HB

227

HOUSE BILL NO. 227

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-NINTH LEGISLATURE - SECOND SESSION

BY REPRESENTATIVE SEATON

Introduced: 1/8/16
Referred: Prefiled

A BILL

FOR AN ACT ENTITLED

"An Act relating to medical assistance reform measures; relating to administrative appeals of civil penalties for medical assistance providers; relating to the duties of the Department of Health and Social Services; relating to audits and civil penalties for medical assistance providers; relating to medical assistance cost containment measures by the Department of Health and Social Services; relating to medical assistance coverage of clinic and rehabilitative services; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* **Section 1.** The uncodified law of the State of Alaska is amended by adding a new section to read:

MEDICAL ASSISTANCE REFORM: LEGISLATIVE FINDINGS AND INTENT. The legislature finds that the current Medicaid program is not sustainable. Although annual growth has fallen from 6.45 percent to 4.8 percent, further reductions are needed. In order to maintain a viable Medicaid program, it is the intent of the legislature that

all necessary action to capture federal revenue and offset state general funds and evaluate the most cost-effective method for revising expansion coverage, including more efficient benefit plans, cost sharing, utilization control, and other innovative health care financing strategies;

(2) the Department of Health and Social Services be instructed to

(A) evaluate and implement meaningful Medicaid reform measures, including working with tribal and community partners to develop innovative practices leading to a sustainable Medicaid program available for future generations;

(B) evaluate all options available to it, including

(i) obtaining waivers to the Medicaid program to address choice, statewide compatibility, or other core Medicaid requirements; and

(ii) regulatory action to improve provider and recipient compliance with program rules;

(3) the Department of Health and Social Services establish prevention of disease as a primary model of health care in the state, as requested by the legislature in Legislative Resolve 16 of the Twenty-Seventh Alaska State Legislature.

* **Sec. 2.** AS 44.62.330(a) is amended by adding a new paragraph to read:

(47) Department of Health and Social Services relating to civil penalties assessed against medical assistance providers under AS 47.05.250.

* **Sec. 3.** AS 47.05.010 is amended to read:

Sec. 47.05.010. Duties of department. The Department of Health and Social Services shall

(1) administer adult public assistance, the Alaska temporary assistance program, and all other assistance programs, and receive and spend money made available to it;

(2) adopt regulations necessary for the conduct of its business and for carrying out federal and state laws granting adult public assistance, temporary cash assistance, diversion payments, or self-sufficiency services for needy families under the Alaska temporary assistance program, and other assistance;

(3) establish minimum standards for personnel employed by the department and adopt necessary regulations to maintain those standards;

that, in its judgment, are necessary, and pay the premiums on them;

(5) cooperate with the federal government in matters of mutual concern pertaining to adult public assistance, the Alaska temporary assistance program, and other forms of public assistance;

(6) make the reports, in the form and containing the information, that the federal government from time to time requires;

(7) cooperate with the federal government, its agencies, or instrumentalities in establishing, extending, and strengthening services for the protection and care of homeless, dependent, and neglected children in danger of becoming delinquent, and receive and expend funds available to the department by the federal government, the state, or its political subdivisions for that purpose;

(8) cooperate with the federal government in adopting state plans to make the state eligible for federal matching in appropriate categories of assistance, and in all matters of mutual concern, including adoption of the methods of administration that are found by the federal government to be necessary for the efficient operation of welfare programs;

(9) adopt regulations, not inconsistent with law, defining need, prescribing the conditions of eligibility for assistance, and establishing standards for determining the amount of assistance that an eligible person is entitled to receive; the amount of the assistance is sufficient when, added to all other income and resources available to an individual, it provides the individual with a reasonable subsistence compatible with health and well-being; an individual who meets the requirements for eligibility for assistance shall be granted the assistance promptly upon application for it;

(10) grant to a person claiming or receiving assistance and who is aggrieved because of the department's action or failure to act, reasonable notice and an opportunity for a fair hearing by the office of administrative hearings (AS 44.64.010), and the department shall adopt regulations relative to this;

(11) enter into reciprocal agreements with other states relative to public assistance, welfare services, and institutional care that are considered advisable;

welfare services, and institutional care that are considered advisable, subject to the limitations of other laws of the state, or law or regulation imposed as conditions for federal financial participation;

(13) establish the divisions and local offices that are considered necessary or expedient to carry out a duty or authority assigned to it and appoint and employ the assistants and personnel that are necessary to carry on the work of the divisions and offices, and fix the compensation of the assistants or employees, except that a person engaged in business as a retail vendor of general merchandise, or a member of the immediate family of a person who is so engaged, may not serve as an acting, temporary, or permanent local agent of the department, unless the commissioner of health and social services certifies in writing to the governor, with relation to a particular community, that no other qualified person is available in the community to serve as local welfare agent; for the purposes of this paragraph, a "member of the immediate family" includes a spouse, child, parent, brother, sister, parent-in-law, brother-in-law, or sister-in-law;

(14) provide education and health-related services and referrals designed to reduce the number of out-of-wedlock pregnancies and the number of induced pregnancy terminations in the state;

(15) investigate reports of abuse, neglect, or misappropriation of property by certified nurse aides in facilities licensed by the department under AS 47.32;

(16) establish state policy relating to and administer federal programs subject to state control as provided under 42 U.S.C. 3001 - 3058ee (Older Americans Act of 1965), as amended, and related federal regulations;

(17) administer the older Alaskans service grants under AS 47.65.010 - 47.65.050 and the adult day care and family respite care grants under AS 47.65.100;

(18) establish guidelines for medical assistance providers to develop health care delivery models that encourage adequate nutrition and disease prevention.

* **Sec. 4.** AS 47.05.200(a) is amended to read:

statewide sample of all medical assistance providers in order to identify overpayments and violations of criminal statutes. The audits conducted under this section may not be conducted by the department or employees of the department. The number of audits under this section **may not be less than 50** each year [, AS A TOTAL FOR THE MEDICAL ASSISTANCE PROGRAMS UNDER AS 47.07 AND AS 47.08, SHALL BE 0.75 PERCENT OF ALL ENROLLED PROVIDERS UNDER THE PROGRAMS, ADJUSTED ANNUALLY ON JULY 1, AS DETERMINED BY THE DEPARTMENT, EXCEPT THAT THE NUMBER OF AUDITS UNDER THIS SECTION MAY NOT BE LESS THAN 75]. The audits under this section must include both on-site audits and desk audits and must be of a variety of provider types. The department may not award a contract under this subsection to an organization that does not retain persons with a significant level of expertise and recent professional practice in the general areas of standard accounting principles and financial auditing and in the specific areas of medical records review, investigative research, and Alaska health care criminal law. The contractor, in consultation with the commissioner, shall select the providers to be audited and decide the ratio of desk audits and on-site audits to the total number selected. **In identifying providers who are subject to an audit under this chapter, the department shall attempt to minimize concurrent state or federal audits.**

* Sec. 5. AS 47.05.200(b) is amended to read:

(b) Within 90 days after receiving each audit report from an audit conducted under this section, the department shall begin administrative procedures to recoup overpayments identified in the audits and shall allocate the reasonable and necessary financial and human resources to ensure prompt recovery of overpayments unless the attorney general has advised the commissioner in writing that a criminal investigation of an audited provider has been or is about to be undertaken, in which case, the commissioner shall hold the administrative procedure in abeyance until a final charging decision by the attorney general has been made. The commissioner shall provide copies of all audit reports to the attorney general so that the reports can be screened for the purpose of bringing criminal charges. **The department may assess**

subsection shall be calculated using the statutory rates for postjudgment interest accruing from the date of the issuance of the final audit.

* **Sec. 6.** AS 47.05 is amended by adding a new section to read:

Sec. 47.05.250. Civil penalties. (a) The department may adopt regulations to assess a civil penalty against a medical assistance provider who violates a provision of this chapter, AS 47.07, or a regulation adopted under this chapter or AS 47.07.

(b) A civil penalty imposed under this section may not be less than $100 or more than $25,000 for each occurrence.

(c) The provisions of this section are in addition to any other remedies available under this chapter, AS 47.07, or regulations adopted under this chapter or AS 47.07.

(d) A medical assistance provider who is assessed a civil penalty under this section may appeal the decision in the manner provided for appeals under AS 44.62 (Administrative Procedure Act). The office of administrative hearings (AS 44.64.010) shall conduct the hearing for an appeal.

* **Sec. 7.** AS 47.07.020(g) is amended to read:

(g) For a person whose Medicaid eligibility is not calculated using the modified adjusted gross income standard set out in 42 U.S.C. 1396a(e)(14), the [A] person's eligibility for medical assistance under this chapter may not be denied or delayed on the basis of a transfer of assets for less than fair market value if the person establishes to the satisfaction of the department that the denial or delay would work an undue hardship on the person as determined on the basis of criteria in applicable federal regulations. The department may only consider information provided by a person claiming undue hardship that the department verifies through a source other than the person's own statement.

* **Sec. 8.** AS 47.07.020(m) is amended to read:

(m) For a person whose Medicaid eligibility is not calculated using the modified adjusted gross income standard set out in 42 U.S.C. 1396a(e)(14), and, except [EXCEPT] as provided in (g) of this section, the department shall impose a penalty period of ineligibility for the transfer of an asset for less than fair market value

* **Sec. 9.** AS 47.07.030(d) is amended to read:

(d) The department **shall** [MAY] establish [AS OPTIONAL SERVICES] a primary care case management system or a managed care organization contract in which certain eligible individuals**, including super-utilizers as identified by the department,** are required to enroll and seek approval from a case manager or the managed care organization before receiving certain services. The department shall establish enrollment criteria and determine eligibility for services consistent with federal and state law.

* **Sec. 10.** AS 47.07.030 is amended by adding a new subsection to read:

(h) In an annual report to the legislature, the department shall include information separately describing state costs for optional and mandatory services provided under this section.

* **Sec. 11.** AS 47.07.036(b) is amended to read:

(b) The department, in implementing this section, shall take all reasonable steps to implement cost containment measures that do not eliminate program eligibility or the scope of services required or authorized under AS 47.07.020 and 47.07.030 before implementing cost containment measures under (c) of this section that directly affect program eligibility or coverage of services. The cost containment measures taken under this subsection may include new utilization review procedures, changes in provider payment rates, **and** precertification requirements for coverage [OF SERVICES, AND AGREEMENTS WITH FEDERAL OFFICIALS UNDER WHICH THE FEDERAL GOVERNMENT WILL ASSUME RESPONSIBILITY FOR COVERAGE OF SOME INDIVIDUALS OR SOME SERVICES FOR SOME INDIVIDUALS THROUGH SUCH FEDERAL PROGRAMS AS THE INDIAN HEALTH SERVICE OR MEDICARE].

* **Sec. 12.** AS 47.07.036 is amended by adding new subsections to read:

(d) Notwithstanding (a) - (c) of this section, the department shall

(1) apply for a section 1115 waiver under 42 U.S.C. 1315(a) to use innovative service delivery system models to improve care, increase efficiency, reduce costs, and expand services provided to Indian Health Service beneficiaries through the

(2) apply for a section 1915(i) option under 42 U.S.C. 1396n to improve services and care through home and community-based services to obtain a 50 percent federal match;

(3) apply for a section 1915(k) option under 42 U.S.C. 1396n to provide home and community-based services and support to increase the federal match for these programs from 50 percent to 56 percent;

(4) evaluate and seek permission from the United States Department of Health and Human Services Centers for Medicare and Medicaid Services to participate in various demonstration projects, including payment reform, care management programs, workforce development and innovation, and innovative services delivery models; and

(5) enhance telemedicine capability and reimbursement to incentivize its use for Medicaid recipients.

(e) Notwithstanding (a) - (c) of this section and in addition to the projects and services described under (d) of this section, the department shall apply for a section 1115 waiver under 42 U.S.C. 1315(a) to establish one or more demonstration projects focused on innovative payment models for one or more groups of medical assistance recipients in one or more specific geographic areas. The demonstration project or projects may include

(1) managed care organizations as described under 42 U.S.C. 1396u-2;

(2) community care organizations;

(3) patient-centered medical homes as described under 42 U.S.C. 256a-1; or

(4) other innovative payment models that ensure access to health care without reducing the quality of care.

(f) The department shall design and implement at least one demonstration project under (e) of this section that is a coordinated care demonstration project using a global payment fee structure. The demonstration project must include a managed care system that operates within a fixed budget to reduce medical cost inflation, improves the quality of health care for recipients, and results in a healthier population.

assistance expenditures with a goal of reducing the per capita growth rate for medical assistance expenditures by at least two percentage points. The managed care system must implement alternative payment methodologies and create a network of patient-centered primary care homes, and will be measured based on quality and performance outcomes. The department shall prepare a report regarding the progress of this demonstration project and shall, on or before February 1, 2019, deliver the report to the senate secretary and the chief clerk of the house of representatives and notify the legislature that the report is available.

(g) In this section, "telemedicine" means the practice of health care delivery, evaluation, diagnosis, consultation, or treatment, using the transfer of medical data through audio, visual, or data communications that are performed over two or more locations between providers who are physically separated from the recipient or from each other.

*** Sec. 13.** AS 47.07.900(4) is amended to read:

(4) "clinic services" means services provided by state-approved outpatient community mental health clinics [THAT RECEIVE GRANTS UNDER AS 47.30.520 - 47.30.620], state-operated community mental health clinics, outpatient surgical care centers, and physician clinics;

*** Sec. 14.** AS 47.07.900(17) is amended to read:

(17) "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];

*** Sec. 15.** The uncodified law of the State of Alaska is amended by adding a new section to read:

DEMONSTRATION PROJECT: REDUCING PRE-TERM BIRTHS. On or before January 1, 2017, the Department of Health and Social Services shall design and implement a

current rate of 8.5 percent. The demonstration project shall provide for the voluntary enrollment of approximately 500 recipients who are eligible for medical assistance under AS 47.07.020(b)(14). The Department of Health and Social Services shall offer pregnancy counselling, nutritional counselling, and, as necessary, vitamin D supplementation to maintain levels of 40 ng/ml vitamin D during pregnancy for participants in the demonstration project. The demonstration project may be modeled after the Protect Our Children NOW! project implemented as a cooperative project of the South Carolina Department of Health and Human Services and private health organizations. The goal of the demonstration project is to achieve a reduction in pre-term births in the state, consistent with the results of the following published studies: Wagner, C. L., et al., "A Randomized Trial of Vitamin D Supplementation in Two Community Health Center Networks in South Carolina," American Journal of Obstetrics and Gynecology 208 (February 2013); Bodnar, L. M., et al., "Maternal 25-Hydroxyvitamin D and Preterm Birth in Twin Gestations," Obstetrics and Gynecology 122 (July 2013).

*** Sec. 16.** The uncodified law of the State of Alaska is amended by adding a new section to read:

MEDICAID MANAGED CARE FOR SUPER-UTILIZERS. On or before January 1, 2017, the Department of Health and Social Services shall

(1) establish a primary care case management system or a managed care organization contract under AS 47.07.030(d), as amended by sec. 9 of this Act, for super-utilizers, as identified by the department; and

(2) deliver a report on the system or contract to the senate secretary and the chief clerk of the house of representatives and notify the legislature that the report is available.

*** Sec. 17.** The uncodified law of the State of Alaska is amended by adding a new section to read:

MEDICAID REDESIGN; REPORTS TO LEGISLATURE. (a) On or before May 30, 2016, the Department of Health and Social Services shall deliver to the senate secretary and chief clerk of the house of representatives the Report on Recommended Action and Evaluation Plans for Expansion and Reform prepared for the department under the Medicaid

number 2015-0600-3077, issued April 21, 2015, and the department shall notify the legislature that the report is available.

(b) The Department of Health and Social Services shall prepare a report summarizing cost-sharing measures implemented before October 1, 2015, by the Department of Health and Social Services under AS 47.07.042 and describing the effect of those measures on the state budget. On or before the 20th day following the effective date of this section, the Department of Health and Social Services shall deliver a copy of the report to the senate secretary and chief clerk of the house of representatives and notify the legislature that the report is available.

(c) On or before February 1, 2019, the Department of Health and Social Services shall complete a report informing the legislature of the results of the applications for waivers and options under AS 47.07.036(d)(1) - (3), enacted by sec. 12 of this Act, and shall deliver the report to the senate secretary and chief clerk of the house of representatives and notify the legislature that the report is available. The report must include

(1) information explaining whether the department's applications for a section 1115 waiver under 42 U.S.C. 1315(a), a section 1915(i) option under 42 U.S.C. 1396n, and a section 1915(k) option under 42 U.S.C. 1396n were approved by the United States Department of Health and Human Services;

(2) a description of cost savings to the state resulting from the programs implemented under the waivers, including

(A) the extent to which the programs implemented under the section 1115 waiver under 42 U.S.C. 1315(a) achieved the savings estimated by the department;

(B) the extent to which the programs implemented under the section 1915(i) and (k) options under 42 U.S.C. 1396n achieved the savings estimated by the department.

*** Sec. 18.** The uncodified law of the State of Alaska is amended by adding a new section to read:

MEDICAID STATE PLAN INSTRUCTIONS; NOTICE TO REVISOR OF STATUTES. The Department of Health and Social Services shall immediately amend and

Act. The Department of Health and Social Services shall apply to the United States Department of Health and Human Services for any waivers necessary to implement this Act. The commissioner of health and social services shall notify the revisor of statutes in writing if the United States Department of Health and Human Services approves the provisions of AS 47.07.030(d), as amended by sec. 9 of this Act, and the provisions of secs. 12(e), 12(f), 15, and 16 of this Act.

*** Sec. 19.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: REGULATIONS. The Department of Health and Social Services may adopt regulations necessary to implement the changes made by this Act. The regulations take effect under AS 44.62 (Administrative Procedure Act), but not before the effective date of the relevant provision of this Act implemented by the regulation.

*** Sec. 20.** The uncodified law of the State of Alaska is amended by adding a new section to read:

REVISOR'S INSTRUCTION. The revisor of statutes is requested to change the catch line of AS 47.07.036 from "Cost containment measures authorized" to "Medical assistance cost-containment and reform measures authorized."

*** Sec. 21.** The uncodified law of the State of Alaska is amended by adding a new section to read:

CONDITIONAL EFFECT. (a) AS 47.07.030(d), as amended by sec. 9 of this Act, and sec. 16 of this Act take effect only if the commissioner of health and social services notifies the revisor of statutes in writing under sec. 18 of this Act, on or before January 1, 2017, that all of the provisions added by AS 47.07.030(d), as amended by sec. 9 of this Act, and all of the provisions of sec. 16 of this Act have been approved by the United States Department of Health and Human Services.

(b) Section 12(e) of this Act takes effect only if the commissioner of health and social services notifies the revisor of statutes in writing under sec. 18 of this Act, on or before February 1, 2019, that all of the provisions added by sec. 12(e) of this Act have been approved by the United States Department of Health and Human Services.

(c) Section 12(f) of this Act takes effect only if the commissioner of health and social

February 1, 2019, that all of the provisions added by sec. 12(f) of this Act have been approved by the United States Department of Health and Human Services.

(d) Section 15 of this Act takes effect only if the commissioner of health and social services notifies the revisor of statutes in writing under sec. 18 of this Act, on or before January 1, 2017, that all of the provisions added by sec. 15 of this Act have been approved by the United States Department of Health and Human Services.

* **Sec. 22.** If AS 47.07.030(d), as amended by sec. 9 of this Act, and sec. 16 of this Act take effect, they take effect on the day after the date the commissioner of health and social services makes a certification to the revisor of statutes under secs. 18 and 21(a) of this Act.

* **Sec. 23.** If sec. 12(e) of this Act takes effect, it takes effect on the day after the date the commissioner of health and social services notifies the revisor of statutes in writing under secs. 18 and 21(b) of this Act.

* **Sec. 24.** If sec. 12(f) of this Act takes effect, it takes effect on the day after the date the commissioner of health and social services notifies the revisor of statutes in writing under secs. 18 and 21(c) of this Act.

* **Sec. 25.** If sec. 15 of this Act takes effect, it takes effect on the day after the date the commissioner of health and social services notifies the revisor of statutes in writing under secs. 18 and 21(d) of this Act.

* **Sec. 26.** Sections 17(a), 18, 19, and 21 of this Act take effect immediately under AS 01.10.070(c).

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REPRESENTATIVE PAUL SEATON

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Sponsor Statement
House Bill 227

House Bill 227 renews the conversation around necessary and cost saving reforms to the state Medicaid program. In the current budget climate, it is imperative that the state look for savings wherever possible. The changes included in HB 227 will save the state $309,947,000 over the next five years from known cost shifting options, with even greater future savings possible through the successful implementation of demonstration projects and improved systems. In addition to state savings, HB 227 will improve the health of Alaskans and create a better program for providers and recipients alike.

The reforms range from small administrative changes, such as reducing redundant audits, to deeper shifts in policy propelled by demonstration projects which envision a healthier, more effective healthcare system. These steps have been previously analyzed by the House Health and Social Service Committee. Some components have savings that are easy to quantify, including the Home and Community-Based Services 1915(i) and (k) options. By approving these amendments to the Medicaid state plan we can shift services that are already being provided to vulnerable adults from 100% state general funds to a 50-56% federal match, an annual saving of $24 million. Other savings do not appear on the fiscal notes but have tremendous potential. The demonstration of a global payment model as proposed by section 12 has local support and will limit the overall cost of care for the region where it is implemented. Research has shown that educating and supplementing pregnant women, demonstrated in section 15, can reduce preterm birthrates by 50%. At an average cost of $55,000 per pre-term birth, a reduction of even 25-50% would lead to annual savings of $1,330,000-$6,775,000 to the Denali Kid Care program. Examining these reforms and initiatives remains as important as last session, because many if not all will require legislative approval before the Department can implement these cost saving changes.

HB 227 also enhances legislative oversight of Medicaid reform. The Department of Health and Social Services is required to report on the progress of various initiatives. These reports will include whether or not the predicted cost savings have been achieved and to what degree, allowing the legislature to monitor the success of the Medicaid program.

True healthcare reform is a constant process, and we must continually search for large and small changes that will make our system healthier and more efficient. Improvements to the state's

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Sectional Analysis
House Bill 227

Please note that a sectional analysis of a bill or resolution should not be considered an authoritative interpretation of the measure itself. The legislation is the best statement of its contents.

Section 1
Page 1-2
Legislative intent language that asserts that the current Medicaid Program is unsustainable. The department of Health and Social Services should take the steps necessary to capture additional federal revenue, obtain waivers for tribal partnerships and altemative service models, and establish prevention of disease a primary model of health care.

Section 2
Page 2
Adds civil penalties assessed against Medicaid providers to the procedures covered by administrative adjudication under AS 44.62.330.

Section 3
Page 2-4
Directs the Department of Health and Social service to assist Medicaid providers in developing health care models that encourage nutrition and disease prevention by adding to the duties of the department under AS 47.05.010.

Section 4
Page 4-5
Amends AS 47.05.200(a) to clarify the minimum number of audits that DHSS should conduct each year and that DHSS should minimize duplicative state and federal audits for Medicaid providers to the extent possible.

Section 5
Page 5-6
Amends AS 47.05.200(b) to allow DHSS to impose interest penalties on identified overpayments using the post judgment statutory rate.

Section 6

Page 6-8
Amends AS 47.07.020(g) and (m) to clarify when DHSS may impose transfer of asset penalties when determining eligibility for Medicaid. Clarifies under (g) that the department may only consider information that is verified through a source other than the claimant.

Section 9
Page 7
Amends AS 47.07.030(d) to make the establishment of a primary care case management for identified super-utilizers a mandatory service for the department.

Section 10
Page 7
Requires the department to include in an annual report to the legislature a description of state costs for optional and mandatory Medicaid services.

Section 11 and 12
Page 7
Amends AS 47.07.036(b) to remove conflicting language and adds AS 47.07.036(d) to outline cost reform measures that DHSS shall undertake, including demonstration waivers, applying for the 1915 (i) and (k) options, and improving telemedicine for Medicaid recipient. Directs the department to implement at least one demonstration project using a global payment project and allows for other similar projects.

Section 13 and 14
Page 9
Amends AS 47.07.900(4) and (17) to remove the requirement that behavioral health providers be a grantee of the state of Alaska in order to bill Medicaid.

Section 15
Page 9
Directs the department to design and implement a demonstration project utilizing nutritional counselling and supplementation to reduce preterm birth rates among pregnancies eligible for the Denali Kid Care program.

Section 16
Page 10
Requires the Department of Health and Social Services to establish a primary care case management system for super-utilizers and deliver a report on the project by January 1, 2017.

Section 17
Page 10
Requires the Department of Health and Social Services to provide to the legislature reports on the Medicaid Redesign and Expansion Technical Assistance study, current cost-sharing measures in the Medicaid program, and on the progress and cost savings of the of the waivers and options applied for under section 12 of this legislation.

federal approval for the state plan amendments necessary under section 9, 12, 15, and 16 of this Act.

Section 19
Page 12
Permits the Department of Health and Social Services to adopt the regulations necessary to implement this act, not before the effective date of the relevant provisions.

Section 20
Page 12
Instructs the revisor of statutes to make technical amendments to the title of AS 47.07.036 to conform with the changes in this Act.

Section 21
Page 12
Clarifies that changes enacted in sections 9, 12, 15, and 16 only take effect if the Department of Health and Social Services receives the necessary federal approval by the deadlines created in this Act.

Section 22-25
Page 13-14
States that if AS 47.07.0309(d) as amended by section 9 and section 16, section 12(e), section 12(f), and section 15 receive federal approval, each section will take effect the day after the date the commissioner of health and social services notifies the revisor of statutes in writing, as required by sections 18 and 21.

Section 26
Page 13
Provides that sections 17(a), 18, 19 and 21 take effect immediately.

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Projected health care savings related to vitamin D sufficiency

HB 227 Section 3 page 2 - 4

From: An estimate of the economic burden and premature deaths due to vitamin D deficiency in Canada- Grant et al., 2010, Molecular Nutrition & Food Research

In 2005, the estimated total economic burden of disease was $200 billion plus $10 billion for dental care.

The estimated reduction in economic burden through higher serum 25(OH)D levels was 6.9% or **$14.4 billion.**

The 2006 estimated population of Canada was 32.6 million. This means an **annual savings of $442 per person**

From: The estimated benefits of vitamin D for Germany – A. Zittermann, 2010, Molecular Nutrition & Food Research

The total estimated annual cost savings in Germany from improved vitamin D levels was **€37.5** billion.

The population of Germany during this study was 82 million.

That is an average **annual saving of €457 per person.**

According to ISER, Alaska spent over $412 million dollars on Medicaid in 2010.

A 6.9% reduction in economic burden would mean nearly **$28.5 million** in annual savings, merely by raising the vitamin D status of Medicaid recipients. In 2010 the Alaska Medicaid

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HB 227 Section 15: Page 9– Preterm birth reduction

A Purpose of Medicaid Reform is to save the state money.

Protect Our Children Now(POCN) is a health project model currently underway in South Carolina which is partially supported by SelectHealth, a private insurance company and Medicaid managed care organization. The project is also supported by cooperation with Eau Claire Cooperative Health Centers and the Medical University of South Carolina.

So what does it mean for Alaska?

- Each preterm birth costs Alaska about $55,000 extra.
- The research which forms the basis for the POCN counseling/nutrition project model showed the S.C. preterm rate reduced by over 50%.
- Alaska's preterm birth rate is 8.5% so the potential reduction 4.25%.
- The Denali KidCare (Medicaid) annual birth rate is over 5,000.
- Potential avoided preterm births are 5,000 x 4.25% = 212.
- Potential Direct expense avoided is 212 x $55,000. = $11,660,000.
- Total POCN counseling/nutrition cost is $450,000 per 500 pregnancies.
- For the total 5,000 births the cost = $4,500,000.
- **POCN potential savings equals** $7,160,000 per year ($7.16 million).

The reform initiative in HB 227 has the department design and implement a voluntary pilot project to lower the preterm birth rate for Alaska.

Of course the $7.16 million annual savings will not occur in the first year with only a small population of participants. The savings may also be reduced by variables such as the compliance

the predominately poor, African American clientele and the culture of that southern state. That model may or may not translate to the Medicaid population of the northern-most state. That is why a demonstration project should be used to explore the potential Medicaid savings in Alaska.

Alaska Department of Health & Social Services
MEDICAID EXPANSION & REFORM: STATE SAVINGS & FEDERAL REVENUE
Assumption: Full Enrollment with HB 148-H Reforms
Except for Spending per Enrollee, Costs/Savings are in Thousands

			FY 2016	FY2017	FY2018	FY2019	FY2020	FY2021	Total
		Newly Eligibles	41,910	41,980	42,050	42,120	42,190	42,260	
		Spending per Enrollee *(in whole dollars)*	$7,248	$7,495	$7,752	$8,018	$8,293	$8,433	
		Federal Medical Assistance Participation (FMAP) [1]	100%	97.8%	95.2%	94.3%	92.6%	91.3%	
EXPANSION	Health Care	Federal Revenue	$303,763.7	$307,718.0	$310,325.0	$318,468 2	$323,990.4	$325,373.6	$1,889,638.
		State Spending	$0.0	$6,922.1	$15,646.6	$19,250.0	$25,891.3	$31,005.0	$98,715.
	Administrative Costs	Federal Revenue	$1,538.5	$1,526.0	$664.7	$664.7	$664.7	$664.7	$ 5,723.
		State Spending [2]	$0	$1,526.0	$664.7	$664.7	$664.7	$664.7	$4,184.
	Savings from CAMA, Corrections and Behavioral Health Grants	State Savings	($6,583.6)	($13,300.0)	($20,901.0)	($24,999.7)	($28,027.6)	($28,055.7)	($121,867.
REFORM	Administrative Costs [3]	Federal Revenue	$561.7	$474.8	$648.3	$343 1	$343.1	$343.1	$2,714.
		State Spending	$481.5	$394.7	$568.1	$343.1	$343.1	$343.1	$2,473.
	Primary Care Case Management [3]	Federal Savings	($3,124.1)	($3,408.2)	($3,408.2)	($3,408 2)	($3,408 2)	($3,408 2)	($20,165.
		State Savings	($3,124.1)	($3,408.1)	($3,408.1)	($3,408.1)	($3,408.1)	($3,408.1)	($20,164.
	1115 Waiver for Tribal Partnerships [3]	Federal Revenue	$0.0	$6,500.0	$26,000.0	$56,500.0	$56,500.0	$87,000.0	$232,500.
		State Savings	$0.0	($6,500.0)	($26,000.0)	($56,500.0)	($56,500.0)	($87,000.0)	($232,500.
	Home & Community-Based Services 1915(i) and 1915(k) Options [3]	Federal Revenue	$0.0	$0.0	$19,472.4	$19,507.5	$19,995.3	$20,034.7	$79,009.9
		State Savings	$0 0	$0.0	($15,117.4)	($15,117.4)	($14,762.0)	($14,759.2)	($59,756.
		Total New Federal Revenue	**$302,739.8**	**$312,810.6**	**$353,702.2**	**$392,075.3**	**$398,085.3**	**$430,007.9**	**$2,189,421.1**
		Total State General Fund Savings	**($9,226.2)**	**($14,365.3)**	**($48,547.1)**	**($79,767.4)**	**($75,798.6)**	**($101,210.2)**	**($328,914.**

[1] = FMAP based on federal calendar year rates: 2015 - 100%, 2016 - 100%; 2017 - 95% ; 2018 - 94%, 2019 - 93%, 2020 & beyond - 90%
The FMAP is adjusted to reflect the 100% FMAP rate received when Indian Health Service beneficiaries receive services at a tribal health facilities.

[2] = MHTAAR funds of $1,538.5 will cover FY2016 adminstrative costs

[3] = From CSH8148 (HSS) fiscal notes

5/7/201

Distributed by Representative Paul Seaton

Fiscal Note Number:

() Publish Date:

Identifier: HB227-DHSS-SDMS-1-30-16
Title: MEDICAL ASSISTANCE REFORM
Sponsor: SEATON
Requester: House HSS

Department: Department of Health and Social Services
Appropriation: Medicaid Services
Allocation: Senior and Disabilities Medicaid Services
OMB Component Number: 2662

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2017 Appropriation Requested	Included in Governor's FY2017 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY 2017**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits	17,061.0		17,061.0	17,061.0	17,061.0	17,061.0	17,061.0
Miscellaneous							
Total Operating	**17,061.0**	**0.0**	**17,061.0**	**17,061.0**	**17,061.0**	**17,061.0**	**17,061.0**
Fund Source (Operating Only)							
1002 Fed Rcpts	8,530.5	2,900.0	14,984.1	34,237.7	43,737.7	48,687.7	53,637.7
1003 G/F Match	8,530.5	(2,900.0)	2,076.9	(17,176.7)	(26,676.7)	(31,626.7)	(36,576.7)
Total	**17,061.0**	**0.0**	**17,061.0**	**17,061.0**	**17,061.0**	**17,061.0**	**17,061.0**
Positions							
Full-time							
Part-time							
Temporary							
Change in Revenues							

Estimated SUPPLEMENTAL (FY2016) cost: 0.0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2017) cost: 0 0 *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? Yes
If yes, by what date are the regulations to be adopted, amended or repealed? 07/01/18

Why this fiscal note differs from previous version:

Not applicable; initial version.

Prepared By: Duane Mayes, Director Phone: (907)269-2083

Analysis

Under **Section 12 (d) (1)** of the bill, the Department must apply for an 1115 Demonstration Waiver to use innovative service delivery models to improve Medicaid use of the tribal health providers. The Department will continue to explore 1115 Waiver options under **Section 12**; however, the Center for Medicare and Medicaid (CMS) recently informed Alaska that it is changing national policy and an 1115 is no longer the appropriate vehicle to pursue the tribal health model. The new policy will allow states to broaden the range of services eligible for 100% Federal Medical Assistance Percentage (FMAP) available for Alaska Natives and American Indians (AI/AN) served by Tribal Health Organizations. CMS has yet to publish the new policy in full detail, so the Department is cautious in projecting the impacts in the initial years of implementation.

Based on this information from CMS, we have examined Medicaid data from FY2015 that gives us a count of the numbers of Alaska Native/American Indian (AN/AI) beneficiiaries who received services at non-tribal facilities in order to estimated the additional federal Medicaid funds Alaska could claim under the new rule.

For the Division of Seniors and Disabilities Services, the impact cam be seen by tribal memebers at nontribal nursing facilities. The fiscal note addresses a percentage (spanning across FY2017 to FY2022) of the total expanditures for AN/AI recipients starting with larger communities and then phasing in the rest of the state. SDS will implement these provisions for home and community and based services in FY2019 to accommodate the implementation of the CMS-mandated Conflict Case Management in FY2017 and FY2018.

Total Nursing Facility for 2015

Includes 139 unduplicated AI/AN recipients at 14 non-tribal sites in SFY2015 (excluding existing tribal facilities).
50 percent of the 12 month total of $25,650.0 = **$12,800.0 to be realized over 5 year, FY2017 - FY2022 period.**
In **2017, $2,900.0**
In **2018, $5,200.0**
In **2019, $8,300.0**
In **2020, $9,800.0**
In **2021, $11,300.0**
In **2022, $12,800.0**

Total Home and Community Based (HCB) for 2015

Total of 1,486 unduplicated AI/AN recipients at non-tribal HCB agencies in SFY2015 (excluding existing tribal facilities).
50 percent of the 12 month total of **$59,600,000 = $29,800,000 to be realized over the four year, FY2019 - FY2022 period.**
In **2019, $14,900.0**
In **2020, $22,900.0**
In **2021, $26,350.0**
In **2022, $29,800.0**

nursing facilities	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022
fed	$ 2,900.0	$ 5,200.0	$ 8,300.0	$ 9,800.0	$ 11,300.0	$ 12,800.0
GF match	$ (2,900.0)	$ (5,200.0)	$ (8,300.0)	$ (9,800.0)	$(11,300.0)	$(12,800.0)

HCB svcs	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022
fed			$ 14,900.0	$ 22,900.0	$ 26,350.0	$ 29,800.0
GF match			$(14,900.0)	$(22,900.0)	$(26,350.0)	$(29,800.0)

SDMS Total	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022
fed	$ 2,900.0	$ 5,200.0	$ 23,200.0	$ 32,700.0	$ 37,650.0	$ 42,600.0
GF match	$ (2,900.0)	$ (5,200.0)	$(23,200.0)	$(32,700.0)	$(37,650.0)	$(42,600.0)

Analysis Continued

Section 12 of the bill directs the department to apply for the **1915(k)** option under Medicaid. The "Community First Choice Option" (CFC), also known as 1915(k), will be used for people who meet an institutional level of care (LOC). The 1915(k) option authorities will replace all current 1915(c) waivers, as all 1915(c) recipients do meet the LOC. The 1915(k) option offers a 56% federal match, an increase of 6%, thus lowering the general fund match to 44%.

The service of Personal Care Assistance (PCA), for persons on the 1915(c) waivers, would transition to the 1915(k) state plan option authority.

Number of recipients on the 1915(c) waiver also receiving PCA Services = 1,603
General fund Spend (current) at FMAP (50%) = $ 20,893.4
General fund Spend for PCA under proposed 1915(k) option at FMAP (56%) = $ 18,386.2
The program transition results in an general fund savings of 2,507.2

Implementation of the new funding option will require substantial changes to the current Home and Community Based Services (HCBS) operational infrastructure. The estimated effective date for this refinancing proposal from (c) to (k) is 1/1/17 (FY2018).

This section also directs the Department to apply for the **1915(i)** option under Medicaid. The 1915(i) option includes a federal match of 50%, reducing to 50% what is currently a 100% general fund contribution for certain services.

The Department will use this option to refinance portions of the following 100% GF-funded grant programs: General Relief/Temporary Assistance (GR), certain Senior Community Based Grant components, and Community Developmental Disabilities Grant (CDDG).

<u>1915(i) Refinancing ($8,530.5 estimated net GF savings across SDS grant programs and SD Medicaid):</u>
General Relief/Temporary Assistance Grants: Services for 349 of 545 current recipients at an average cost of $13,438.35 = $4,689.9, or $2,345.0 in net GF savings

Adult Day Grants: Services for 114 of 423 recipients at an average cost of $4,153.69 = $473.5, or $236.8 in net GF savings

Senior In-Home Grants: Services for 123 of 1,371 recipients at an average cost of $2,127.84 = $267.1, or $130.8 in net GF savings

Senior Community Based Grant: Services for all recipients, total grant budget of $11,635.8, or $5,817.9 in net GF savings

State Plan and regulation changes are required to implement the new option and would involve extensive public comment. The Department expects the 1915(i) option to be implemented by FY2019.

Fiscal Note Number:

() Publish Date:

Identifier: HB227-DHSS-SDMS-2-2-16
Title: MEDICAL ASSISTANCE REFORM
Sponsor: SEATON
Requester: House HSS

Department: Department of Health and Social Services
Appropriation: Medicaid Services
Allocation: Senior and Disabilities Medicaid Services
OMB Component Number: 2662

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2017 Appropriation Requested	Included in Governor's FY2017 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY 2017**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits				17,061.0	17,061.0	17,061.0	17,061.0
Miscellaneous							
Total Operating	**0.0**	**0.0**	**0.0**	**17,061.0**	**17,061.0**	**17,061.0**	**17,061.0**
Fund Source (Operating Only)							
1002 Fed Rcpts		2,900.0	6,453.6	34,237.7	43,737.7	48,687.7	53,637.7
1003 G/F Match		(2,900.0)	(6,453.6)	(17,176.7)	(26,676.7)	(31,626.7)	(36,576.7)
Total	**0.0**	**0.0**	**0.0**	**17,061.0**	**17,061.0**	**17,061.0**	**17,061.0**
Positions							
Full-time							
Part-time							
Temporary							
Change in Revenues							

Estimated SUPPLEMENTAL (FY2016) cost: 0.0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2017) cost: 0.0 *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? Yes
If yes, by what date are the regulations to be adopted, amended or repealed? 07/01/18

Why this fiscal note differs from previous version:

Corrects the first year of anticipated UGF savings under 1915(i) option from FY2017 to FY2019, aligning with related fiscal notes for the three SDS grants program components, GR/TAL, SCBG, and CDDG.

Prepared By: Duane Mayes, Director Phone: (907)269-2083

Analysis

Under **Section 12 (d) (1)** of the bill, the Department must apply for an **1115** Demonstration Waiver to use innovative service delivery models to improve Medicaid use of the tribal health providers. The Department will continue to explore **1115** Waiver options under **Section 12;** however, the Center for Medicare and Medicaid (CMS) recently informed Alaska that it is changing national policy and an **1115** is no longer the appropriate vehicle to pursue the tribal health model. The new policy will allow states to broaden the range of services eligible for 100% Federal Medical Assistance Percentage (FMAP) available for Alaska Natives and American Indians (AI/AN) served by Tribal Health Organizations. CMS has yet to publish the new policy in full detail, so the Department is cautious in projecting the impacts in the initial years of implementation.

Based on this information from CMS, we have examined Medicaid data from FY2015 that gives us a count of the numbers of Alaska Native/American Indian (AN/AI) beneficiaries who received services at non-tribal facilities in order to estimated the additional federal Medicaid funds Alaska could claim under the new rule.

For the Division of Seniors and Disabilities Services, the impact cam be seen by tribal memebers at nontribal nursing facilities . The fiscal note addresses a percentage (spanning across FY2017 to FY2022) of the total expanditures for AN/AI recipients starting with larger communities and then phasing in the rest of the state. SDS will implement these provisions for home and community and based services in FY2019 to accommodate the impiementation of the CMS-mandated Conflict Case Management in FY2017 and FY2018.

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In **2019, $8,300.0**
In 2020, $9,800.0
In **2021, $11,300.0**
In 2022, $12,800.0

Total Home and Community Based (HCB) for 2015

Total of 1,486 unduplicated AI/AN recipients at non-tribal HCB agencies in SFY2015 (excluding existing tribal facilities).
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In **2019, $14,900.0**
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In **2021, $26,350.0**
In **2022, $29,800.0**

nursing facilities	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022
fed	$ 2,900.0	$ 5,200.0	$ 8,300.0	$ 9,800.0	$ 11,300.0	$ 12,800.0
GF match	$ (2,900.0)	$ (5,200.0)	$ (8,300.0)	$ (9,800.0)	$(11,300.0)	$(12,800.0)

HCB svcs	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022
fed			$ 14,900.0	$ 22,900.0	$ 26,350.0	$ 29,800.0
GF match			$(14,900.0)	$(22,900.0)	$(26,350.0)	$(29,800.0)

SDMS Total	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022
fed	$ 2,900.0	$ 5,200.0	$ 23,200.0	$ 32,700.0	$ 37,650.0	$ 42,600.0
GF match	$ (2,900.0)	$ (5,200.0)	$(23,200.0)	$(32,700.0)	$(37,650.0)	$(42,600.0)

Analysis Continued

Section 12 of the bill directs the department to apply for the **1915(k)** option under Medicaid. The "Community First Choice Option" (CFC), also known as 1915(k), will be used for people who meet an institutional level of care (LOC). The 1915(k) option authorities will replace all current 1915(c) waivers, as all 1915(c) recipients do meet the LOC. The 1915(k) option offers a 56% federal match, an increase of 6%, thus lowering the general fund match to 44%.

The service of Personal Care Assistance (PCA), for persons on the 1915(c) waivers, would transition to the 1915(k) state plan option authority.

