0.00	- days	0.00	0.00	-	0.00	0.00	0.00
SNF	2.4	130.00	310.7 days	224.93	5.82	-	0.00	0.00	5.82
Subtotal	25.0	28.76	719.3 days	$525.64	$31.51	-	$0.00	$0.00	$31.51
Outpatient									
Observation			3.5 visits	$3,577.10	$1.04	-	$0.00	$0.00	$1.04
Emergency Room			274.3 visits	485.20	11.09	-	0.00	0.00	11.09
Surgery			61.4 visits	2,210.72	11.31	0.7	11.89	0.00	11.31
Radiology			71.5 visits	310.30	1.85	4.8	15.19	0.01	1.84
Pathology/Lab			164.2 visits	71.69	0.98	8.5	1.08	0.00	0.98
Pharmacy			8.5 visits	486.14	0.34	0.4	1.82	0.00	0.34
Cardiovascular			5.7 visits	280.36	0.13	0.6	20.69	0.00	0.13
PT/OT/ST			32.2 visits	488.76	1.31	-	0.00	0.00	1.31
Psychiatric			11.8 visits	255.36	0.25	0.4	3.00	0.00	0.25
Alcohol & Drug Abuse			0.2 visits	69.00	0.00	-	0.00	0.00	0.00
Preventive			74.1 visits	36.11	0.22	2.9	0.51	0.00	0.22
Other Outpatient Facility			28.9 visits	227.64	0.55	1.1	2.62	0.00	0.55
Subtotal					$29.09			$0.01	$29.08
Professional									
Inpatient/Outpatient Surgery			232.0 proced	457.23	8.84	6.6	2.33	0.00	6.51
Maternity			1.5 proced	764.49	0.09	-	0.00	0.00	0.09
Inpatient Visits			95.8 visits	339.91	2.71	0.4	4.50	0.00	2.71
Office/Home Visits			1,997.9 visits	139.49	23.22	46.9	3.01	0.01	23.21
Urgent Care Visits			27.8 visits	128.51	0.30	1.1	3.00	0.00	0.30
Office Administered Drugs/Allergy Testing			88.3 proced	110.49	0.81	0.7	3.00	0.00	0.81
Allergy Immunotherapy			39.7 visits	36.03	0.12	1.1	3.00	0.00	0.12
Miscellaneous Medical			306.9 proced	184.06	4.71	0.7	3.00	0.00	4.71
Preventive Exams			513.2 visits	182.57	7.81	2.6	3.00	0.00	7.81
Other Preventive			983.3 proced	36.22	2.97	2.2	2.25	0.00	2.97
ER Visits and Observation			283.3 visits	149.55	3.53	14.5	3.00	0.00	3.53
Vision, Hearing and Speech Exams			351.9 visits	184.81	5.42	0.6	3.00	0.00	5.42
Physical Therapy/Chiropractor			940.1 visits	162.64	12.74	0.2	3.00	0.00	12.74
Cardiovascular			51.3 proced	88.84	0.38	2.8	2.00	0.00	0.38
Radiology			420.1 proced	57.38	2.01	18.8	2.63	0.00	2.00
Pathology/Lab			530.8 proced	20.03	0.89	3.3	2.17	0.00	0.89
Outpatient Psychiatric			1,313.0 visits	291.04	31.84	0.6	7.00	0.00	31.84
Applied Behavioral Analysis			-	0.00	0.00	-	0.00	0.00	0.00
Outpatient Alcohol & Drug Abuse			28.3 visits	824.98	1.95	-	0.00	0.00	1.95
Subtotal					$110.34			$0.02	$110.32
Other									
Prescription Drugs			3,162.5 scripts	$118.83	$31.32	-	$0.00	$0.00	$31.32
Private Duty Nursing/Home Health			0.7 visits	687.01	0.04	-	0.00	0.00	0.04
Ambulance			9.7 visits	1,469.38	1.19	-	0.00	0.00	1.19
DME and Supplies			191.2 proced	108.39	1.73	-	0.00	0.00	1.73
Prosthetics			1.3 proced	277.47	0.03	-	0.00	0.00	0.03
Subtotal					$34.31			$0.00	$34.31
Additional Benefits									
Glasses/Contacts			448.8 visits	$34.69	$1.30	0.4	$3.00	$0.00	$1.30
Other - General			- proced	0.00	0.00	-	0.00	0.00	0.00
Other - Hearing Aids			12.5 proced	350.44	0.37	-	0.00	0.00	0.37
Other - Dental			7,174.6 proced	92.05	55.04	-	0.00	0.00	55.04
Other - Acupuncture			- proced	0.00	0.00	-	0.00	0.00	0.00
Other - Reproductive Medicine			- proced	0.00	0.00	-	0.00	0.00	0.00
Other - Temporary Codes			324.3 proced	68.18	1.84	-	0.00	0.00	1.84
Other - Documentation/Unclassified			- proced	0.00	0.00	-	0.00	0.00	0.00
Other - Non-Emergency Transportation			292.0 proced	165.04	4.02	-	0.00	0.00	4.02
Subtotal					$62.56			$0.00	$62.56
Total Medical Cost					$267.81			$0.03	$267.77