Number of recipients on the 1915(c) waiver also receiving PCA Services = 1,603
General fund Spend (current) at FMAP (50%) = $ 20,893.4
General fund Spend for PCA under proposed 1915(k) option at FMAP (56%) = $ 18,386.2
The program transition results in an general fund savings of 2,507.2

Implementation of the new funding option will require substantial changes to the current Home and Community Based Services (HCBS) operational infrastructure. The estimated effective date for this refinancing proposal from (c) to (k) is 1/1/17 (FY2018).

This section also directs the Department to apply for the **1915(i)** option under Medicaid. The 1915(i) option includes a federal match of 50%, reducing to 50% what is currently a 100% general fund contribution for certain services.

The Department will use this option to refinance portions of the following 100% GF-funded grant programs: General Relief/Temporary Assistance (GR), certain Senior Community Based Grant components, and Community Developmental Disabilities Grant (CDDG).

<u>1915(i) Refinancing ($8,530.5 estimated net GF savings across SDS grant programs and SD Medicaid):</u>
General Relief/Temporary Assistance Grants: Services for 349 of 545 current recipients at an average cost of $13,438.35 = $4,689.9, or $2,345.0 in net GF savings

Adult Day Grants: Services for 114 of 423 recipients at an average cost of $4,153.69 = $473.5, or $236.8 in net GF savings

Senior In-Home Grants: Services for 123 of 1,371 recipients at an average cost of $2,127.84 = $267.1, or $130.8 in net GF savings

Community Developmental Disabilities Grants: Services for all recipients, total grant budget of $11,635.8, or $5,817.9 in net GF savings

State Plan and regulation changes are required to implement the new option and would involve extensive public comment. The Department expects the 1915(i) option to be implemented by FY2019.

Fiscal Note Number:

() Publish Date:

Identifier: HB227-DHSS-BHMS-1-29-16
Title: MEDICAL ASSISTANCE REFORM
Sponsor: SEATON
Requester: House HSS

Department: Department of Health and Social Services
Appropriation: Medicaid Services
Allocation: Behavioral Health Medicaid Services
OMB Component Number: 2660

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2017 Appropriation Requested	Included in Governor's FY2017 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY 2017**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Fund Source (Operating Only)							
1002 Fed Rcpts		2,750.0	3,575.0	4,400.0	5,225.0	6,050.0	6,050.0
1004 Gen Fund		(2,750.0)	(3,575.0)	(4,400.0)	(5,225.0)	(6,050.0)	(6,050.0)
Total	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Positions							
Full-time							
Part-time							
Temporary							
Change in Revenues							

Estimated SUPPLEMENTAL (FY2016) cost: 0.0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2017) cost: 0.0 *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? No
If yes, by what data are the regulations to be adopted, amended or repealed? n/a

Why this fiscal note differs from previous version:

Not applicable; initial version.

Prepared By: Randall Burns, Acting Director Phone: (907)269-5948

Analysis

Under **Section 12 (d) (1)** of the bill, the Department must apply for an 1115 Demonstration Waiver to use innovative service delivery models to improve Medicaid use of the tribal health providers. The Department will continue to explore 1115 Waiver options under **Section 12 ;** however, the Center for Medicare and Medicaid (CMS) recently informed Alaska that it is changing national policy and an 1115 is no longer the appropriate vehicle to pursue the tribal health model. The new policy will allow states to broaden the range of services eligible for 100% Federal Medical Assistance Percentage (FMAP) available for Alaska Natives and American Indians (AI/AN) served by Tribal Health Organizations. CMS has yet to publish the new policy in full detail, so the Department is cautious in projecting the impacts in the initial years of implementation.

Based on this information from CMS, we have examined Medicaid data from FY2015 that gives us a count of the numbers of Alaska Native/American Indian (AN/AI) beneficiaries who received services at non-tribal facilities, in order to estimate the additional federal Medicaid funds Alaska could claim under the new rule.

For the Division of Behavioral Health, the impact can be seen in the use of services by tribal members at non-tribal RPTCs (residential psychiatric treatment facilities). This fiscal note addresses a percentage (spanning across FY2017 - FY2022) of the total expenditures for AN/AI recipients served at the largest in-state, *non-tribal* RPTC's facilities, then working into the out-of-state medium and smaller sized facilities as the contracting process is refined. The fiscal note recognizes that in changing the fund source from GF to federal, the reimbursement increases from 50% to 100% federal match for AN/AI beneficiaries.

RPTC svcs	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022
fed	$ 2,750.0	$ 3,575.0	$ 4,400.0	$ 5,225.0	$ 6,050.0	$ 6,050.0
GF match	$ (2,750.0)	$ (3,575.0)	$ (4,400.0)	$ (5,225.0)	$ (6,050.0)	$ (6,050.0)

While this fiscal note addresses the tribal impacts, we acknowledge that the language in Section 12 related to the 1115 (non-tribal) waiver, as well as other sections of the bill (Sections 1 and 16), clearly impact the Division's efforts to improve the effectiveness and efficiencies of its programs under Medicaid reform. The bill will provide significant opportunities to improve access to services by Alaska residents. In particular, a behavioral health 1115 waiver, to which the Division is fully committed, will allow the Division to establish a managed behavioral system of care, improving resident access to quality care while reducing costs as the new managed system becomes fully functional. These benefits will also accrue to persons served by other divisions within the department, such as the adults and children served by Public Assistance, Office of Children's Services, and Division of Juvenile Justice, as well as to Alaskans served by various entities within the criminal justice system. However, we are unable to quantify those benefits at this time.

Fiscal Note Number:

() Publish Date:

Identifier: HB227-DHSS-BHMS-2-2-16
Title: MEDICAL ASSISTANCE REFORM
Sponsor: SEATON
Requester: House HSS

Department: Department of Health and Social Services
Appropriation: Medicaid Services
Allocation: Behavioral Health Medicaid Services
OMB Component Number: 2660

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2017 Appropriation Requested	Included in Governor's FY2017 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY 2017**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Fund Source (Operating Only)							
1002 Fed Rcpts		2,750.0	3,575.0	4,400.0	5,225.0	6,050.0	6,050.0
1037 GF/MH		(2,750.0)	(3,575.0)	(4,400.0)	(5,225.0)	(6,050.0)	(6,050.0)
Total	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Positions							
Full-time							
Part-time							
Temporary							
Change in Revenues							

Estimated SUPPLEMENTAL (FY2016) cost: 0.0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2017) cost: 0.0 *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? No
If yes, by what date are the regulations to be adopted, amended or repeated? n/a

Why this fiscal note differs from previous version:

Corrects fund source code for expected UGF savings.

Prepared By: Randall Burns, Acting Director Phone: (907)269-5948

Analysis

Under **Section 12 (d) (1)** of the bill, the Department must apply for an **1115** Demonstration Waiver to use Innovative service delivery models to improve Medicaid use of the tribal health providers. The Department will continue to explore **1115** Waiver options under **Section 12** ; however, the Center for Medicare and Medicaid (CMS) recently informed Alaska that it is changing national policy and an **1115** is no longer the appropriate vehicle to pursue the tribal health model. The new policy will allow states to broaden the range of services eligible for 100% Federal Medical Assistance Percentage (FMAP) available for Alaska Natives and American Indians (AI/AN) served by Tribal Health Organizations. CMS has yet to publish the new policy in full detail, so the Department is cautious in projecting the impacts in the initial years of implementation.

Based on this information from CMS, we have examined Medicaid data from FY2015 that gives us a count of the numbers of Alaska Native/American indian (AN/AI) beneficiaries who received services at non-tribal facilities, in order to estimate the additional federal Medicaid funds Alaska could claim under the new rule.

For the Division of Behavioral Health, the impact can be seen in the use of services by tribal members at non-tribal RPTCs (residential psychiatric treatment facilities). This fiscal note addresses a percentage (spanning across FY2017 - FY2022) of the total expenditures for AN/AI recipients served at the largest in-state, *non-tribal* RPTC's facilities, then working into the out-of-state medium and smaller sized facilities as the contracting process is refined. The fiscal note recognizes that in changing the fund source from GF to federal, the reimbursement increases from 50% to 100% federal match for AN/AI beneficiaries.

RPTC svcs	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022
fed	$ 2,750.0	$ 3,575.0	$ 4,400.0	$ 5,225.0	$ 6,050.0	$ 6,050.0
GF/MH	$ (2,750.0)	$ (3,575.0)	$ (4,400.0)	$ (5,225.0)	$ (6,050.0)	$ (6,050.0)

While this fiscal note addresses the tribal impacts, we acknowledge that the language in Section 12 related to the 1115 (non-tribal) waiver, as well as other sections of the bill (Sections 1 and 16), clearly impact the Division's efforts to improve the effectiveness and efficiencies of its programs under Medicaid reform. The bill will provide significant opportunities to improve access to services by Alaska residents. In particular, a behavioral health 1115 waiver, to which the Division is fully committed, will allow the Division to establish a managed behavioral system of care, improving resident access to quality care while reducing costs as the new managed system becomes fully functional. These benefits will also accrue to persons served by other divisions within the department, such as the adults and children served by Public Assistance, Office of Children's Services, and Division of Juvenile Justice, as well as to Alaskans served by various entities within the criminal justice system. However, we are unable to quantify those benefits at this time.

Fiscal Note Number:

() Publish Date:

Identifier: HB227-DHSS-BHA-1-29-16
Title: MEDICAL ASSISTANCE REFORM
Sponsor: SEATON
Requester: House HSS

Department: Department of Health and Social Services
Appropriation: Behavioral Health
Allocation: Behavioral Health Administration
OMB Component Number: 2665

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2017 Appropriation Requested	Included in Governor's FY2017 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY 2017**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**
Personal Services	115.9		115.9	115.9	115.9	115.9	115.9
Travel	2.0		2.0	2.0	2.0	2.0	2.0
Services	9.4		9.4	9.4	9.4	9.4	9.4
Commodities	8.1		0.5	0.5	0.5	0.5	0.5
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	**135.4**	**0.0**	**127.8**	**127.8**	**127.8**	**127.8**	**127.8**
Fund Source (Operating Only)							
1002 Fed Rcpts	67.7		63.9	63.9	63.9	63.9	63.9
1003 G/F Match	67.7		63.9	63.9	63.9	63.9	63.9
Total	**135.4**	**0.0**	**127.8**	**127.8**	**127.8**	**127.8**	**127.8**
Positions							
Full-time	1.0		1.0	1.0	1.0	1.0	1.0
Part-time							
Temporary							
Change in Revenues							

Estimated SUPPLEMENTAL (FY2016) cost: 0.0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2017) cost: 0.0 *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? no
If yes, by what date are the regulations to be adopted, amended or repealed? n/a

Why this fiscal note differs from previous version:

Not applicable; initial version.

Prepared By: Randall Burns, Acting Director Phone: (907)269-5948

Analysis

Section 12 of this bill directs the Department to apply for a 1915(i) plan amendment under 42 U.S.C. 1396(n), as well as apply for a section 1115 waiver under 42 U.S.C. 1315(a). Recommendations recently released in the Agnew::Beck Consulting report, "Recommended Medicaid Redesign and Expansion Strategies for Alaska," suggest that the 1115 waiver will be the most effective vehicle for redesign of the behavioral health system in Alaska.

One position, a Social Services Program Officer (Range 21, step A, SS, located in Anchorage at $115.9 annually, not including ancillary travel, services and commodities cost), will be required to assist in the development of the 1115 waiver application, beginning in FY2017.

Funding for the position will be 50% federal and 50% GF match and is requested for all 12 months of FY2017. The Division of Behavioral Health anticipates having this position filled by July 1, 2016 as the incumbent is expected to come up to speed, work quickly and assist in completion of the Intensive waiver application in a short period of time.

This position will also supplement and support the Medicaid redesign consulting contract that the Alaska Mental Health Trust has established to advise its members and staff, as well as the Department and the Division, as the Trust and the Department work together to successfully implement the significant reforms to the State's current behavioral health system described in the Medicaid redesign report.

Fiscal Note Number:
() Publish Date:

Identifier: HB227-DHSS-WCFH-1-29-16
Title: MEDICAL ASSISTANCE REFORM
Sponsor: SEATON
Requester: House HSS

Department: Department of Health and Social Services
Appropriation: Public Health
Allocation: Women, Children and Family Health
OMB Component Number: 2788

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2017 Appropriation Requested	Included in Governor's FY2017 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY 2017**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**
Personal Services	143.1		143.1	143.1			
Travel	8.0		8.0	8.0			
Services	500.0		500.0	500.0			
Commodities	10.0		10.0	10.0			
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	**661.1**	**0.0**	**661.1**	**661.1**	**0.0**	**0.0**	**0.0**
Fund Source (Operating Only)							
1004 Gen Fund	661.1		661.1	661.1			
Total	**661.1**	**0.0**	**661.1**	**661.1**	**0.0**	**0.0**	**0.0**
Positions							
Full-time							
Part-time							
Temporary							
Change in Revenues							

Estimated SUPPLEMENTAL (FY2016) cost: 0.0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2017) cost: 0.0 *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? yes
If yes, by what date are the regulations to be adopted, amended or repealed? 01/01/17

Why this fiscal note differs from previous version:

Not applicable; initial version.

Prepared By: Jay C. Butler, MD, Chief Medical Officer/Director Phone: (907)269-6680

Analysis

Section 15
On or before January 1, 2017, the department is directed to design and implement a "demonstration project" for the purpose of reducing pre-term birth rates in the state from the current rate of 8.5%. The Department is directed to provide for a "voluntary enrollment of approximately 500 recipients who are eligible for medical assistance." In addition, the Department is directed to "offer pregnancy counseling, nutritional counseling, and, as necessary, vitamin D supplementation to maintain levels of 40ng/ml vitamin D levels during pregnancy" for those enrolled in the demonstration project.

The total cost for this project is estimated to be $1,983.3 ($661.1 per year for 3 years).

This project constitutes a human subjects research project and would require approval from an institutional review board. An institutional review board (IRB) is a committee formally designated to approve, monitor, and review biomedical and behavioral research involving humans. The department does not have the capacity to engage in research involving human subjects and would need to establish a contract with a university or medical school affiliated organization experienced in clinical research.

A 1.0 FTE Nurse Consultant II (range 24, step C, GG, Anchorage) with clinical training is needed to coordinate and oversee the project and overall study fidelity, write the request for proposals, and manage the awarded contract. In addition, the position would be responsible for researching the best practices for content to fulfill the required "pregnancy counseling" and "nutritional counseling," develop or research the training for clinicians to use with enrolled pregnant women to meet the research protocol and IRB requirements, as well develop the materials for the patients that meet cultural norms and standards for Alaska. An existing position will be repurposed. Salary $92.8, benefits $50.3.

The contractor would write the study design and protocol, obtain IRB approval from not only the contracted university, but potentially numerous tribal IRBs. The study would enroll 500 Medicaid eligible pregnant women, follow them through their pregnancies, take blood samples at designated periods during the study, run the samples and collect the results, supervise the "pregnancy counseling and nutritional counseling" including distribution and supervision of the administration of vitamin D supplementation, analyze the data, and write the report for the legislature. In order to validate the data and determine significance, a control group would be needed as a comparison which could escalate the cost of the study from the current estimate. Reducing the treatment group to 250 pregnant women is an option, but this number as an experimental group may not provide adequate power to the study to ascertain significance.

The contractor would be required to contract with a certified laboratory that would be required to use standard testing methodology. The University of Alaska is not known to be conducting national clinical research on newborn and prenatal vitamin D levels so presumably the contracted laboratory would be from out of state. Standard laboratory procedure for vitamin D testing for certified labs require serum taken via venipuncture and use Liquid Chromatography Tandem Mass Spectrography instrumentation. This type of testing requires CLIA (Clinical Laboratory Improvement Amendments of 1988) approval, as it is a highly complex test to determine vitamin D levels. CLIA are federal laboratory regulations that apply to all clinical laboratories that test human specimens for diagnosing, preventing, or treating disease. The costs quoted by two nationally certified laboratories ranged from $125 to $230 per test; this fiscal note assumes $180 per test for upwards of three tests for 500 enrolled.

The fiscal note includes additional costs for supplies, rent, utilities, phone, IT, and other administrative services. If the department is expected to provide ongoing technical assistance to the participating health care providers on the project, testing procedures, or research protocols, additional staff may be required.

Analysis Continued

Likely, enrolled participants in the study would be dispersed across Alaska, so travel for training and counseling is included in the direct costs.

The bill does not address a final report to be published; therefore, this fiscal note does not include any costs for the contractor to write a scientific report or article.

The study would not start until FY2018 and is estimated to take a full 18 months. The IRB process alone would take a full 12 months. Staff will need to be hired prior to the January 1, 2017 start date of this project to promulgate regulations, procure contract agreements, develop educational materials and begin planning the research protocol.

The fund source is GF because Medicaid does not reimburse costs for studies of an experimental nature.

Fiscal Note Number:

() Publish Date:

Identifier: HB227-DHSS-SDSA-1-30-16
Title: MEDICAL ASSISTANCE REFORM
Sponsor: SEATON
Requester: House HSS

Department: Department of Health and Social Services
Appropriation: Senior and Disabilities Services
Allocation: Senior and Disabilities Services Administration
OMB Component Number: 2663

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2017 Appropriation Requested	Included in Governor's FY2017 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY 2017**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**
Personal Services	99.0		324.0	324.0	324.0	324.0	324.0
Travel	2.1		6.8	6.8	6.8	6.8	6.8
Services	186.5		193.9	540 8	10.6	10.6	10.6
Commodities	2.3		7.6	7.6	7.6	7.6	7.6
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	**289.9**	**0.0**	**532.3**	**879.2**	**349.0**	**349.0**	**349.0**
Fund Source (Operating Only)							
1002 Fed Rcpts	185.1		306.2	479.7	174.5	174.5	174.5
1003 G/F Match	104.8		226.1	399.5	174.5	174.5	174.5
Total	**289.9**	**0.0**	**532.3**	**879.2**	**349.0**	**349.0**	**349.0**
Positions							
Full-time	1.0		3.0	3.0	3.0	3 0	3 0
Part-time							
Temporary							
Change in Revenues							

Estimated SUPPLEMENTAL (FY2016) cost: 0 0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2017) cost: 0.0 *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? yes
If yes, by what date are the regulations to be adopted, amended or repealed? 07/01/18

Why this fiscal note differs from previous version:

Not applicable; initial version.

Prepared By: Duane Mayes, Director Phone: (907)269-2083

Analysis

In part, **HB227 version H** authorizes DHSS to apply for federal waivers and options to reform the Medicaid program and to assess the most cost-effective method for revising expansion coverage.

Section 12 (d) (1) and (2) of the bill requires the State to apply to the Centers for Medicare and Medicaid Services (CMS) to develop two new Medicaid funding authorities, the 1915(i) and 1915(k) State Plan options. Under these new authorities the state will realize savings in the provision of home and community-based services (HCBS).

Services under these new funding authorities will reduce general fund expenditures by replacing 100% general fund services (1915(i) option) or capturing a higher federal match rate (1915(k)).

In FY2019 the Department anticipates new costs associated with initial eligibility assessments of individuals previousiy served through the general fund grant programs or services. The estimated number of new assessments = 1,539. Cost per assessment = $225.41 (not including travel). Estimated cost to manage the 1,539 initial eligibility assessments = $346.9 in FY2019.

In FY2017, FY2018 and FY2019 the Department anticipates additional expenditures related to the "Automated Services Plan" management information system. State staff, providers, and consumers will have access to the system and a public web resource center. The Department will plan and configure substantial, necessary software changes to this system for new assessments, additional programmatic elements, and interfaces with other department data management systems. Additional user accounts and licenses, and training and support for all users, will need to be developed and supported.

Estimated costs for case management system development and increased assessments = $550.0, of which $300.0 is eligible for enhanced federal funding at a 90% federal match, and the remaining $250.0 is eligible for the standard 50% federal match. Much of these costs will be realized in the development years (one-third each in FY2017-FY2019), while the savings will continue and grow as overall expenditures grow.

To plan, develop, and manage the new program, beginning in FY2017 Senior and Disabilities Services will require three additional full-time staff: one staff person beginning in August 2016 (FY2017), and two more staff beginning in FY2018. These will be Health Program Manager II positions, located in Anchorage, in the GG unit, each = $108.0; Travel = $2.3; Services = $3.5; Commodities = $2.5. FY2017 costs are prorated to reflect the August 1, 2016 start date.

Regulation changes are required to implement the new options and would involve extensive public comment. The estimated effective date of regulation changes is July 2018.

Fiscal Note Number:

() Publish Date:

Identifier: HB227-DHSS-SCBG-1-30-16
Title: MEDICAL ASSISTANCE REFORM
Sponsor: SEATON
Requester: House HSS

Department: Department of Health and Social Services
Appropriation: Senior and Disabilities Services
Allocation: Senior Community Based Grants
OMB Component Number: 2787

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2017 Appropriation Requested	Included in Governor's FY2017 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY 2017**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits				(735.2)	(735.2)	(735.2)	(735.2)
Miscellaneous							
Total Operating	**0.0**	**0.0**	**0.0**	**(735.2)**	**(735.2)**	**(735.2)**	**(735.2)**
Fund Source (Operating Only)							
1004 Gen Fund				(735.2)	(735.2)	(735.2)	(735.2)
Total	**0.0**	**0.0**	**0.0**	**(735.2)**	**(735.2)**	**(735.2)**	**(735.2)**
Positions							
Full-time							
Part-time							
Temporary							
Change in Revenues							

Estimated SUPPLEMENTAL (FY2016) cost: 0.0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2017) cost: 0.0 *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? yes
If yes, by what date are the regulations to be adopted, amended or repealed? 07/01/18

Why this fiscal note differs from previous version:

Not applicable; initial version.

Prepared By: Duane Mayes, Director Phone: (907)269-2083

Analysis

In part, **HB227 version H** authorizes the DHSS to apply for federal waivers and options to reform the Medicaid program and to assess the most cost-effective method for revising expansion coverage.

Section 12 of the bill directs the department to apply for the 1915(i) option under Medicaid.

Making use of the 1915(i) option offers the department the opportunity to shifting eligible recipients from 100% general funded grants programs to the 50% fed/50% GF funded 1915(i) Medicaid option.

The department will use this option to refinance the Senior Community Based Grant component's Adult Day and Senior In-Home Services for those who are receiving the service and are also Medicaid eligible.

Adult Day Grant: Total general fund expenditures = $1,757.0, serving 423 recipients. Of those, SDS anticipates serving 114 under the 1915(i) option with an average cost per individual of $4,153.69. Estimated general fund Adult Day grant services to be refinanced with the 1915(i) Medicaid option = $473.5.

Senior In-Home Grant: Total general fund expenditures = $2,917.3, serving 1,371 individuals. Of those, SDS anticipates serving 123 under the 1915(i) option with an average cost per individual of $2,127.84. Estimated general Senior In-Home grant services to be refinanced with the 1915(i) Medicaid option = $261.7.

The combined estimated general fund to be refinanced through the use of the 1915(i) option = $735.2.

State Plan and regulation changes are required to implement the new option and would involve extensive public comment. The Department expects the 1915(i) option to be implemented by FY2019.

Fiscal Note Number:

() Publish Date:

Identifier: HB227-DHSS-RR-1-29-16
Title: MEDICAL ASSISTANCE REFORM
Sponsor: SEATON
Requester: House HSS

Department: Department of Health and Social Services
Appropriation: Health Care Services
Allocation: Rate Review
OMB Component Number: 2696

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2017 Appropriation Requested	Included in Governor's FY2017 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY 2017**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**
Personal Services							
Travel							
Services	500.0		100.0	100.0	100.0	100.0	100.0
Commodities							
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	**500.0**	**0.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Fund Source (Operating Only)							
1002 Fed Rcpts	250.0		50.0	50.0	50.0	50.0	50.0
1003 G/F Match	250.0		50.0	50.0	50.0	50.0	50.0
Total	**500.0**	**0.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Positions							
Full-time							
Part-time							
Temporary							
Change in Revenues							

Estimated SUPPLEMENTAL (FY2016) cost: 0.0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2017) cost: 0.0 *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? No
If yes, by what date are the regulations to be adopted, amended or repealed? n/a

Why this fiscal note differs from previous version:

Not applicable; initial version.

Prepared By: Margaret Brodie, Director Phone: (907)334-2520

Analysis

Section 12(d)-(f) requires the Department to apply for a §1115 demonstration waiver to establish one or more demonstration projects focused on innovative payment models. The projects may include managed care organizations, community care organizations, patient-centered medical homes, or innovative payment models.

One demonstration project must focus on coordinated care that includes a global payment fee structure (i.e., a "managed care system"). One goal of the managed care system is to reduce the per capita growth rate for medical assistance expenditures by at least two percentage points. The managed care system will be measured based on quality and performance outcomes.

Redesigning payment processes and/or service delivery models would require changes in regulation, and possibly State Plan Amendments (in addition to the demonstration waiver). Changes in regulation would vary for each provider type and would require stakeholder input before implementation.

Demonstration projects that focus on innovative payment models, including a managed care system with care coordination and global payments, will involve complex data analysis and calculations that require actuarial expertise. Once an innovative payment model is established, administration of the system would still require actuarial expertise that is available by contract.

The initial and ongoing costs associated with hiring a contractor to perform this work are not fully known at this time. Based on consultation with other states and experts concerning the cost of actuarial services for Medicaid managed care systems, the Department estimates a one-time $500.0 contract for a firm to analyze and implement one or more innovative payment models, and an annual $100.0 contract for actuarial work and assistance with administration.

Fiscal Note Number:

() Publish Date:

Identifier: HB227-DHSS-MAA-1-30-16
Title: MEDICAL ASSISTANCE REFORM
Sponsor: SEATON
Requester: House HSS

Department: Department of Health and Social Services
Appropriation: Health Care Services
Allocation: Medical Assistance Administration
OMB Component Number: 242

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2017 Appropriation Requested	Included in Governor's FY2017 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY 2017**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**
Personal Services	137.5		190.6	137.5	84.5	84.5	84.5
Travel							
Services							
Commodities	18.2		4.0	3.0	2.0	2.0	2.0
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	**155.7**	**0.0**	**194.6**	**140.5**	**86.5**	**86.5**	**86.5**
Fund Source (Operating Only)							
1002 Fed Rcpts	77.9		97.3	70.3	43.3	43.3	43.3
1003 G/F Match	77.8		97.3	70.2	43.2	43.2	43.2
Total	**155.7**	**0.0**	**194.6**	**140.5**	**86.5**	**86.5**	**86.5**
Positions							
Full-time	1.0		1.0	1.0	1.0	1.0	1.0
Part-time							
Temporary	1.0		1.0	1.0			
Change in Revenues							

Estimated SUPPLEMENTAL (FY2016) cost: 0.0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2017) cost: 0.0 *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? No
If yes, by what date are the regulations to be adopted, amended or repealed? n/a

Why this fiscal note differs from previous version:

Not applicable; initial version.

Prepared By: Margaret Brodie, Director Phone: (907)334-2520

Analysis

Under Section 6 of the bill, the department anticipates appeals from this policy through the Office of Administrative Hearings. It therefore requests one long-term non-permanent Medical Assistance Administrator III position starting January 1, 2017 through December 31, 2018 (24 months, spanning three fiscal years). Administrative costs assume $9.4 per full time equivalent (FTE) annually for office space, phones, and other contractual costs; $2.6 *one-time* costs per FTE for computers and software; $5.0 *one-time* costs per FTE for office equipment; $2.0 per full time equivalent FTE annually for supplies.

1 Long-Term Non-Perm Medical Asst Administrator III - range 20, Anchorage, $53.0 (six months in FY2017)
FY2017 Personal services total $53.0

Office supplies - $1.0
FY2017 Commodities, ongoing total $1.0

Computer, software - $2.6
One-time office set-up - $5.0
FY2016 Commodities, one-time total $7.6

Under Section 12 (d) (1) of the bill the Department anticipates that the Division of Health Care Services will need to add one Medicaid Assistance Administrator I to process, track, and oversee the contracting process associated with CMS policy clarification. The Department anticipates hiring the Medical Assistance Administrator I effective July 1, 2017.

Administrative costs assume $9.4 per full time equivalent (FTE) annually for office space, phones, and other contractual costs; $2.6 *one-time* costs per FTE for computers and software; $5.0 *one-time* costs per FTE for office equipment; $2.0 per full time equivalent FTE annually for supplies.

1 Medical Asst Administrator I- range 16, Anchorage, $84.5
FY2017 Personal services total $84.5

Office supplies - $2.0
FY2017 Commodities, ongoing total $2.0

Computer, software - $2.6
One-time office set-up - $5.0
FY2016 Commodities, one-time total $7.6

Section 17(b) requires the Department to prepare a report on cost sharing implementation on or before the 20th day following the effective date of this section. The report should result in a nominal expense to the Department. However, with anticipated future impacts from federal cost sharing regulations, reporting requirements may require MMIS and ARIES system changes in order to capture the income contingent cost sharing rules set in new federal regulations.

Fiscal Note Number:
() Publish Date:

Identifier: HB227-DHSS-HCMS-1-30-16
Title: MEDICAL ASSISTANCE REFORM
Sponsor: SEATON
Requester: House HSS

Department: Department of Health and Social Services
Appropriation: Medicaid Services
Allocation: Health Care Medicaid Services
OMB Component Number: 2077

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2017 Appropriation Requested	Included in Governor's FY2017 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY 2017**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**
Personal Services							
Travel							
Services	1,100.0		1,100.0	1,100.0	1,100.0	1,100.0	1,100.0
Commodities							
Capital Outlay							
Grants & Benefits	(9,066.0)		(9,026.5)	(8,981.1)	(8,981.1)	(8,981.1)	(8,981.1)
Miscellaneous							
Total Operating	**(7,966.0)**	**0.0**	**(7,926.5)**	**(7,881.1)**	**(7,881.1)**	**(7,881.1)**	**(7,881.1)**
Fund Source (Operating Only)							
1002 Fed Rcpts	(4,050.5)	6,700.0	9,349.5	12,949.5	16,549.5	20,149.5	20,149.5
1003 G/F Match	(4,050.4)	(6,700.0)	(17,450.4)	(21,050.4)	(24,650.4)	(28,250.4)	(28,250.4)
1108 Stat Desig	134.9		174.4	219.8	219.8	219.8	219.8
Total	**(7,966.0)**	**0.0**	**(7,926.5)**	**(7,881.1)**	**(7,881.1)**	**(7,881.1)**	**(7,881.1)**
Positions							
Full-time							
Part-time							
Temporary							
Change in Revenues							

Estimated SUPPLEMENTAL (FY2016) cost: 0.0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2017) cost: 7,850.0 *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? yes
If yes, by what date are the regulations to be adopted, amended or repealed? 07/01/17

Why this fiscal note differs from previous version:

Not applicable; initial version.

Prepared By: Margaret Brodie, Director Phone: (907)334-2520

Analysis

Section 5 of the bill allows the Department to assess interest on recoveries for audits performed under AS 47.05.200 as well as other audits and reviews conducted by the state and federal government. There is no additional cost to the department to implement interest penalties on identified overpayments, but recoveries will increase.

The Department estimates it will take three years to reach the current volume of outstanding appeals subject to interest penalties. Interest penalty recoveries are calculated by taking the current amount of outstanding appeals and applying an estimated recovery percentage. The result is multiplied by the statutory rate for post-judgment interest of 3.75% and phased in over a period of three years, as shown below. (50% fed/50% GF match)

Amount of Interest Penalty Recoveries FY2017	$ 84,910
Amount of Interest Penalty Recoveries FY2018	$127,365
Amount of Interest Penalty Recoveries FY2019	$169,821
FY2020 and beyond	$169,821

Section 6 of this legislation grants the Department of Health and Social Services the authority to assess civil fines against Medicaid providers. Fines are to be assessed within a range of from $100 to $25,000 per occurrence or offense. There is no additional cost to the department to implement fines under this section.

Recoveries based on implementing fines in this section are calculated by taking the estimated number of civil fines and applying an average fine amount. It is estimated the amount of fines imposed per recovery will increase over time, but the number of fines assessed will decrease over time. The estimated amount of the recoveries would be $50.0 per year. (50% fed/50% GF match)

Section 6(d): Office of Administrative Hearings Reimbursable Services Agreement $500,000: The department anticipates the need for a reimbursable services agreement with the Office of Administrative Hearings to pay for the increased costs of appeals to the change in policy for overutilizers of emergency services. The department requests $500,000 to cover the costs of these hearings. (services line expenditure, 50% fed/50% GF match)

Sections 9 and 16 require the Department to establish a primary care case management system for super-utilizers, and produce a report to the legislature on the program. This will require an assigned case manager to who will enroll and approve certain services for super-utilizers. Costs to implement include: Increase Alaska Medicaid Coordinated Care Initiative contract to manage this population: $5.00 x 10,000 x 12 = $600.0

Savings from implementation include: The estimated cost savings is based upon a Medicaid emergency room overutilizer population of approximately 10,000. The Department believes that it can reduce the number of emergency room visits by this overutilizer group by 30% with case management.

Number of paid ER visits in FY2015 - 114,570
Average price per ER visit FY2015 (only for physician services) - $613.39
Assumes overutilizer made at least five trips to ER in FY2015 - 10,000 x $613.39 x 5 = $30,669.5 x 30% = $9,200.9

Under **Section 12 (d) (1)** of the bill, the Department must apply for an 1115 Demonstration Waiver to use innovative service delivery models to improve Medicaid use of the tribal health providers. The Department will continue to explore 1115 Waiver options under Section 12; however, the Center for Medicare and Medicaid (CMS) recently informed Alaska that it is changing national policy and an 1115 is no longer the appropriate vehicle to pursue the tribal health model. The new policy will allow states to broaden the range of services eligible for 100% Federal Medical Assistance Percentage

Analysis Continued

Tribal Health Organizations. CMS has yet to publish the new policy in full detail, so the Department is cautious in projecting the impacts in the initial years of implementation.

Total Transportation to *US TRAVEL* for 2015 Payments
Total Monthly average reimbursement for AI/AN transportation claims = $3,000,000
Monthly average X 12 months = $3,000,000 x 12 = $36,000,000 total costs. Refinancing from 50% federal/50% GF match to 100% federal results in **$18,000,000 in GF match savings**, with a reciprocal increase to federal costs. This fund source change is to be equally spread at 20% per year for five years, or $3,600,000 in annual, cumulatively building GF match savings across each subsequent year from FY2017-2021. The multi-year spread is because the cost shift to 100% federal is assumed to take several years. Full savings achieved in FY2021, year five of the effort.

Total Ground and Air Ambulance for 2015
Total quarterly average reimbursement for AI/AN claims = $3,100,000
Total quarterly at $3,100,000 X 4 quarters = $12,400,000 total costs. Results in **$6,200,000 GF match savings** and a reciprocal increase in federal costs. Assume a two-year spread to shift costs to 100% federal. $3,100,000 in annual, cumulatively building GF match savings across the two-year span, FY2017-2018. Full savings achieved in FY2018, year two.

US Travel	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022
fed	$ 3,600.0	$ 7,200.0	$ 10,800.0	$ 14,400.0	$ 18,000.0	$ 18,000.0
GF match	$ (3,600.0)	$ (7,200.0)	$(10,800.0)	$(14,400.0)	$(18,000.0)	$(18,000.0)

ambulance	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022
fed	$ 3,100.0	$ 6,200.0	$ 6,200.0	$ 6,200.0	$ 6,200.0	$ 6,200.0
GF match	$ (3,100.0)	$ (6,200.0)	$ (6,200.0)	$ (6,200.0)	$ (6,200.0)	$ (6,200.0)

HCMS Total	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022
fed	$ 6,700.0	$ 13,400.0	$ 17,000.0	$ 20,600.0	$ 24,200.0	$ 24,200.0
GF match	$ 16,700.0)	$(13,400.0)	$(17,000.0)	$(20,600.0)	$(24,200.0)	$(24,200.0)

Section 17 directs the department to deliver three reports to the legislature. The department does not anticipate additional associated costs.

***** ***** *****

CAPITAL BUDGET COSTS (90% federal/10% GF match) associated with Section 12:

Section 12 (d)(2) of the bill directs the department to apply for a section 1915(i) option under 42 U.S.C. 1396n to improve services and care through home and community-based services to obtain a 50 percent federal match. To comply with this request, the department estimates the cost to make changes to the Medicaid Management Information System to be $3,000.0. The department will commence planning for the system changes in FY2016.

Changes that need to be made to the Medicaid Management Information System are:
1) New benefit and enrollment plans
2) New accounting structures including all appropriate funding codes
3) New eligibility code structures

Analysis Continued

4) New program limit structures
5) New reporting structures

Section 12 (d)(3) of the bill directs the department to appiy for a section 1915(k) option under 42 U.S.C. 1396n to provide home and community-based services and support to increase the federal match for these programs from 50 percent to 56 percent. To comply with this request, the department estimates the cost to make changes to the Medicaid Management Information System to be $3,000.0. The department will commence planning for the system changes in 2016.

Changes that need to be made to the Medicaid Management Information System are:
1) New benefit and enrollment plans
2) New accounting structures including all appropriate funding codes
3) New eligibility code structures
4) New program limit structures
5) New reporting structures

Section 12 (d)(2) and **Section 12 (d)(3)** of the bill may require funds for requirements identification and development related to Health Information Technology and the Health Information Exchange. The department estimates costs at $1,850.0 for design and engineering for integrated support systems.

These items include:
1) Professional services contracts to design system interfaces
2) Professional services contracts to design data interfaces
3) Telemedicine

Fiscal Note Number:

() Publish Date:

Identifier: HB227-DHSS-GRTAL-1-30-16
Title: MEDICAL ASSISTANCE REFORM
Sponsor: SEATON
Requester: House HSS

Department: Department of Health and Social Services
Appropriation: Senior and Disabilities Services
Allocation: General Relief/Temporary Assisted Living
OMB Component Number: 2875

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2017 Appropriation Requested	Included in Governor's FY2017 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY 2017**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits				(4,689.9)	(4,689.9)	(4,689.9)	(4,689.9)
Miscellaneous							
Total Operating	**0.0**	**0.0**	**0.0**	**(4,689.9)**	**(4,689.9)**	**(4,689.9)**	**(4,689.9)**
Fund Source (Operating Only)							
1004 Gen Fund				(4,689.9)	(4,689.9)	(4,689.9)	(4,689.9)
Total	**0.0**	**0.0**	**0.0**	**(4,689.9)**	**(4,689.9)**	**(4,689.9)**	**(4,689.9)**
Positions							
Full-time							
Part-time							
Temporary							
Change in Revenues							

Estimated SUPPLEMENTAL (FY2016) cost: 0.0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2017) cost: 0.0 *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? yes
If yes, by what date are the regulations to be adopted, amended or repealed? 07/01/18

Why this fiscal note differs from previous version:

Not applicable; initial version.

Prepared By: Duane Mayes, Director Phone: (907)269-2083

Analysis

In part, **H8227 version H** authorizes the DHSS to apply for federal waivers and options to reform the Medicaid program and to assess the most cost-effective method for revising expansion coverage.

Section 12 of the bill directs the Department to apply for the 1915(i) option under Medicaid.

Making use of the 1915(i) option offers the department the opportunity to shifting eligible recipients from 100% general funded grants programs to the 50% fed/50% GF funded 1915(i) Medicaid option.

General Relief/Temporary Assistance (GR) provides temporary residential care for vulnerable adults who are ineligible for assistance from other programs. The Department assumes that all general relief recipients will be assessed for eligibility under the 1915(i) or behavioral health 1115 demonstration project. Of those assessed, the department anticipates 349 being eligible for the 1915(i) option.

Current funding for GR program: $7,323.9
Total number served: 545
Average cost per individual: $13,438.35

Estimated eligible for 1915(i): 349
General fund services to be refinanced through the 1915(i) Medicaid option = $ 4,689.9

State Plan and regulation changes are required to implement the new option and would involve extensive public comment. The Department expects the 1915(i) option to be implemented by FY2019.

Fiscal Note Number:
() Publish Date:

Identifier: HB227-DHSS-CDDG-1-30-16
Title: MEDICAL ASSISTANCE REFORM
Sponsor: SEATON
Requester: House HSS

Department: Department of Health and Social Services
Appropriation: Senior and Disabilties Services
Allocation: Community Developmental Disabilities Grants
OMB Component Number: 309

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2017 Appropriation Requested	Included in Governor's FY2017 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY 2017**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits				(11,635.8)	(11,635.8)	(11,635.8)	(11,635.8)
Miscellaneous							
Total Operating	**0.0**	**0.0**	**0.0**	**(11,635.8)**	**(11,635.8)**	**(11,635.8)**	**(11,635.8)**
Fund Source (Operating Only)							
1037 GF/MH				(11,635.8)	(11,635.8)	(11,635.8)	(11,635.8)
Total	**0.0**	**0.0**	**0.0**	**(11,635.8)**	**(11,635.8)**	**(11,635.8)**	**(11,635.8)**
Positions							
Full-time							
Part-time							
Temporary							
Change in Revenues							

Estimated SUPPLEMENTAL (FY2016) cost: 0.0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2017) cost: 0.0 *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? yes
If yes, by what date are the regulations to be adopted, amended or repealed? 07/01/18

Why this fiscal note differs from previous version:

Not applicable; initial version.

Prepared By: Duane Mayes, Director Phone: (907)269-2083

Analysis

In part, **HB227 version H** authorizes DHSS to apply for federal waivers and options to reform the Medicaid program and to assess the most cost-effective method for revising expansion coverage.

Section 12 of the bill directs the Department to apply for the 1915(i) option under Medicaid.

Making use of the 1915(i) option offers the department the opportunity to shifting eligible recipients from 100% general funded grants programs to the 50% fed/50% GF funded 1915(i) Medicaid option.

Individuals receiving home and community-based services through the Community Developmental Disabilities Grant (CDDG) program must meet the eligibility requirements in AS 47.80.900. The CDDG program provides home and community-based services to support individuals' desire to live as independently as they are able.

The Department will use the 1915(i) funding option to refinance services provided through the Community Developmental Disabilities Grant program. 969 Individuals accessed CDDG services in FY2015 with an average cost per recipient of $12,008.04 per individual per year, for a total budget of $11,635.8 general funds. All recipients could be transitioned from the CDDG program to the 1915(1) Medicaid option.

State Plan and regulation changes are required to implement the new option and would involve extensive public comment. The Department expects the 1915(i) option to be implemented by FY2019.

Proposed Amendments to HB 227

As of 3:00 pm March 2, 2016

Amendments in the order they will be considered

Listed by drafting number

H.7 – Representative Vazquez – *read on 2/23/2016*

H.8 – Representative Vazuez – *read on 2/23/2016*

H.5 – Representative Seaton – *read on 2/23/2016*

H.6 – Representative Seaton – *read on 2/23/2016*

H.9 – Representative Seaton – *read on 2/23/2016*

H.11 – Representative Seaton

H.12 – Representative Seaton

H.13 – Representative Seaton

H.14 – Representative Talerico

H.15 – Representative Seaton

H.16- Representative Seaton

AMENDMENT

OFFERED IN THE HOUSE BY REPRESENTATIVE VAZQUEZ

TO: HB 227

Page 5, line 5:

Delete "**may not be less than 50**"

Page 5, lines 5 - 10:

Delete "[, AS A TOTAL FOR THE MEDICAL ASSISTANCE PROGRAMS UNDER AS 47.07 AND AS 47.08, SHALL BE 0.75 PERCENT OF ALL ENROLLED PROVIDERS UNDER THE PROGRAMS, ADJUSTED ANNUALLY ON JULY 1, AS DETERMINED BY THE DEPARTMENT, EXCEPT THAT THE NUMBER OF AUDITS UNDER THIS SECTION MAY NOT BE LESS THAN 75]"

Insert ", as a total for the medical assistance programs under AS 47.07 and AS 47.08, shall be 0.75 percent of all enrolled providers under the programs, adjusted annually on July 1, as determined by the department, except that the number of audits under this section may not be less than 75"

AMENDMENT

OFFERED IN THE HOUSE BY REPRESENTATIVE VAZQUEZ

TO: HB 227

Page 8, lines 2 - 7:
Delete all material.