TRIBAL MEMBER, NON-TRIBAL PROVIDER SCHIP POPULATION
27,786 Member Months

Alaska Department of Health and Social Services
Medicaid Redesign Initiatives
Claims Incurred 1/2014 through 12/2014, Paid through 9/2015
Summary of Experience Data: All Claims and Encounters

COB PMPM: $4.06

Benefit	Annual Admits Per 1,000	Average Length of Stay	Annual Utilization Per 1,000	Average Allowed Per Service	Allowed PMPM	Patient Pay Utilization Per 1,000	Average Patient Pay	Patient Pay PMPM	Paid PMPM
Inpatient									
Medical/Surgical	8.2	3.74	30.7 days	$3,387.72	$8.66	-	$0.00	$0.00	$8.66
Newborn	0.9	48.00	41.5 days	$1,947.40	$6.73	-	$0.00	$0.00	$6.73
Psychiatric	14.7	35.62	523.0 days	632.84	27.58	-	0.00	0.00	27.58
Alcohol & Drug Abuse	-	0.00	- days	0.00	0.00	-	0.00	0.00	0.00
Mother - Deliveries	0.9	2.50	2.2 days	$2,657.30	$0.48	-	$0.00	$0.00	$0.48
Non-Deliveries	0.4	1.00	0.4 days	2,666.62	0.10	-	0.00	0.00	0.10
SNF	6.0	107.00	646.9 days	229.90	12.39	-	0.00	0.00	12.39
Subtotal	31.1	40.03	1,244.7 days	$539.28	$55.93	-	$0.00	$0.00	$55.93
Outpatient									
Observation			2.6 visits	$3,769.54	$0.81	-	$0.00	$0.00	$0.81
Emergency Room			130.0 visits	523.12	5.67	-	0.00	0.00	5.67
Surgery			44.9 visits	2,196.33	8.22	0.4	9.12	0.00	8.22
Radiology			38.0 visits	363.16	1.15	0.9	21.17	0.00	1.15
Pathology/Lab			70.4 visits	87.04	0.51	3.0	7.05	0.00	0.51
Pharmacy			11.2 visits	5,718.57	5.35	-	0.00	0.00	5.35
Cardiovascular			4.8 visits	323.98	0.13	-	0.00	0.00	0.13
PT/OT/ST			17.7 visits	435.34	0.64	-	0.00	0.00	0.64
Psychiatric			13.0 visits	400.73	0.43	-	0.00	0.00	0.43
Alcohol & Drug Abuse			- visits	0.00	0.00	-	0.00	0.00	0.00
Preventive			33.7 visits	34.49	0.10	2.6	1.32	0.00	0.10
Other Outpatient Facility			21.6 visits	278.81	0.50	2.2	5.37	0.00	0.50
Subtotal					$23.52			$0.00	$23.51
Professional									
Inpatient/Outpatient Surgery			190.9 proced	603.63	9.60	2.2	4.20	0.00	5.40
Maternity			4.8 proced	779.27	0.31	0.9	3.00	0.00	(2.69)
Inpatient Visits			178.4 visits	466.67	6.94	2.2	4.80	0.00	6.94
Office/Home Visits			2,400.3 visits	278.85	55.78	11.7	3.00	0.00	55.77
Urgent Care Visits			18.6 visits	132.14	0.20	-	0.00	0.00	0.20
Office Administered Drugs/Allergy Testing			92.4 proced	121.90	0.94	0.4	3.00	0.00	0.94
Allergy Immunotherapy			4.8 visits	611.44	0.24	-	0.00	0.00	0.24
Miscellaneous Medical			254.4 proced	140.94	2.99	-	0.00	0.00	2.99
Preventive Exams			338.6 visits	377.83	10.66	0.9	3.00	0.00	10.66
Other Preventive			701.4 proced	111.97	6.54	-	0.00	0.00	6.54
ER Visits and Observation			326.1 visits	141.49	3.84	5.6	3.00	0.00	3.84
Vision, Hearing and Speech Exams			349.0 visits	342.30	9.95	-	0.00	0.00	9.95
Physical Therapy/Chiropractor			369.3 visits	198.08	6.09	-	0.00	0.00	6.09
Cardiovascular			49.2 proced	119.06	0.49	0.4	3.00	0.00	0.49
Radiology			388.7 proced	60.24	1.95	6.5	2.40	0.00	1.95
Pathology/Lab			454.8 proced	41.41	1.57	2.2	1.80	0.00	1.57
Outpatient Psychiatric			1,303.8 visits	391.55	42.54	0.9	3.00	0.00	42.54
Applied Behavioral Analysis			-	0.00	0.00	-	0.00	0.00	0.00
Outpatient Alcohol & Drug Abuse			61.8 visits	874.64	4.50	-	0.00	0.00	4.50
Subtotal					$165.15			$0.01	$165.14
Other									
Prescription Drugs			2,755.3 scripts	$79.83	$18.33	-	$0.00	$0.00	$18.33
Private Duty Nursing/Home Health			- visits	0.00	0.00	-	0.00	0.00	0.00
Ambulance			27.2 visits	2,039.93	4.63	-	0.00	0.00	4.63
DME and Supplies			72.1 proced	140.87	0.85	-	0.00	0.00	0.85
Prosthetics			- proced	0.00	0.00	-	0.00	0.00	0.00
Subtotal					$23.80			$0.00	$23.80
Additional Benefits									
Glasses/Contacts			422.8 visits	$35.46	$1.25	0.4	$3.00	$0.00	$1.25
Other - General			- proced	0.00	0.00	-	0.00	0.00	0.00
Other - Hearing Aids			4.8 proced	50.25	0.02	-	0.00	0.00	0.02
Other - Dental			5,708.5 proced	144.52	68.75	-	0.00	0.00	68.75
Other - Acupuncture			- proced	0.00	0.00	-	0.00	0.00	0.00
Other - Reproductive Medicine			- proced	0.00	0.00	-	0.00	0.00	0.00
Other - Temporary Codes			228.0 proced	60.11	1.14	-	0.00	0.00	1.14
Other - Documentation/Unclassified			- proced	0.00	0.00	-	0.00	0.00	0.00
Other - Non-Emergency Transportation			5,282.7 proced	142.84	62.88	-	0.00	0.00	62.88
Subtotal					$134.04			$0.00	$134.04
Total Medical Cost					$402.44			$0.01	$402.43