Page 8, line 8:
Delete "(4)"
Insert "(2)"

Page 8, line 13:
Delete "(5)"
Insert "(3)"

Page 11, line 12:
Delete "applications for waivers and"
Insert "application for a waiver"

Page 11, line 13:
Delete "options under AS 47.07.036(d)(1) - (3)"
Insert "under AS 47.07.036(d)(1)"

Page 11, line 16:
Delete "applications"
Insert "application"

Page 11, lines 17 - 18:

Delete ", a section 1915(i) option under 42 U.S.C. 1396n, and a section 1915(k) option under 42 U.S.C. 1396n were"

Insert "was"

Page 11, line 20:

Delete "programs"

Insert "program"

Page 11, line 21:

Delete "waivers"

Insert "waiver"

Page 11, lines 21 - 22:

Delete "(A)"

Page 11, line 24:

Delete ";"

Insert "."

Page 11, lines 25 - 27:

Delete all material.

29-LS1096\H.5
Glover
2/19/16

AMENDMENT

OFFERED IN THE HOUSE BY REPRESENTATIVE SEATON

TO: HB 227

Page 6, line 3, following "audit.":

Insert

"The department may not assess interest under this subsection if a provider

(1) identifies and reports an overpayment to the department independent of an audit conducted under this section; and

(2) repays the amount of the overpayment to the department within five months after the date the provider received the overpayment."

AMENDMENT

OFFERED IN THE HOUSE BY REPRESENTATIVE SEATON

TO: HB 227

Page 9, line 30:

Delete "DEMONSTRATION"

Insert "PILOT"

Page 9, line 31:

Delete "January"

Insert "July"

Page 9, line 31, through page 10, line 1:

Delete "design and implement a demonstration project"

Insert "contract with a third party to establish a care coordination pilot project for approximately 500 voluntary participants who are eligible for medical assistance under AS 47.07.020(b)(14)"

Page 10, lines 2 - 4:

Delete "The demonstration project shall provide for the voluntary enrollment of approximately 500 recipients who are eligible for medical assistance under AS 47.07.020(b)(14). The Department of Health and Social Services shall"

Insert "The care coordination pilot project must focus on nutritional sufficiency and"

Page 10, line 6:

Delete "demonstration"

Insert "care coordination pilot"

Page 10, line 7:

Delete "demonstration"

Insert "care coordination pilot"

Page 10, line 9:

Delete "demonstration"

Insert "care coordination pilot"

Page 10, line 15, following "(July 2013).":

Insert "Two years after the date the Department of Health and Social Services first enrolls recipients in the care coordination pilot project, the Department of Health and Social Services shall deliver a report to the senate secretary and the chief clerk of the house of representatives and notify the legislature that the report is available. The report shall describe the results of the care coordination pilot project, any difference in the pre-term birth rate for participants in the pilot project as compared to the pre-term birth rate for the state, and the estimated savings to the state resulting from the pilot project."

AMENDMENT

OFFERED IN THE HOUSE BY REPRESENTATIVE SEATON

TO: HB 227

Page 7, lines 14 - 26:

Delete all material.

Renumber the following bill sections accordingly.

Page 7, line 31, through page 8, line 1:

Delete "provided to Indian Health Service beneficiaries through the Indian Health Service and tribal health facilities"

Insert "for recipients of behavioral health services, as defined by the department by regulation"

Page 11, line 13:

Delete "sec. 12"

Insert "sec. 11"

Page 11, following line 27:

Insert a new bill section to read:

"* Sec. 17. The uncodified law of the State of Alaska is amended by adding a new section to read:

IMPLEMENT FEDERAL POLICY ON TRIBAL MEDICAID REIMBURSEMENT. (a) The Department of Health and Social Services shall collaborate with Alaska tribal health organizations and the United States Department of Health and Human Services to implement changes fully in federal policy that authorize 100 percent federal funding for services

provided to American Indian and Alaska Native individuals eligible for Medicaid.

(b) In this section, "Alaska tribal health organization" means an organization recognized by the United States Indian Health Service to provide health-related services."

Renumber the following bill sections accordingly.

Page 12, lines 6 - 7:

Delete "and the provisions of secs. 12(e), 12(f), 15, and 16"

Insert "the provisions of AS 47.07.036(e) and (f), added by sec. 11 of this Act, and the provisions of secs. 14 and 15"

Page 12, line 22:

Delete "sec. 16"

Insert "sec. 15"

Page 12, line 23:

Delete "sec. 18"

Insert "sec. 19"

Page 12, line 25:

Delete "sec. 16"

Insert "sec. 15"

Page 12, line 27:

Delete "Section 12(e) of this Act"

Insert "AS 47.07.036(e), added by sec. 11 of this Act,"

Page 12, line 29:

Delete "added by sec. 12(e) of this Act"

Insert "of AS 47.07.036(e), added by sec. 11 of this Act,"

Page 12, line 31:

Delete "Section 12(f) of this Act"

Insert "AS 47.07.036(f), added by sec. 11 of this Act,"

Page 13, line 2:

Delete "added by sec. 12(f) of this Act"

Insert "of AS 47.07.036(f), added by sec. 11 of this Act,"

Page 13, line 4:

Delete "Section 15"

Insert "Section 14"

Page 13, line 6:

Delete "sec. 15"

Insert "sec. 14"

Page 13, line 8:

Delete "sec. 16"

Insert "sec. 15"

Page 13, line 11:

Delete "sec. 12(e) of this Act"

Insert "AS 47.07.036(e), added by sec. 11 of this Act,"

Page 13, line 14:

Delete "sec. 12(f) of this Act"

Insert "AS 47.07.036(f), added by sec. 11 of this Act,"

Page 13, line 17:

Delete "sec. 15"

Insert "sec. 14"

Page 13, line 20:

Delete "17(a)"

Insert "16(a)"

AMENDMENT

OFFERED IN THE HOUSE BY REPRESENTATIVE SEATON

TO: HB 227

Page 8, line 27:

Delete "design and"

Page 9, line 1:

Delete "department shall design the managed care system"

Insert "managed care system must be designed"

AMENDMENT

OFFERED IN THE HOUSE BY REPRESENTATIVE SEATON

TO: HB 227

Page 8, line 2, following "42 U.S.C. 1396n":

Insert "designed to result in cost savings to the state and"

Page 8, line 5, following "42 U.S.C. 1396n":

Insert "designed to result in cost savings to the state and"

29-LS1096\H.13
Glover
2/29/16

AMENDMENT

OFFERED IN THE HOUSE BY REPRESENTATIVE SEATON

TO: HB 227

Page 9, line 14, following "other":

Insert "or between a provider and a recipient who are physically separated from each other"

AMENDMENT

OFFERED IN THE HOUSE BY REPRESENTATIVE TALERICO

TO: HB 227

Page 9, following line 9:

Insert a new subsection to read:

"(g) To the extent consistent with federal law, the department may not increase provider payment rates unless and until the department

(1) implements a demonstration project under (e) or (f) of this section that results in a cost savings of at least 10 percent for provider payments as compared to provider payments for fiscal year 2016 for the group or groups of medical assistance recipients participating in the project; and

(2) determines that implementation of the payment model tested in the demonstration project for all medical assistance recipients will save a minimum of 10 percent of the amount spent for provider payments in fiscal year 2016 for all medical assistance recipients."

Reletter the following subsection accordingly.

Page 12, lines 6 - 7:

Delete "and the provisions of sec. 12(e), 12(f), 15, and 16"

Insert "the provisions of AS 47.07.036(e) - (g), added by sec. 12 of this Act, and the provisions of secs. 15 and 16"

Page 12, line 27:

Delete "Section 12(e) of this Act"

Insert "AS 47.07.036(e), added by sec. 12 of this Act,"

Page 12, line 29:

Delete "added by sec. 12(e) of this Act"

Insert "of AS 47.07.036(e), added by sec. 12 of this Act,"

Page 12, line 31:

Delete "Section 12(f)"

Insert "AS 47.07.036(f), added by sec. 12,"

Page 13, line 2:

Delete "added by sec. 12(f) of this Act"

Insert "of AS 47.07.036(f), added by sec. 12 of this Act,"

Page 13, following line 3:

Insert a new subsection to read:

"(d) AS 47.07.036(g), added by sec. 12 of this Act, takes effect only if the commissioner of health and social services notifies the revisor of statutes in writing under sec. 18 of this Act, on or before January 1, 2017, that all of the provisions of AS 47.07.036(g), added by sec. 12 of this Act, have been approved by the United States Department of Health and Human Services."

Reletter the following subsection accordingly.

Page 13, line 11:

Delete "sec. 12(e)"

Insert "AS 47.07.036(e), added by sec. 12 of this Act,"

Page 13, line 14:

Delete "AS 47.07.036(f), added by sec. 12 of this Act,"

Page 13, following line 16:

"* **Sec. 25.** If AS 47.07.036(g), added by sec. 12 of this Act, takes effect, it takes effect on the day after the date the commissioner of health and social services notifies the revisor of statutes in writing under secs. 18 and 21(d) of this Act."

Renumber the following bill sections accordingly.

Page 13, line 19:

Delete "21(d)"

Insert "21(e)"

AMENDMENT

OFFERED IN THE HOUSE BY REPRESENTATIVE SEATON

TO: HB 227

Page 2, following line 13:

Insert a new subparagraph to read:

"(C) collaborate with community mental health clinics and drug or alcohol treatment centers that receive state grants and that have historically provided behavioral health services in the state to expand the availability of behavioral health services while maintaining quality and cost controls;"

AMENDMENT

OFFERED IN THE HOUSE BY REPRESENTATIVE SEATON

TO: HB 227

Page 6, following line 3:

Insert a new bill section to read:

"* **Sec. 6.** AS 47.05.200 is amended by adding a new subsection to read:

(f) After reviewing audit reports received under this section, the department may collaborate with medical assistance providers or provider entities to provide or create educational information for medical assistance providers regarding the most frequent errors or overpayment types."

Renumber the following bill sections accordingly.

Page 10, line 21:

Delete "sec. 9"

Insert "sec. 10"

Page 11, line 13:

Delete "sec. 12"

Insert "sec. 13"

Page 12, line 6:

Delete "sec. 9"

Insert "sec. 10"

Page 12, lines 6 - 7:

Delete "and the provisions of secs. 12(e), 12(f), 15, and 16"

Insert "the provisions of AS 47.07.036(e) and (f), added by sec. 13 of this Act, and the provisions of secs. 16 and 17"

Page 12, line 21:

Delete "sec. 9"

Insert "sec. 10"

Page 12, line 22:

Delete "sec. 16"

Insert "sec. 17"

Page 12, line 23:

Delete "sec. 18"

Insert "sec. 19"

Page 12, line 24:

Delete "sec. 9"

Insert "sec. 10"

Page 12, line 25:

Delete "sec. 16"

Insert "sec. 17"

Page 12, line 27:

Delete "Section 12(e) of this Act"

Insert "AS 47.07.036(e), added by sec. 13 of this Act,"

Page 12, line 28:

Delete "sec. 18"

Insert "sec. 19"

Page 12, line 29:

Delete "added by sec. 12(e) of this Act"

Insert "of AS 47.07.036(e), added by sec. 13 of this Act,"

Page 12, line 31:

Delete "Section 12(f) of this Act"

Insert "AS 47.07.036(f), added by sec. 13 of this Act,"

Page 13, line 1:

Delete "sec. 18"

Insert "sec. 19"

Page 13, line 2:

Delete "added by sec. 12(f) of this Act"

Insert "of AS 47.07.036(f), added by sec. 13 of this Act,"

Page 13, line 4:

Delete "Section 15"

Insert "Section 16"

Page 13, line 5:

Delete "sec. 18"

Insert "sec. 19"

Page 13, line 6:

Delete "sec. 15"

Insert "sec. 16"

Page 13, line 8:

Delete "sec. 9"

Insert "sec. 10"

Delete "sec. 16"

Insert "sec. 17"

Page 13, line 10:

Delete "secs. 18 and 21(a)"

Insert "secs. 19 and 22(a)"

Page 13, line 11:

Delete "sec. 12(e) of this Act"

Insert "AS 47.07.036(e), added by sec. 13 of this Act,"

Page 13, line 13:

Delete "secs. 18 and 21(b)"

Insert "secs. 19 and 22(b)"

Page 13, line 14:

Delete "sec. 12(f) of this Act"

Insert "AS 47.07.036(f), added by sec. 13 of this Act,"

Page 13, line 16:

Delete "secs. 18 and 21(c)"

Insert "secs. 19 and 22(c)"

Page 13, line 17:

Delete "sec. 15"

Insert "sec. 16"

Page 13, line 19:

Delete "secs. 18 and 21(d)"

Insert "secs. 19 and 22(d)"

Page 13, line 20:

Delete "17(a), 18, 19, and 21"

Insert "18(a), 19, 20, and 21"

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REPRESENTATIVE PAUL SEATON

Rep.Paul.Seaton@akleg.gov

Summary of Changes: Version H to Version N
HB 227 - Medical Assistance Reform

Title:
On line 6 the title has been expanded to include 'federal reimbursement for Alaska Native health services,' to reflect the new section 18.

Section 1
Subsection (2)(c) has been added to the legislative intent language. Subsection (2)(c) directs the Department of Health and Social Services to collaborate with clinics and centers that have historically provided behavioral health services.

Section 4
Language was placed back into this section to return the number of annual audits required under this subsection to the current statutory level of 0.75% of all enrolled providers, with a minimum of 75 audits a years.

Section 5
New subsections (1) and (2) have been added to AS 47.05.200(b) to state that the department may not assess interest on overpayments under this section if a provider self identifies and reports an overpayment independent of an audit and repays it within five months of reporting.

New Section 6
A new section 6 has been added to the bill. Section 6 adds subsection (f) to AS 47.05.200 allowing the department to collaborate with medical assistance providers to create educational material regarding common provider errors and overpayment types.

Previous Section 11 – deleted
Section 11 of HB 227 version H has been removed from the bill. The language originally being removed from AS 47.07.036(b) under this section is no longer in conflict with new sections and will remain in statute.

Section 12
Subsection (d)(1) has been amended to change the target population for the 1115 waiver

the applications for the 1915(1) and 1915(k) options to result in cost savings to the state.
The term 'design' has been deleted from subsection (f) to clarify that the department will not be required to design the demonstration project implemented under this section.
Language has been added to subsection (g) to state that telemedicine can be performed between a provider and a recipient who are physically separated.

Section 15
This section has been amended to change the pre-term birth reduction project from a demonstration project conducted by the department into a care coordination pilot project contracted with a third party. The implementation date has been changed from January of 2017 to July. A report on the success of the pilot project is required after two years.

Section 17
The date of the report required by subsection (c) has been changed from February 1, 2019 and will now include two separate reports. The first report is due November 1, 2018, and the second is due November 1, 2019.

New section 18
A new section has been added to the uncodified law directing the department to collaborate with Alaska tribal health organizations and the federal government to fully implement changes to federal policy regarding 100% reimbursement for American Indian and Alaska Native recipients. Collaboration may include incentives for providers to participate.

Section 22
The effective date under subsection (d) has been updated from January 1, 2017 to July 1, 2017 to reflect the date change in section 15 of this bill.

Other sections have been renumbered to reflect these changes.

CS FOR HOUSE BILL NO. 227(HSS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-NINTH LEGISLATURE - SECOND SESSION

BY THE HOUSE HEALTH AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

Sponsor(s): REPRESENTATIVE SEATON

A BILL

FOR AN ACT ENTITLED

"An Act relating to medical assistance reform measures; relating to administrative appeals of civil penalties for medical assistance providers; relating to the duties of the Department of Health and Social Services; relating to audits and civil penalties for medical assistance providers; relating to medical assistance cost containment measures by the Department of Health and Social Services; relating to medical assistance coverage of clinic and rehabilitative services; relating to federal reimbursement for Alaska Native health services; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** The uncodified law of the State of Alaska is amended by adding a new section to read:

MEDICAL ASSISTANCE REFORM: LEGISLATIVE FINDINGS AND INTENT. The legislature finds that the current Medicaid program is not sustainable. Although annual growth has fallen from 6.45 percent to 4.8 percent, further reductions are needed. In order to

(1) the governor, through the Department of Health and Social Services, take all necessary action to capture federal revenue and offset state general funds and evaluate the most cost-effective method for revising expansion coverage, including more efficient benefit plans, cost sharing, utilization control, and other innovative health care financing strategies;

(2) the Department of Health and Social Services be instructed to

(A) evaluate and implement meaningful Medicaid reform measures, including working with tribal and community partners to develop innovative practices leading to a sustainable Medicaid program available for future generations;

(B) evaluate all options available to it, including

(i) obtaining waivers to the Medicaid program to address choice, statewide compatibility, or other core Medicaid requirements; and

(ii) regulatory action to improve provider and recipient compliance with program rules;

(C) collaborate with community mental health clinics and drug or alcohol treatment centers that have received state grants and that have historically provided behavioral health services in the state to expand the availability of behavioral health services while maintaining quality and cost controls;

(3) the Department of Health and Social Services establish prevention of disease as a primary model of health care in the state, as requested by the legislature in Legislative Resolve 16 of the Twenty-Seventh Alaska State Legislature.

* **Sec. 2.** AS 44.62.330(a) is amended by adding a new paragraph to read:

(47) Department of Health and Social Services relating to civil penalties assessed against medical assistance providers under AS 47.05.250.

* **Sec. 3.** AS 47.05.010 is amended to read:

Sec. 47.05.010. Duties of department. The Department of Health and Social Services shall

(1) administer adult public assistance, the Alaska temporary assistance program, and all other assistance programs, and receive and spend money made available to it;

(2) adopt regulations necessary for the conduct of its business and for

assistance, diversion payments, or self-sufficiency services for needy families under the Alaska temporary assistance program, and other assistance;

(3) establish minimum standards for personnel employed by the department and adopt necessary regulations to maintain those standards;

(4) require those bonds and undertakings from persons employed by it that, in its judgment, are necessary, and pay the premiums on them;

(5) cooperate with the federal government in matters of mutual concern pertaining to adult public assistance, the Alaska temporary assistance program, and other forms of public assistance;

(6) make the reports, in the form and containing the information, that the federal government from time to time requires;

(7) cooperate with the federal government, its agencies, or instrumentalities in establishing, extending, and strengthening services for the protection and care of homeless, dependent, and neglected children in danger of becoming delinquent, and receive and expend funds available to the department by the federal government, the state, or its political subdivisions for that purpose;

(8) cooperate with the federal government in adopting state plans to make the state eligible for federal matching in appropriate categories of assistance, and in all matters of mutual concern, including adoption of the methods of administration that are found by the federal government to be necessary for the efficient operation of welfare programs;

(9) adopt regulations, not inconsistent with law, defining need, prescribing the conditions of eligibility for assistance, and establishing standards for determining the amount of assistance that an eligible person is entitled to receive; the amount of the assistance is sufficient when, added to all other income and resources available to an individual, it provides the individual with a reasonable subsistence compatible with health and well-being; an individual who meets the requirements for eligibility for assistance shall be granted the assistance promptly upon application for it;

(10) grant to a person claiming or receiving assistance and who is

opportunity for a fair hearing by the office of administrative hearings (AS 44.64.010), and the department shall adopt regulations relative to this;

(11) enter into reciprocal agreements with other states relative to public assistance, welfare services, and institutional care that are considered advisable;

(12) establish the requirements of residence for public assistance, welfare services, and institutional care that are considered advisable, subject to the limitations of other laws of the state, or law or regulation imposed as conditions for federal financial participation;

(13) establish the divisions and local offices that are considered necessary or expedient to carry out a duty or authority assigned to it and appoint and employ the assistants and personnel that are necessary to carry on the work of the divisions and offices, and fix the compensation of the assistants or employees, except that a person engaged in business as a retail vendor of general merchandise, or a member of the immediate family of a person who is so engaged, may not serve as an acting, temporary, or permanent local agent of the department, unless the commissioner of health and social services certifies in writing to the govemor, with relation to a particular community, that no other qualified person is available in the community to serve as local welfare agent; for the purposes of this paragraph, a "member of the immediate family" includes a spouse, child, parent, brother, sister, parent-in-law, brother-in-law, or sister-in-law;

(14) provide education and health-related services and referrals designed to reduce the number of out-of-wedlock pregnancies and the number of induced pregnancy terminations in the state;

(15) investigate reports of abuse, neglect, or misappropriation of property by certified nurse aides in facilities licensed by the department under AS 47.32;

(16) establish state policy relating to and administer federal programs subject to state control as provided under 42 U.S.C. 3001 - 3058ee (Older Americans Act of 1965), as amended, and related federal regulations;

(17) administer the older Alaskans service grants under AS 47.65.010 -

(18) establish guidelines for medical assistance providers to develop health care delivery models that encourage adequate nutrition and disease prevention.

* **Sec. 4.** AS 47.05.200(a) is amended to read:

(a) The department shall annually contract for independent audits of a statewide sample of all medical assistance providers in order to identify overpayments and violations of criminal statutes. The audits conducted under this section may not be conducted by the department or employees of the department. The number of audits under this section each year, as a total for the medical assistance programs under AS 47.07 and AS 47.08, shall be 0.75 percent of all enrolled providers under the programs, adjusted annually on July 1, as determined by the department, except that the number of audits under this section may not be less than 75. The audits under this section must include both on-site audits and desk audits and must be of a variety of provider types. The department may not award a contract under this subsection to an organization that does not retain persons with a significant level of expertise and recent professional practice in the general areas of standard accounting principles and financial auditing and in the specific areas of medical records review, investigative research, and Alaska health care criminal law. The contractor, in consultation with the commissioner, shall select the providers to be audited and decide the ratio of desk audits and on-site audits to the total number selected. **In identifying providers who are subject to an audit under this chapter, the department shall attempt to minimize concurrent state or federal audits.**

* **Sec. 5.** AS 47.05.200(b) is amended to read:

(b) Within 90 days after receiving each audit report from an audit conducted under this section, the department shall begin administrative procedures to recoup overpayments identified in the audits and shall allocate the reasonable and necessary financial and human resources to ensure prompt recovery of overpayments unless the attorney general has advised the commissioner in writing that a criminal investigation of an audited provider has been or is about to be undertaken, in which case, the commissioner shall hold the administrative procedure in abeyance until a final

provide copies of all audit reports to the attorney general so that the reports can be screened for the purpose of bringing criminal charges. **The department may assess interest and penalties on any identified overpayment. Interest under this subsection shall be calculated using the statutory rates for postjudgment interest accruing from the date of the issuance of the final audit. The department may not assess interest under this subsection if a provider**

(1) identifies and reports an overpayment to the department independent of an audit conducted under this section; and

(2) repays the amount of the overpayment to the department within five months after the date the provider reported the overpayment to the department.

*** Sec. 6.** AS 47.05.200 is amended by adding a new subsection to read:

(f) After reviewing audit reports received under this section, the department may collaborate with medical assistance providers or provider entities to provide or create educational information for medical assistance providers regarding the most frequent errors or overpayment types.

*** Sec. 7.** AS 47.05 is amended by adding a new section to read:

Sec. 47.05.250. Civil penalties. (a) The department may adopt regulations to assess a civil penalty against a medical assistance provider who violates a provision of this chapter, AS 47.07, or a regulation adopted under this chapter or AS 47.07.

(b) A civil penalty imposed under this section may not be less than $100 or more than $25,000 for each occurrence.

(c) The provisions of this section are in addition to any other remedies available under this chapter, AS 47.07, or regulations adopted under this chapter or AS 47.07.

(d) A medical assistance provider who is assessed a civil penalty under this section may appeal the decision in the manner provided for appeals under AS 44.62 (Administrative Procedure Act). The office of administrative hearings (AS 44.64.010) shall conduct the hearing for an appeal.

*** Sec. 8.** AS 47.07.020(g) is amended to read:

modified adjusted gross income standard set out in 42 U.S.C. 1396a(e)(14), the [A] person's eligibility for medical assistance under this chapter may not be denied or delayed on the basis of a transfer of assets for less than fair market value if the person establishes to the satisfaction of the department that the denial or delay would work an undue hardship on the person as determined on the basis of criteria in applicable federal regulations. The department may only consider information provided by a person claiming undue hardship that the department verifies through a source other than the person's own statement.

* **Sec. 9.** AS 47.07.020(m) is amended to read:

(m) For a person whose Medicaid eligibility is not calculated using the modified adjusted gross income standard set out in 42 U.S.C. 1396a(e)(14), and, except [EXCEPT] as provided in (g) of this section, the department shall impose a penalty period of ineligibility for the transfer of an asset for less than fair market value by an applicant or an applicant's spouse consistent with 42 U.S.C. 1396p(c)(1).

* **Sec. 10.** AS 47.07.030(d) is amended to read:

(d) The department shall [MAY] establish [AS OPTIONAL SERVICES] a primary care case management system or a managed care organization contract in which certain eligible individuals, including super-utilizers as identified by the department, are required to enroll and seek approval from a case manager or the managed care organization before receiving certain services. The department shall establish enrollment criteria and determine eligibility for services consistent with federal and state law.

* **Sec. 11.** AS 47.07.030 is amended by adding a new subsection to read:

(h) In an annual report to the legislature, the department shall include information separately describing state costs for optional and mandatory services provided under this section.

* **Sec. 12.** AS 47.07.036 is amended by adding new subsections to read:

(d) Notwithstanding (a) - (c) of this section, the department shall

(1) apply for a section 1115 waiver under 42 U.S.C. 1315(a) to use innovative service delivery system models to improve care, increase efficiency, reduce

the department by regulation;

(2) apply for a section 1915(i) option under 42 U.S.C. 1396n designed to result in cost savings to the state and to improve services and care through home and community-based services to obtain a 50 percent federal match;

(3) apply for a section 1915(k) option under 42 U.S.C. 1396n designed to result in cost savings to the state and to provide home and community-based services and support to increase the federal match for these programs from 50 percent to 56 percent;

(4) evaluate and seek permission from the United States Department of Health and Human Services Centers for Medicare and Medicaid Services to participate in various demonstration projects, including payment reform, care management programs, workforce development and innovation, and innovative services delivery models; and

(5) enhance telemedicine capability and reimbursement to incentivize its use for Medicaid recipients.

(e) Notwithstanding (a) - (c) of this section and in addition to the projects and services described under (d) of this section, the department shall apply for a section 1115 waiver under 42 U.S.C. 1315(a) to establish one or more demonstration projects focused on innovative payment models for one or more groups of medical assistance recipients in one or more specific geographic areas. The demonstration project or projects may include

(1) managed care organizations as described under 42 U.S.C. 1396u-2;

(2) community care organizations;

(3) patient-centered medical homes as described under 42 U.S.C. 256a-1; or

(4) other innovative payment models that ensure access to health care without reducing the quality of care.

(f) The department shall implement at least one demonstration project under (e) of this section that is a coordinated care demonstration project using a global payment fee structure. The demonstration project must include a managed care system

quality of health care for recipients, and results in a healthier population. The managed care system must be designed to reduce the growth in medical assistance expenditures with a goal of reducing the per capita growth rate for medical assistance expenditures by at least two percentage points. The managed care system must implement alternative payment methodologies and create a network of patient-centered primary care homes, and will be measured based on quality and performance outcomes. The department shall prepare a report regarding the progress of this demonstration project and shall, on or before February 1, 2019, deliver the report to the senate secretary and the chief clerk of the house of representatives and notify the legislature that the report is available.

(g) In this section, "telemedicine" means the practice of health care delivery, evaluation, diagnosis, consultation, or treatment, using the transfer of medical data through audio, visual, or data communications performed over two or more locations between providers who are physically separated from the recipient or from each other or between a provider and a recipient who are physically separated from each other.

*** Sec. 13.** AS 47.07.900(4) is amended to read:

(4) "clinic services" means services provided by state-approved outpatient community mental health clinics [THAT RECEIVE GRANTS UNDER AS 47.30.520 - 47.30.620], state-operated community mental health clinics, outpatient surgical care centers, and physician clinics;

*** Sec. 14.** AS 47.07.900(17) is amended to read:

(17) "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];

*** Sec. 15.** The uncodified law of the State of Alaska is amended by adding a new section to read:

Department of Health and Social Services shall contract with a third party to establish a care coordination pilot project for approximately 500 voluntary participants who are eligible for medical assistance under AS 47.07.020(b)(14) for the purpose of reducing pre-term birth rates in the state from the current rate of 8.5 percent. The care coordination pilot project must focus on nutritional sufficiency and offer pregnancy counselling, nutritional counselling, and, as necessary, vitamin D supplementation to maintain levels of 40 ng/ml vitamin D during pregnancy for participants in the pilot project. The care coordination pilot project may be modeled after the Protect Our Children NOW! project implemented as a cooperative project of the South Carolina Department of Health and Human Services and private health organizations. The goal of the care coordination pilot project is to achieve a reduction in pre-term births in the state, consistent with the results of the following published studies: Wagner, C. L., et al., "A Randomized Trial of Vitamin D Supplementation in Two Community Health Center Networks in South Carolina," American Journal of Obstetrics and Gynecology 208 (February 2013); Bodnar, L. M., et al., "Maternal 25-Hydroxyvitamin D and Preterm Birth in Twin Gestations," Obstetrics and Gynecology 122 (July 2013). Two years after the date the Department of Health and Social Services first enrolls recipients in the care coordination pilot project, the Department of Health and Social Services shall deliver a report to the senate secretary and the chief clerk of the house of representatives and notify the legislature that the report is available. The report must describe the results of the care coordination pilot project, any difference in the pre-term birth rate for participants in the pilot project as compared to the pre-term birth rate for the state, and the estimated savings to the state resulting from the pilot project.

*** Sec. 16.** The uncodified law of the State of Alaska is amended by adding a new section to read:

MEDICAID MANAGED CARE FOR SUPER-UTILIZERS. On or before January 1, 2017, the Department of Health and Social Services shall

(1) establish a primary care case management system or a managed care organization contract under AS 47.07.030(d), as amended by sec. 10 of this Act, for super-utilizers, as identified by the department; and

(2) deliver a report on the system or contract to the senate secretary and the

available.

* **Sec. 17.** The uncodified law of the State of Alaska is amended by adding a new section to read:

MEDICAID REDESIGN; REPORTS TO LEGISLATURE. (a) On or before May 30, 2016, the Department of Health and Social Services shall deliver to the senate secretary and chief clerk of the house of representatives the Report on Recommended Action and Evaluation Plans for Expansion and Reform prepared for the department under the Medicaid Redesign and Expansion Technical Assistance study, advertised under request for proposal number 2015-0600-3077, issued April 21, 2015, and the department shall notify the legislature that the report is available.

(b) The Department of Health and Social Services shall prepare a report summarizing cost-sharing measures implemented before October 1, 2015, by the Department of Health and Social Services under AS 47.07.042 and describing the effect of those measures on the state budget. On or before the 20th day following the effective date of this section, the Department of Health and Social Services shall deliver a copy of the report to the senate secretary and chief clerk of the house of representatives and notify the legislature that the report is available.

(c) The Department of Health and Social Services shall complete two reports informing the legislature of the results of the applications for waivers and options under AS 47.07.036(d)(1) - (3), enacted by sec. 12 of this Act and shall deliver the reports to the senate secretary and chief clerk of the house of representatives and notify the legislature that the reports are available. The Department of Health and Social Services shall deliver the first report on or before November, 1, 2018, and the second report on or before November 1, 2019. The reports must include

(1) information explaining whether the department's applications for a section 1115 waiver under 42 U.S.C. 1315(a), a section 1915(i) option under 42 U.S.C. 1396n, and a section 1915(k) option under 42 U.S.C. 1396n were approved by the United States Department of Health and Human Services;

(2) a description of cost savings to the state resulting from the programs implemented under the waivers, including

1115 waiver under 42 U.S.C. 1315(a) achieved the savings estimated by the department;

(B) the extent to which the programs implemented under the section 1915(i) and (k) options under 42 U.S.C. 1396n achieved the savings estimated by the department.

*** Sec. 18.** The uncodified law of the State of Alaska is amended by adding a new section to read:

IMPLEMENT FEDERAL POLICY ON TRIBAL MEDICAID REIMBURSEMENT. (a) The Department of Health and Social Services shall collaborate with Alaska tribal health organizations and the United States Department of Health and Human Services to implement changes fully in federal policy that authorize 100 percent federal funding for services provided to American Indian and Alaska Native individuals eligible for Medicaid. Collaboration may include incentives for providers to participate in contracts for referrals, as permitted under federal law.

(b) In this section, "Alaska tribal health organization" means an organization recognized by the United States Indian Health Service to provide health-related services.

*** Sec. 19.** The uncodified law of the State of Alaska is amended by adding a new section to read:

MEDICAID STATE PLAN INSTRUCTIONS; NOTICE TO REVISOR OF STATUTES. The Department of Health and Social Services shall immediately amend and submit for federal approval a state plan for medical assistance coverage consistent with this Act. The Department of Health and Social Services shall apply to the United States Department of Health and Human Services for any waivers necessary to implement this Act. The commissioner of health and social services shall notify the revisor of statutes in writing if the United States Department of Health and Human Services approves the provisions of AS 47.07.030(d), as amended by sec. 10 of this Act, the provisions of AS 47.07.036(e) and (f), added by sec. 12 of this Act, and the provisions of secs. 15 and 16 of this Act.

*** Sec. 20.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: REGULATIONS. The Department of Health and Social Services may

effect under AS 44.62 (Administrative Procedure Act), but not before the effective date of the relevant provision of this Act implemented by the regulation.

*** Sec. 21.** The uncodified law of the State of Alaska is amended by adding a new section to read:

REVISOR'S INSTRUCTION. The revisor of statutes is requested to change the catch line of AS 47.07.036 from "Cost containment measures authorized" to "Medical assistance cost-containment and reform measures authorized."

*** Sec. 22.** The uncodified law of the State of Alaska is amended by adding a new section to read:

CONDITIONAL EFFECT. (a) AS 47.07.030(d), as amended by sec. 10 of this Act, and sec. 16 of this Act take effect only if the commissioner of health and social services notifies the revisor of statutes in writing under sec. 19 of this Act, on or before January 1, 2017, that all of the provisions added by AS 47.07.030(d), as amended by sec. 10 of this Act, and all of the provisions of sec. 16 of this Act have been approved by the United States Department of Health and Human Services.

(b) AS 47.07.036(e), added by sec. 12 of this Act, takes effect only if the commissioner of health and social services notifies the revisor of statutes in writing under sec. 19 of this Act, on or before February 1, 2019, that all of the provisions of AS 47.07.036(e), added by sec. 12 of this Act, have been approved by the United States Department of Health and Human Services.

(c) AS 47.07.036(f), added by sec. 12 of this Act, takes effect only if the commissioner of health and social services notifies the revisor of statutes in writing under sec. 19 of this Act, on or before February 1, 2019, that all of the provisions added by AS 47.07.036(f), added by sec. 12 of this Act, have been approved by the United States Department of Health and Human Services.

(d) Section 15 of this Act takes effect only if the commissioner of health and social services notifies the revisor of statutes in writing under sec. 19 of this Act, on or before July 1, 2017, that all of the provisions added by sec. 15 of this Act have been approved by the United States Department of Health and Human Services.

*** Sec. 23.** If AS 47.07.030(d), as amended by sec. 10 of this Act, and sec. 16 of this Act

services makes a certification to the revisor of statutes under secs. 19 and 22(a) of this Act.

* **Sec. 24.** If AS 47.07.036(e), added by sec. 12 of this Act, takes effect, it takes effect on the day after the date the commissioner of health and social services notifies the revisor of statutes in writing under secs. 19 and 22(b) of this Act.

* **Sec. 25.** If AS 47.07.036(f), added by sec. 12 of this Act, takes effect, it takes effect on the day after the date the commissioner of health and social services notifies the revisor of statutes in writing under secs. 19 and 22(c) of this Act.

* **Sec. 26.** If sec. 15 of this Act takes effect, it takes effect on the day after the date the commissioner of health and social services notifies the revisor of statutes in writing under secs. 19 and 22(d) of this Act.

* **Sec. 27.** Sections 17(a), 19, 20, and 22 of this Act take effect immediately under AS 01.10.070(c).

Be advised of the following participation in the Tuesday, Feb. 2nd House Health and Social Services Committee hearing on House Bill 227 – Medicaid Reform. Out-of-town participants will call in to 1-844-586-9085. Their numbers are listed in case they are cut off.

Tanecka Hansen legislative aide Rep Seaton

- Valerie Davidson, Commissioner, in the room and providing brief testimony;
- Jon Sherwood, Deputy Commissioner, in the room and providing an overview of fiscal notes and answering questions, if requested;
- Karen Forrest, Deputy Commissioner, in the room and available for questions;
- Margaret Brodie, Director, Division of Health Care Services, in the room and available for questions;
- Sean O'Brien, Director, Division of Public Assistance, in the room and available for questions;
- Duane Mayes, Director, Division of Senior and Disabilities Services, in the room and available for questions;
- Randall Burns, Acting Director, Division of Behavioral Health, on the phone and available for questions (907-269-S948);
- Jared Kosin, Director, Office of Rate Review, on the phone (907-334-2447);
- Stephanie Wrightsman-Birch, Section Chief, Women's, Children's & Family Health, Division of Public Health (907-334-2424)

Tony Newman | Legislative Liaison
Office of the Commissioner | Alaska Department of Health and Social Services

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From: Newman, Anthony (HSS) <anthony.newman@alaska.gov>
Sent: Tuesday, February 16, 2016 7:48 PM
To: Taneeka Hansen
Cc: Woods, Sarah B (HSS); Davidson, Valerie J (HSS); Sherwood, Jon (HSS); Ashenbrenner, Chris (HSS); Martin, Monique R (HSS); Erickson, Deborah L (HSS); Martin, Monique R (HSS); Brodie, Margaret C (HSS); Peterson, Darwin R (GOV); Wilcox, Lacy J (GOV); McClanahan, Natasha S (GOV)
Subject: RE: HB 227 questions

Taneeka,

In response to committee members' questions from the Tuesday 2/2 hearing, please see below.

1. Representative Vazquez would like to know all grants to behavioral health providers to date for FY15 and FY 16. She would also like a list of all the grantees for the same time period, if possible.

   As noted earlier, this information is available from the web at:

   http://dhss.alaska.gov/fms/Documents/FY16GrantBook.pdf

   http://dhss.alaska.gov/fms/Documents/FY15GrantBook.pdf

2. Regarding the audits, Representative Seaton would like to know what 0.75% of providers would look like, generally. In partial response to this Jon Sherwood noted that there are different provider classifications (only some of which get audited?) and that the department has been averaging in the 30s. The committee would like to see a list of these different provider classifications and what 0.75% would mean for each group in terms of auditing. You can provide that as the number of provider audits last year, or the average over the last few years, whichever is easier to provide.

   Our most recent data pull showed 5,823 active Medicaid billing providers. 0.75% of 5,823 would be 44 providers.

   For audit purposes, we have classified providers along Medicaid Division Authority and Responsibility lines. In the past our audits have been split roughly like this:

Health Care Services	45% to 50%
Senior and Disabilities Services	35% to 40%
Behavioral Health	10% to 15%

3. Representative Vazquez would like to have the citation of the federal regulations on a fiscal note. In my notes, it appears she was talking about Fiscal note 2, DHSS-MAA. In that case, I believe she was talking about the federal cost sharing regulations at the end of the fiscal narrative, however if that is not your memory from the meeting you may have to check with Representative Vazquez's office.

   Federal regulations on Medicaid premiums and cost sharing are found at 42 CFR 447.51 – 42. CFR 447.57.

federal government to keep the waiver cost neutral, please list the expected FMAPS for administration, Denali kid care, tribal, normal, etc.

Under an 1115 waiver, CMS must determine that the costs to the federal government are cost neutral. Therefore, the waiver may contain a limitation on the amount of federal money that will be provided regardless of the underlying match rate, depending on what the State proposed. However, we can identify the match rates that would be used to calculate cost neutrality. These are the same match rates that would apply if the costs were incurred under the regular Medicaid program.

Administration
Basic Administrative costs: 50%
Enhanced Administrative costs: 75%
System development costs: 90%

Services

Regular FMAP	50%
CHIP eligible	88%
Family Planning	90%
Medicaid Expansion	90-100% (depending on the year)
Tribal Eligible	100%

Should the State's proposal include services that could not be covered under federal rules or cover people who are not be eligible for Medicaid under federal rules, then CMS might impose a limit on the total federal match for expenditures under the waiver.

Thanks, and please let us know if this information generates any additional questions.

Tony

From: Taneeka Hansen [mailto:Taneeka.Hansen@akleg.gov]
Sent: Friday, February 05, 2016 5:17 PM
To: Newman, Anthony (HSS)
Subject: Committee questions from week of Feb 1-5

Good evening Tony,
Thank you for your work on the bills this week. Here are the questions I have written down from Tuesday, the **presentation of HB 227.**
Representative Vazquez would like to know all grants to behavioral health providers to date for FY15 and FY 16. She would also like a list of all the grantees for the same time period, if possible.

Regarding the audits, Representative Seaton would like to know what 0.75% of providers would look like, generally. In partial response to this Jon Sherwood noted that there are different provider classifications (only some of which get audited?) and that the department has been averaging in the 30s. The committee would like to see a list of these different provider classifications and what 0.75% would mean for each group in terms of auditing. You can provide that as the number of provider audits last year, or the average over the last few years, whichever is easier to provide.

Representative Vazquez would like to have the citation of the federal regulations on a fiscal note. In my notes, it appears she was talking about Fiscal note 2, DHSS-MAA. In that case, I believe she was talking about the federal cost

Finally, during the discussion of fiscal note 3, rate review, Representative Vazquez requested a list of all the different FMAPS we could expect under the 1115 waivers required to pursue the demonstration projects listed in the fiscal note. Understanding that we cannot know the FMAP for certain because you negotiate with the Federal government to keep the waiver cost neutral, please list the expected FMAPS for administration, Denali kid care, tribal, normal, etc.

Taneeka Hansen
Legislative Aide
Representative Paul Seaton
Committee Aide, Health and Social Services
(907) 465-3923

Representative Seaton asked how many Alaska Medicaid enrollees were dually enrolled in Medicaid and Medicare:

Taneeka, in response to your email below:

Currently, DHSS has 15,500 Medicaid enrollees who also have Medicare coverage (dually enrolled).

This overlap group doesn't contain any individuals newly covered through Medicaid expansion, because expansion was specifically for childless, *non-elderly* adults, whereas Medicare is for adults age 65+.

Medicare recipients may be considered for Medicaid eligibility if they meet Medicaid criteria for being considered disabled or blind.

Thank you.

Tony

Tony Newman | Legislative Liaison
Office of the Commissioner | Alaska Department of Health and Social Services

In response to committee questions asked during her presentation on February 16, of Becky Hultberg, ASHNHA provided the following:

I wanted to follow up with some additional information on readmissions. The information I gave the committee was partially accurate, but I had gotten a few things confused. I think this will help clarify. Specifically, a readmission is for any cause within 30 days, but it does not include a planned hospitalization.

Here are a few links to information about the Colorado RCCO program.

https://www.colorado.gov/pacific/hcpf/accountable-care-collaborative

http://www.cohealthinfo.com/glossary/regional-care-collaborative-organization-rcco/

Becky

Hospital Readmission Reduction Program (HRRP)

A hospital readmission occurs when a patient is admitted to a hospital within a specified time period after being discharged from an earlier (initial) hospitalization. For Medicare, this time period is defined as 30 days, and includes hospital readmissions to any hospital, not just the hospital at which the patient was originally hospitalized.

Medicare uses an "all-cause" definition of readmission, meaning that hospital stays within 30 days of a discharge from an initial hospitalization are considered readmissions, regardless of the reason for the readmission. This all-cause definition is used in calculating both the national average readmission rate and each hospital's specific readmission rate. Starting in 2014, CMS began making an exception for *planned* hospitalizations (such as a scheduled coronary angioplasty) within the 30-day window; these are no longer counted as readmissions.

The current focus in the HRRP is on readmissions occurring after *initial* hospitalizations for selected conditions—namely, heart attack, heart failure, pneumonia, chronic obstructive pulmonary disease (COPD), and elective hip or knee replacement. CMS also collects hospitals' overall readmission rates (regardless of initial diagnoses), but these overall rates are not currently used in the HRRP to calculate readmissions penalties.

payments to hospitals that have relatively high readmission rates for patients in traditional Medicare. It started in 2013 as a permanent component of Medicare's inpatient hospital payment system (i.e., not a temporary demonstration project), and applies to most acute care hospitals. Hospitals exempt from the HRRP include psychiatric, rehabilitation, long term care, children's, cancer, critical access hospitals, and all hospitals in Maryland.

Under the HRRP, hospitals with readmission rates that exceed the national average are penalized by a reduction in payments across *all* of their Medicare admissions—not just those which resulted in readmissions. Before comparing a hospital's readmission rate to the national average, CMS adjusts for certain demographic characteristics of both the patients being readmitted and each hospital's patient population (such as age and illness severity). After these adjustments, CMS calculates a rate of "excess" readmissions, which links directly to the hospital's readmission penalty—the greater each hospital's rate of excess readmissions, the higher its penalty.

--

Becky Hultberg, President/CEO

Alaska State Hospital and Nursing Home Association

1049 W. 5th Ave., Ste 100

Anchorage, AK 99501

907-646-1444

907-209-9293 cell

Of the decrease in general fund dollars in the Department of Health and Social Service included in the governor's budget, please provide the amount that is actual cuts and the amount that results from shifting to a federal fund source.

> Clarification, please. Do you seek a comparison of FY2016 Management Plan to the proposed FY2017 Governor's Amended budget, or something else? And do you want data for the entire department, or only specific to the Medicaid Services program?

Please provide the summary or overall narrative of the HB 227 fiscal notes that Jon Sherwood referred to during the meeting.

> Attached – "micro version." Also attached – graphs of savings resulting from HB227.

Representative Stutes requested more information on how much is paid for travel, how travel is authorized, and the rate of "no-show" for authorized travel.

> If medically necessary services are not available in a person's home community, it may be necessary to travel to another location in Alaska to meet the needs of the patient. In these cases. All non-emergency travel must be preauthorized by the state. The health care provider contacts the state to request authorization of travel outside the patient's home community.
>
> Emergency and nonemergency travel and accommodation in FY2015 costs were $79,440,796 ($67,711,600 for travel and $11,729,196 for accommodations). This was based on reports run on Jan. 26, 2016.
>
> The "no-show" at appointments for which travel has been authorized is low although there is a persistent belief that it is otherwise. The Division of Health Care Services examined a significant amount of Medicaid recipient data from a recent two-year period in which there was no bill for medical services attached to a period of travel. The Division conducted a survey to determine why there was no billing for a medical service. Generally, the results are as follows.
>
> - Almost 75 percent were due to weather delays. The appointment was subsequently rescheduled as well as the travel. So no travel occurred on the original date.
> - The recipient's health deteriorated during travel and instead of an appointment in a doctor's office, the recipient had an emergency room visit.
> - Some occurrences were follow-up appointments for things such as surgery so the initial billing was global and covered all services associated. (The Division verified with the doctor's offices that they did attend).
> - Many recipients had secondary insurance that would pay for the medical visits but not the travel.
> - The doctor cancelled and rescheduled the appointment.

Thanks

GOVERNOR BILL WALKER

FINANCE AND MANAGEMENT SERVICES
Juneau Office

P.O Box 110650
Juneau, Alaska 99811-0650
Main: 907.465.3082
Fax: 907.465.2499

February 25, 2016

The Honorable Louise Stutes
Alaska State Legislature
State Capitol, Room 416
Juneau, AK 99801-1182

Dear Representative Stutes:

On February 18, 2016 the Department of Health and Social Services received the following question from you regarding the Department's budget:

- ***Of the decrease in general fund dollars in the Department of Health and Social Services included in the governor's budget, please provide the amount that is actual cuts and the amount that results from shifting to a federal fund source.***

The following is submitted in response:

In FY2016 the Department reduced unrestricted general funds (UGF) by $88,400.5, and in FY2017 the Department is proposing a reduction of UGF by $46,700.8. Due to Medicaid Expansion Federal receipt authority for Medicaid services was increased by $147,029.0 in FY2016 and $173,692.1 in FY2017.

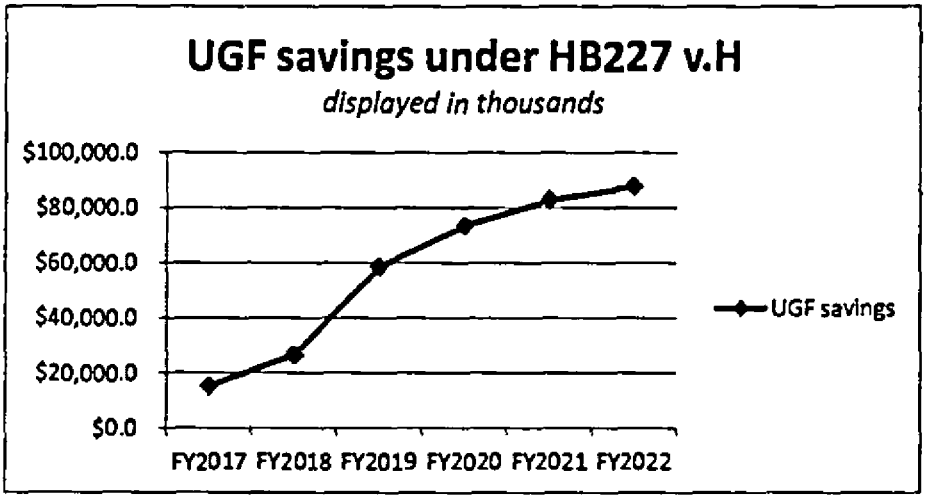
If you have any additional questions, please contact me at 465-1630.

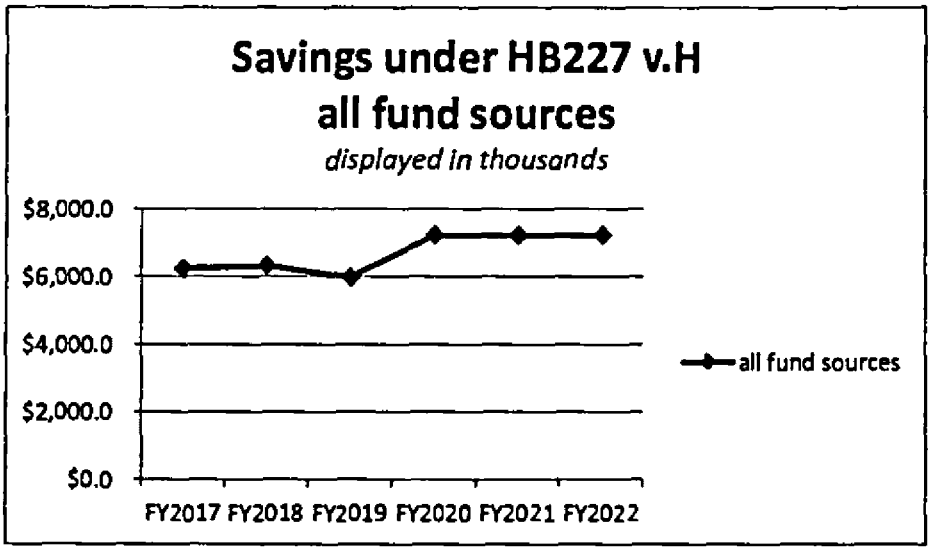
Sincerely,

Sana

Sana Efird
Assistant Commissioner

cc: Amanda Ryder, Fiscal Analyst, Legislative Finance
Neil Steininger, Office of Management and Budget
Valerie Davidson, Commissioner
Jay Butler, Chief Medical Officer
Jon Sherwood, Deputy Commissioner


UGF savings under HB227 v.H
displayed in thousands
$100,000.0
$80,000.0
$60,000.0
$40,000.0
$20,000.0
$0.0
FY2017 FY2018 FY2019 FY2020 FY2021 FY2022
UGF savings


Savings under HB227 v.H
all fund sources
displayed in thousands
$8,000.0
$6,000.0
$4,000.0
$2,000.0
$0.0
FY2017 FY2018 FY2019 FY2020 FY2021 FY2022
all fund sources

Rep. Seaton's HB227 version "H" DHSS fiscal note calculations

Federal Policy on Tribal Health

TOTALS by service and category

	FY2017	*FY2018*	*FY2019*	*FY2020*	*FY2021*	*FY2022*
Fed	$12,464.8	$22,282.2	$44,707.2	$58,632.2	$68,007.2	$72,957.2
GF match	($9,485.3)	($18,492.9)	($40,092.9)	($53,192.9)	($61,742.9)	($66,692.9)
GF	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
GF/MH	($2,750.0)	($3,575.0)	($4,400.0)	($5,225.0)	($6,050.0)	($6,050.0)
MHTAAR	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
SD/PR	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
TOTAL	**$229.5**	**$214.3**	**$214.3**	**$214.3**	**$214.3**	**$214.3**
UGF subtotal	($12,235.3)	($22,067.9)	($44,492.9)	($58,417.9)	($67,792.9)	($72,742.9)

(Medicaid RDU subtotal)

	FY2016	*FY2017*	*FY2018*	*FY2019*	*FY2020*	*FY2021*
Fed	$12,350.0	$22,175.0	$44,600.0	$58,525.0	$67,900.0	$72,850.0
GF match	($9,600 0)	($18,600.0)	($40,200.0)	($53,300.0)	($61,850 0)	($66,800.0)
GF	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
GF/MH	($2,750.0)	($3,575.0)	($4,400.0)	($5,225.0)	($6,050.0)	($6,050.0)
MHTAAR	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
SD/PR	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
TOTAL	**$0.0**	**$0.0**	**$0.0**	**$0.0**	**$0.0**	**$0.0**
UGF subtotal	($12,350.0)	($22,175.0)	($44,600.0)	($58,525.0)	($67,900 0)	($72,850.0)

Rep. Seaton's HI

1915(i) and (k)

TOTALS by service and category

	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022
Fed	$185.1	$1,559.8	$11,S17.4	$11,212.2	$11,212.2	$11,212.2
GF match	$104.8	($1,027.5)	$6,422.8	$6,197.8	$6,197.8	$6,197.8
GF	$0.0	$0.0	($5,425.1)	($5,425.1)	($5,425.1)	($5,425.1)
GF/MH	$0.0	$0.0	($11,635.8)	($11,635.8)	($11,635.8)	($11,635.8)
MHTAAR	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
SD/PR	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
TOTAL	**$289.9**	**$532.3**	**$879.3**	**$349.1**	**$349.1**	**$349.1**
UGF subtotal	$104.8	($1,027.5)	($10,638.1)	($10,863.1)	($10,863.1)	($10,863.1)

(Medicaid RDU subtotal)

	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021
Fed	$0.0	$1,253.6	$11,037.7	$11,037.7	$11,037.7	$11,037.7
GF match	$0.0	($1,253.6)	$6,023.3	$6,023.3	$6,023.3	$6,023.3
GF	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
GF/MH	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
MHTAAR	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
SD/PR	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
TOTAL	**$0.0**	**$0.0**	**$17,061.0**	**$17,061.0**	**$17,061.0**	**$17,061.0**
UGF subtotal	$0.0	($1,253.6)	$6,023.3	$6,023.3	$6,023.3	$6,023.3

Rep. Seaton's HI

OAH Appeals

TOTALS by service and category

	FY2017	*FY2018*	*FY2019*	*FY2020*	*FY2021*	*FY2022*
Fed	$280.8	$304.0	$277.0	$250.0	$250.0	$250.0
GF match	$280.8	$304.1	$277.0	$250.0	$250.0	$250.0
GF	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
GF/MH	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
MHTAAR	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
SD/PR	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
TOTAL	**$561.6**	**$608.1**	**$554.0**	**$500.0**	**$500.0**	**$500.0**
UGF subtotal	$280.8	$304.1	$277.0	$250.0	$250.0	$250.0

(Medicaid RDU subtotal)

	FY2016	*FY2017*	*FY2018*	*FY2019*	*FY2020*	*FY2021*
Fed	$250.0	$250.0	$250.0	$250.0	$250.0	$250.0
GF match	$250.0	$250.0	$250.0	$250.0	$250.0	$250.0
GF	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
GF/MH	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
MHTAAR	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
5D/PR	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
TOTAL	**$500.0**	**$500.0**	**$500.0**	**$500.0**	**$500.0**	**$500.0**
UGF subtotal	$250.0	$250.0	$250.0	$250.0	$250.0	$250.0

Rep. Seaton's HI

Innovative Payment Model Demos

TOTALS by service and category

	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022
Fed	$250.0	$50.0	$50.0	$50.0	$50.0	$50.0
GF match	$250.0	$50.0	$50.0	$50.0	$50.0	$50.0
GF	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
GF/MH	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
MHTAAR	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
SD/PR	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
TOTAL	**$500.0**	**$100.0**	**$100.0**	**$100.0**	**$100.0**	**$100.0**
UGF subtotal	$250.0	$50.0	$50.0	$50.0	$50.0	$50.0

(Medicaid RDU subtotal)

	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021
Fed	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
GF match	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
GF	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
GF/MH	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
MHTAAR	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
SD/PR	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
TOTAL	**$0.0**	**$0.0**	**$0.0**	**$0.0**	**$0.0**	**$0.0**
UGF subtotal	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0

Rep. Seaton's HI

Pre-term Birth/Vit D Demo

TOTALS by service and category

	FY2017	*FY2018*	*FY2019*	*FY2020*	*FY2021*	*FY2022*
Fed	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
GF match	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
GF	$661.1	$661.1	$661.1	$0.0	$0.0	$0.0
GF/MH	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
MHTAAR	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
SD/PR	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
TOTAL	**$661.1**	**$661.1**	**$661.1**	**$0.0**	**$0.0**	**$0.0**
UGF subtotal	$661.1	$661.1	$661.1	$0.0	$0.0	$0.0

(Medicaid RDU subtotal)

	FY2016	*FY2017*	*FY2018*	*FY2019*	*FY2020*	*FY2021*
Fed	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
GF match	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
GF	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
GF/MH	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
MHTAAR	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
SD/PR	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
TOTAL	**$0.0**	**$0.0**	**$0.0**	**$0.0**	**$0.0**	**$0.0**
UGF subtotal	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0

Rep. Seaton's HI

SUPER-UTILIZER DEMO

TOTALS by service and category

	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022
Fed	($4,300.5)	($4,300.5)	($4,300.5)	($4,300.5)	($4,300.5)	($4,300.5)
GF match	($4,300.4)	($4,300.4)	($4,300.4)	($4,300.4)	($4,300.4)	($4,300.4)
GF	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
GF/MH	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
MHTAAR	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
SD/PR	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
TOTAL	($8,600.9)	($8,600.9)	($8,600.9)	($8,600.9)	($8,600.9)	($8,600.9)
UGF subtotal	($4,300.4)	($4,300.4)	($4,300.4)	($4,300.4)	($4,300.4)	($4,300.4)

(Medicaid RDU subtotal)

	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021
Fed	($4,300.5)	($4,300.5)	($4,300.5)	($4,300.5)	($4,300.5)	($4,300.5)
GF match	($4,300.4)	($4,300.4)	($4,300.4)	($4,300.4)	($4,300.4)	($4,300.4)
GF	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
GF/MH	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
MHTAAR	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
SD/PR	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
TOTAL	($8,600.9)	($8,600.9)	($8,600.9)	($8,600.9)	($8,600.9)	($8,600.9)
UGF subtotal	($4,300.4)	($4,300.4)	($4,300.4)	($4,300.4)	($4,300.4)	($4,300.4)

Rep. Seaton's HI

INTEREST PENALTIES

TOTALS by service and category

	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022
Fed	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
GF match	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
GF	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
GF/MH	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
MHTAAR	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
SD/PR	$84.9	$124.4	$169.8	$169.8	$169.8	$169.8
TOTAL	**$84.9**	**$124.4**	**$169.8**	**$169.8**	**$169.8**	**$169.8**
UGF subtotal	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0

(Medicaid RDU subtotal)

	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021
Fed	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
GF match	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
GF	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
GF/MH	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
MHTAAR	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
SD/PR	$84.9	$124.4	$169.8	$169.8	$169.8	$169.8
TOTAL	**$84.9**	**$124.4**	**$169.8**	**$169.8**	**$169.8**	**$169.8**
UGF subtotal	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0

Rep. Seaton's HI

CIVIL FINES

TOTALS by service and category

	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022
Fed	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
GF match	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
GF	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
GF/MH	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
MHTAAR	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
SD/PR	$50.0	$50.0	$50.0	$50.0	$50.0	$50.0
TOTAL	**$50.0**	**$50.0**	**$50.0**	**$50.0**	**$50.0**	**$50.0**
UGF subtotal	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0

(Medicaid RDU subtotal)

	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021
Fed	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
GF match	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
GF	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
GF/MH	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
MHTAAR	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
SD/PR	$50.0	$50.0	$50.0	$50.0	$50.0	$50.0
TOTAL	**$50.0**	**$50.0**	**$50.0**	**$50.0**	**$50.0**	**$50.0**
UGF subtotal	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0

Rep. Seaton's HI

TOTALS by component

TOTALS by service and category

GRAND TOTAL	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022
Fed	$8,880.2	$19,895.5	$52,251.1	$65,843.9	$75,218.9	$80,168.9
GF match	($13,150.1)	($23,466.7)	($37,643.5)	($50,995.5)	($59,545.5)	($64,495.5)
GF	$661.1	$661.1	($4,764.0)	($5,425.1)	($5,425.1)	($5,425.1)
GF/MH	($2,750.0)	($3,575.0)	($16,035.8)	($16,860.8)	($17,685.8)	($17,685.8)
MHTAAR	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
SD/PR	$134.9	$174.4	$219.8	$219.8	$219.8	$219.8
TOTAL	**($6,223.9)**	**($6,310.7)**	**($5,972.4)**	**($7,217.7)**	**($7,217.7)**	**($7,217.7)**
UGF subtotal	($15,239.0)	($26,380.6)	($58,443.3)	($73,281.4)	($82,656.4)	($87,606.4)

(Medicaid RDU subtotal)

Medicaid RDU Total	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022
Fed	$8,299.5	$19,378.1	$51,587.2	$65,512.2	$74,887.2	$79,837.2
GF match	($13,650.4)	($23,904.0)	($38,227.1)	($51,327.1)	($59,877.1)	($64,827.1)
GF	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
GF/MH	($2,750.0)	($3,575.0)	($4,400.0)	($5,225.0)	($6,050.0)	($6,050.0)
MHTAAR	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
SD/PR	$134.9	$174.4	$219.8	$219.8	$219.8	$219.8
TOTAL	**($7,966.0)**	**($7,926.5)**	**$9,179.9**	**$9,179.9**	**$9,179.9**	**$9,179.9**
UGF subtotal	($16,400.4)	($27,479.0)	($42,627.1)	($56,552.1)	($65,927.1)	($70,877.1)

Federal Policy on Tribal Health

	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022
Fed	$12,464.8	$22,282.2	$44,707.2	$58,632.2	$68,007.2	$72,957.2
GF match	($9,485.3)	($18,492.9)	($40,092.9)	($53,192 9)	($61,742.9)	($66,692.9)
GF	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
GF/MH	($2,750.0)	($3,575.0)	($4,400.0)	($5,225.0)	($6,050.0)	($6,050 0)
MHTAAR	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
SD/PR	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
TOTAL	**$229.5**	**$214.3**	**$214.3**	**$214.3**	**$214.3**	**$214.3**
UGF subtotal	($12,235.3)	($22,067.9)	($44,492.9)	($58,417.9)	($67,792.9)	($72,742 9)

1915(i) and (k)

	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022
Fed	$185.1	$1,559.8	$11,517.4	$11,212.2	$11,212.2	$11,212.2
GF match	$104.8	($1,027.5)	$6,422.8	$6,197.8	$6,197.8	$6,197.8
GF	$0.0	$0.0	($5,425.1)	($5,425.1)	($5,425.1)	($5,425.1)
GF/MH	$0.0	$0.0	($11,635.8)	($11,635.8)	($11,635.8)	($11,635.8)
MHTAAR	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
SD/PR	$0.0	$0.0	$0 0	$0.0	$0 0	$0.0
TOTAL	**$289.9**	**$532.3**	**$879.3**	**$349.1**	**$349.1**	**$349.1**
UGF subtotal	$104.8	($1,027.5)	($10,638.1)	($10,863.1)	($10,863.1)	($10,863.1)

SUPER-UTILIZER OEMO

	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022
Fed	($4,300.5)	($4,300.5)	($4,300.5)	($4,300.5)	($4,300.5)	($4,300.5)
GF match	($4,300.4)	($4,300.4)	($4,300 4)	($4,300.4)	($4,300 4)	($4,300.4)
GF	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
GF/MH	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
MHTAAR	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
SD/PR	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
TOTAL	($8,600.9)	($8,600.9)	($8,600.9)	($8,600.9)	($8,600.9)	($8,600.9)
UGF subtotal	($4,300.4)	($4,300.4)	($4,300 4)	($4,300 4)	($4,300.4)	($4,300.4)

TOTAL of above three

	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022
Fed	$8,349.4	$19,541.5	$51,924.1	$65,543.9	$74,918.9	$79,868.9
GF match	($13,680.9)	($23,820 8)	($37,970 5)	($51,295.5)	($59,845.5)	($64,795.5)
GF	$0.0	$0.0	($5,425.1)	($5,425.1)	($5,425.1)	($5,425.1)
GF/MH	($2,750.0)	($3,575 0)	($16,035.8)	($16,860 8)	($17,685.8)	($17,685 8)
MHTAAR	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
SD/PR	$0.0	$0.0	$0.0	$0.0	$0.0	$0 0
TOTAL	**($8,081.5)**	**($7,854.3)**	**($7,507.3)**	($8,037.5)	**($8,037.5)**	($8,037.5)

Taneeka, be advised of the following attendance by DHSS staff at tomorrow's House Health and Social Services Committee hearing. We understand that there is no current plan for testimony or Q&A for the Department, but that if public testimony runs short you may solicit comments from DHSS regarding the amendments that will be introduced by committee members.

Telephonic participants will call in to 1-844-586-9085.

- Valerie Davidson, Commissioner
- Jon Sherwood, Deputy Commissioner
- Karen Forrest, Deputy Commissioner
- Margaret Brodie, Director, Division of Health Care Services (by phone)
- Randall Burns, Acting Director, Division of Behavioral Health (by phone)
- Duane Mayes, Director, Division of Senior and Disabilities Services (by phone)
- Sean O'Brien, Director, Division of Public Assistance (by phone)
- Jared Kosin, Director, Office of Rate Review
- Rebekah Morisse, Manager, Perinatal & Early Chiidhood, Division of Public Health (by phone, designee for Dr. Jay Butler)

Tony Newman | Legislative Liaison
Office of the Commissioner | Alaska Department of Health and Social Services

350 Main Street, Room 404| Juneau AK 99811
(desk) 907.465.1611 |(cell) 907.321.3989
anthony.newman@alaska.gov

Nancy Marriman- Executive Director of the Primary Care Association- *by phone*

Monica Adams –Chief Executive Officer, Peninsula Community Health Services, Soldotna

Dr. Carl Heine – Juneau Emergency Physician

Tom Chard- Executive Director, Alaska Behavioral Health Association

Jeannie Monk- Alaska State Hospital and Nursing Home Association

Jocelyn Pemberton – Executive Director- The Alaska Hospitalist Group- 907-375-3310

Dr. Timothy Bateman- Alaska Hospitalist Group, AIM (Alaska Innovative Medicine, Inc.) – 9079292560 or 9077795079

Dr. Jeremy Gitomer-AIM (Alaska Innovative Medicine, Inc) *by phone*

Dr. Matthew Hirschfeld- All Alaska Pediatric Partnership - 907-360-5620

Tamar Ben-Yosef- Executive Director – All Alaska Pediatric Partnership

Dr. Michael Sobocinski- Alaska Psychological Association

Dr. David Logan *or sub*- Alaska Dental Association

Jeff Jesse- Mental Health Trust *(Unconfirmed)*

Taneeka, we understand that at tomorrow's House Health & Social Services Committee hearing on HB 227 you will hear from several invited speakers to provide brief testimony; then Chair Seaton will facilitate a roundtable discussion with these folks, and the Department is invited to participate. Thank you. Commissioner Davidson will be present and available for questions along with her team:

- Jon Sherwood, Deputy Commissioner
- Karen Forrest, Deputy Commissioner
- Margaret Brodie, Director, Division of Health Care Services (by phone)
- Randall Burns, Acting Director, Division of Behavioral Health (by phone)
- Duane Mayes, Director, Division of Senior and Disabilities Services (by phone)
- Jared Kosin (pronounced "KOE-sin"), Director, Office of Rate Review (by phone)
- Rebeka Morisse, Manager, Perinatal & Early Childhood Program, Division of Public Health (by phone, designee for Dr. Jay Butler)

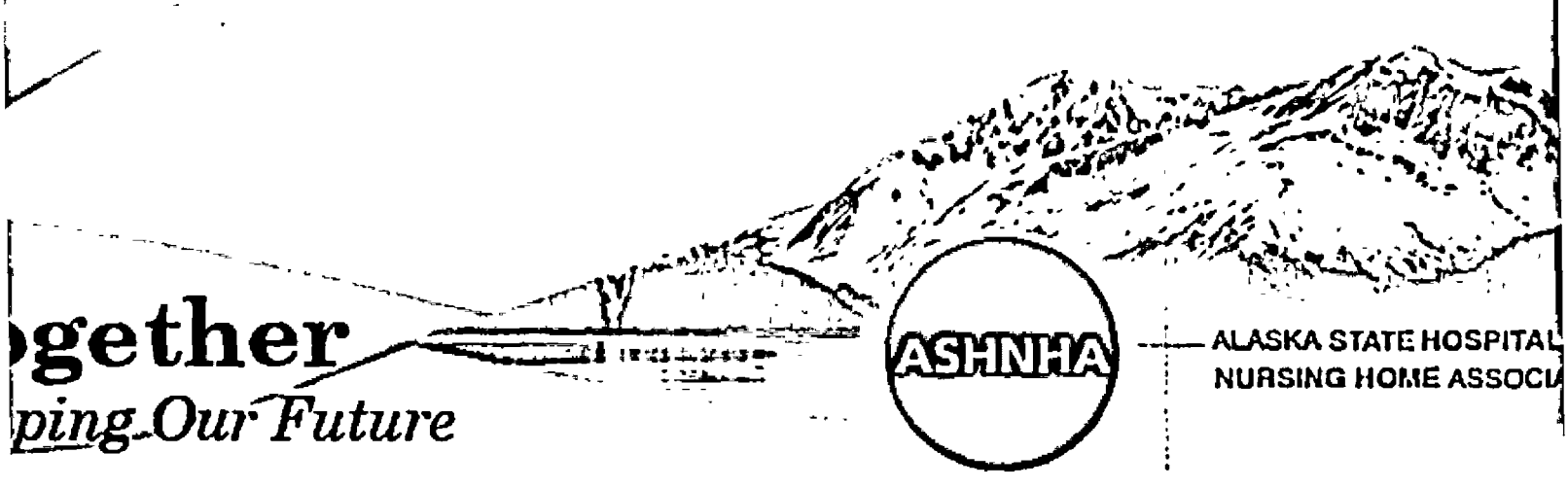
S H N H A

Hospitals and payment reform

Becky Hultberg, President/CEO

House Health & Social Services Committee

Feb. 16, 2016



S H N H A

Alaska State Hospital and Nursing Home Association (ASHNHA)

)UR VISION

\ unified Association providing effective statewide leadership to address health are delivery challenges affecting all Alaskans.

)UR MISSION

'o be the premier provider advocate bringing unity to the health care community ı addressing health care issues and to support our members' goal to improve laskan's health.

ASHNHA

ALASKA STATE HOSPITAL
NURSING HOME ASSOCI

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Definitions: concepts

ANAGED CARE

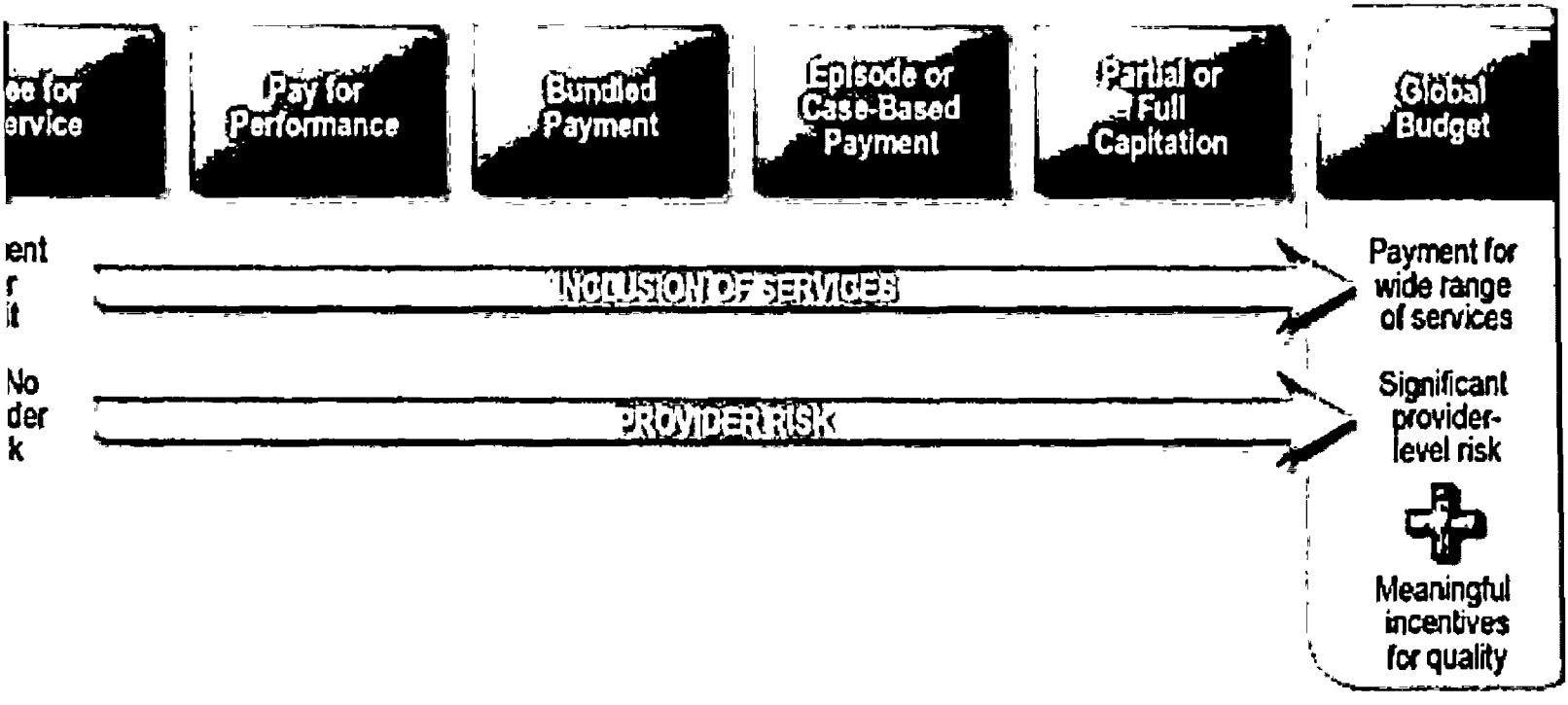
ıethod of health care delivery that focuses on collaboration among and ırdination of all services to avoid overlap, duplication and delays and to reduce ts. There is an emphasis on efficacy and timeliness of interventions. Payment is ically something other than fee-for-service

E-FOR-SERVICE

ayment model where services are unbundled and paid for separately. In health e, it gives an incentive to provide more treatments because payment is ıendent on the quantity of care, rather than quality of care.

S H N H A

Types of payment: risk continuum



romising payment reform, risk-sharing with Accountable Care
ions." The Commonwealth Fund, 2011

ASHNHA

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Definitions: types of payment

\Y FOR PERFORMANCE

y-for-performance programs offer financial incentives to physicians and ıer healthcare providers who meet defined performance targets which ıd to focus on quality, efficiency, or related areas.

INDLED PAYMENT

ıdled payment, also known as episode-based payment, episode ment, episode-of-care payment, case rate, evidence-based case rate, package cing, or packaged pricing, is defined as the reimbursement of health care viders (such as hospitals and physicians) "on the basis of expected costs for ically-defined episodes of care." (e.g. a hip replacement)

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Definitions: types of payment

ıPITATION

ıayment arrangement that pays a provider or group of providers a set amount for :h enrolled person assigned to them, per period of time, whether or not that ·son seeks care.

OBAL BUDGET

ɛd-dollar payments for the care that patients may receive in a given time period, ·h as a month or year. Global payments place providers at financial risk for both · occurrence of medical conditions as well as the management of those ıditions.

S H N H A

Definitions: types of organizations

:O: An accountable care organization (ACO) is a healthcare organization ıracterized by a payment and care delivery model that seeks to tie provider ɪbursements to quality metrics and reductions in the total cost of care for an igned population of patients.

:O: A Coordinated Care Organization (CCO) is a network of all types of ılth care providers who have agreed to work together in their local communities people who receive health care coverage under the Oregon Health Plan edicaid).

:O: A managed care organization (MCO) is a health care provider or a group or anization of medical service providers who offers managed care health plans. It health organization that contracts with insurers or self-insured employers and ınces and delivers health care using a specific provider network and specific vices and products.

SO: Independent Physician Associations, ient-Centered Medical Homes, etc.

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lume to value

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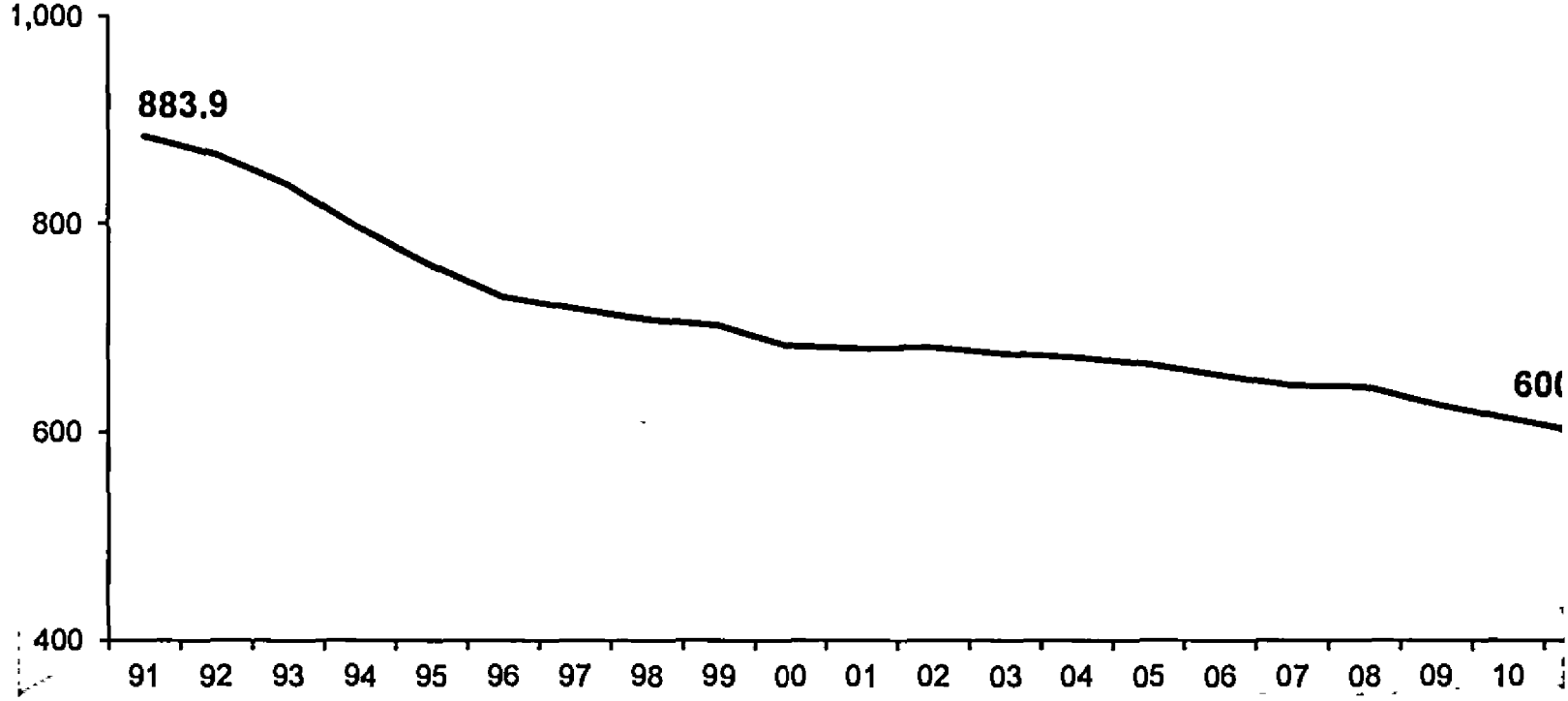
spital trends: lower inpatient use

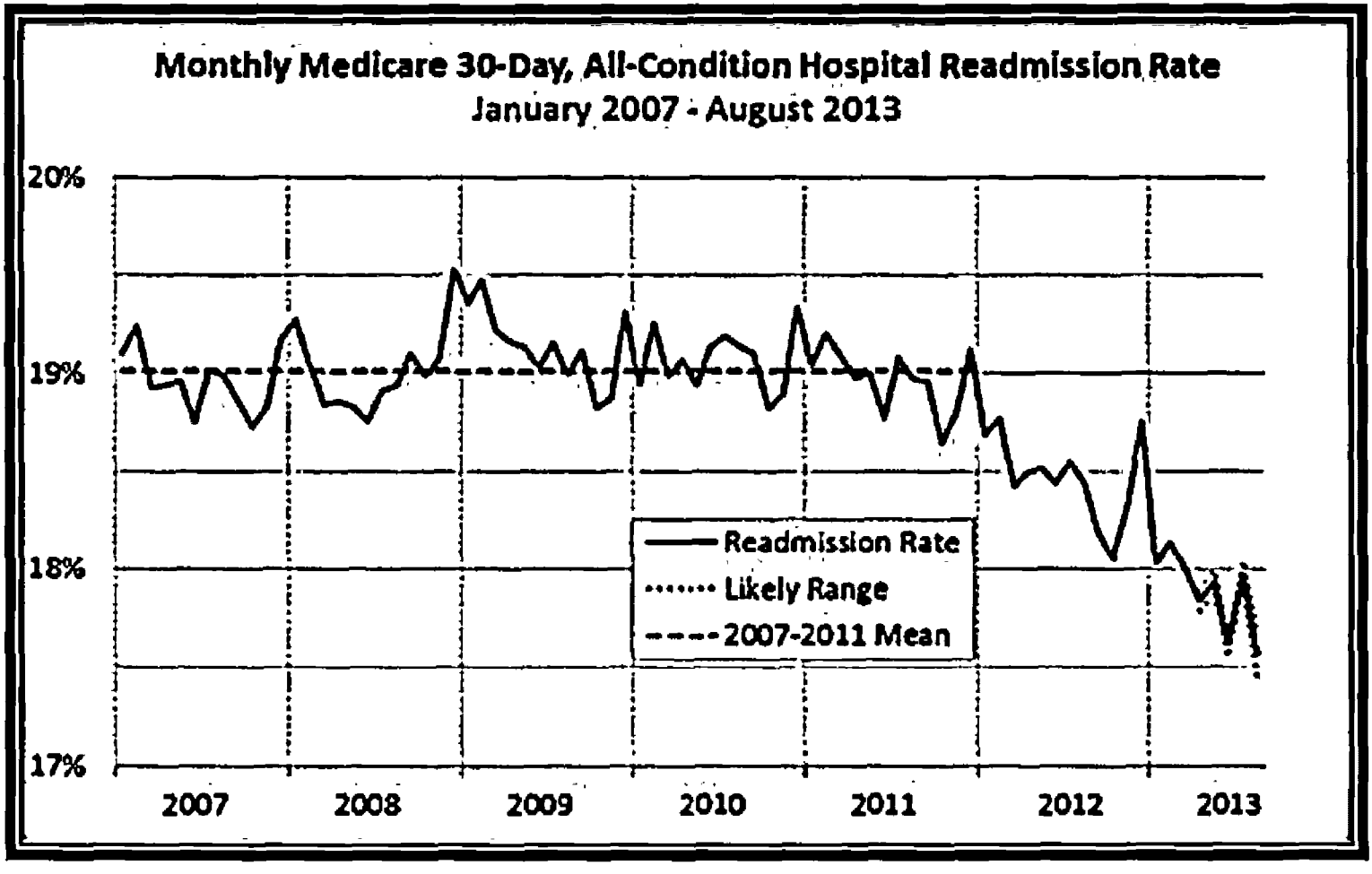
atient Days per 1,000 Persons, 1991 – 2011



Source: Avalere Health analysis of American Hospital Association Annual Survey data, 2011, for community hospitals. US Census Bureau: National and State Population Estimates, July 1, 2011.
Link: http://www.census.gov/popest/data/state/totals/2011/index.html.