TRIBAL MEMBER, TRIBAL PROVIDER SCHIP POPULATION
27,786 Member Months

Alaska Department of Health and Social Services
Medicaid Redesign Initiatives
Claims Incurred 1/2014 through 12/2014, Paid through 9/2015
Summary of Experience Data: All Claims and Encounters

								COB PMPM:	$5.61
Benefit	Annual Admits Per 1,000	Average Length of Stay	Annual Utilization Per 1,000	Average Allowed Per Service	Allowed PMPM	Patient Pay Utilization Per 1,000	Average Patient Pay	Patient Pay PMPM	Paid PMPM
Inpatient									
Medical/Surgical	6.5	3.93	25.5 days	$2,605.16	$5.53	-	$0.00	$0.00	$5.53
Newborn	2.2	2.00	4.3 days	$2,656.13	$0.96	-	$0.00	$0.00	$0.96
Psychiatric	-	0.00	- days	0.00	0.00	-	0.00	0.00	0.00
Alcohol & Drug Abuse	-	0.00	- days	0.00	0.00	-	0.00	0.00	0.00
Mother - Deliveries	0.9	2.50	2.2 days	$2,533.96	$0.46	-	$0.00	$0.00	$0.46
Non-Deliveries	-	0.00	- days	0.00	0.00	-	0.00	0.00	0.00
SNF	2.6	1.83	4.8 days	2,659.13	1.05	-	0.00	0.00	1.05
Subtotal	12.1	3.04	36.7 days	$2,613.96	$8.00	-	$0.00	$0.00	$8.00
Outpatient									
Observation			0.4 visits	$486.00	$0.02	-	$0.00	$0.00	$0.02
Emergency Room			329.1 visits	535.78	14.69	-	0.00	0.00	14.53
Surgery			41.9 visits	1,024.47	3.58	-	0.00	0.00	3.58
Radiology			47.5 visits	403.20	1.60	-	0.00	0.00	1.60
Pathology/Lab			313.5 visits	175.57	4.59	-	0.00	0.00	4.56
Pharmacy			8.6 visits	291.50	0.21	-	0.00	0.00	0.21
Cardiovascular			6.9 visits	351.96	0.20	-	0.00	0.00	0.20
PT/OT/ST			60.9 visits	488.81	2.48	-	0.00	0.00	2.40
Psychiatric			11.2 visits	545.07	0.51	-	0.00	0.00	0.51
Alcohol & Drug Abuse			- visits	0.00	0.00	-	0.00	0.00	0.00
Preventive			78.6 visits	155.97	1.02	-	0.00	0.00	1.02
Other Outpatient Facility			398.6 visits	452.61	15.03	-	0.00	0.00	14.91
Subtotal					$43.93			$0.00	$43.51
Professional									
Inpatient/Outpatient Surgery			6.9 proced	174.81	0.10	-	0.00	0.00	0.10
Maternity			- proced	0.00	0.00	-	0.00	0.00	0.00
Inpatient Visits			- visits	0.00	0.00	-	0.00	0.00	0.00
Office/Home Visits			33.3 visits	562.51	1.56	-	0.00	0.00	1.56
Urgent Care Visits			- visits	0.00	0.00	-	0.00	0.00	0.00
Office Administered Drugs/Allergy Testing			- proced	0.00	0.00	-	0.00	0.00	0.00
Allergy Immunotherapy			- visits	0.00	0.00	-	0.00	0.00	0.00
Miscellaneous Medical			3.0 proced	134.29	0.03	-	0.00	0.00	0.03
Preventive Exams			6.5 visits	511.66	0.28	-	0.00	0.00	0.28
Other Preventive			28.1 proced	184.84	0.43	-	0.00	0.00	0.43
ER Visits and Observation			9.9 visits	564.00	0.47	-	0.00	0.00	0.47
Vision, Hearing and Speech Exams			6.5 visits	550.20	0.30	-	0.00	0.00	0.30
Physical Therapy/Chiropractor			- visits	0.00	0.00	-	0.00	0.00	0.00
Cardiovascular			- proced	0.00	0.00	-	0.00	0.00	0.00
Radiology			1.7 proced	141.00	0.02	-	0.00	0.00	0.02
Pathology/Lab			- proced	0.00	0.00	-	0.00	0.00	0.00
Outpatient Psychiatric			279.4 visits	1,015.09	23.64	-	0.00	0.00	23.22
Applied Behavioral Analysis									
Outpatient Alcohol & Drug Abuse			23.8 visits	1,188.27	2.35	-	0.00	0.00	2.35
Subtotal					$29.17			$0.00	$28.75
Other									
Prescription Drugs			- scripts	$0.00	$0.00	-	$0.00	$0.00	$0.00
Private Duty Nursing/Home Health			- visits	0.00	0.00	-	0.00	0.00	0.00
Ambulance			2.2 visits	3,937.49	0.71	-	0.00	0.00	0.71
DME and Supplies			- proced	0.00	0.00	-	0.00	0.00	0.00
Prosthetics			- proced	0.00	0.00	-	0.00	0.00	0.00
Subtotal					$0.71			$0.00	$0.71
Additional Benefits									
Glasses/Contacts			- visits	$0.00	$0.00	-	$0.00	$0.00	$0.00
Other - General			- proced	0.00	0.00	-	0.00	0.00	0.00
Other - Hearing Aids			- proced	0.00	0.00	-	0.00	0.00	0.00
Other - Dental			- proced	0.00	0.00	-	0.00	0.00	0.00
Other - Acupuncture			- proced	0.00	0.00	-	0.00	0.00	0.00
Other - Reproductive Medicine			- proced	0.00	0.00	-	0.00	0.00	0.00
Other - Temporary Codes			21.2 proced	291.47	0.51	-	0.00	0.00	0.51
Other - Documentation/Unclassified			- proced	0.00	0.00	-	0.00	0.00	0.00
Other - Non-Emergency Transportation			148.6 proced	48.87	0.60	-	0.00	0.00	0.60
Subtotal					$1.12			$0.00	$1.12
Total Medical Cost					$82.93			$0.00	$82.08