S H N H A

duced readmission rates



CMS: 2,610 PPS hospitals to receive penalties in 2015

Source: Centers for Medicare and Medicaid Services, Offices of Enterprise Management

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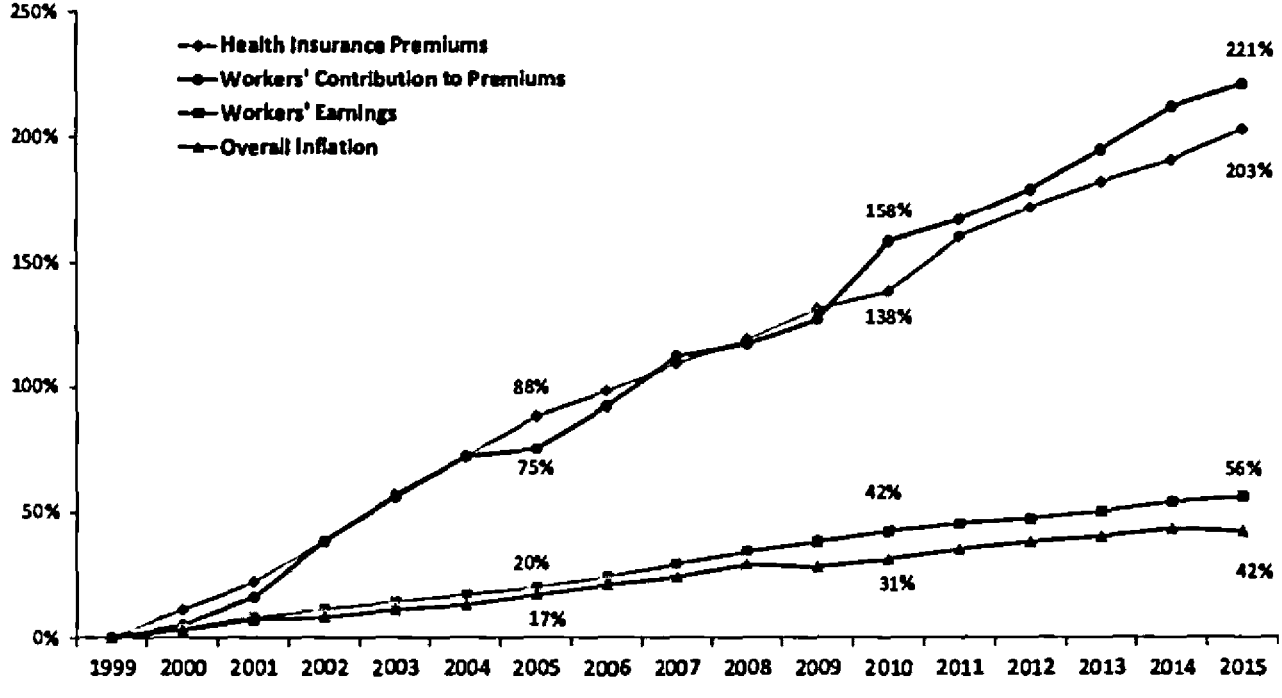
ıployer health insurance

Cumulative Increases in Health Insurance Premiums, Workers' Contributions to Premiums, Inflation, and Workers' Earnings, 1999-2015



SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2015. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 1999-2015; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1999-2015 (April to April).

KAISER FAMILY FOUNDATION AND HRET

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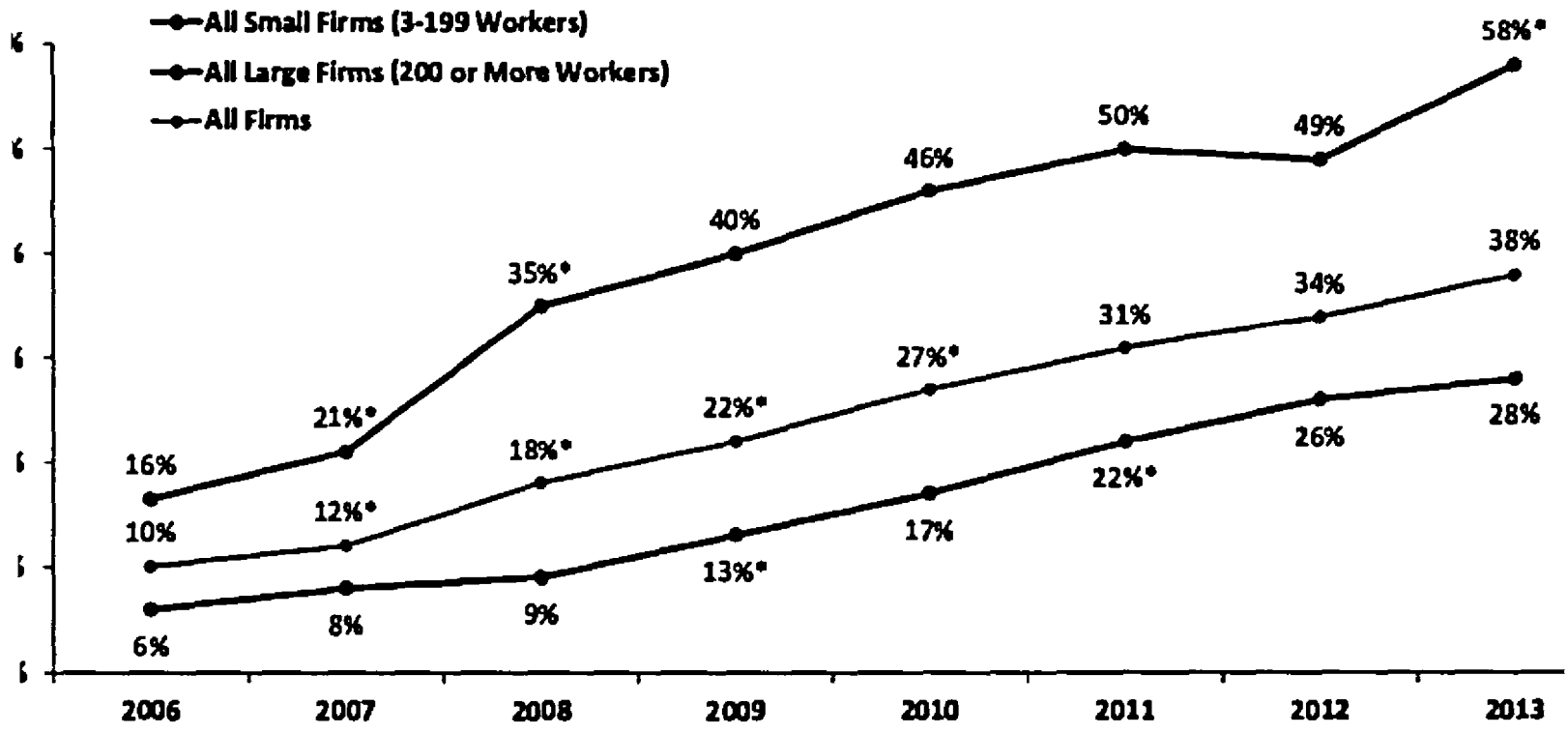
owth in high deductible plans



te is statistically different from estimate for the previous year shown (p<.05).

ese estimates include workers enrolled in HDHP/SO and other plan types. Average general annual health plan deductibles for PPOs, s, and HDHP/SOs are for in-network services.

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2013.

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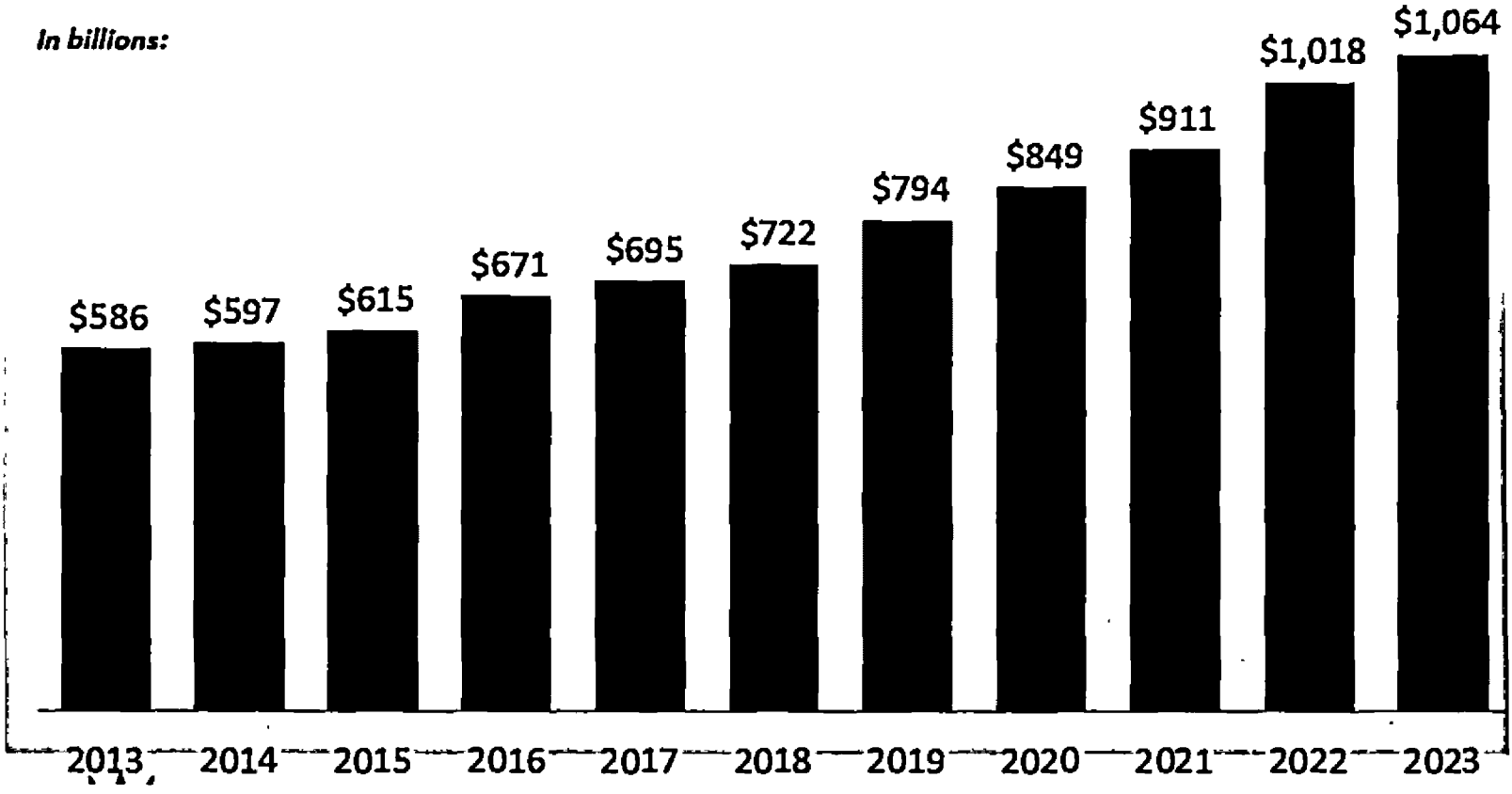
Projected Medicare Spending, 2013-2023



SOURCE: Congressional Budget Office (CBO) Medicare Baseline, May 2013.

S H N H A

dicare payment policies

acted Cuts as a Percent of Total FFS Medicare Revenue 15 year summary value	10.0%

Cuts Enacted (2010-2024): Legislative	
ACA Marketbasket Cuts	($266,013,300)
Sequestration	(93,961,800)
Medicare DSH Cuts	(79,844,200)
Quality	(6,743,300)
ATRA Coding	(9,932,500)
Bad Debt at 65%	(2,180,700)
Total Legislative Cuts	**($458,675,800)**

Cuts Enacted (2010-2024): Regulatory	
Coding Cuts	($127,744,400)
2-Midnight Offset	(4,769,600)
Total Regulatory Cuts	**($132,514,000)**
Total Cuts Enacted	**($591,189,800)**

Cuts Under Consideration (2015-2024)	
Rural Cuts	($228,923,000)
OPD Cuts	(46,733,800)
IME/DGME Cuts	(14,218,200)
Bad Debt Elimination	(10,567,500)
CMS Coding Cut	(9,821,600)
Post Acute Cuts	(9,500,700)
Total Cuts Under Consideration	**($319,764,800)**

These cuts will cost Alaska hospitals $591 million over 15 years.

Cuts under consideration could reduce revenue by an additiona $320 million if enacted. (This does not include recent reductions proposed in the President's budget.)

15-Year Medicare Cut Analysis, DataGen, February 2015.

S H N H A

dicare delivery system changes

News

FOR IMMEDIATE RELEASE
January 26, 2015

Contact: HHS Press Of
202-690-6

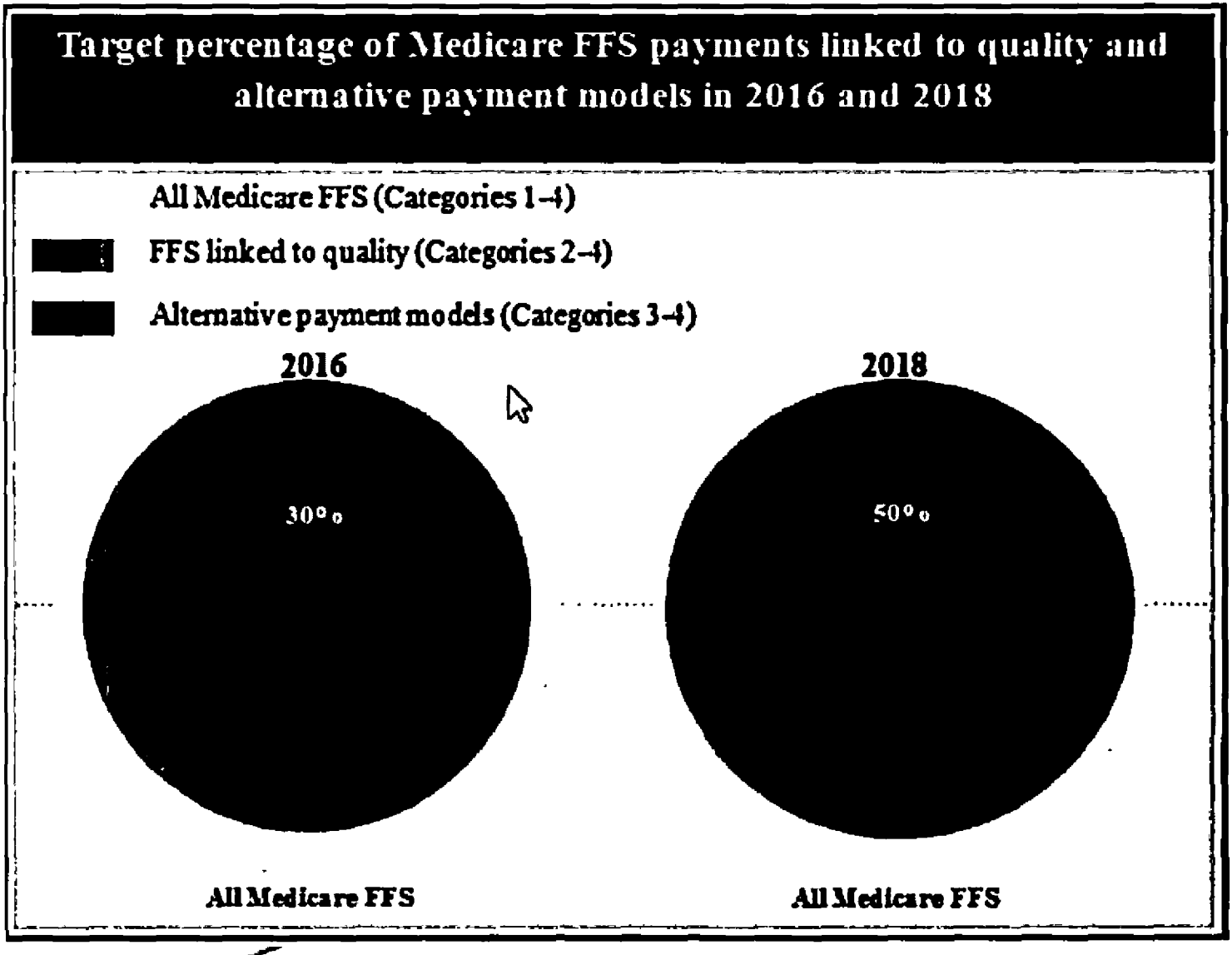
Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value

In a meeting with nearly two dozen leaders representing consumers, insurers, providers, and business leaden Health and Human Services Secretary Sylvia M. Burwell today announced measurable goals and a timeline to move the Medicare program, and the health care system at large, toward paying providers based on the quali rather than the quantity of care they give patients.

HHS has set a goal of tying 30 percent of traditional, or fee-for-service, Medicare payments to quality or valu through alternative payment models, such as Accountable Care Organizations (ACOs) or bundled payment arrangements by the end of 2016, and tying 50 percent of payments to these models by the end of 2018. HH also set a goal of tying 85 percent of all traditional Medicare payments to quality or value by 2016 and 90 percent by 2018 through programs such as the Hospital Value Based Purchasing and the Hospital Readmission Reduction Programs. This is the first time in the history of the Medicare program that HHS has set explicit go for alternative payment models and value-based payments.

9

Shrinking of Traditional Payment



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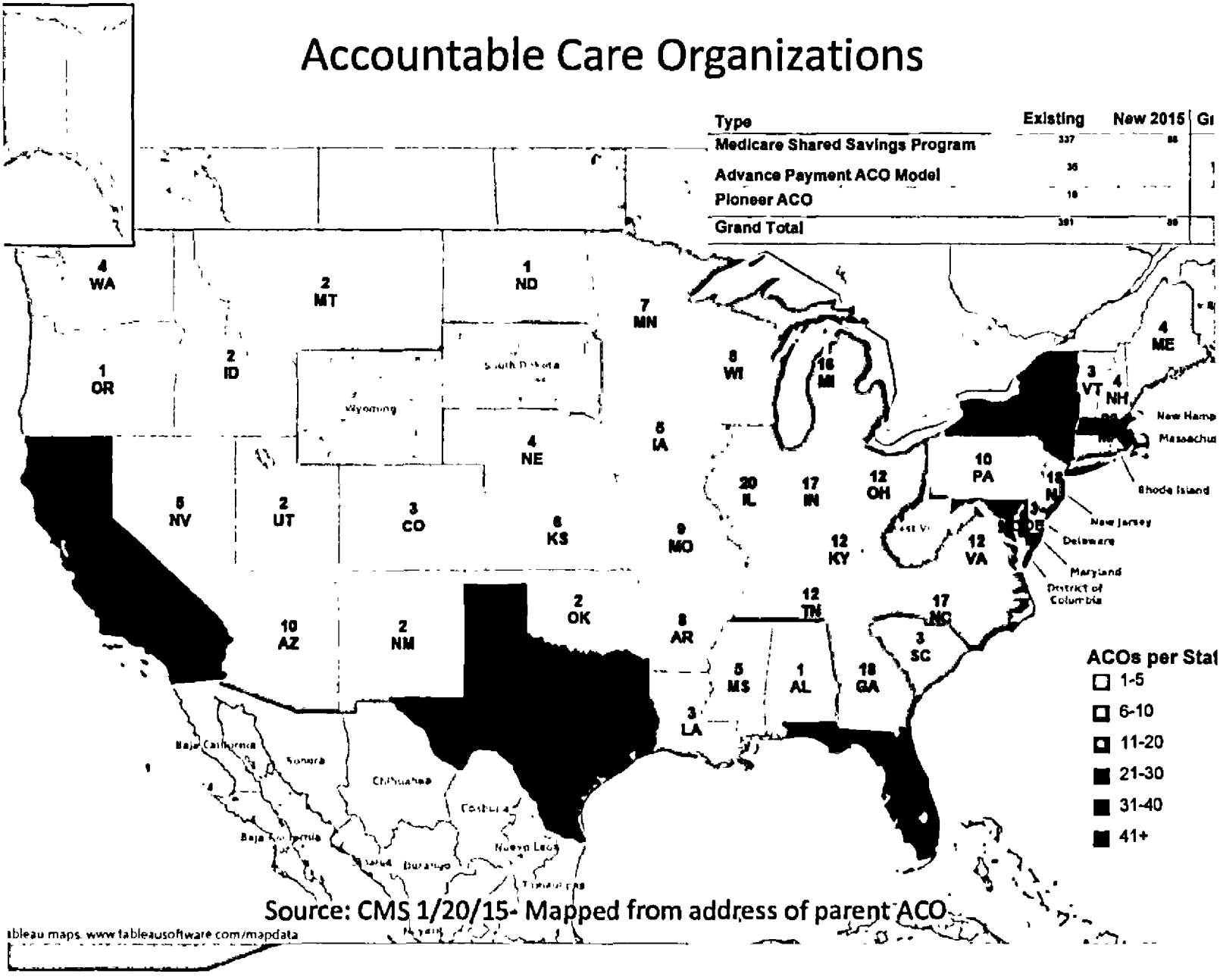
Move to Population-based Payment

Payment Taxonomy Framework				
	Category 1: *Fee for Service—No Link to Quality*	**Category 2:** *Fee for Service—Link to Quality*	**Category 3:** *Alternative Payment Models Built on Fee-for-Service Architecture*	**Category 4:** *Population-Based Payment*
Description	*Payments are based on volume of services and not linked to quality or efficiency*	*At least a portion of payments vary based on the quality or efficiency of health care delivery*	*Some payment is linked to the effective management of a population or an episode of care. Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk*	*Payment is not directly triggered by service delivery so volume is not linked to payment. Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g. ≥1 yr)*
Medicare FFS	• Limited in Medicare fee-for-service • Majority of Medicare payments now are linked to quality	• Hospital value-based purchasing • Physician Value-Based Modifier • Readmissions Hospital Acquired Condition Reduction Program	• Accountable care organizations • Medical homes • Bundled payments • Comprehensive primary care initiative • Comprehensive ESRD • Medicare-Medicaid Financial Alignment Initiative Fee-For-Service Model	• Eligible Pioneer accountable care organizations in years 3-5

S H N H A

Accountable Care Organizations



Source: CMS 1/20/15- Mapped from address of parent ACO

ableau maps. www.tableausoftware.com/mapdata

t replacement comprehensive pay model

HEALTHCARE BUSINESS NEWS

Medicare Proposes First Mandatory Comprehensive Pay Model

HOSPITAL ADVISORS NOTED THAT PREVIOUS PAYMENT BUNDLES MAY PROVIDE USEFUL LESSONS TO PARTICIPATING ORGANIZATIONS IN THE SELECTED AREAS.

July 10—A new Medicare joint replacement payment model would be the first to require acute care hospitals in certain geographic areas to participate.

The proposed five-year Comprehensive Care for Joint Replacement model would subject hospitals to pay cuts or bonuses based on their quality and cost outcomes for joint replacement patients through 90 days post-discharge. The Centers for Medicare & Medicaid Services (CMS) said the model would generate $153 million in savings.

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out, MACRA in

Advocacy

Advocacy Topics

▸ Medicare Physician Payment Reform

Advocacy Update

Events

Federal Advocacy

Grassroots Advocacy

Political Action: AMPAC

State Advocacy: ARC

Health Policy

A | A Text size Print Email

Medicare Physician Payment Reform

Understanding how H.R. 2 will impact physicians

Following years of advocacy by the nation's physicians standing up for their patients and their practices, Congress repealed the sustainable growth rate (SGR) formula. H.R. 2, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was signed into law on April 16, 2015. The legislation (P.L. 114-10) provides positive annual payment updates of 0.5 percent, starting July 1 and lasting through 2019.

While the bill supports physicians who choose to adopt new payment and delivery models, it also retains Medicare's fee-for-service model. Participation in new models is entirely voluntary.

Physicians have choices with MACRA

Fee for service

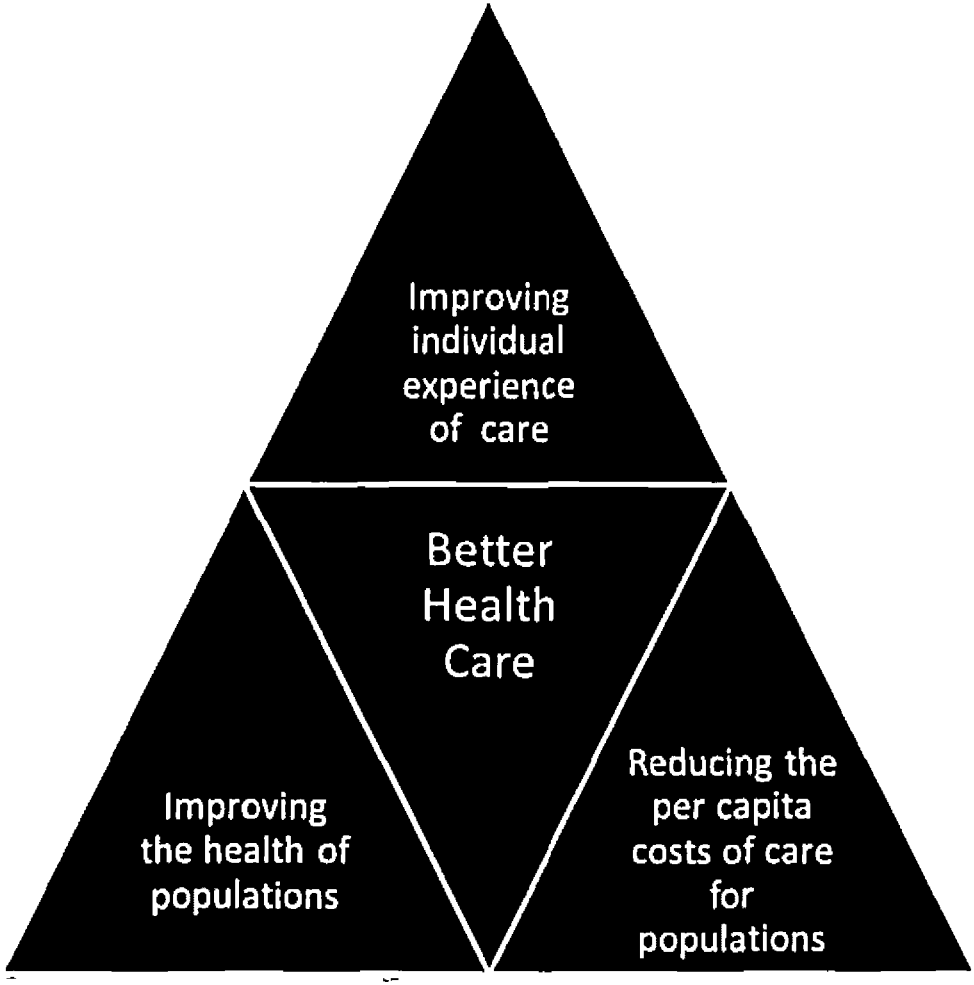
- 0.5 percent July 2015–2019; 0 percent 2020–2025; After that, those in APM get 0.75, others get 0.25 percent
- Former reporting programs consolidated into Merit-Based Incentive Payment System (MIPS) with greater flexibility
- Penalty risks reduced; potential bonuses added
- Benchmarks set prospectively, more timely feedback on performance
- Permanent coverage of chronic care management services with no annual wellness or preventive examination

Alternative payment models (APMs)

- 5 percent bonuses for six years aid transition to new models with more than nominal risk
- Physicians' role in creating new models specified
- Qualified medical homes count as APMs without requiring financial risk
- Demonstrated savings will produce higher payments
- Participants exempt from MIPS

S H N H A

ume to value: implications for the market



S H N H A

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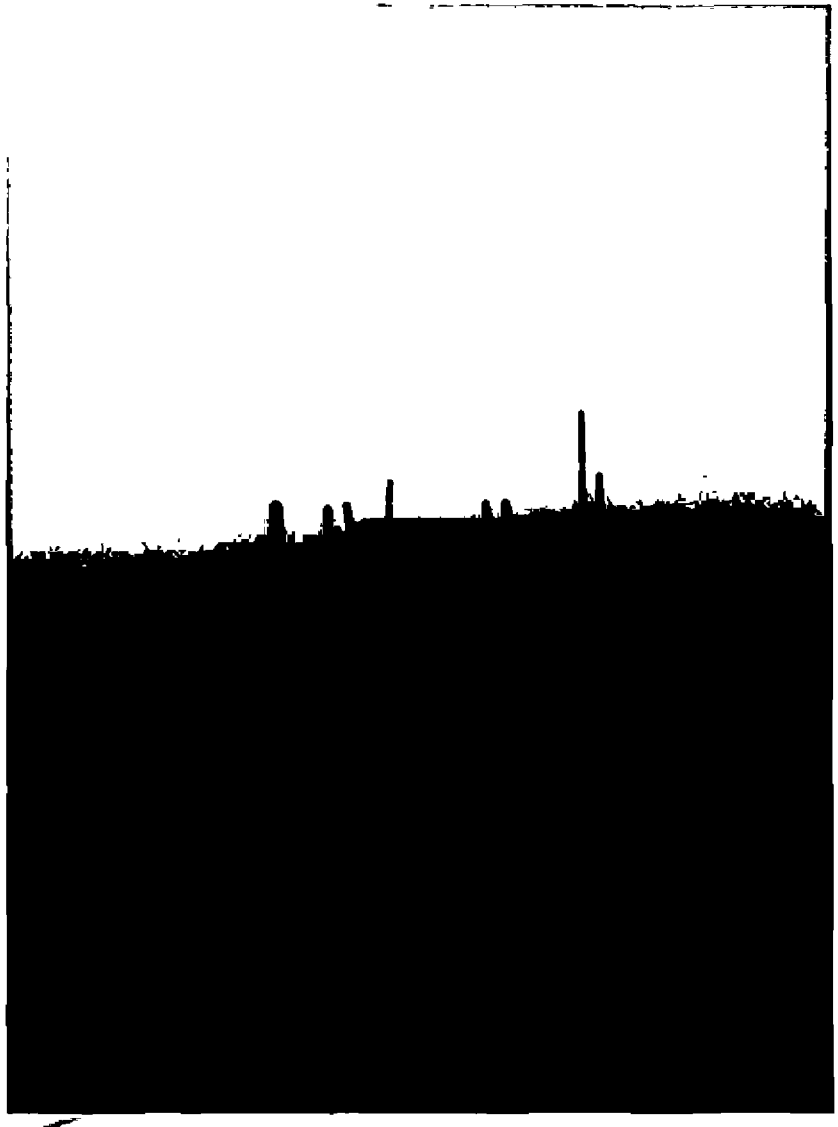
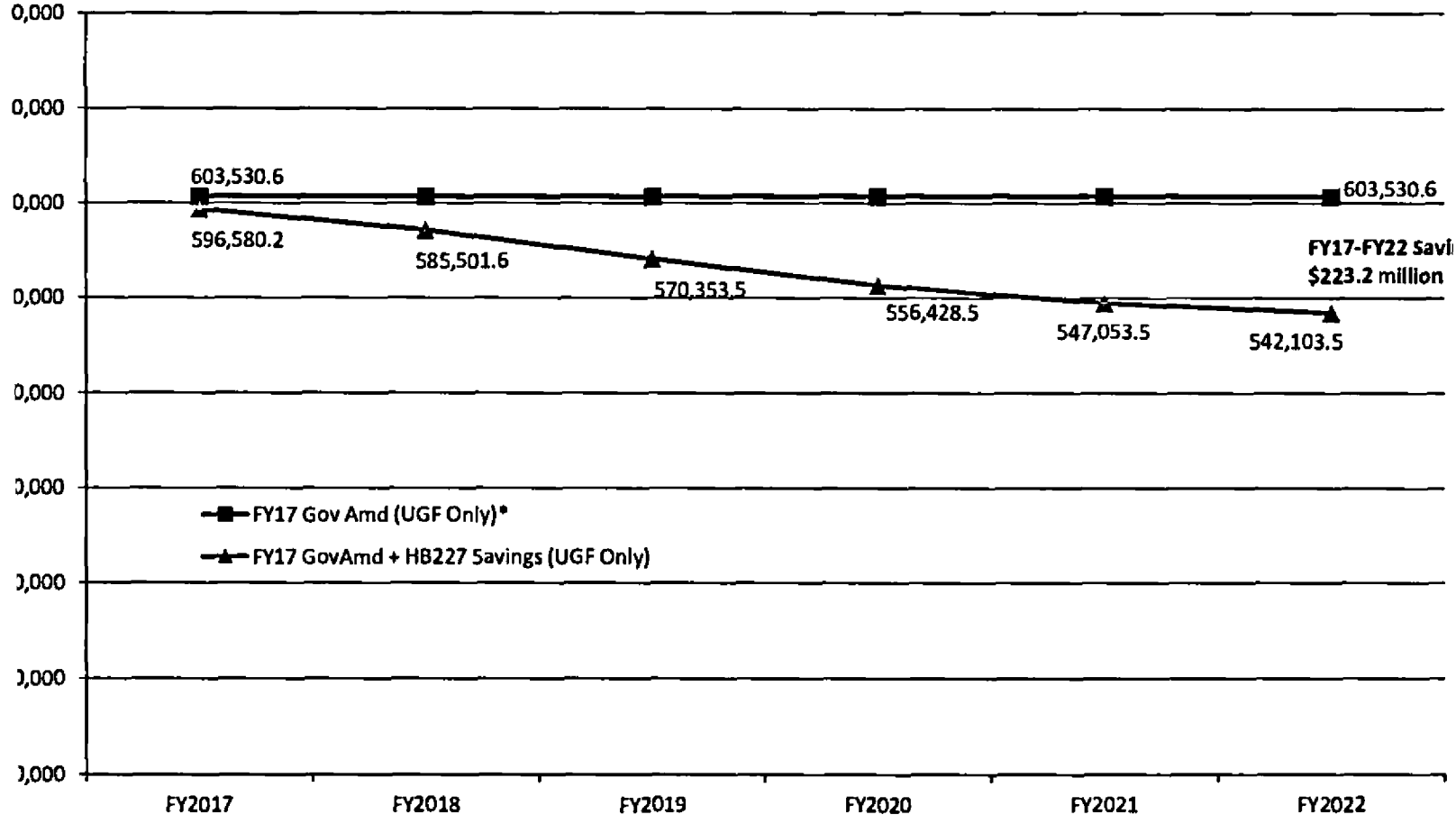


Thank you.
Questions?

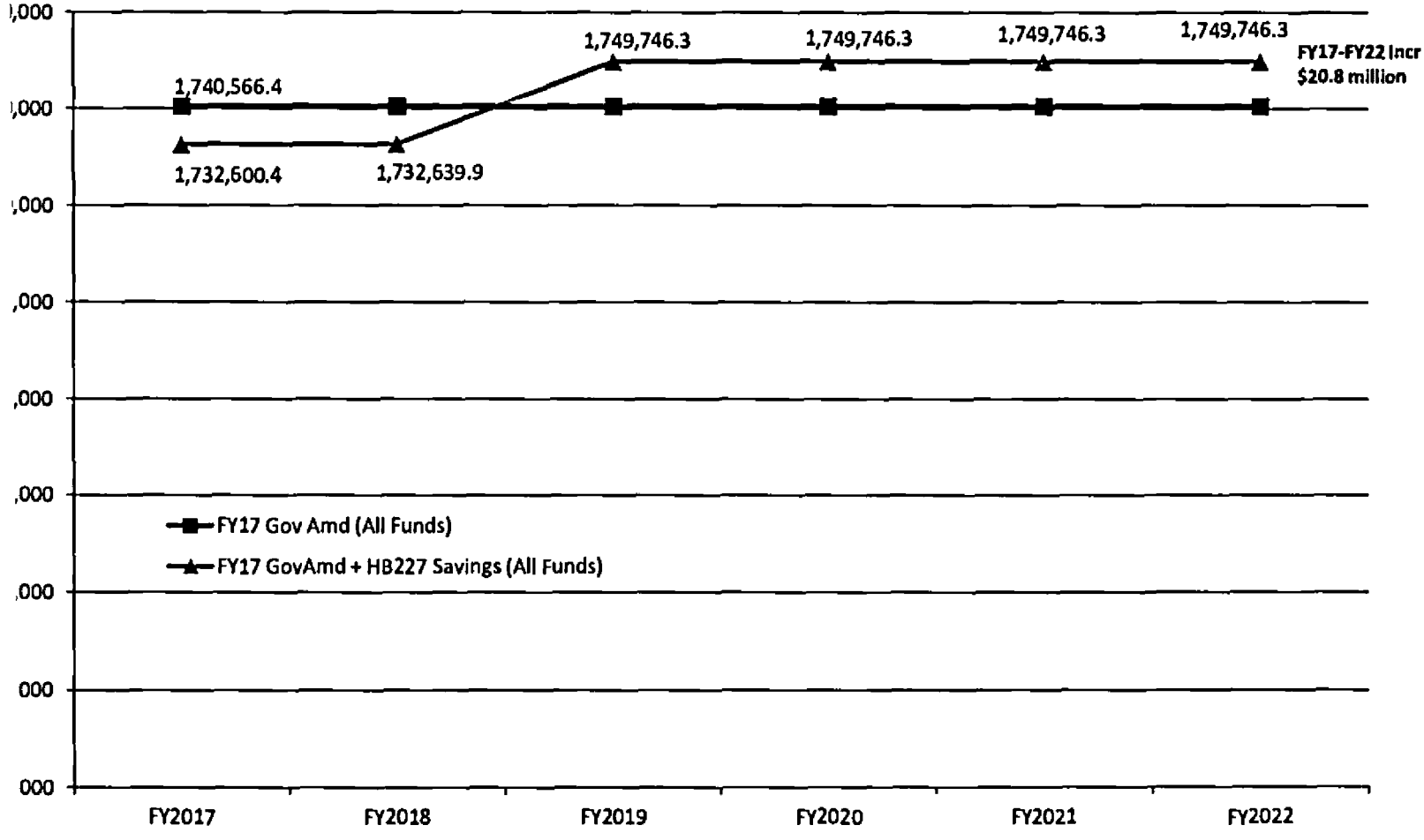
ogether
ping Our Future

FY17 Governor's Amended Budget to HB 227 Fiscal Notes
Department of Health and Social Services
(UGF Only)
($ Thousands)



) avoid double counting, the "FY17 Gov Amd (UGF)" line incorporates $9.45 million in UGF savings to reflect the anticipated change in CMS policy regardir
idicaid travel reimbursements for Tribal Health Organizations.

FY17 Governor's Amended Budget to HB 227 Fiscal Notes
Department of Health and Social Services
(All Funds)
($ Thousands)



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February 22, 2016

Honorable Paul Seaton
Chairman House Health & Social Services
Homer, AK 99603

Representative Paul Seaton,

I would like to submit written comment on House Bill 227, specifically the section that pertains to the removal of the grant requirement to be able to be reimbursed by Medicaid for behavioral health services provided.

As the Executive Director of one of the largest statewide children's Behavioral Health Service providers in Alaska I support the removal of the grant requirement. Our agency has in fact advocated for well over a decade to multiple State Commissioners to eliminate the requirement that a provider organization must also be a grantee to be able to bill Medicaid. Our position on this issue is based on the fact that there is neither a benefit nor logical business reason to connect the two items and as a result it can and does result in an excess administrative burden and financial waist to both providers and the State. Some of the excess administrative burden for providers comes from the preparation of applications and quarterly reporting which require significant man-hours while providing no benefit to the State, the provider, or the recipient of services. Additionally the labor involved by State employees in this process can be assumed to be equal or greater.

There are numerous examples of the State issuing grants to providers for $100 or less to allow them to meet the current State requirements to be eligible to bill Medicaid. This fact we believe highlights that the requirement has no meaningful value while it initiates a significant valueless paperwork burden.

In summary the elimination of the requirement will do nothing to reduce the quality of the services delivered or the assurance that Medicaid funding is properly spent, because Medicaid audits are the process to assure appropriate use of funding not the grant process.

I appreciate your consideration of our testimony and will be available to answer any questions.

Sincerely

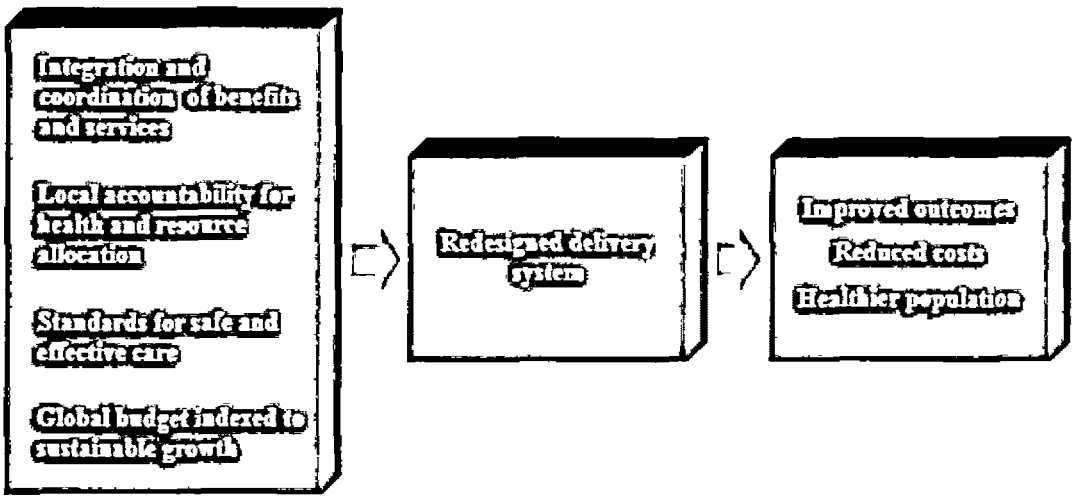
John W Regitano
Executive Director
Family Centered Services of Alaska

The global payment demonstration under consideration for the Kenai Peninsula is based on the Coordinated Care Organization model (CCO) currently operating in Eastern Oregon. A CCO consists of a network of health care providers (mix of physical health, mental health, and dental) and an insurer that will be formed and governed locally to serve the Kenai Peninsula Medicaid population.

Community Care Organizations are focused on prevention and assisting people with management of chronic conditions, such as diabetes, cardiovascular disease, respiratory disease etc. The coordinated management of a CCO aids in reducing unnecessary emergency room visits and over utilization of services without reducing benefits. A CCO has flexibility within their budgets to provide benefits with the goal of meeting the Triple Aim of better health, better care and lower costs for the population they serve.

The CCO would operate within a fixed global (single) budget, reduce medical cost inflation, improve member quality and outcomes and create a healthier population. The CCO will implement alternate payment methodologies, create a network of Patient Centered Primary Care Homes and will be measured based on quality and performance outcomes that are set established in conjunction with the State of Alaska. The CCO is governed by a partnership among the health care providers, insurer, community members, and stakeholders that have financial responsibility and risk.

Coordinated Care Organization



Key Financial Elements

- Operating within the global budget
- CCO incentive measures
- Full Risk model/Alternate payment methodologies

K. John McConnell, PhD
Center for Health Systems Effectiveness and Department of Emergency Medicine, Oregon Health & Science University, Portland.

In 2012, the state of Oregon transformed its Medicaid program by establishing 16 "coordinated care organizations," or CCOs, to provide comprehensive care for its Medicaid population. Coordinated care organizations can be considered a type of accountable care organization (ACO): they are locally governed; are accountable for access, quality, and health spending; and emphasize primary care medical homes. However, CCOs differ from most Medicare and commercial ACOs in their acceptance of full financial risk in the form of a global budget. Coordinated care organizations are also required to integrate financing and delivery systems for a broad scope of services, including mental health, addiction, and dental services. Approximately 90% of the state's 1.1 million Medicaid enrollees now receive care through CCOs that take a variety of forms that reflect the local context. These CCOs include a mix of for-profit and not-for-profit organizations and vary in the size of the population covered (from fewer than 11 000 enrollees to more than 200 000 enrollees). Some CCOs were formed out of previous Medicaid managed care organizations, whereas others were created out of new alliances and partnerships.

Oregon's transformation was made possible through a remarkable arrangement with the Centers for Medicare & Medicaid Services (CMS), which, beginning in 2012, would provide a total of $1.9 billion over 5 years to support transformation.[1] In exchange, the state agreed to reduce the rate of per capita Medicaid spending growth from a historical average of 5.4% to 3.4% within 3 years. Expenditures on Oregon's Medicaid acute care program totaled $3.6 billion in fiscal year 2013; the 2% reduction was forecast to generate $8 6 billion in total savings over 10 years.[2] Approximately 76% ($6.5 billion) of these savings would accrue to CMS, resulting in a substantial positive return on the initial federal investment. The prespecified growth rate represented a departure from arrangements that set Medicaid managed care rates through negotiations or according to a historical trend.

The Oregon-CMS agreement also required that the quality of care, as defined by 33 measures, would not diminish over time. Accountability was applied in the form prespecified spending or quality targets, ranging from $150 million in the second year to $185 million in years 3 and 4. While the investment from CMS exceeded the maximum penalties by close to $1 billion, much of the funding was used to fill a budget gap that would otherwise necessitate sizeable reductions in reimbursement rates. Thus, the state and its CCOs had strong incentives to meet their targets and avoid any penalties.

Oregon is now 3 years into this experiment, providing an opportunity to assess the performance midway through this ambitious Medicaid ACO reform. To date, the CCO model appears robust, despite initial concerns that the rapid transformation and constraints of the global budget could restrict access to care or create an infeasible business model.[3] The state has met its spending targets each year, avoiding potential financial penalties. Compared with a 2011 baseline, the Oregon Health Authority reported that per-member per-month spending for inpatient care had decreased in 2014 by 14.8%.[4] Per-member per-month spending on outpatient care was also lower, by 2.4%. However, outpatient spending trends masked a 19.2% increase in spending on primary care services—a change some observers might find encouraging, given the historical access challenges for the Medicaid population. Of note, reductions in spending were also observed in 2013, suggesting that these decreases were not primarily attributable to an influx of healthier Medicaid enrollees who joined CCOs in 2014. Together, the reductions in inpatient and outpatient spending suggest that Oregon is on track to meet its 5-year 3.4% spending growth target.

> Oregon's experience provides a number of lessons that are applicable to other states, regardless of whether they are expanding coverage.

Coordinated care organizations also improved quality on measures that were relevant to pay-for-performance bonuses. The 2014 CCO bonus pool was based on 3% of the global budget and determined by performance on 17 incentive measures. Thirteen CCOs received 100% of their bonus payments, and the remaining 3 CCOs received at least 60% of their bonus payments. In total, the state paid out more than $128 million to CCOs in 2014—approximately $150 for every Medicaid enrollee managed by the CCOs. Overall, statewide improvement was observed for all of the incentive measures for which 2011 data were available.

One of the most substantial improvements occurred in the rate of screening, brief intervention, and referral to treatment for alcohol and substance use, which moved from a statewide average of 0.1% in 2011 to 7.3% in 2014.[4] The change in this measure is noteworthy because it demonstrates the effect of incentive payments and because this quality measure, focused on

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creases in the percentage of their patients enrolled in a recognized patient-centered primary care home (PCPCH), moving from a statewide average of 51.8% in 2012 to 81.0% in 2014.[4]

However, CCOs demonstrated mixed performance across a range of measures that were not connected to incentive payments. Immunizations for children and adolescents and tobacco cessation efforts improved over the 2011-2014 time period. But rates of chlamydia screening, cervical cancer screening, and well-child visits in the first 15 months declined.

Although these results are promising, they are preliminary. A rigorous National Institutes of Health– and foundation-funded evaluation is under way. Even if Oregon and the CCOs meet their obligations to CMS, a formal analysis is necessary to determine the extent to which observed changes can be attributed to the CCO model, as opposed to larger, secular trends in health care.

Coordinated care organizations will face a number of important challenges in the upcoming years. The observed early successes may be largely attributable to an overall slowdown in health care spending and the ability of CCOs to identify easily achievable goals, such as improving the management of selected high-cost patients or reducing readmissions through care transition programs. Longer-term efforts to keep the growth rate of health care expenditures at 3.4% and improve quality may require more substantial changes in the delivery system. Furthermore, as part of the Affordable Care Act, Oregon expanded its Medicaid coverage, adding more than 400 000 people in 2014, a 69% increase over 2013 levels. Although 2014 data suggest CCOs were able to enroll these new members, the CCO transformation and the survival of the global budget mechanism will also require flexibility in the regulatory and actuarial requirements imposed by CMS. Whereas the state of Oregon and CCOs originally envisioned a model that moved away from the fee-for-service payment model to a global budget focused on outcomes, CMS has increased its scrutiny of the budgeting mechanism and its requirements for detailed claims and encounter data as the basis for rate setting.[6] This development challenges the ability for CCOs to invest in quality or upstream public health initiatives and limits the transformative potential of the original CCO model.

Oregon's experience provides a number of lessons that are applicable to other states, regardless of whether they are expanding coverage. The Oregon-CMS exchange, if successful, could serve as a template for Medicaid reform. By providing an up-front investment to states but holding them accountable for the increase in spending, CMS has an opportunity to test reform models that have built in incentives to achieve savings. The CCO model also offers an important test of the potential to contain the cost of the Medicaid program through policies that focus on reforming the delivery system, as opposed to reforms that engage patients through greater cost-sharing or premiums. Furthermore, as part of the ACO model, the lessons from Oregon will provide yet another indication of what types of ACO models have the best chance of improving the value of care.[7] Overall, lessons from Oregon will provide important evidence about the extent to which new models can provide adequate access, improve population health, and slow the growth of health care spending.

ARTICLE INFORMATION

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Role of the Funder/Sponsor: The funding sources had no role in the preparation, review, or approval of the manuscript.

REFERENCES

1. McConnell KJ, Chang AM, Cohen DJ, et al. Oregon's Medicaid transformation: an innovative approach to holding a health system accountable for spending growth. *Healthc (Amst).* 2014;2(3):163-167.

2. Oregon's Medicaid waiver agreement. Oregon Health & Science University http://www.ohsu.edu/xd/research/centers-institutes/center-for-health-systems-effectiveness/oregon-medicaid-waiver.cfm. Accessed February 1, 2016.

3. Stecker EC. The Oregon ACO experiment, bold design, challenging execution. *N Engl J Med* 2013;368(11):982-985.

4. Oregon's health system transformation 2014 final report. Oregon Health Authority http://www.oregon.gov/oha/Metrics/Documents/2014-Final-Report-June-2015-ADA-Accessible.pdf. Accessed January 25, 2016.

5. Lewis VA, Colla CH, Tierney K, Van Citters AD, Fisher ES, Meara E. Few ACOs pursue innovative models that integrate care for mental illness and substance abuse with primary care. *Health Aff (Millwood).* 2014;33(10):1808-1816.

6. Methodology: 2015 rate redevelopment for coordinated care organizations. Oregon Health Authority http://www.oregon.gov/oha/analytics/OHPRates/2015%20Rate%20Methodology%20Summary.pdf. Accessed January 25, 2016.

7. Nyweide DJ, Lee W, Cuerdon TT, et al. Association of Pioneer Accountable Care Organizations vs traditional Medicare fee for service with spending, utilization, and patient experience. *JAMA.* 2015;313(21):2152-2161.

I hope this message find you well. To begin, I would like to thank you for your advocacy on behalf of Alaska's children and families. Your continued advocacy for common-sense approaches to health and wellness are a stellar example of leadership in action. Your current Medicaid reform bill is no exception. I applaud many of the initiatives and efficiencies highlighted by your legislation, including

- Application for 1115 and 1915 i/k waivers
- Increased efficiency and coordination of administrative audits
- Improved management of super-utilizers

Each of these steps promises to improve the efficiency and delivery of health care services while controlling, and in some cases reducing, the cost of care. Along with my general support of your efforts, I must also voice a word of caution. Included in your proposed legislation is language which, at first glance, appears to remove the grantee requirement for medical assistance providers of behavioral health services. The exact of impact of this change is not entirely clear to me, but I'm concerned that it could carry with it a host of unintended consequences. Removing the grantee language would surely increase the pool of behavioral health providers; however, it would also open the door to providers who, for various reasons, may not operate according to the standards with which the State and the provider community have become accustomed. For example, under the current requirements, in order to qualify for a behavioral health grant, an applicant must be a non-profit corporation (or State or tribal entity) which is accredited by a national accrediting body. These requirements may be unnecessary for the provision of clinical services (which constitute a relatively small percentage of Medicaid behavioral health expenditures); however, **I strongly urge you to retain the current grantee requirements for the provision of behavioral health rehabilitative services.** In order to provide these services, providers need to have well-structured, mission-driven service programs which are closely monitored by regulatory and accrediting bodies. Poorly monitored, profit-driven companies should not be granted access to expensive, high volume billing opportunities paid for at public expense. Allowing such access would significantly increase the probability of fraud, waste, and abuse (as we've seen in other community-based healthcare services), and could jeopardize the behavioral health rehabilitative services sector.

If the legislature wishes to increase access to behavioral health rehabilitative services, I suggest that, rather than increasing the number of providers, there should be a concerted effort to streamline the current service delivery system through regionalization of grant funds,

eligibility.

Again, I believe that there is some justification for expanding the pool of providers for clinical services (i.e. to include all licensed behavioral health providers), as these providers are vetted and monitored by State boards and the cost of clinical services is relatively modest. However, I strongly urge you to retain the grantee requirement for rehabilitative services. Thank you for considering these suggestions, and do let me know if there is anything I can do to support you in your efforts.

Sincerely,

Chris Gunderson, MA, MEd, NCC

President/CEO

Denali Family Services

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Alaska ACEP Recommendations for Medicaid Redesign

The Alaska chapter of the American College of Emergency Physicians shares the goals of Medicaid redesign. We would like to help seize the opportunity to improve patient outcomes, optimize access, increase the value of services, and provide cost containment for all patients, not just Medicaid enrollees.

Improved Patient Access to Appropriate Care: Focus on coordinating care between ED's and further outpatient care has been shown in Washington state to save Medicaid dollars. When patients have Medicaid we should be able to assess, treat, stabilize, and, when they do not require admission, point them toward timely primary care and specialist follow up. This will decrease revisits, potentially avoid admissions, and decompress waiting rooms. It may also help decrease individual ED visit time and cost when we feel confident appropriate further work up will happen. (1,4) We specifically suggest doing this by the following suggestions.

1. **Assigning Primary Care Physicians at Time of Enrollment:** Making enrollment as simple as possible and assigning a PCP at time of enrollment will create an immediate medical home. This would also improve patients' access to care, as they know where to start and have an advocate for their health. PCP information could be available every time a Medicaid Patient uses their insurance so pharmacies, ED, specialist, case works can all easily identify the medical "home" for this patient. This would help provide continuity of care to patients, reducing redundancy in testing or delayed preventive care. The State will need to create an adequate network of primary care physicians in all regions to achieve this. Adequate compensation and a model that does not shift risk onto primary care will be necessary. (4)
2. **Encouraging Participating Primary Care Providers to Hold "Urgent Openings" for ED Follow Up:** Access to primary care follow up will help avoid repeat ED visits. A mechanism to notify participating primary care and specialists of the need for ASAP follow up will be key to avoiding repeat visits for the same issue. This could be as simple as a voice message system to leave a notification of encounter and requested time to follow up. A patient should be able to leave the ED assured they will get appropriate further care. (1)
3. **Ensure Adequate Specialist Networks.** While this is important for primary care, it is important for specialist too. The ED operates under EMTALA which mandates we have specialists on call to help treat and stabilize emergent patients. The EMTALA specialist also sees urgent follow up in their office. Adequate participation of specialists will be key to ensuring follow up is seamless, and that patients are not confronted with an uncovered visit. Adequate compensation will be necessary to gain participation. Medicaid should cover all EMTALA follow up care, or a patient will end up back in the ED with a costlier, emergency complication.

4. **Continuity of Coverage:** A system (and staff) that helps patients enrolled in Medicaid stay enrolled in Medicaid without gaps in coverage will help patients maintain appropriate outpatient care. When patients no longer qualify for Medicaid, a process that helps them get onto appropriate coverage will save Medicaid dollars, and ensure seamless patient care.

Addressing the Needs of the Vulnerable and High Utilizing Patients: Behavioral Health, Drug and EtOH treatment, Case Management:

5. **Care Coordination of High Utilizers of the System.** High Utilizer to the emergency department often have difficult social environments, behavioral health issues, substance abuse, and complex medical issues. Care coordination of behavioral health and medical care will help to improve care and contain cost for patients that often struggle to follow through with both their medical and behavioral health care. Care coordinators who are community based, and focused on ED high utilization, with 24 hr access, are key for this to be successful. We see this as a collaboration between the Emergency Department, primary care providers, mental health providers, the court, state funded case mangers, and hospital based social workers. (1)
6. **Creating Financial Incentives to Build Acute Psychiatric Crisis and Drug and Alcohol Centers to Stabilize Substance Abuse and Psychiatric patients.** Psychiatric emergency departments are often built in connection to emergency departments to allow a single point of access for patients facing a crisis that is often multifactorial. There is currently only one in the state. More ED's in all regions of the state need this capability without unduly impacting their care for medical patients. By doing so, we could avoid unnecessary inpatient psychiatric admission, unclog emergency departments and help to provide treatment for those ready to receive it. Drug and alcohol detox centers are in extremely short supply in all areas of the state; increasing availability would provide supervised detox for patients ready for this process and help patients avoid repeat visits. For example, please see the Alameda Model Reference.(2)
7. **Increasing Inpatient Psychiatric Beds:** This will allow sick patients with acute exacerbation of psychiatric disease to be treated appropriately rather than being treated in jail or sent back to their outpatient setting in a decompensated state. Many patients are spending multiple nights held in an Emergency Department bed awaiting transfer to inpatient psychiatric care.

Information Exchange:

9. **Improved Medical Information Exchange.** This would improve quality of care, decrease redundancy in care and testing, decrease prescribing errors, and improve ability to track ED use in real time. Currently PAMC and Alaska Regional are on a compatible system that allows providers to see the other facilities testing results

and notes (since ARH started using EPIC). It also allows providers to see that a patient had been in the other facility, something that previously is only known if a patient discloses the information. Creating a way for Emergency Departments to share visit information without relying on inter hospital requests for information would be a huge step in improving and streamlining care. Supporting systems like the EDIE system would allow all hospitals to receive "pushed" data and prevent over testing and improve coordinated care.

10. **Fully Funding and Improving the Interface with the AK Prescription Database.** The database is our most effective tool to track narcotic use and abuse. The current system has tenuous funding and is difficult to use. An improved system will not only help curb inappropriate prescriptions, but will also save lives.

Supporting Systems of Care:

11. **Developing a Statewide Transfer Call Center to Improve Statewide Coordinated Services.** A statewide transfer call center would streamline movement of patients from more rural or regional care centers to a higher level of care for trauma, cardiac, stroke, complex medical and behavioral health care. Statewide mapping of resources available in real time accessible to providers and EMS would also help facilitate efficient movement of patients. This would allow improved use of current resources and reduce medical transport services. A statewide transfer center could implement standardized air transport guidelines and prevent bypassing the closest appropriate center, saving cost. Longterm data from a transfer center would also allow the state to ensure there are adequate networks of specialist to serve the regional needs of the patient population given longterm transfer pattems.
12. **Coordination of statewide EMS including protocol standardization, training and direction.** While we recognize the need for variable EMS service capabilities given the large geographic area, and highly variable population density, the disjointed nature of AK EMS direction and structure leads to unserved areas, highly variable protocols, increased air transportation, and a challenging urban to rural interface. Statewide coordination could improve EMS system interface, ensure modern treatment protocols across the state, and ensure adequate coverage. Statewide Coordination should also include increased state support for rural EMS staffing, and include development of road system EMS transport capability. This would further support rural crews, often volunteers, and their communities, who lose their only ambulance and crew when transporting to the nearest facility. Road system EMS transport could not only avoid air transport and save cost for patients that do not need flight transfer, but also serve as a valuable back up for flight transfer when weather is bad, saving a patient from weather hold in a facility unable to give definitive care.

Creating a Safety Net While Minimizing Defensive Medicine:

12. **True Tort Reform:** Reform would go a long way to encourage rational medicine as opposed to defensive medicine. Emergency Department providers and the community specialists on EMTALA call are the only physicians required to see and treat any patient that needs their services. This places providers at a different level of liability risk in an environment that often requires care and stabilization to be performed with limited information. Removing individual liability in this environment while encouraging a strong QA/QI process would go a long way to improve quality of care, encounter value, and contain costs. Creating a patient compensation fund from multiple stakeholder sources could ensure that patients that are harmed by misdiagnosis or medical error are cared for and compensated appropriately, while also improving access and quality to EMTALA care. Decreasing risk of providing EMTALA care may increase subspecialty amiability when helping to provide an EMTALA safety net. Please see reference for ACEP EMTALA legislation proposal. (3)

Thank you for allowing AK ACEP to be a partner in the development of Medicaid expansion. Other resources, including a link to the Washington State ACEP 7 best practices shown to save 33 million dollars annually, are below. (1)

(1) "Implementing Best Practices Improves Emergency Care, Reduces States Medicaid Costs" July 24, 2013 ACEP press release
http://www.acep.org/Legislation-and-Advocacy/State-Legislation---Advocacy/Implementing-Best-Practices-Improves-Emergency-Care,-Reduces-States--Medicaid-Costs/

(2) Effects of a Dedicated Regional Psychiatric Emergency Service in Boarding of Psychiatric Patients in Are Emergency Departments. Western Journal of Emergency Medicine. Zeller et al. Volume XV No 1, February 2014
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3935777/pdf/wjem-15-1.pdf

(3) ACEP EMTALA Reform
http://www.acep.org/Liability-Reform-HR-836/

(4)Medicaid and CHIP Payment and Access Commission "Revisiting Emergency Department Use in Medicaid" July 2014
http://2c4xez132caw2w3cpr1il98fssf.wpengine.netdna-cdn.com/wp-content/uploads/2014/08/MACFacts-EDuse_2014-07.pdf

February 19, 2016

Senator Pete Kelly, Co-Chair
Senator Anna McKinnon, Co-Chair
Senate Finance Committee
Alaska State Capitol Building
Juneau, AK 99801-1120

RE: Proposed Medicaid Reform Legislation

Dear Senate Finance Co-Chairs and Members of the Committee:

The Alaska Psychological Association (AK-PA) was formed as a member-based organization to advance psychology as science, profession and as a means for promoting human welfare in Alaska. Licensed psychologists are highly trained, independent professionals who, if permitted to practice to the full extent of their licenses, can contribute meaningfully to improve patient mental health and primary care outcomes. There is a shortage of mental health professionals in Alaska, and the anticipated expansion of the Medicaid population, along with the movement toward integrated healthcare will increase demand for quality mental health services. Thus, Medicaid programs should recognize and cover on a consistent basis psychotherapy, testing and evaluation services performed by psychologists within the state's scope of practice. This will promote patient choice of provider, and allow Medicaid patients to access the range of psychological services available to patients in the private sector.

Therefore, as the State of Alaska and the Alaska Legislature undertakes Medicaid Reform, we are advocating for specific policy changes that would result in more effective, accessible, and efficient mental health treatment, and result in reduced healthcare costs.

Our recommendations are as follows:

I. **Revise the definition of 'physician' to include licensed psychologists for the purposes of providing mental health services under the State of Alaska Medicaid program.** Currently, psychologists are required to practice under the supervision of a physician, often resulting in unnecessary additional costs; bottlenecked delivery of mental health services and under-utilization of Alaska licensed professional psychologists. Other states have incorporated such a model in their Medicaid plans and received federal approval. We commit to working with your staff and DHSS to craft language to accomplish this recommendation.

II. **Expand the services that licensed psychologists are approved to provide in accordance with 7 AAC 105.210.** Currently, licensed psychologists can only provide psychological testing in an unrestricted manner. Licensed psychologists cannot provide the full array of psychological services, unless they work under the supervision of a physician or within a state grantee recipient organization. Additionally, licensed psychologists in integrated care settings are not able to bill for the Health and Behavior (H&B) Assessment/Intervention codes or for the Screening, Brief Intervention, Treatment to Referral (SBIRT) interventions unless they are supervised by a physician and located within a Federally Qualified Health Center (FQHC). This represents an unnecessary limitation in the provision of services that psychologists are trained to deliver.

requirements and typically have more formal education and training than Master's level interns. Thus, Doctoral Psychology Interns, with appropriate supervision, should be able to bill under the psychotherapy and psychological testing codes. This will allow for additional training sites and opportunities in Alaska that will attract and retain more interns, thus providing more qualified providers to serve our growing communities. These interns are then likely to remain in our state and become resident Licensed Psychologists.

AK-PA stands ready to assist you in your efforts. We can access tremendous resources through our national association database to support these and other proposals. Please consider us as a resource.

Sincerely,

Michael Sobocinski, PhD
President, Alaska Psychological Association

cc: Members of Senate Finance Committee
Commissioner Davidson, DHSS
Randall Burns, Director, Division of Behavior Health, DHSS
Jeff Jessee, CEO Alaska Mental Health Trust Authority

TRAUMA CARE IN ALASKA 2016

In 2008, the American College of Surgeons conducted a review of Alaska's state-wide trauma system and made several recommendations.

In 2010 the Alaska Legislature passed the Trauma Fund Act (AS 18.08.085) creating grants to state certified trauma centers. Since passage of this act, there has been rapid and sustained development of an inclusive trauma system in Alaska.

The number of Alaska hospitals meeting the standards for trauma center designation has increased from 5 of 24 hospitals in 2009 (20%) to 17 hospitals currently (70%) -15 level IV (basic) and 2 level IIs (highest in Alaska). There still is a need for Level III trauma centers in mid-sized communities.

Alaskans now have quicker access to medical providers with special training in care of injured patients.

Better protocols and cooperation between hospitals working as a system have resulted in a decrease in patients in rural areas requiring two hospital evaluations and multiple medical transports to reach definitive care.

In 2014 there was a 33% decrease in double transports. Seriously injured patients are now more frequently brought directly to the hospitals where they can get definitive care. This resulted in approximately 50 fewer indirect air medical transports in 2015 compared to 2010.

The average cost for an air medical transport from the bush to Anchorage was $64,000. Approximately 20% of all trauma medical evacuations are Medicaid recipients.

Physicians in Fairbanks report that, since Providence Alaska Medical Center became a level II Trauma Center in February 2015, there has been a decrease in sending injured patients from Fairbanks to Harborview Trauma Center in Seattle.

Fairbanks to Seattle (Harborview) air ambulance transports cost $153,655. Fairbanks to Anchorage air ambulance transports cost $36,745. Sending trauma patients from Fairbanks to Anchorage instead of to Seattle results in significant savings in air ambulance transport costs.

Trauma centers provide teams of trauma trained medical professionals available to care for severely injured patients without delay. On notification of the pending arrival of a seriously injured patient, hospital resources and personnel are mobilized to be immediately available to evaluate, stabilize and treat the injuries. This is a proven approach that has resulted in up to a 25% reduction in death from serious injury.

American College of Surgeons triage criteria, and are applied based on the medical condition of the patient.

Trauma centers, like EMS, fire and police departments, are available 24 hours, 7 days a week. Few trauma centers are publically financed in a similar manner to EMS, fire, and police which are primarily funded through local taxpayer dollars.

FUNDING and OPTIONS

From 2010-2015, $5.9 million was allocated and dispersed to the 17 designated trauma centers through the Alaska Trauma Fund. All money went to trauma training, equipment and personnel. A 2015 audit by DHSS showed all funds were used appropriately.

In FY 2016 no money was allocated to the trauma fund.

Most states use directed fees or surtaxes to fund their trauma systems. The Alaska Constitution makes this a difficult option due to the prohibition of dedicated funds.

1. **Appropriate money for the trauma fund.** This is a time of significant austerity but the trauma fund has been an excellent investment and has helped institute a system not just for treating injured patients but also a process for moving Alaskans with any time critical condition to the right place in the right amount of time.

2. **Permit Medicaid to pay for trauma team activations at designated trauma centers and require private insurers doing business in Alaska to pay for trauma activations.** In most of the U.S., the Centers for Medicare and Medicaid Services (CMS) and private insurers pay trauma activation fees to designated trauma centers for care of seriously injured patients. Prior notification by outside medical entities (i.e. EMS or transferring hospital) is required.

The trauma team activation fee was designed to better reimburse the cost of readiness and trauma team activation. Trauma team activations are based on levels of activation, determined by the local community, state, or the American College of Surgeons triage criteria, and are applied based on the patient's medical condition. Fees are based on the amount necessary to operate the trauma center for all who need it, but typically vary based on the level of activation.

The level of commitment by trauma centers coupled with the public expectation for high quality care requires trauma centers to make considerable investments in readiness.

Appropriation of money to the trauma fund and assuring that private insurance carriers in Alaska and Medicaid pay for trauma activations at designated trauma centers will help sustain the gains made in trauma system development. Lack of financial support to offset the costs of higher training and availability of qualified medical personnel threatens those gains. The cost of readiness is expended regardless of patient volume or insurance status. Allowing trauma centers to recoup some of their readiness costs will help sustain and develop our trauma system resulting in both improved patient care and outcomes and significant cost savings.

Frank Sacco, MD, FACS, Chief of Surgery, Alaska Native Medical Center

Chairman, Alaska Trauma System Review Committee

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Mark S. Johnson, MPA

Member, Alaska Trauma System Review Committee

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Page 2, line 7, add "local physicians," in front of "tribal"

Delete p. 7, lines 3 to 9 and replace with the following:

(d) On or before December 1, 2016, the Department of Health and Social Services shall enter into a contract or contracts with one or more organization(s) led by persons, which must include Alaska-based physicians, with experience in managing high risk Alaskan patient populations and bundled payment programs, that includes Alaska based physician ownership to:

(1) operate a care management program that includes identification and active management of care by medical professionals for the highest utilizer of Medicaid services to improve the quality and efficiency of care delivery to this patient population.

(2) establish a community based project to reduce the cost of care associated with hospitalizations for specific episodes which includes the period of 90 days post discharge. This project will be similar to the CMS Innovation Model for Bundled Payments for Care Improvement (BPCI) initiative. The provider-led entity shall operate the project, with the support from the department, which will include shared savings for participating physicians. The project must include:

(A) A process for defining and identifying patients that meet criteria for inclusion into the program

(B) A process for assisting patients with plans of care post discharge and for assisting patients in making appointments with primary care providers within 96 hours after a hospitalization.

(C) A physician-led, clinical case management and care coordination program

(D) A procedure to allow for patient choice.

(E) An option to elect bundles in either Model 2 or Model 3, which both involve a retrospective bundled payment arrangement where actual expenditures are reconciled against a target prices for an episode of care.

a. In Model 2, the episode includes the inpatient stay at an acute care hospital plus the post-acute care and all related services up to 90 days after hospital discharge.

b. In Model 3, the episode of care is triggered by an acute care hospital stay but begins at initiation of post-acute care services with a skilled nursing facility, inpatient rehabilitation facility, long-term care hospital or home health agency.

(F) And may also include bundles not involving hospital stays, including, but not limited to pediatric, maternity, chronic kidney disease and orthopedic episodes of care.

(G) The department shall share historical cost data associated with episodes of care with the provider-led entity so that a cost baseline can be agreed upon.

(H) The department shall share cost data with the provider-led entity in a timely manner.

(3) operate one or more primary care clinics to provide and manage primary care and related services for beneficiary who have experienced an episode of care in connection with the program set forth in subjection (d)(2) above after such beneficiary has completed such episode of care. The goal of the primary care clinic shall be to improve long term outcomes for beneficiary while reducing utilization of services among high risk populations.

(e) The department shall adopt regulations necessary to implement the provision set forth in subsection (d) above, request technical assistance from the United States Department of Health and Human Services and apply to the United States Department of Health and Human Services for waivers or amendments to the state plan as necessary to implement the project under this section.

(f) In connection with subsection (d) above, the department shall create a performance and quality reporting system. Any entity being awarded a contract in connection with subsection (d) must include at least twenty percent ownership by residents of the state of Alaska, including health care providers actively providing care to high risk patients in the state of Alaska.

Page 7, line 21 add "bundled or episodic payment programs, including programs similar to the Bundled Payment for Care Improvement Program operated by CMS," in front of "changes in provider payments".

Delete Page 8, line 21 and replace with:

(1) Bundled or episodic payment programs, including programs similar to the Bundled Payment for Care Improvement Program operated by CMS.

Page 8, line 29 delete "a global payment fee structure and replace with "a bundled or episodic payment programs, including programs similar to the Bundled Payment for Care Improvement Program operated by CMS," in front of "changes in provider payments".

Delete p. 8, line 29 starting with "The demonstration project must..." through line 31.

Page 9, delete lines 1 to 5 and "outcomes." on line 6.

Page 9, line 7 change 2019 to 2020

Page 9, line 9 add at the end of the paragraph:

Any entity being awarded a contract in connection with 47.07.036(d) must include at least twenty percent ownership by residents of the state of Alaska, including health care providers actively providing care to high risk patients in the state of Alaska.

Page 10 delete lines 18 to 25 and replace with:

On or before December 1, 2016, the Department of Health and Social Services shall enter into a contract or contracts with one or more organization(s) led by persons, which must include Alaska-based physicians, with experience in managing high risk Alaskan patient populations and bundled payment programs, that includes Alaska based physician ownership to:

(1) operate a care management program that includes identification and active management of care by medical professionals for the highest utilizer of Medicaid services to improve the quality and efficiency of care delivery to this patient population.
(2) establish a community based project to reduce the cost of care associated with hospitalizations for specific episodes which includes the period of 90 days post discharge. This project will be similar to the CMS Innovation Model for Bundled Payments for Care Improvement (BPCI) Initiative. The provider-led entity shall operate the project, with the

support from the department, which will include shared savings for participating physicians. The project must include:

(A) A process for defining and identifying patients that meet criteria for inclusion into the program

(B) A process for assisting patients with plans of care post discharge and for assisting patients in making appointments with primary care providers within 96 hours after a hospitalization.

(C) A physician-led, clinical case management and care coordination program

(D) A procedure to allow for patient choice.

(E) An option to elect bundles in either Model 2 or Model 3, which both involve a retrospective bundled payment arrangement where actual expenditures are reconciled against a target prices for an episode of care.

a. In Model 2, the episode includes the inpatient stay at an acute care hospital plus the post-acute care and all related services up to 90 days after hospital discharge.

b. In Model 3, the episode of care is triggered by an acute care hospital stay but begins at initiation of post-acute care services with a skilled nursing facility, inpatient rehabilitation facility, long-term care hospital or home health agency.

(F) And may also include bundles not involving hospital stays, including, but not limited to pediatric, maternity, chronic kidney disease and orthopedic episodes of care.

(G) The department shall share historical cost data associated with episodes of care with the provider-led entity so that a cost baseline can be agreed upon.

(H) The department shall share cost data with the provider-led entity in a timely manner.

(3) operate one or more primary care clinics to provide and manage primary care and related services for beneficiary who have experienced an episode of care in connection with the program set forth in this Section above after such beneficiary has completed such episode of care. The goal of the primary care clinic shall be to improve long term outcomes for beneficiary while reducing utilization of services among high risk populations.

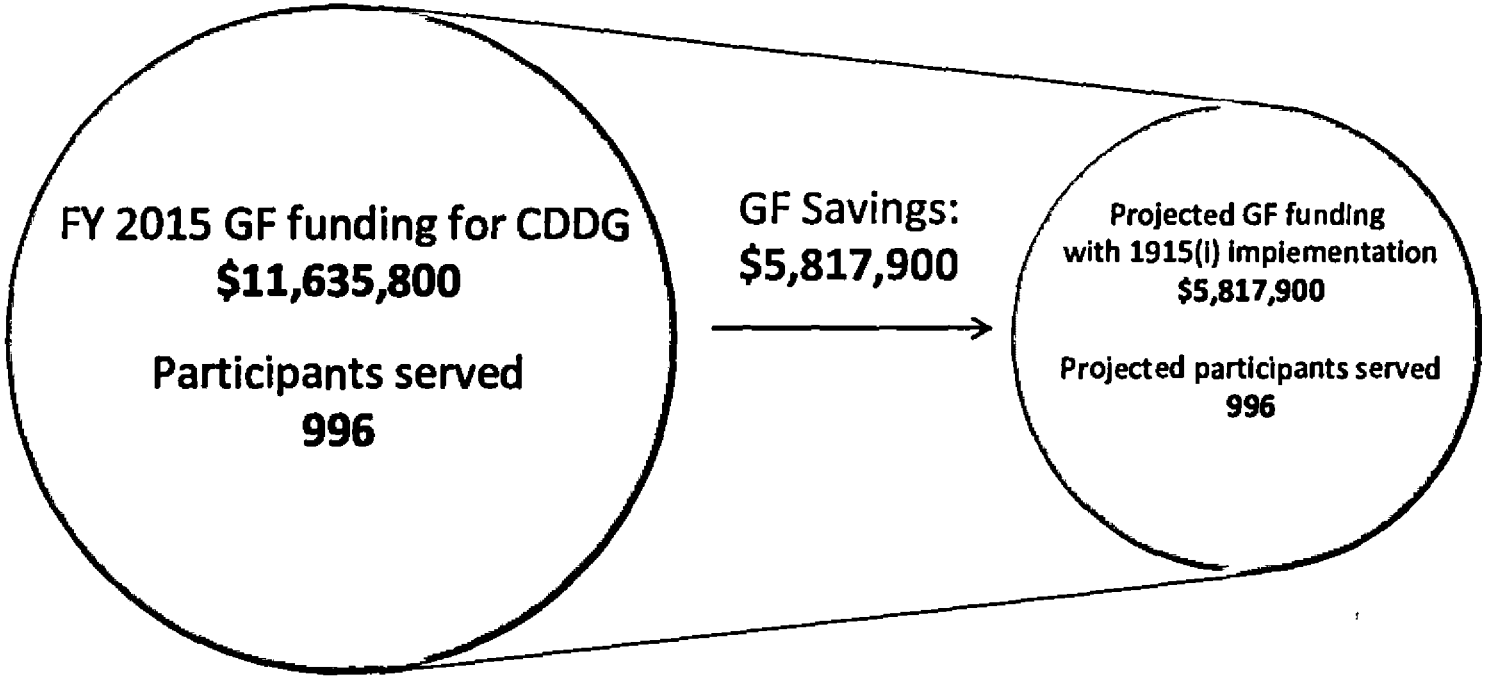
The department shall adopt regulations necessary to implement the provision set forth in this Section, request technical assistance from the United States Department of Health and Human Services and apply to the United States Department of Health and Human Services for waivers or amendments to the state plan as necessary to implement the project under this section.. Any entity being awarded a contract in connection with subsection (d) must include at least twenty percent ownership by residents of the state of Alaska, including health care providers actively providing care to high risk patients in the state of Alaska.

caid Reform in Alaska
dicaid State Plan Options
1915(i) and 1915(k)

Community Developmental Disabilities Grants 1915(i) Impact

	Current CDDG funding and individuals served	Projected CDDG funding and individuals served with 1915(i) implementation
luals served	996	996
ding	$11,635,800	$5,817,900
l funding	$0	$5,817,900

ividuals currently receiving CDDG would be eligible for 1915(i) option. As a result, all of the t GF funding ($11,635,800) can be refinanced under 1915(i) at a 50% federal match.



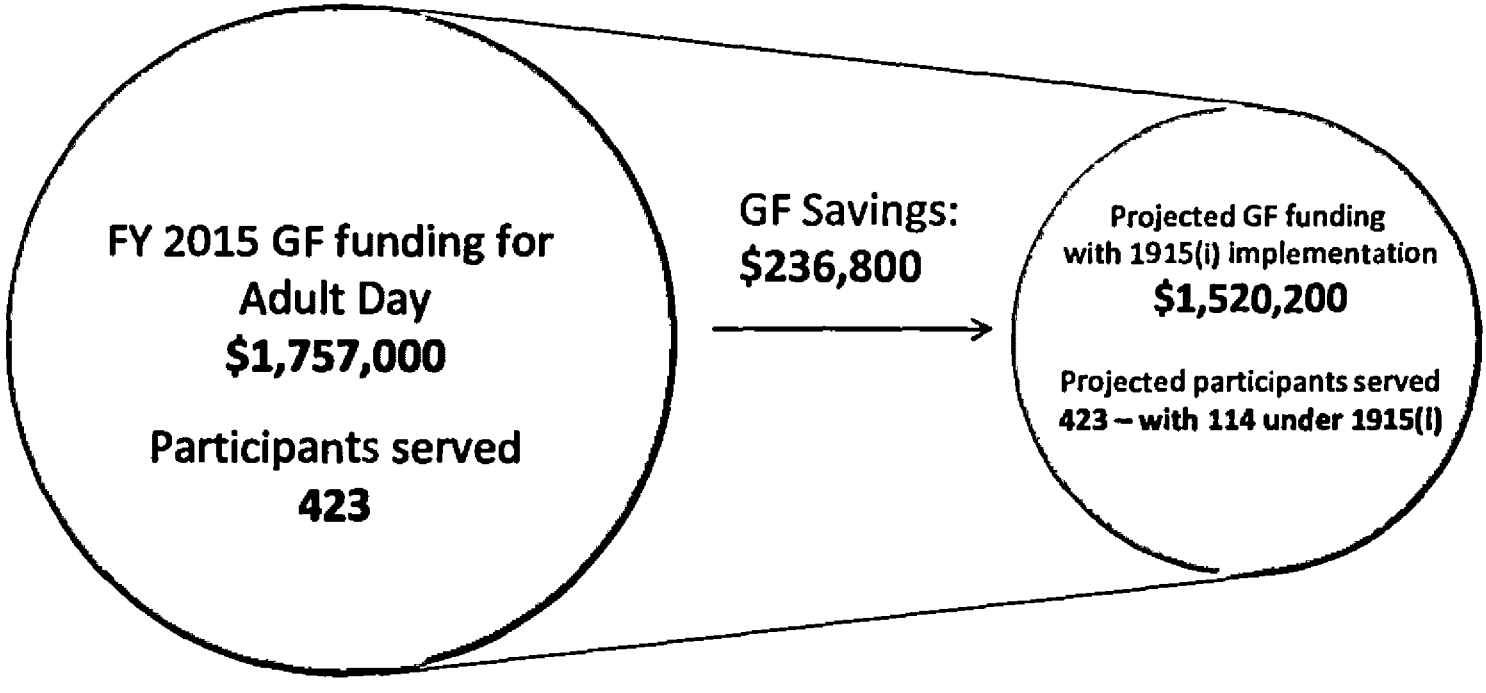
artment of Health and Social Services, Division of Senior and Disabilities Services

caid Reform in Alaska
dicaid State Plan Options
1915(i) and 1915(k)

Senior Community Based Grants – Adult Day 1915(i) Impact

	Current Adult Day funding and individuals served	Projected Adult Day funding and individuals served with 1915(i) implementation
luals served	423	423 (114 eligible for 1915(i))
ding	$1,757,000	$1,520,000
l funding	$0	$236,800

dividuals currently receiving Senior Community Based Grants -- Adult Day services would be eligible for 1S(i) option. As a result, $473,500 of the current GF funding can be refinanced at a 50% federal match.



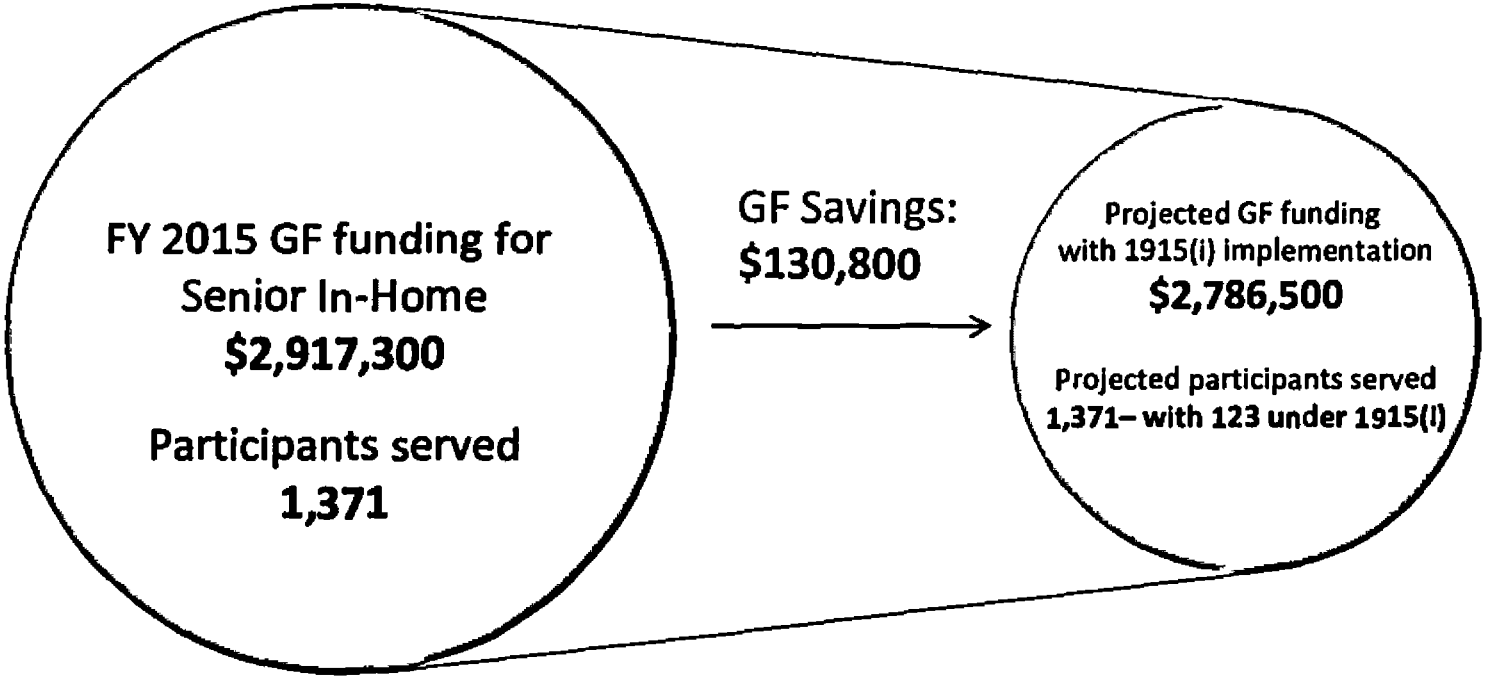
artment of Health and Social Services, Division of Senior and Disabilities Services

caid Reform in Alaska
dicaid State Plan Options
1915(i) and 1915(k)

Senior Community Based Grants – Senior In-Home 1915(i) Impact

	Current Senior In-Home funding and individuals served	Projected Senior In-Home funding and individuals served with 1915(i) implementation
luals served	1,371	1,371 (123 eligible for 1915(i))
ıding	$2,917,300	$2,786,500
ıl funding	$0	$130,800

dividuals currently receiving Senior Community Based Grants -- Senior In-Home services would be eligible
: 1915(i) option. As a result, $261,700 of the current GF funding can be refinanced at a 50% federal match.



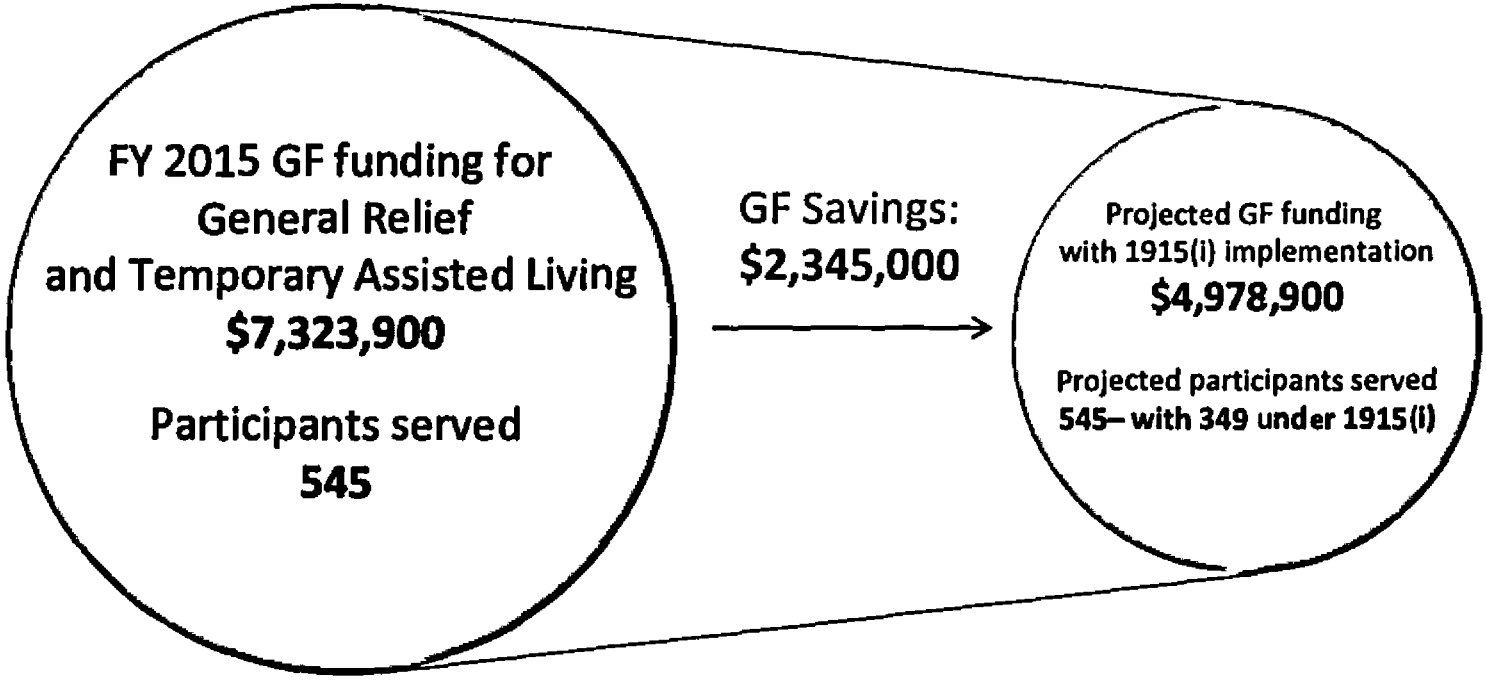
artment of Health and Social Services, Division of Senior and Disabilities Services

icaid Reform in Alaska
dicaid State Plan Options
1915(i) and 1915(k)

General Relief/Temporary Assisted Living 1915(i) Impact

	Current GR/Temporary Assisted Living funding and individuals served	Projected GR/Temporary Assisted Living funding and individuals served with 1915(i) implementation
duals served	545	545 (349 eligible for 1915(i))
nding	$7,323,900	$4,978,900
al funding	$0	$2,345,000

ndividuals currently receiving General Relief/Temporary Assisted Living services would be eligible for the i) option. As a result, $4,689,900 of the current GF funding can be refinanced at a 50% federal match.



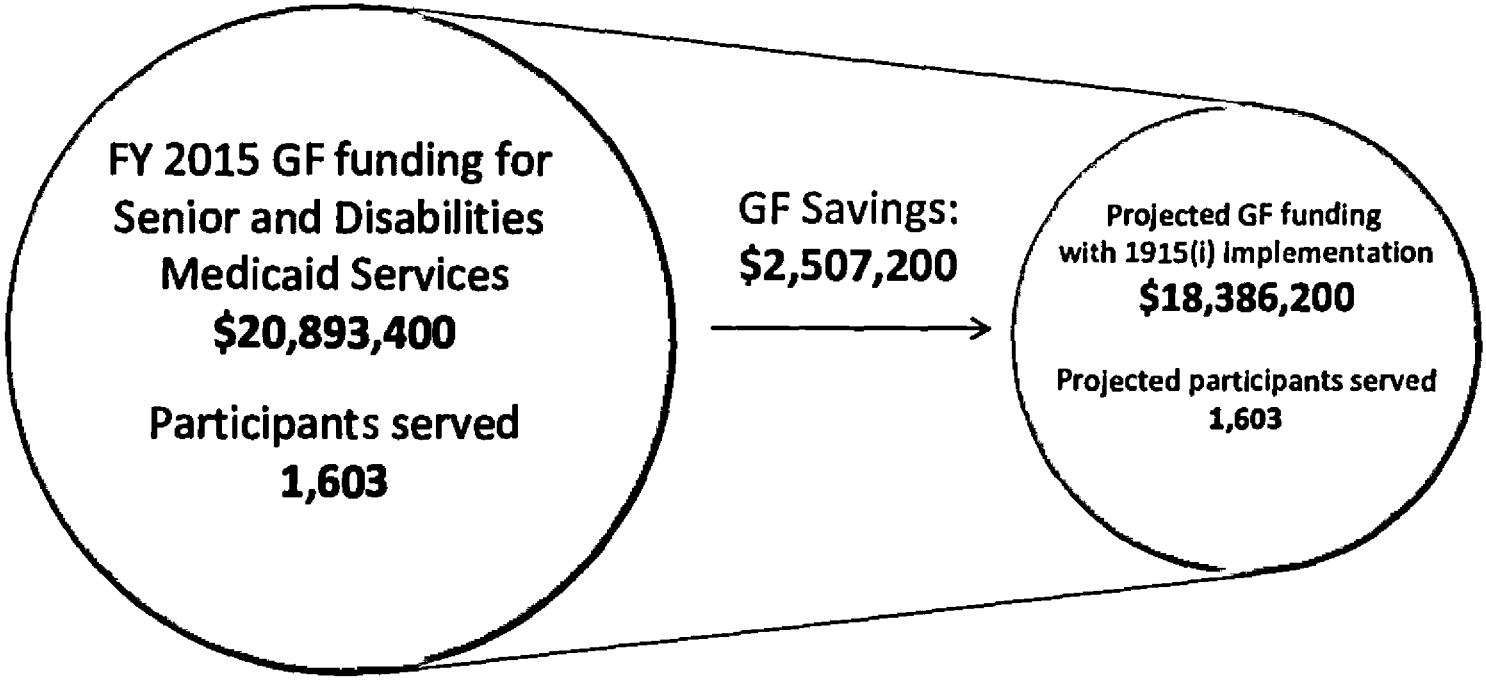
artment of Health and Social Services, Division of Senior and Disabilities Services

icaid Reform in Alaska
dicaid State Plan Options
1915(i) and 1915(k)

Senior and Disabilities Medicaid Services 1915(k) Impact

	Senior and Disabilities Medicaid Services funding and individuals served	Projected Senior and Disabilities Medicaid Services funding and individuals served with 1915(k) implementation
duals served	1,603	1,603
nding	$20,893,400	$18,386,200
al funding	$0	$2,507,200

the 1,603 individuals currently receiving 1915(c) and Personal Care services would be eligible for the k) option. This would result in an additional 6% federal match.



artment of Health and Social Services, Division of Senior and Disabilities Services

Prepared by the Department of Health and Social Services,
Division of Senior and Disabilities Services

AUTHORITY	DESCRIPTION	KEY FLEXIBILITIES AND/OR LIMITATIONS
Section 1915(c) "Home and Community-Based Services (HCBS)" Waivers	Renewable waiver authority that allows states to provide long-term care services delivered in community settings as an alternative to institutional settings. The state must select the specific target population and/or sub-population the waiver will serve. 1915(c) waivers are renewable for 5 years after the initial, 3-year approval (or, if applicable, initial 5-year approval).	• Freedom of choice is required absent a concurrent Medicaid authority that permits the state to waive this requirement. • Can implement in limited geographic areas. • Comparability of services with non-waiver enrollees is not required; however, services must be comparable within the waiver population. • Must demonstrate cost neutrality. • Must specify the maximum number of participants for each waiver year, and criteria for selection of entrants. • May include individuals with income up to 300% of the Federal SSI benefit rate.
Section 1915(i) "Home and Community-Based Services" State Plan Option	States can amend their state plans to offer HCBS as a state plan optional benefit statewide. If states choose the option to target the benefit to specific populations, CMS approval would be for a 5-year period and such states will be able to request CMS renewal for an additional 5-year period if federal and state requirements are met.	• Participants do not have to meet an institutional level of care. • Income eligibility at or below 150% of FPL, but states can opt to also provide HCBS to individuals with incomes up to 300% of the Federal SSI benefit rate if eligible for HCBS under 1915(c) or 1115 demonstration. • Must specify needs-based eligibility criteria. • Comparability of services is not required. • No cost neutrality requirement. • No waiting lists or limits on the number of participants. • Cannot waive statewideness.

Section 1915(k) Community First Choice	Allows states to provide home-and community-based attendant services and supports for beneficiaries on a statewide basis. States must cover assistance and maintenance with activities of daily living, instrumental activities of daily living, and health-related tasks; ensure continuity of services and supports; and provide voluntary training on how to select, manage and dismiss staff. Services can be provided through an agency or a self-directed model. This does not create a new eligibility group; eligible individuals are those who are eligible for Medicaid under the state plan, have incomes up to 150% FPL or over 150% FPL and meet institutional level of care standards.	• States provided a 6 percentage point increase in Federal matching payments for service expenditures under this option. • States have the option to cover transition costs, expenditures related to participant's independence and services, or supports linked to an assessed need or goal. • Financial management services must be available when provided through a self-directed model. • Cannot waive statewideness.

Bill Streur, Commissioner
Alaska Department of Health and Social Services
3601 C Street
Anchorage, Alaska 99503

BY EMAIL AND FIRST CLASS MAIL

Re: Streamlining Initiative Report

Dear Commissioner Streur,

At the start of the year, the Advisory Board on Alcoholism and Drug Abuse (ABADA), Alaska Mental Health Board (AMHB), and Alaska Behavioral Health Association (ABHA) began an initiative with the help of our partners in the Division of Behavioral (DBH) and several representatives from behavioral health providers throughout Alaska. The purpose of the Streamlining Initiative was to examine why we are doing what we are doing and determine if the administrative cost outweighed the benefit to the client and their family, the community, and the State.

We started with an ambitious set of objectives – to survey Federal and State law and regulation, examine requirements from our national accreditors, and review current policy and procedures. We reviewed requirements, collected information from two larger workgroup meetings, worked with individual providers on their data collection and processes, and solicited input from key informants for more in-depth information. Our aim was to deliver a product that could immediately be put into practice to improve our system's efficiency and effectiveness. It was important to us that we deliver this final report to you on time.

The Streamlining Initiative provided two distinct benefits. Working with the people who collect data from clients, prepare for site visits and audits, and input data into our systems, we learned how their efforts inform the system and helped close the gap between their efforts and our collective intention. Comparing current practice against requirements and standards helped us quickly identify activities that were not contributing to quality service delivery.

We encourage the Department to consider a system where information about how we might improve efficiency and effectiveness is continually collected and periodically, and purposefully, analyzed. We recognize there will be resistance to change (there always is), but we believe the enclosed findings and recommendations will improve our system of care by focusing on what is important rather than what is familiar. We conferred with leadership from the Division of Behavioral Health on these recommendations, and it seems that the greatest consensus and opportunity for immediate implementation exists around policy recommendations. We look forward to the more public discussion on other proposed changes.

quality and efficiency of our behavioral health system of care, we provide the following 11 recommendations from the Streamlining Initiative.

Kate Burkhart
AMHB and ABADA

Tom Chard
ABHA

cc: Craig Christenson, DHSS Deputy Commissioner
Albert Wall, Division of Behavioral Health, Director

GOVERNOR SEAN PARNELL

DIVISION OF BEHAVIORAL HEALTH
Director's Office

3601 C Street, Suite 878
Anchorage, Alaska 99503-5924
Main: 907.269.3600
Toll Free: 800.770.3930
Fax: 907.269.3623

MEMORANDUM

DATE: June 30, 2014

TO: William J. Streur
Commissioner

THRU: Craig J. Christenson
Deputy Commissioner

FROM: Albert E. Wall
Director

SUBJECT: Streamlining Initiative

At your request, the Alaska Mental Health Board, in cooperation with the Alaska Behavioral Health Association, has finalized a report concerning the Streamlining Initiative (Initiative) for the Division of Behavioral Health (DBH or the Division). As you know, the Initiative was 1) to identify the various reporting requirements placed upon grantees of DBH, 2) to identify areas where reporting requirements were too stringent or duplicative, and 3) to make recommendations concerning potential changes that may streamline the reporting process.

The Division of Behavioral Health would like to extend its thanks to the Alaska Mental Health Board and to the Alaska Behavioral Health Association for the thorough work they have done on this project and for reaching out to many different types of grantees for their input. I would particularly like to thank them for the matrix they put together that summarizes statutory, regulatory, and other reporting requirements in one place for reference. Some of the recommendations in their report are changes that DBH has already started to initiate or have been in progress and can be sped up to implement. Other recommendations will take time and consideration to evaluate and develop.

The Division has a vested interest in both adequate reporting for tracking performance based measures and program management AND making those requirements realistic for the wide variety of grantees we support. We are committed to continuing to work with our grantees as we address issues of reporting and streamlining.

RECOMMENDATIONS
JUNE 30, 2014

Summary:

The purpose of this Streamlining Initiative is to provide concrete recommendations to behavioral health providers and the Department of Health and Social Services (DHSS) on ways to consolidate information gathering and documentation practices that comply with federal and state law, regulation, and policy while reducing administrative burden. The scope of work and methodology used are attached (*see* Appendix A).

This process helped clarify what was required of providers and the State of Alaska and why. Closing the gap in understanding and practice about activities and intended outcomes helps improves effectiveness and ensure efficiency. It is strongly recommended that this analysis be repeated periodically and that an interim mechanism be established to collect input on potentially ineffective and inefficient requirements.

Recommendations (overview):

1) Eliminate the Requirement of Grantees to Submit Quarterly AKAIMS Summary Reports
2) Eliminate Logic Models in Grant Application and Reporting Process
3) Eliminate Requirement that All Grantees Submit Quarterly Community Action Plan Reports
4) Eliminate Pro Forma Quarterly Narrative Reports
5) Return to 6-month CSR Schedule OR Decouple Administration of the CSR from Mandatory Treatment Plan Updates (Adults Only)
6) Eliminate Required AKAIMS Reporting for Services Not Funded by DHSS
7) Expand Annual Service Limits for Behavioral Health Medicaid Services Pursuant to 7 AAC 135.040
8) Develop Clear and Consistent Standards and Policies for DHSS Audits, Site Visits
9) Align DHSS Quality Assurance Processes with Accreditor Processes to Eliminate Duplication of Effort
10) Eliminate Requirement for Enrollment Prior to Brief (Non-Emergency) Services
11) Eliminate Discharge Requirement for SMI Clients

Recommendation 1: Eliminate the Requirement of Grantees to Submit Quarterly AKAIMS Summary Reports

The data elements required in quarterly reports for the Comprehensive Behavioral Health Treatment and Recovery Grants, as well as specialty service grants, revealed that at least 40% of the information submitted by grantees each quarter was duplicative of information already entered by grantees into AKAIMS. (*See* Exhibit A.) These reporting requirements are in addition to the quarterly AKAIMS Summary Report required of grantees.

DHSS and the provider community have invested significant resources in developing AKAIMS and learning how to use it effectively. There are providers currently taking advantage of AKAIMS functionalities in their quality assurance and improvement efforts. However, the current grant management and reporting structure does not effectively use this resource, instead creating redundant processes for both DHSS staff and providers.

We recommend that quarterly grant reports focus on information not already available through AKAIMS. Report elements such as the number of client demographics; clients admitted, served, and discharged; referrals to and from other agencies; client employment and housing status, etc. are all available to DHSS grant managers through AKAIMS. We recommend that DHSS staff use the information available contemporaneously in AKAIMS for ongoing management and monitoring of grantee services. We also recommend that provider managers use AKAIMS for program management and monitoring.

What is not available to DHSS staff is the information about the agency itself and the community/communities it serves. *See* **Recommendations 3-4** for more on enhancing narrative reporting value to providers and DHSS.

Recommendation 2: Eliminate Logic Models in Grant Application and Reporting Process

There is little evidence that the logic model framework used for grant application and reporting adds value to either the providers' management of treatment programs or DHSS management of the overall behavioral health system. While DHSS has supported, and continues to support, use of logic models, the department has shifted focus and resources to a core service and results-based accountability (RBA) framework. (*See* Exhibit B.)

The Division of Behavioral Health is working to align the long-standing Performance Based Funding system with the indicators and measures adopted by in the departmental RBA framework. As these efforts appear to be far more likely to support effective management and

recommend that:

a) Logic models no longer be required for applying for any behavioral health treatment grant from DHSS;
b) Logic model reporting no longer be required of behavioral health treatment grantees;
c) Providers be informed about the DHSS core service and RBA frameworks at the Fall/Winter Change Agent Conference;
d) Providers be given the opportunity to participate in current efforts to align the Performance Based Funding system with the RBA framework;
e) The treatment grant application and reporting process be aligned with the core service and RBA frameworks in a way that is efficient for and provides value to DHSS and providers.

Recommendation 3: Eliminate Requirement that All Grantees Submit Quarterly Community Action Plan Reports

Currently, all treatment grantees must submit a Community Action Planning report. This results in a pro forma process by grantees with multiple submissions of the same report every quarter. As discussed above, the opportunity to collect more substantive and timely information about the context and environment in which providers operate through narrative reports can be gained by reducing requirements that do not add value to either side of the reporting relationship. We recommend that locally designed, comprehensive community action plans be submitted, as required by state law (AS 47.30.530(a)(8); AS47.37.040(1)), with grant applications and then reported on at the end of each fiscal year. We also recommend that DHSS allow this information to be submitted by one party on behalf of the entire Community Action Planning Team/Group to one point of contact within the department.

Recommendation 4: Eliminate Pro Forma Quarterly Narrative Reports

Information about recruitment and retention of staff, continuing education needs, changes in board leadership, community need, the effect of changes made to the larger behavioral health system as well as within the community, and unexpected developments (sudden resignations, financial issues, natural disasters, etc.) is important for the effective management of the behavioral health system but is currently not well collected. We recommend that grantees be asked for more substantive grant narratives, in a format flexible enough to permit a true picture of the context and environment of their practice to be shared. We recommend that grantees continue to provide the minutes/records of full board and board committee meetings to DHSS –

and finance committee meetings of providers for which they are responsible.

Recommendation 5: Return to 6-month CSR Schedule OR Decouple Administration of the CSR from Mandatory Treatment Plan Updates (Adults Only)

We recommend adjusting the required administration of the CSR after admission to every 6 months, or removing the requirement to update the treatment plan after each CSR, for adult clients. Federal reporting standards require information collected on the CSR every six months.[1] While there may be benefits from the decision to collect the information more frequently (every 90-135 days per 7 AAC 135.100(c)(6)), the cost to providers and clients has proven substantial.

With the increased frequency of CSRs comes the requirement of more frequent updates of treatment plans (7 AAC 135.120(a)(6)). While providers report that completing the CSR with clients can take just 15 minutes, updating the treatment plan takes an average of 1 hour per client per clinician. For medication management only clients (adults experiencing SMI who are stable), the requirement to update the treatment plan is often without any clinical significance and/or resisted by these clients. The additional burden of CSR and treatment planning – absent any clinical basis for the updating of the treatment plan – results in a significant reduction in clinical capacity and access to services.

The benefit of more frequent CSRs must be weighed against the cost to the client, provider, and State. Without compelling evidence of the clinical benefit of the more frequent treatment planning schedule, we recommend that DHSS separate the requirement to update the treatment plan from administration of the CSR or collect information every 6 months only.

Recommendation 6: Eliminate Required AKAIMS Reporting for Services Not Funded by DHSS

AKAIMS data is not as precise as it could be. Currently, grantees are asked to enter data for clients that are receiving services paid for with public resources *as well as* for those who pay for their own treatment or whose treatment is paid for by private insurance or other means. As a consequence of this policy, data does not accurately describe the behavioral health system managed by DHSS.

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[1] Core Client Outcome Measures (reflected in the National Outcomes Measures (NOMS)) reporting is required by the Government Performance Results Act (GPRA) and GPRA Modernization Act of 2010 (GPRAMA), which require the Substance Abuse and Mental Health Services Administration to set program-specific performance targets, to measure program performance on a regular basis against those targets, and to report annually to Congress on the Agency's results. Block grant recipients must comply with NOMS reporting requirements.

The current policy -- reporting on all clients – is not fairly enforced. Tribal behavioral health providers have consistently argued against reporting on services delivered to customer owners/tribal members funded exclusively by the Indian Health Service or by non-state payers. Those tribal providers who have chosen not to report all behavioral health clients through AKAIMS have not reported any penalty or funding consequences. Thus, this policy creates an unfair and disparate burden on community behavioral health centers not affiliated with tribal authorities.

In addition to being inconsistently implemented, the current policy creates a barrier to developing third party and other reimbursement streams. Providers are required to collect information and complete processes that are not reimbursed by private payers, and that inconvenience clients used to the private behavioral health system. The policy has been identified as an impediment to achieving the obligation to determine individuals' and private payers' shared role in the behavioral health system.

We recommend that DHSS withdraw the requirement for AKAIMS reporting on all clients served. Instead, providers should be required to report the minimum data set only on clients that are a) Medicaid eligible; b) Medicare eligible; or c) receiving services at reduced or no cost pursuant to a Comprehensive Behavioral Health Treatment, specialty service grant, or other funds from DHSS.

Recommendation 7: Expand Annual Service Limits for Behavioral Health Medicaid Services Pursuant to 7 AAC 135.040

Service Authorizations were originally intended to act as a Prior Authorization of services, to help ensure that only medically necessary services were delivered to Medicaid eligible individuals. Current practice – by providers and the Division of Behavioral Health – has evolved to make this process moot, while still achieving the intent of cost containment and ensuring only medically necessary services are provided.

Providers must submit a service authorization any time services exceed the annual service limit. Originally, these Authorizations were contemplated as occurring before services were initiated (serving as Prior Authorizations). However, given the needs of the client population served, services are typically begun even before the authorization was received.

Current business practice is that Service Authorizations are typically submitted as clients begin services or while services are ongoing. This results in a shifting of risk from the State of Alaska to providers, who assume financial responsibility for services delivered pending authorization.

behavioral health Medicaid services were denied at an extremely low rate. Troubleshooting efforts during the MMIS transition have included automatic approval of certain types of service authorizations, rendering this process a pro forma requirement in many instances.

The low denial rate for Service Authorizations and the use of automatic approvals of service authorizations during the current MMIS situation lead to the recommendation that annual service limits for standard clinical and rehabilitative services be raised based on review of the actual Service Authorization data from FY2012-2014. Service Authorizations require an immense amount of time and effort from providers, DHSS, and Xerox – without actually serving as the mechanism to contain costs and ensure only medically necessary services are provided.

Providers report than the majority of clients' treatment plans show medically necessary services exceeding the current regulatory annual limits. We recommend that the Division of Behavioral Health and Health Care Services work together with providers to determine annual service limits pursuant to 7 AAC 135.040 that are more aligned with the medically necessary treatment needs of clients served, with the goal of reducing the need for pro forma Service Authorizations. We also recommend that DHSS explore whether Service Authorizations for standard behavioral health services (therapy, etc.) provide any value to the system (and if not, act to remove the requirement entirely). This recommendation does not extend to travel/transportation or pharmacy/prescription prior authorization processes.

Recommendation 8: Develop Clear and Consistent Standards and Policies for DHSS Audits, Site Visits

Behavioral health providers are subject to a variety of site visits and audits by state, federal and accrediting entities. DHSS is required by law to "visit each [mental health] treatment facility at least annually to review methods of care or treatment for patients" (AS 47.30.660(b)(11)), investigate patient complaints (AS 47.30.660(b)(12)), and "inspect, on a regular basis, approved public and private [substance abuse] treatment facilities at reasonable times and in a reasonable manner" (AS 47.37.140(b)).

The director of the Division of Behavioral Health has asserted that providers should look forward to visits from DHSS staff. However, state audits and site visits have come to be seen as punitive and laborious by providers, especially when multiple audits and site visits occur at the same or within a short period of time. These visits can divert scarce resources from treatment services, so every effort should be made to reduce the overall number and impact to clients and providers.

These authorities are interested in the same (or very similar) information. Audits frequently overlap, and site visits occur at times that do not take into account staff capacity or other

of care and compliance, are delayed for sometimes years with little to no communication providing updates.

We recommend that DHSS develop clear and concise policies outlining both the process and intended outcome of DHSS audits and site visits – to include standardized information gathering and reporting protocols. We also recommend that DHSS designate a coordinator of state audits and site visits of behavioral health providers, to ensure coordination and reduce the number and overlapping nature of efforts. We recommend that the coordinator and behavioral health program manager work together toward consistent information sharing with providers – and to allow providers to elect to share information from audits/site visits with their colleagues if it promotes system improvements.

Recommendation 9: Align DHSS Quality Assurance Processes with Accreditor Processes to Eliminate Duplication of Effort

National accreditors, specifically those expressly required in regulation governing delivery of behavioral health services, are independent and well-respected experts in the field of quality assurance and continuous quality improvement for behavioral health services. The Joint Commission has been recognized as the leader in health care standards of care and accreditation for over 50 years. CARF has international experience and recognition related to accrediting substance abuse treatment providers and human services facilities. The Council on Accreditation, founded in 1977, specializes in behavioral health and family-services accreditation. These accreditors constantly solicit input from the industry and revise their standards to keep pace with national trends.

DHSS has mandated accreditation – to ensure Alaskans receive the best services possible. However, DHSS continues to engage in quality assurance efforts that duplicate those of the accreditation processes that behavioral health providers spend a lot of money, time and effort to go through. We recommend that DHSS deem all duly accredited providers as meeting the requirements of Title 47 related to being "approved" treatment facilities under the Uniform Alcoholism and Intoxication Treatment Act and/or the Community Mental Health Services Act.

Recommendation 10: Eliminate Requirement for Enrollment Prior to Brief (Non-Emergency) Services

Not all people who seek services from community behavioral health centers are within priority populations. A significant number of people seeking services are eventually determined to have mild or moderate disorders (if their problems even rise to the disorder threshold at all). Thus any services delivered are not eligible for reimbursement.

intake including screening (AST) and assessment, an initial CSR, and a treatment plan before services can be offered. The actual amount of time spent on the intake process can easily exceed the value it offers when dealing with individuals needing only brief direction (non-clinical referrals up to very brief case management, etc.) or who decide that they do not want to enter treatment.

It appears that short-term brief crisis intervention services can also be provided to adults experiencing emotional disturbances (*see* 7 AAC 135.020), which would allow providers to address the needs of these clients without incurring unreimbursed costs. We recommend that DHSS clarify whether and how these short-term brief crisis intervention services can be used and then offer training to providers on appropriate use of this service type. If this service type does not offer a solution to this problem, we recommend eliminating the requirement for enrollment prior to brief non-emergency services.

Recommendation 11: Eliminate Discharge Requirement for SMI Clients

Both the federal government and DHSS have committed to the integration of behavioral health and primary care services as a way to improve client health outcomes. This integration of health care requires alignment of clinical and business practices, as well as state policy and regulation. One concrete example of where behavioral health policy is contrary to the practices and policies of integrated care is the emphasis on discharge/disenrollment.

In the context of primary care (physical health), a person is encouraged to have a consistent provider whom they see on a regular basis (not just when he is sick). For those individuals with chronic health care conditions, like diabetes, this stable ongoing health care relationship is even more strongly encouraged. Thus, a primary care patient is "empaneled for life" (or until they move to a new provider or die).

In our system, the emphasis is on discrete and time-limited episodes of care rather than providing services for on-going mental and emotional health care. Not only is this emphasis out of sync with the larger health care perspective, it does not reflect the dynamic and variable nature of recovery for people experiencing behavioral health disorders. Neither does this policy create an environment that promotes individual help-seeking when there is a risk relapse or crises (or after relapse/crisis).

Requiring discharge of clients creates an unnecessary burden on providers who must re-empanel clients who return for services. Providers have access to clients' information and clinical histories through AKAIMS and their own clinical records. Yet providers must begin all over

the client's information and moving more quickly into services.

Medicaid eligible Alaskans receiving primary care services, or services for chronic health conditions, are not required to "start from scratch" each time they seek services. Therefore, this policy treats Medicaid recipients and Medicaid providers differently on the basis of disability. We recommend that DHSS eliminate those policies and requirements that prevent behavioral health clients from being "empaneled for life" and having ready access to necessary services as needed. This recommendation will allow DHSS policies and practice to better support integration of health care, acknowledge and support the unique nature of recovery in behavioral health, and provide for equitable treatment of Medicaid recipients and providers across the health care system.

For Ongoing Streamlining Efforts:

- **Recommendation 1: Develop Suite of Standardized Forms That Meet All State, Federal, Accreditor Requirements**
- **Recommendation 2: Develop Guidance Documents for Implementation of Electronic Health Records in Conjunction with AKAIMS and the Health Information Exchange**

These were intended deliverables from the Streamlining Initiative. Unfortunately, the ambitious scope of work exceeded the six-month timeframe. The Streamlining Initiative has begun comprehensive review of providers' forms and documents, in order to determine what elements will meet the needs of all entities exerting oversight. The Streamlining Initiative has also begun intensive stakeholder interviews about the use of AKAIMS and EHRs. The Alaska Behavioral Health Association, the Alaska Mental Health Board, and Advisory Board on Alcoholism and Drug Abuse will continue to work with Initiative partners and DHSS to develop these forms and guidance documents for consideration.

Appendix A

PROPOSED SCOPE AND WORK PLAN

Purpose:

The purpose of this Streamlining Initiative is, by building and expanding upon similar efforts, to provide concrete recommendations to behavioral health providers and the Department of Health and Social Services (DHSS) of ways to consolidate information gathering and documentation practices to comply with federal and state law, regulation, and policy while reducing administrative burden. We intend to complete this work by June 30, 2014.

Scope of Work:

1. Identify all federal and state laws and regulations governing intake, assessment, treatment, and discharge policies and practices.
2. Identify all policies and expectations related to intake, assessment, treatment, and discharge required by accrediting bodies (Joint Commission, CARF, etc.).
3. Create a comprehensive list of baseline information required by law, regulation, and accreditation.
    a. Identify the reason such information is collected.
    b. Identify all concrete uses of such information by DHSS, DBH, providers, and others.
    c. Identify data elements that contribute to trend analyses.
4. Create a comprehensive list of information needed to meet state policy and/or accepted standards of care.
    a. Identify the reason such information is collected.
    b. Identify all concrete uses of such information by DHSS, DBH, providers, and others.
    c. Identify data elements that contribute to trend analyses.
5. Define the current "minimum dataset" and recommend any changes.
6. Acquire and review all intake, assessment, treatment, and discharge forms and policies currently implemented by Alaska behavioral health providers.
    a. Identify those components that meet requirements of law and accreditation.
    b. Identify those components that meet policy and standard of care expectations.
    c. Identify additional components to meet requirements of law and accreditation.
    d. Identify additional components that meet policy and standard of care expectations.
7. Quantify the cost of collecting data and information under current structures.
8. Review all AKAIMS data fields.
    a. Identify those components that meet requirements of law and accreditation.
    b. Identify those components that meet policy and standard of care expectations.

    d. Identify additional components that meet policy and standard of care expectations.
9. Develop a suite of standardized and accessible model intake, assessment, treatment, and discharge forms that comply with legal and accreditation requirements.
    a. Develop standard language for treatment plans and other documentation that meets legal and accreditation requirements.
10. Identify AKAIMS data fields that can be removed or made optional.
11. Identify AKAIMS data fields that should be added to meet legal and accreditation requirements.
12. Quantify the cost of collecting data and information under recommended structures.
13. Develop guidance documents related to behavioral health electronic health records and the health information exchange to promote streamlining.
    a. Identify business practices to promote efficient and effective use of AKAIMS

Timeline: (dates are "by when")

February 5, 2014	Invitations to participants
February 10, 2014	Federal and State Requirements Identified (DBH,Boards)
February 17, 2014	First work group meeting – focus on statutory authority
February 28, 2014	Accreditation Requirements Identified (ABHA)
March 10, 2014	Second work group meeting – focus on accreditation requirements
March 31, 2014	Provider intake etc. paperwork acquired, provided to work group (ABHA)
April 30, 2014	In-person third work session – minimum data set (10-4:30)
May 15, 2014	AKAIMS data fields provided (DBH)
May 30, 2014	In person fourth work session – AKAIMS recommendations (10-4:30)
June 5, 2014	Draft standardized forms, tools to workgroup
June 15, 2014	Fifth work session – review draft forms, recommendations
June 25, 2014	Draft of all recommendations, tools to work group
June 30, 2014	Approval of work group products to forward to DHSS

Representing	Agency	Contact (lead in bold)
Behavioral Health Providers	ABHA	**Tom Chard, Co-Chair** tom.abha@gmail.com
Planning Councils	AMHB and ABADA	**Kate Burkhart, Co-Chair** kate.burkhart@alaska.gov Pat Sidmore patrick.sidmore@alaska.gov
Adult Mental Health	JAMHI	Pam Watts pam@jamhi.org **Doug Harris** dough@jamhi.org Rachel Gearhart rachel@jamhi.org Erika Lindsey Erika@jamhi.org
Adult Substance Abuse	Akeela	Rosalie Nadeau madeau@akeela.org **Courtney Kitiona** ckitiona@akeela.org Melanie Yuknis myuknis@akeela.org
Adult Substance Abuse/ Methadone Clinic	Interior Aids	**Anna Nelson** anna@interioraids org
Youth Behavioral Health/Private	North Star Behavioral Health	**Laura McKenzie** laura.mckenzie@uhsinc.com Ron Meier ron meier@uhsinc.com
Youth Behavioral Health Residential (BRS)	Alaska Baptist Family Services	**Lorie Morris** akfamilies@gci.net
Tribal Behavioral Health	Southcentral Foundation	**Chanda Aloysius** CAloysius@southcentralfoundation com

Behavioral Health Medicaid	DBH	lisa.brown@alaska.gov **Deedee Raymond** deedee.raymond@alaska.gov
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Severe Emotional Disturbance Program	DBH	**Bradley Grigg** bradley.grigg@alaska.gov
Policy & Planning	DBH	**Mark Haines-Simeon** mark.haines-simeon@alaska.gov
Serious Mental Illness Program	DBH	**Jim McLaughlin** james.mclaughlin@alaska.gov
System Program and Policy	AMHTA	**Katie Baldwin-Johnson** katie.johnson@alaska.gov

ALASKA
GOVERNOR BILL WALKER

ALASKA COMMISSION ON AGING
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March 3, 2016

The Honorable Paul Seaton, Chair
House Health and Social Services Committee
Alaska State Capitol, Room 102
Juneau, Alaska 99811-1182

Subject: HB 227, Medical Assistance Reform

Dear Representative Seaton:

The Alaska Commission on Aging is a Governor-appointed body within the Department of Health and Social Services that serves to ensure the dignity and independence of all older Alaskans by addressing their needs through planning, advocacy, and education through interagency coordination efforts. Home- and community-based long-term support services provided through the Medicaid waiver and Personal Care Assistance support seniors who are Medicaid-eligible and need assistance with activities of daily living and instrumental activities of daily living so that they may live in their homes and communities for as long as possible. The Commission has provided recommendations to the Medicaid Reform Advisory Group and serves as a member of the Department of Health and Social Services Medicaid Redesign Key Partner Committee.

Based on findings from the FY2014-2015 Alaska Senior Survey, access to health care was identified as the most pressing concern for Alaska seniors according to 48% of the 2,280 survey respondents who are age 55 years and older. Last fall, the Commission conducted four community forums held at senior centers in Anchorage, Fairbanks, Juneau, and Mat-Su to share information about the proposed Medicaid health care reform efforts and to seek input from the senior community regarding them. There were a total of 45 participants who attended the community forums representing seniors, family caregivers, senior providers, and other public members. We want to take this opportunity to provide a summary of their recommendations for Medicaid health care reform as they relate to HB 227.

- Improve access to information: Seniors appreciate clear instruction of how public members can access medical assistance health care services and to have this information communicated in multiple media formats such as television, radio, and the newspaper, as well as by electronic means, and to distribute this information to senior centers, adult day programs, the Aging and Disability Resource Centers, among other senior settings. Improved access to concise and easy to understand information about Medicaid was a consistent theme across all forums.

- Strengthen primary care: Seniors depend on their primary care providers for the majority of their health care needs. Forum participants desire a comprehensive patient-centered, case management system that addresses an individual's integrated health care needs in the primary care setting and provides assistance to the patient and their family with navigating health care options. This enhanced case management approach has shown to work well for seniors because it provides whole patient

Medicaid health care reform particularly for individuals with multiple chronic care needs and those newly discharged from the hospital. Patient case managers can check-in with patients and their caregivers to ensure they are following medical/aftercare discharge instructions and are connecting with appropriate home- and community-based services to support their health and recovery efforts. Further, frail seniors, persons with sensory loss, and those with cognitive impairments who do not have a trusted family member or friend to accompany them to medical appointments would benefit from a patient navigator to facilitate an accurate exchange of information between the patient and their doctor and to ensure that patients are included in decision-making affecting their care.

- Family caregivers: Families and other natural support caregivers provide the foundation of long-term care for seniors and others with disabilities at a low cost to the state but often at a high cost to caregiver health and finances, especially for those who care for loved ones at home with dementia. Forum participants noted that targeted training and supports could reduce personal caregiver costs and lengthen the amount of time caregivers are able to provide quality care at home and should be included under Medicaid reform as a strategy to control long-term care costs.

- Telehealth: The senior community supports building capacity and implementing greater use of telehealth in order to address Alaska's shortage of healthcare providers, enhance access to specialty services such as geriatric health care and dementia care, and to improve access to health care in rural and remote settings utilizing licensed Alaskan health care providers.

- Medicaid State Plan Options: The senior community also supports developing and implementing Medicaid State Plan options as part of Medicaid Reform efforts. The 1915(k) State Plan option, for example, is a promising strategy to refinance Personal Care Assistance and waiver services with an increased 6% federal reimbursement rate. In addition, the 1915 (i) State Plan option could be used to extend waiver services for vulnerable Alaskans with cognitive impairments, such as those with early to mid-stage Alzheimer's disease, who do not qualify for the level of care required by the waiver. Personal care, adult day, behavioral supports such as cueing and supervision, case management, family caregiver supports, and other services could be covered under this option thus saving General Funds. The 1915(i) option could also provide a more appropriate funding source for the General Relief program (funded with 100% GF), administered by Senior and Disabilities Services, which is intended to provide emergency and temporary assisted living home placement but is often extended when other payment sources are not available. Further, the 1915(i) could also refinance the Pioneer Home's Payment Assistance Program for residents with dementia who do not qualify for the level of care required by the waiver.

- Maintain Medicaid adult optional services for dental, vision, and hearing as these services, not covered by Medicare, are very important for seniors with limited incomes.

We appreciate the good work of the Legislature, the Department of Health and Social Services, other state agencies, and stakeholders who collaborated in drafting this legislation and for the ongoing commitment to Medicaid health care reform. Please feel free to contact Denise Daniello, ACoA's Executive Director by phone (465-4879) or email (denise.daniello@alaska.gov), for further information as needed. Thank you.

Sincerely,

Sincerely,

SHO #16-002

Re: Federal Funding for Services "Received Through" an IHS/Tribal Facility and Furnished to Medicaid-Eligible American Indians and Alaska Natives

February 26, 2016

Dear State Health Official:

The purpose of this letter is to inform state Medicaid agencies and other state health officials about an update in payment policy affecting federal funding for services received by Medicaid-eligible individuals, who are American Indians and Alaska Natives (AI/AN) through facilities of the Indian Health Service (IHS), whether operated by IHS or by Tribes. As described in this letter, IHS/Tribal facilities[1] may enter into care coordination agreements with non-IHS/Tribal providers to furnish certain services for their patients who are AI/AN Medicaid beneficiaries, and the amounts paid by the state for services requested by facility practitioners in accordance with those agreements would be eligible for the enhanced federal matching authorized under section 1905(b) of the Social Security Act at a rate of 100 percent. Upon execution of a written care coordination agreement, this will be effective immediately for states for the expenditures for services furnished by non-IHS/Tribal providers to AI/AN Medicaid beneficiaries who are patients of an IHS/Tribal facility acting under such agreement, as described below. This update in payment policy is intended to help states, the IHS, and Tribes to improve delivery systems for AI/ANs by increasing access to care, strengthening continuity of care, and improving population health.

Background

The IHS, a federal agency within the Department of Health and Human Services, is responsible for furnishing comprehensive, culturally-appropriate health services to almost 2.2 million AI/ANs who are eligible for services from the IHS, per regulations at 42 CFR Part 136. To achieve this goal, IHS operates its own hospitals and clinics and partners with Tribes as authorized by the Indian Self-Determination and Education Assistance Act, P.L. 93-638, as amended. The IHS also provides funding for Urban Indian Health Organizations to operate Urban Indian Health Programs (UIHPs) under title V of the Indian Health Care Improvement Act, P.L. 94-437, as amended. The IHS, Tribes, and UIHPs operate health programs in 36 states.[2]

[1] For purposes of this document, Tribal facilities are facilities that are operated by Tribes and Tribal organizations under the Indian Self-Determination and Education Assistance Act, P.L. 93-638.

[2] As of the date of this SHO, the states are: AL, AK, AZ, CA, CO, CT, FL, ID, IL, IN, IA, KS, LA, ME, MD, MA, MI, MN, MS, MT, NE, NV, NM, NY, NC, ND, OK, OR, RI, SC, SD, TX, UT, WA, WI, and WY. This list is

they reside are entitled to Medicaid coverage, whether or not they are eligible for services from IHS. IHS-eligible AI/ANs who are also Medicaid beneficiaries may choose to receive covered services from an IHS facility, a Tribal facility, a UIHP, or from any other provider participating in a state's Medicaid program.

Under section 1905(b) of the Social Security Act, the federal government is required to match state expenditures at the Federal Medical Assistance Percentage (FMAP) rate, which is 100 percent for state expenditures on behalf of AI/AN Medicaid beneficiaries for covered services "received through" an Indian Health Service facility whether operated by the Indian Health Service or by a Tribe or Tribal organization (as defined in section 4 of the Indian Health Care Improvement Act)." If services are not "received through" an IHS/Tribal facility, the federal government will match the state's payment for the services at the state's regular FMAP rate, which in FY 2016 ranges from 50.00 percent to 74.17 percent.

Our long-standing interpretation of this statutory provision as reflected in sub-regulatory guidance,[3] Departmental Appeals Board decisions,[4] and federal court decisions,[5] has been that 100 percent FMAP is available for amounts expended for services under the following circumstances:

(1) The service must be furnished to a Medicaid-eligible AI/AN;
(2) The service must be a "facility service" – i.e., within the scope of services that a facility (e.g., inpatient hospital, outpatient hospital, clinic, Federally Qualified Health Center/Rural Health Clinic, nursing facility) can offer under Medicaid law and regulation;
(3) The service must be furnished by an IHS/Tribal facility or by its contractual agent as part of the facility's services; and
(4) The IHS/Tribal facility must maintain responsibility for the provision of the service and must bill the state Medicaid program directly for the service.

Last year, the Centers for Medicare & Medicaid Services (CMS) announced it was strongly considering re-interpreting the statutory language to expand the services it considers "received through" an IHS/Tribal facility and eligible for the 100 percent FMAP. Specifically, in October 2015, we posted on the CMS Medicaid.gov website a Request for Comment, in which we sought comments on a proposal to re-interpret the statutory language providing 100 percent FMAP for "services received through an IHS facility" by: (1) Modifying the scope of services eligible for enhanced FMAP; (2) Expanding the meaning of contractual agent to be an enrolled Medicaid provider that provides services that are identified in the state's approved Medicaid plan and are arranged for and overseen by the IHS/Tribal facility; and (3) Increasing the flexibility for billing arrangements so that IHS/Tribal facilities or their contractual agents could bill Medicaid directly

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[3] Memorandum of Agreement (MOA) between IHS and HCFA (July 11, 1996); HCFA Memorandum to Associate Regional Administrators (May, 1997).

[4] *North Dakota Dept of Human Services*, DAB No. 1854 (2002); *South Dakota Dept of Social Services*, DAB No. 1847 (2002); *Arizona Health Care Cost Containment System*, DAB No. 1779 (2001); *Alaska Department of Health and Social Services*, DAB No. 1919 (2004).

[5] *North Dakota ex. Rel. Olson v. Centers for Medicare & Medicaid Services*, 403 F.3d 537 (8th Cir. 2005); *Alaska Department of Health & Social Services v Centers for Medicare & Medicaid Services*, 424 F. 3rd 931 (9th Cir.

organizations, Urban Indian Health Organizations, states, and other stakeholders. We have reviewed and considered those comments in establishing this new policy interpretation.

Permitting a Wider Scope of Services

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

This scope of service change also applies to transportation that is covered as a service under the state Medicaid plan. Under regulations at 42 CFR 440.170(a), a state can elect to cover transportation and other related travel expenses determined necessary to secure medical examinations and treatment for a beneficiary. Related travel expenses include the cost of meals and lodging en route to and from medical care, and while receiving medical care, as well as the cost for an attendant to accompany the beneficiary, if necessary. Covered transportation services can include both emergency medical transportation and non-emergency medical transportation.

Medicaid Beneficiary and IHS/Tribal Facility Participation is Voluntary

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

In this letter, CMS also revises its interpretation to provide that a service may be considered "received through" an IHS/Tribal facility when an IHS/Tribal facility practitioner requests the service, for his or her patient, from a non-IHS/Tribal provider (outside of the IHS/Tribal facility), who is also a Medicaid provider, in accordance with a care coordination agreement meeting the criteria described below. The purpose of this revised policy interpretation is to enable IHS/Tribal facilities to expand the scope of services they are able to offer to their AI/AN patients while ensuring coordination of care in accordance with best medical practice standards.

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

A non-IHS/Tribal provider from which an IHS/Tribal facility practitioner could request services could include an Urban Indian Health Organization that participates in Medicaid, or any other Medicaid-participating provider. Furthermore, the relationship between the IHS/Tribal facility practitioner and the patient could be based on visits, including the initial visit, through telehealth procedures that meet state and/or IHS standards for such procedures, if the IHS/Tribal facility has that capacity[6].

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

At a minimum, care coordination will involve:

(I) The IHS/Tribal facility practitioner providing a request for specific services (by electronic or other verifiable means) and relevant information about his or her patient to the non-IHS/Tribal provider;

[6] Or as specified in a demonstration project authorized under section 1637 of the Indian Health Care Improvement

patient, including the results of any screening, diagnostic or treatment procedures, to the IHS/Tribal facility practitioner;

(3) The IHS/Tribal facility practitioner continuing to assume responsibility for the patient's care by assessing the information and taking appropriate action, including, when necessary, furnishing or requesting additional services; and

(4) The IHS/Tribal facility incorporating the patient's information in the medical record through the Health Information Exchange or other agreed-upon means.

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

Medicaid Billing and Payments to Non-IHS/Tribal Providers

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

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

A second option is for the IHS or Tribal facility to handle all billing. In that case, the IHS/Tribal facility would have to separately identify services provided by non-IHS/Tribal providers under agreement that can be claimed as services of the IHS/Tribal facility ("IHS/Tribal facility services") from those that cannot. Inpatient services that are furnished by non-IHS providers outside of IHS/Tribal facilities could never be claimed as IHS/Tribal facility services. For IHS, other services provided by non-IHS providers outside of an IHS facility generally cannot be claimed as IHS facility services. Tribal facilities generally may have more flexibility than IHS and should consult with their state to determine the circumstances in which other services provided by non-Tribal providers can be claimed as Tribal facility services. The circumstances under which Tribal facilities may claim services as their own are the same as those that apply for other similar facilities in the state (e.g., inpatient or outpatient hospitals, nursing facilities, Federally Qualified Health Centers, etc.). Services that can properly be claimed as IHS/Tribal facility services may be billed directly by the IHS/Tribal facility and are paid at the applicable Medicaid state plan IHS/Tribal facility rate. For all other services provided by non-IHS/Tribal

the payment rate would be the state plan rate applicable to the furnishing provider and the service, not the applicable Medicaid state plan IHS/Tribal facility rate. These services are still eligible for the 100 percent FMAP, provided other requirements have been met.

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

Managed Care

The discussion above assumes that the Medicaid-eligible AI/AN has "received [services] through" the IHS/Tribal facility on a fee-for-service basis. In some cases, however, Medicaid-eligible AI/ANs may be enrolled in a risk-based Medicaid managed care organization (MCO), prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP), in which case the state Medicaid agency is making monthly capitation payments on behalf of the AI/AN enrollee to the MCO, PIHP, or PAHP. The state may claim 100 percent FMAP for the portion of the capitation payment attributable to the cost of services "received through" an IHS/Tribal facility if the following conditions are met:

(1) The service is furnished to an AI/AN Medicaid beneficiary who is enrolled in the managed care plan;
(2) The service meets the same requirements to be considered "received through" an IHS/Tribal facility as would apply in a fee-for-service delivery system and the managed care plan maintains auditable documentation to demonstrate that those requirements are met;
(3) The non-IHS/Tribal provider is a network provider of the enrollee's managed care plan;
(4) The non-IHS/Tribal provider is paid by the managed care plan consistent with the network provider's contractual agreement with the managed care plan; and
(5) The state has complied with section 1932(h)(2)(C)(ii) of the Act consistent with CMS guidance.

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

Compliance and Documentation

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

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

Applicability to Section 1115 Demonstrations

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

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

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

We intend to issue additional guidance materials after the release of this SHO. CMS is available to work closely with each state to implement the policy established in this state health official letter regarding receiving 100 percent FMAP for services "received through" an IHS/Tribal facility. If you have any questions regarding this information, please contact TribalAffairs@cms.hhs.gov or Kirsten Jensen, Director, Division of Benefits and Coverage, 410-786-8146.

Sincerely,
/s/
Vikki Wachino
Director

cc:

National Association of Medicaid Directors

National Academy for State Health Policy

American Public Human Services Association

National Governors Association

Council of State Governments

Association of State and Territorial Health Officials

Sent: Wednesday, February 24, 2016 9:22 PM
To: Taneeka Hansen
Cc: Davidson, Valerie J (HSS); Forrest, Karen L (HSS); Burns, Randall P (HSS); Sherwood, Jon (HSS); Martin, Monique R (HSS); Ashenbrenner, Chris (HSS)
Subject: understanding the "30% rule"

Categories: committee

Taneeka, we thought you might find this summary of the "30% rule" helpful as you seek to understand and explain behavioral health system needs as an element of Medicaid reform. Thanks to Randall Burns and Karen Forrest for pulling this together.

The 30% rule is found in State regulation; as such, we have the ability to modify it. While we clearly need to increase access to behavioral health services, we also need to ensure that changes to behavioral health regulations are made carefully/strategically, given the many complexities that they involve. We need to ensure we manage costs, utilization, and quality. The proposed regulation change is one that will be reviewed, especially given Section 17 of the new Work Draft, which requires that the Department manage a comprehensive and integrated behavioral health program that include services from a wide array of providers and reduces operational barriers that currently exist.

More information on the 30% rule:

Federal rule **requires that "clinic services" must be "furnished at the clinic by or under the direction of a physician."** (42 CFR 440.90). (This means that *billable Medicaid services* furnished at a clinic must be provided by or under the direction of a physician.)

Alaska behavioral health program regulations **allow for "clinic services" to be provided through two provider eligibility categories:**

1) **"community behavioral health services provider"** (7 AAC 70.100(a)); and
2) A **"mental health physician clinic** (7 AAC 135.030(d))

In order to reimburse under Medicaid, a community behavioral health services provider "must have a documented formal agreement with a physician for the purpose of providing general direction and direct clinical services." 7 AAC 70.100(a). According to State regulation, "general direction means a physician provides general program and clinical consultative services when needed" (7 AAC 135.990(14)).

In order to reimburse a mental health physician clinic under Medicaid, the mental health services provided at clinic must be provided by a psychiatrist or by a number of licensed mental health professionals "who work under the direct supervision of that psychiatrist." (7 AAC 135.030(d)). "Direct supervision" means that a **psychiatrist is on the premises of the mental health physician clinic to deliver medical services at least 30 percent of the time** the mental health physician clinic is open for providing medical services (7 AAC 135.030(e)).

Tony

Tony Newman | Legislative Liaison
Office of the Commissioner | Alaska Department of Health and Social Services

PARTNERSHIP

All Alaska pediatric Partnership Statement for HB227 – Feb. 25, 2016

The following is our input for the bill language:

- Support Medicaid and insurance reimbursement for trauma activation at designated trauma hospitals
- Support the innovations sections of HB227, including the 1115 waiver
- Section 12 (g) - Telemedicine is defined as "between providers." This definition doesn't save on costs as much as telemedicine between provider and patient or nurse and patient. The latter are billed at a much lower rate than an in-clinic visit. In addition, a statement that states that reimbursement strategies to incentivize telemedicine visits at the same level as in-person visits will increase the use of telemedicine throughout the state by all providers. Increased telemedicine usage will significantly decrease Medicaid costs in Alaska.
- Throughout HB 227, there is talk of preventative care as a method to save costs. Yet, nowhere is there any mention of reimbursement for active case management, integrated behavioral health services, and other aspects of the patient centered medical home that have been proven to save costs over time. This is somewhat mentioned at the bottom of page 8, but I think it should be more explicitly mentioned to show its importance.
- In the bill's language, there is no definition of behavioral health integration as inclusive of behavioral health provided by anyone other than a psychiatrist. There is a tremendous gap in psychiatrists and especially pediatric psychiatrists in Alaska. It is imperative that a patient-centered medical home be able to provide forms of behavioral health by other behavioral health practitioners such as social workers and behavioral health therapists.
- Another area that will decrease the costs of healthcare in Alaska is to improve reimbursement for screening of families at risk, especially those with young children (under 5). Families who are experiencing or have experienced trauma are at high risk for continuing this trauma to subsequent generations. This trauma, which has been called adverse childhood experiences when it is experienced by young children, has been associated with increased risks of high risk behavior, poor health outcomes, and early death when these children grow up to become adults. In addition, these poor health outcomes are highly associated with increased costs to the medical systems that care for them, and preventing bad things happening to young kids will improve the health of the Alaskan population, and the best way to prevent these experiences is to strongly

support programs that assist families with young children get the help they need to be healthy and happy people.

- Medicaid audits: The end result of audits like the one proposed in HB 227 "catch" primarily well intended providers who have made mistakes. If I understand the process correctly, the audits look for "overbilling" but ignore "under-billing"(that also occurs) in a billing and documentation system than is complex and subjective. Penalties occur when providers unknowingly, or accidently don't provide the "required" documentation which is quite different from true fraud and abuse. In addition the audits lead to resentment among the vast majority of well-intentioned providers (whether audited or not) who may then, in a natural human response, tend to lead some to stop seeing Medicaid patients. So I suspect that the overall results of this approach are poor and may lead to more overall cost in the long run. Perhaps there is evidence that this approach is cost effective (OVERALL) but I suspect there are other cost effective methods to find fraud and abuse that also promote cooperative, rather than adversarial relationships.
    - One thought for a better approach would be to use well established evidence-based behavior modification principles to change behavior: reward and or openly praise good and appropriate behavior; discuss problems/concerns with behavior and then help to improve /understand the correct behavior, and add a warning of the consequences if the concerning behavior continues; then punish if problems persist.

February 24, 2016

Representative Paul Seaton
Chair, House Health & Social Services Committee
State Capitol Room 102
Juneau AK, 99801

Subj: Medicaid Expansion and Reform Bills (SB78, SB74, HB148, HB227)

Dear Rep. Seaton:

As a provider of both mental health and substance use disorder treatment services for over 30 years, I have a long-term commitment to ensuring that the organizations I lead are innovative, accountable, and provide the highest quality of care while operating efficiently and effectively. We strive toward excellence using Best Practices and innovation. We measure our outcomes to achieve the best possible results with available resources.

As Medicaid Expansion and reform bills and the budget closeout process moves forward, and decisions are made about systems of care and allocations of resources, please keep in mind the following important considerations:

1. Changes aimed at increasing access to services, including eliminating the requirement that providers have a behavioral health grant as a condition of being eligible to bill Medicaid, will decrease oversight and accountability of providers. This will broaden the potential for intentional or unintentional Medicaid fraud, waste, and abuse. Where would the monitoring control of all these new providers come from?

2. Removing the grant requirement so that anyone could provide behavioral health services will allow new providers to "cherry pick" who they see and what services they provide. Comprehensive community behavioral health centers serve a predominantly low or no income clientele and those who are un-resourced (most of whom are charged on a sliding fee scale with less than 5% of actual cost of care recovered). They provide care for the most high-acuity seriously mentally ill, chronic alcoholics/addicts, and severely emotionally disturbed youth – Alaskans often requiring community based case management services and requiring services from the Psychiatric Emergency Services programs. They are able to provide this level of comprehensive care with the limited resources available, in part, because they are currently able to balance higher cost services with more profitable services. If the grant requirement is lifted and competition grows for the more profitable services, a tipping point will seriously threaten the comprehensive behavioral health provider's abiiity to maintain high-acuity, high cost care.

3. How will the state ensure that a system of care remains available for those who need it as grant funding is reduced and there is no longer a sufficient economy of scale for non-profit providers to offer a continuum of care, and services that no one else wants to take on?

treatment are essential to providing a safety net to keep people from defaulting to the Correctional system, Public Safety, Emergency Department, homeless shelters (if they exist), or other entities/systems where the true cost of caring for them would far exceed the investment in these behavioral health services.

5. Finally, innovative practices have been or are being implemented across the state that have already shown results or show significant promise to address multiple problems and reduce overall costs. These include:

   - Housing First – provides housing and support services to chronic, late-stage alcoholics who have cycled through emergency rooms, hospitals, and jails. Reduces burden on Public Safety, hospitals, courts, and Corrections.
   - Integrated Primary Care Behavioral Health Clinics – persons with serious mental illness, co-occurring disorders, histories of trauma, and chronic health/medical conditions receive one-stop shop services designed to improve overall wellness, reduce expensive medical care and psychiatric hospitalizations, and increase independence in community.
   - Partnerships with the Court System to reduce costs – Community Behavioral Health Centers, substance abuse treatment providers, and others are diligently working with the Court System to mitigate correctional costs by offering specialty courts as an alternative to incarceration. Persons with mental illness or substance use disorders can choose treatment over incarceration, helping keep people out of our overcrowded prisons and reducing the likelihood of recidivism. Community Behavioral Health Centers also partner with Corrections to provide pre-and post-release behavioral health services to incarcerated seriously mentally ill adults to help make their transition back into the community successful to reduce recidivism.

These and other programs provided by state grantees could be lost if funding is cut too drastically and/or there is no grant requirement or other stringent oversight required for behavioral health Medicaid providers. I realize that you have a difficult task and deeply appreciate your diligence and hard work. If you have any questions or require more information, please don't hesitate to contact me.

Respectfully,

Pamela Watts
Executive Director
Juneau Alliance for Mental Health, Inc.

Medicaid Services "Received Through" an Indian Health Service/Tribal Facility: A Request for Comment

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services

October 2015

Introduction

The Centers for Medicare & Medicaid Services (CMS) is updating its policy regarding the circumstances in which 100 percent federal funding would be available for services furnished to Medicaid-eligible American Indian and Alaska Native (AI/AN) individuals through facilities of the Indian Health Service (IHS) or Tribes. The intent of this policy change, which would apply to all states, would be to improve access to care for AI/AN Medicaid beneficiaries. This paper describes the policy options under consideration and seeks feedback from states, Tribes, and other stakeholders.

Current Policy

In general, AI/AN Medicaid beneficiaries may choose to receive covered services from any provider that participates in a state's Medicaid program, including a hospital, clinic, or a qualified IHS/Tribal facility. (Different rules apply to AI/AN beneficiaries who enroll in Medicaid managed care plans). The rate at which the federal government will match the state's payment for the covered service – the Federal Medical Assistance Percentage (FMAP) – varies depending on the provider that furnishes the service to the eligible AI/AN individual. If the provider is not an IHS/Tribal facility, the FMAP is the state-specific FMAP, which in FY 2016 varies from 50 percent to 74 percent, and the state share varies from 50 percent to 26 percent (unless the service qualifies for a special FMAP rate). If the service is "received through" an IHS/Tribal facility, the FMAP is 100 percent and the state pays no share of the cost.

This enhanced IHS/Tribal facility FMAP is based on section 1905(b) of the Social Security Act (the Act), which provides for the federal government to assume 100 percent of amounts paid for covered services "received through an Indian Health Service [IHS] facility whether operated by the Indian Health Service or by a tribe or tribal organization." (Tribal facilities include facilities that are owned or operated by Tribes and tribal organizations under the Indian Self-Determination and Education Assistance Act, P.L. 93-638.)

The current CMS interpretation of this statutory provision is that 100 percent FMAP is available in costs of covered services under the following conditions:

(1) The service must be furnished to a Medicaid-eligible AI/AN individual;

(2) The service must be a "facility service" – i.e., within the scope of services that a facility (e.g., inpatient hospital, outpatient hospital, clinic, Federally Qualified Health Center, nursing facility) can offer under Medicaid law and regulation;

contractual agents as part of the facility's services; and

(4) The IHS or Tribal facility must maintain responsibility for the provision of the service and must bill the state Medicaid program directly for the service.

Policy Changes Under Consideration

State Medicaid programs, Tribes, and others have expressed concern that the current CMS interpretation of section 1905(b) of the Act is overly restrictive. In light of the federal government's traditional role in the delivery and financing of health care to the AI/AN population, states believe that the federal government should assume more of the cost of services provided to Medicaid AI/AN beneficiaries. Tribes believe that the current CMS interpretation does not fully reflect federal legal responsibility for health care for AI/AN individuals. Others have argued that current CMS policy undermines service delivery innovation and reform by IHS/Tribal facilities.

In response to these concerns and to update the policy regarding the availability of the 100 percent federal funding, CMS is strongly considering interpreting section 1905(b) of the Act in manner that would expand the circumstances in which state Medicaid payments for services furnished to AI/AN beneficiaries would be considered to be "received through" an IHS/Tribal facility and therefore qualify for 100 percent FMAP. More specifically, CMS is strongly considering changing the second, third, and fourth conditions of the current interpretation, as set forth above.

We are requesting comments from states, Tribes, and others on the parameters of the proposed change in the interpretation of section 1905(b) of the Act. We are particularly interested in comments regarding the following modifications of our proposed policy to expand the application of 100 percent FMAP:

1. *Modifying the second condition.* Under current CMS policy, to qualify for 100 percent FMAP, the service "received through" an IHS/Tribal facility must be a "facility service" (element 2). CMS is strongly considering an option under which a service "received through" an IHS/Tribal facility could be any service encompassed within a Medicaid state plan benefit category that the IHS/tribal facility is authorized to provide. Current Medicaid state plan benefit categories are described in section 1905(a), 1915(i), 1915(j), 1915(k), 1945, and 1915 (c) of the Act, along with any other state plan authority established in the future as a state plan benefit. In order to be eligible, the services would have to be covered under the state's approved Medicaid state plan. Among the covered services that could be considered "received through" an IHS/Tribal facility would be transportation services, as well as

services, including related travel expenses (such as meals, lodgings, and cost of an attendant pursuant to federal and state requirements). Transportation may be claimed as an optional medical service or as an administrative expense; however, arrangements claimed as an administrative expense are not eligible for the 100 percent FMAP.

2. *Modifying the third condition.* Under current CMS interpretation, to qualify for 100 percent FMAP the service must be furnished in an IHS/Tribal facility or by its employees or contractual agents as part of the facility's services. CMS is strongly considering an option that would expand the meaning of a contractual agent to include a qualified individual or entity that is enrolled as a Medicaid provider and who provides items or services not within the scope of a Medicaid "facility services" benefit but within the IHS/Tribal facility authority, pursuant to a written contract under which the services for the Medicaid beneficiary are arranged and overseen by the IHS/Tribal facility and the individuals served by the contractual agent are considered patients of the facility. The IHS/Tribal facility would need to retain responsibility for the provision of services, meaning that the IHS/Tribal facility must retain control of the medical records, including updating medical records with information from care provided by contractual agents and providing care coordination for the AI/AN individual. In sum, consistent with the changes described in element two, contractual agents would include those that furnish services that are "received through" the IHS/Tribal facility but are not necessarily furnished directly by the IHS/tribal facility. Urban Indian Health Programs could participate as contractual agents.

3. *Modifying the fourth condition.* Under CMS' current interpretation, the IHS/Tribal facility must maintain responsibility for the provision of the service and must bill the state Medicaid program directly for the service (element 4). CMS is strongly considering an option under which IHS/Tribal facilities would have a choice of specifying in the written contracts with contractual agents whether the facility would bill the state Medicaid program for the service (accepting assignment from contractual agents who are not providing a service within a Medicaid facility benefit category) or whether the contractual agent would bill the state Medicaid program directly.

4. *Application to fee-for-service.* Pursuant to each state's Medicaid plan, IHS/Tribal facilities are typically reimbursed for facility services using an all-inclusive rate (AIR), or the Federally Qualified Health Center (FQHC) prospective payment system (PPS) rate or FQHC alternate payment methodology (APM) rate. The practical

follows:

- For services that are of the type that are encompassed within the applicable facility benefit, an IHS/Tribal facility would receive payment at the applicable IHS facility rate under the state plan whether provided by facility employees or contracted providers as a facility service;
- If an IHS/Tribal facility chooses to provide Medicaid services that are of a type that could be funded through the IHS/Tribal authority but are not within the scope of the applicable facility benefit, such as personal care, home health, 1915(c) waiver services, etc., those services will be paid at the state plan rates applicable to those services. This includes non-emergency medical transportation. We note that states retain flexibility in establishing economic and efficient payment rates to sufficiently reimburse for the provision of services.

5. *Application to managed care.* Current CMS policy was designed in the context of fee-for-service Medicaid program. To accommodate the widespread adoption of managed care by state Medicaid programs, CMS is strongly considering the following clarification with respect to services provided to AI/AN individuals enrolled in managed care plans. To the extent that services are furnished by an IHS/Tribal facility or its employees to AI/AN individuals enrolled in a managed care plan, the state would be able to claim the 100 percent FMAP for the portion of the capitation rate representing those services expended by the managed care plan. The portion of the capitation rate that would be eligible for 100 percent FMAP would be for services for which the following conditions are met:

   1. The service is furnished to a Medicaid-eligible, enrolled, AI/AN individual;
   2. The IHS/Tribal facility provides the service, either directly or through a contractual agent, and maintains oversight responsibility as described above; and
   3. The service is payable under the managed care plan and is, in fact, paid by the managed care plan.

   Under this clarified policy, states would be permitted to claim the 100 percent FMAP for a portion of the capitation payment for AI/AN individuals who are enrolled in managed care, even though the state itself may make no direct payment for IHS/Tribal facility services. The portion of the managed care payment eligible to be claimed at 100 percent FMAP must be based on actual expenditures incurred for IHS/tribal encounters. To inform future guidance and technical assistance to states, we are interested in obtaining more information regarding the methods states

64 at the 100 percent FMAP.

Stakeholder Feedback and Comments

CMS is interested in the effect these changes will have in improving the health status of AI/AN Medicaid beneficiaries, as well as their feasibility. CMS invites states, Tribes, and other stakeholders to review and provide feedback on the parameters of the reinterpretation of section 1905(b) of the Act. Please send written comments by November 17, 2015 to TribalAffairs@cms.hhs.gov.

Adapted from: Comparative Analysis of Medicaid HCBS (1915 & 1115) Waivers and State Plan Amendments. Prepared by Cooper, Flanagan, Crisp. January 2014.

Features	§1915(c) Home and Community-Based Services Waiver	§1915(i) SPA State Plan Home and Community Based Services	§1915(k) SPA Community First Choice Option
Authority Type	Waiver - Information found at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Home-and-Community-Based-1915-c-Waivers.html	State plan option - Information found at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Home-and-Community-Based-Services/Home-and-Community-Based-Services-1915-i.html	State plan option - Information found at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Home-and-Community-Based-Services/Community-First-Choice-1915-k.html
Effective Date	1981	Original: January 1, 2007 Revised: October 1, 2010 NPRM issued: May 3, 2012	Original: October 1, 2011 Final Rule: May 7, 2012
Purpose	Provides Home and Community-Based (HCBS) Services to individuals meeting income, resource, and medical (and associated) criteria who otherwise would be eligible to reside in an institution.	Provides HCBS to individuals who require less than institutional level of care and who would therefore not be eligible for HCBS under 1915(c). May also provide services to individuals who meet the institutional level of care.	Provides a new State plan option to provide consumer controlled home and community-based attendant services and supports. Provides a 6% FMAP increase for this option.
Requirements That May Be Waived	• Statewideness. • Comparability. • Community income rules for medically needy population.	• Comparability. • Community income rules for medically needy population.	Community income rules for medically needy population.
Application Process	Application submitted electronically via §1915(c) HCBS waiver application. Application and instructions found at: www.hcbswaivers.net	State plan amendment submitted on pre-print. Draft preprint can be obtained from CMS Regional Offices.	State plan amendment submitted on pre-print. Preprint can be obtained from CMS Regional Offices.

Features	Home and Community-Based Services Waiver	State Plan Home and Community Based Services	Community First Choice Option
Approval Duration	Initial application: 3 years. Renewal: 5 years.	One-time approval. Changes must be submitted to CMS and approved. If using targeting option, renewal every 5 years.	One-time approval. Changes must be submitted to CMS and approved.
Reporting	Annual reports.	Annual reports.	Annual reports on expenditures and utilization and quality measures.
Administration & Operation	Administered by the Single State Medicaid Agency (SSMA). May be operated by another state agency under an interagency agreement or memorandum of understanding.	Administered by the Single State Medicaid Agency (SSMA). May be operated by another state agency under an interagency agreement or memorandum of understanding.	Administered by the Single State Medicaid Agency (SSMA).
Provider Agreements	Required between providers and the SSMA. Delegation allowed to a provider agency under the Organized Health Care Delivery System or Provider of Financial Management Services. Requires written specification of delegated activity.	Required between providers and the SSMA. Delegation allowed to a provider agency under the Organized Health Care Delivery System or Provider of Financial Management Services. Requires written specification of delegated activity.	Required between providers and the SSMA.
Medicaid Eligibility	May use institutional income and resource rules for the medically needy (institutional deeming). May include the special income group of Individuals with income up to 300% of SSI.	All individuals eligible for Medicaid under the State plan up to 150% of Federal Poverty Level. May include special income group of individuals with income up to 300% SSI. Individuals must be eligible for HCBS under a §1915(c), (d), or (e) waiver or §1115 demonstration program.	Individuals eligible for Medicaid under the State plan up to 150% of Federal Poverty Level. Individuals with income greater than 150% of the FPL may use the Institutional deeming rules.

Features	Home and Community-Based Services Waiver	State Plan Home and Community Based Services	Community First Choice Option
Other Eligibility Criteria	Must meet institutional level of care.	For the 300% of SSI income group, must be eligible for HCBS under a §1915(c), (d), or (e) waiver or §1115 demonstration program.	Individuals must meet institutional level of care. May include the special income group and receiving at least one §1915(c) HCBS waiver service per month.
Public Input	CMS encourages States to obtain public input into the development of the waiver. While States are not required to obtain public input other than through the state Medicaid Advisory Committee, soliciting the views of affected parties is a positive practice.	Proposed regulation is silent.	Must create a Development and Implementation Council that includes a majority of members with disabilities, elderly individuals, and their representatives. State must consult and collaborate with the Council when developing and implementing a State Plan amendment to provide HCBS attendant services.
Target Groups	• Aged or disabled. • Intellectually disabled or developmentally disabled. • Mentally ill (ages 22-64). • Any subgroup of the above.	May define and limit the target group(s) served.	No targeting. Services must be provided on a statewide basis, in a manner that provides such services and supports in the most integrated setting appropriate to the individual's needs, and without regard to the individual's age, type or nature of disability, severity of disability, or the form of home and community-based attendant services and supports that the individual requires in order to lead an independent life.

Features	Home and Community-Based Services Waiver	State Plan Home and Community Based Services	Community First Choice Option
Other Unique Requirements	None. **Cannot cover:** Room & board costs except for allowable transition services. Special education and related services provided under IDEA that are education related only & vocational services provided under Rehab Act of 1973.	Multiple State plan amendments covering different target groups permitted. **Cannot cover:** Room & board costs except for allowable transition services. Special education and related services provided under IDEA that are education related only & vocational services provided under Rehab Act of 1973.	MOE requirement for 1st fiscal year for services provided under §1115, §1905(a), and §1915, of the Act. Must establish & consult with a Development & Implementation Council with majority representation from consumers. **Cannot cover:** Certain assistive devices & assistive technology services; medical supplies & equipment, home modifications. Room & board costs except for allowable transition services. Special education and related services provided under IDEA that are education related only & vocational services provided under Rehab Act of 1973. **Increased FMAP** §1915(k)(2) of the Act provides that States offering this option to eligible individuals during a fiscal year quarter occurring on or after October 1, 2011 will be eligible for a 6 percentage point increase in the Federal medical assistance percentage (FMAP).

Features	Home and Community Based Services Waiver	State Plan Home and Community Based Services	Community First Choice Option
Limits on Numbers Served	Allowed.	Not allowed.	Not allowed.
Waiting Lists	Allowed.	Not allowed.	Not allowed.
Combining Service Populations	Combining service populations is limited to: 1) Aged/Disabled. 2) Intellectually Disabled or Developmentally Disabled. 3) Mentally Ill. 4) Any subgroup of the above.	States may combine service populations.	States may combine service populations.
Caps on Individual Resource Allocations or Budgets	Allowed.	May determine process for setting individual budgets for participant-directed services.	May determine process for setting individual budgets for participant-directed services.
Allowable Services	Statutory Services: • Case management services. • Homemaker/home health aide services & personal care services. • Adult day health services. • Habilitation services. • Respite care. • "Dther services requested by State as Secretary may approve." • Day treatment or other partial hospitalization services. • Psychosocial rehabilitation services. • Clinic services. • For individuals with	See §1915(c) services. Includes both §1915(c) statutory services and "other" category of services. Settings where individuals live must comport with community character guidance.	**MUST COVER:** • Assistance w/ ADLs, IADLs, & health related tasks. • Acquisition, maintenance & enhancement of skills necessary for individual to accomplish ADLs, IADLs, & health-related tasks. • Back-up systems or mechanisms to ensure continuity of services & supports. • Voluntary training on how to select, manage and dismiss staff. **MAY COVER** • Fiscal Management Services • Transition costs such as rent and utility

Features	Home and Community-Based Services Waiver	State Plan Home and Community Based Services	Community First Choice Option
Allowable Services (cont'd)	chronic mental illness. Settings where individuals live must comport with community character guidance.		deposits, 1st month's rental and utilities, bedding, basic, kitchen supplies, and other necessities linked to an assessed need for an individual to transition from a NF, institution for mental diseases, or ICF-ID to a home & community-based setting where individual resides. • Expenditures relating to a need identified in an individual's person-centered plan that increases his/her independence or substitutes for human assistance to the extent the expenditures would otherwise be made for the human assistance. Settings where individuals live must comport with community character guidance.
Provider Qualifications	Determined by state, subject to CMS approval.	Determined by state, subject to CMS approval.	Determined by state, subject to CMS approval.
Participant-directed Services	Allowed.	Allowed.	Required.
Hiring of Legally Responsible Individuals	Allowed at the State's discretion.	Allowed at the State's discretion.	Allowed at the State's discretion.
Cash Payments to Participants	Direct cash payments not permitted.	Direct cash payment not permitted.	Direct cash payments are permitted.

Features	Home and Community-Based Services Waiver	State Plan Home and Community Based Services	Community First Choice Option
Financial Management Services	Required if participant direction is offered. May be a waiver service, an administrative function, or performed directly by the SSMA.	Required if participant direction is offered. May be covered as a service, an administrative function, or performed directly by the SSMA.	Required depending on model of participant direction. May be covered as a service, an administrative function, or performed directly by the SSMA.
Employer Status for Participant Direction	Participant may be the employer of record under a Fiscal/Employer Agent model or the entity may be the employer of record under an Agency with Choice model.	Participant may be the employer of record under a Fiscal/Employer Agent model or the entity may be the employer of record under an Agency with Choice model. Financial management supports are required to function as employer of record when the individual elects to exercise supervisory responsibility without employment responsibility.	Agency Provider Model: Services & supports provided by entities under contract or provider agreement. Participant has a significant role in the selection and dismissal of providers. Entity may provide services directly through their employees or arrange for the provision of services under the direction of the individual receiving services. Self-Directed Model with Service Budget: Service plan and budget directed by the individual and based on functional needs assessment. FMS must be available (SSMA may perform). Direct cash or vouchers may also be used. Other Service Delivery Model: States may propose other models
Goods and Services	Permitted as a waiver service.	Permitted as a service.	Permitted as a service.
Direct Payment of Providers	Required (state has options to meet this requirement).	Required.	Required.

Features	Home and Community-Based Services Waiver	State Plan Home and Community Based Services	Community First Choice Option
Provider Payments	Payment item must be listed in the service plan (plan of care), provided by an enrolled provider, and provided prior to reimbursement.	Payment item must be listed in the service plan (plan of care), provided by an enrolled provider, and provided prior to reimbursement.	Payment item must be listed in the service plan (plan of care), provided by an enrolled provider, and provided prior to reimbursement.
Cost Requirements	Must be cost-effective. Average annual cost per person served under §1915(c) cannot exceed average annual cost of institutional care for each target group served.	None. Benefit limits may apply.	None. Benefit limits may apply. For the first full fiscal year in which the State Plan amendment is implemented, a State must maintain, or exceed, the level of expenditures for services provided under §1115, §1905(a), and §1915, of the Act, or otherwise to individuals with disabilities or elderly individuals attributable to the preceding fiscal year.
Quality Management	Extensive quality management and quality improvement activities required per the HCBS Waiver Application, including how state will comply with all multiple waiver assurances and how state will conduct quality oversight, monitoring and discovery, remediation and improvement of issues relating to quality.	Pre-print requires a quality assurance and improvement plan including how state conducts discovery, remediation and quality improvement.	Requires a quality assurance and improvement plan including how state conducts discovery, remediation and quality improvement. State must provide system of performance measures, outcome measures, and satisfaction measures that will be monitored and evaluated.

Features	Home and Community-Based Services Waiver	State Plan Home and Community Based Services	Community First Choice Option
Interaction with State Plan Services, Waivers, & Amendments	Participants have access to and must utilize state plan services before using identical extended state plan services under the waiver. Waiver services may not duplicate state plan services. Individuals may be eligible for and receive State plan, §1915(c), §1915(i) and §1915(j) services simultaneously. May be combined with other waivers such as §1915(a) or (b).	Individuals may be eligible for and receive State plan services, §1915(c), §1915(i) and §1915(j) services simultaneously, so long as the service plan (plan of care) ensures duplication of services is not occurring. May be combined with other waivers such as §1915(a) or (b).	Individuals may be eligible for and receive State plan, §1915(c), §1915(i) and §1915(j) services simultaneously. May be combined with other waivers such as §1915(a) or (b).

Explore Two Options in the Social Security Act Known as Medicaid 1915(i) Home and Community-Based Services and 1915(k) Community First Choice.

Frequently Asked Questions (12-28-15)

State Plan Options 1915(i) and 1915(k)

Overview

1. What is a state plan option?

To receive federal funding for Medicaid services, states must comply with the federal Medicaid law. This law defines what states: (1) must do; (2) can choose to do; and (3) cannot do. Those benefits that a state can choose to include in their Medicaid State Plan is referred to as a "state plan option" or "optional benefit."

2. Why is the State of Alaska pursuing the 1915(i) and the 1915(k) state plan options?

Seniors and people with disabilities in Alaska, by and large, want to stay in their homes and communities. Home and community-based services (HCBS) support these individuals in doing so. Given the State of Alaska's financial concerns, the State needs to leverage as much federal funding as possible to help pay for home and community-based services. When services are administered under the Medicaid State Plan, state dollars are matched by federal dollars. The federal government will pay 50% of the cost of the Medicaid services under 1915(i), and 56% of the cost of the Medicaid services under the 1915(k) option. Some services currently funded by State General Fund dollars only could be administered under the Medicaid State Plan which would bring more federal dollars into the State.

3. Will some seniors and people with disabilities lose their benefits?

The state plan options will extend Medicaid benefits to additional populations for specific services, not exclude individuals currently receiving benefits. While we cannot expand home and community-based services due to the State budget deficit, the state plan options will allow Alaska to draw down more federal dollars to help pay for these services.

4. How is the 1915(i) state plan optional benefit similar to Alaska's 1915(c) waiver?

- The allowed services under the 1915(i) state plan option may be identical to those offered under the waiver. In addition, the 1915(i) state plan option may include personal care services.
- Both 1915(i) state plan option and the 1915(c) waiver include specific targeting criteria for eligibility. For 1915(i), the state may define and limit the target group(s) served. For 1915(c) waiver, the following groups are targeted: aged/disabled, persons with intellectual disabilities/developmental disabilities, persons with severe mental illness.
- Neither the 1915(i) state plan ... 1915

- While the waiver limits home and community-based services benefits to those who meet a Nursing Facility or Intermediate Care Facilities for Individuals with Intellectual Disabilities level of care, the 1915(i) state plan option provides home and community-based services to individuals who would not otherwise meet the Nursing Facility or Intermediate Care Facilities for Individuals with Intellectual Disabilities level of care eligibility requirement.
- While the availability of waiver services can be limited to certain parts of the state, the 1915(i) state plan optional benefit must be provided to everyone who meets eligibility criteria statewide.
- The 1915(c) waiver allows caps on the number of people that can be served and establishes a waiting list (or registry) for those who are eligible but exceed the service cap. The 1915(i) state plan optional benefit is not allowed to set caps on the number served under the benefit and therefore, anyone who meets the eligibility criteria for the benefit is entitled to the service.

6. How is the 1915(k) Community First Choice state plan optional benefit <u>similar</u> to the Personal Care Services state plan benefit?

Both the 1915(k) and Personal Care Services cover personal care attendant services that support individuals with their Activities of Daily Living (e.g., bathing, dressing, eating, etc.) and Instrumental Activities of Daily Living (e.g., meal preparation, housekeeping, etc.).

7. How is the 1915(k) Community First Choice state plan optional benefit <u>different</u> from the Personal Care Services state plan benefit?

- Unlike the Personal Care Services benefit, to be eligible for the 1915(k) state plan optional benefit, an individual must meet the Nursing Facility or Intermediate Care Facilities for Individuals with Intellectual Disabilities level of care.
- While the Personal Care Services benefit receives the traditional federal match to state dollars allocated to fund the program, 1915(k) state plan optional benefits are eligible for an enhanced federal match. In Alaska, the traditional federal match is 50% (for every 50 cents the state puts in, the federal government puts in 50 cents). Under 1915(k), the federal match is 56%.
- In addition to the personal care attendant benefits that both 1915(k) and Personal Care Services cover, 1915(k) also includes additional required and optional benefits spelled out in the response to Question 12.

Eligibility

8. What are the eligibility criteria for 1915(i) and 1915(k)?

- For 1915(i), individuals must be eligible for Medicaid under the State plan up to 150% of Federal Poverty Level, and may include special income group of individuals with income up to 300% Social Security Income.
- For 1915(k), individuals must meet institutional level of care. Individuals must also be eligible for Medicaid under the State plan up to 150% of Federal Poverty Level. Individuals with income greater than 150% of the Federal Poverty Level may use the institutional deeming rules which means that parents' or spouse's income and resources are not taken into account.

9. Can you receive services through the 1915(c) waiver and also be eligible for services under a state plan option?

Injury. Individuals with Fetal Alcohol Spectrum Disorders may be included as well.

Services

11. What services are covered under 1915(i)?

1915(i) services include those services currently covered under 1915(c) waiver:

- Case Management
- Homemaker Services
- Home Health Aide
- Personal Care
- Adult Day Health
- Habilitation
- Respite Care
- For Chronic Mental Illness: Day treatment or Partial Hospitalization, Psychosocial Rehab, Clinic Services

The Affordable Care Act revised 1915(i) to include "additional services requested by the state as the Secretary may approve." For example: Behavioral Supports, Cognitive Rehabilitative Therapy, Crisis Intervention, Exercise and Health Promotion, Health Monitoring, Housing Counseling, Assistive Technology, Live-In Caregiver Payment, and Family Training.

12. What services are covered under 1915(k)?

Services that must be covered include:

- Assistance with Activities of Daily Living such as eating, toileting, grooming, dressing, bathing, and transferring; Instrumental Activities of Daily Living such as meal planning and preparation, managing finances, shopping for food, clothing, and other essential items, performing essential household chores, communicating by phone or other media, and traveling around and participating in the community; and health-related tasks, e.g., assistance with medication administration, catheter, oxygen.
- Skills training to help people to accomplish Activities of Daily Living / Instrumental Activities of Daily Living, and health-related tasks.
- Back-up systems (e.g., emergency response button) and mechanisms to ensure continuity of services and supports.
- Voluntary training on how to select, manage, and dismiss attendants.

Other services that may be covered include:

- Transition costs required for an individual to transition from a nursing facility or other institution to a community-based home setting (e.g., items necessary to establish household to transition from a nursing facility or other institution.)
- Goods and services that increase an individual's independence or substitutes for human assistance, to the extent that expenditures would otherwise be made for human assistance, e.g., ramp that allows person to enter home independently.

- The setting is integrated in and supports full access to the greater community,

- Is selected by the individual from among setting options;

- Ensures individual rights of privacy, dignity and respect, and freedom from coercion and restraint;

- Optimizes autonomy and independence in making life choices; and

- Facilitates choice regarding services and who provides them.

Excluded settings include nursing facilities, institutions for mental disease, intermediate care facilities for individuals with intellectual disabilities, and hospitals. Other Medicaid funding authorities support services provided in these institutional settings.[1]

Functional Assessment and Person-Centered Care Plans

14. I understand the State may develop or adopt a new functional assessment tool to assess an individual's needs for 1915(i) and 1915(k). Why is the State looking at new assessment tools?

The federal government is requiring functional assessment tools to be consistent with "person-centered planning." This type of planning includes processes whereby the needs and preferences of the individual receiving services are described by that person, along with family, friends and other care team members. This helps to ensure that the individual's care plan includes, and the individual receives, the covered services they need in a way that they prefer. These requirements apply across the 1915(c) and 1915(i) programs and are consistent with the final person-centered planning requirements for 1915(k).[2]

15. Will there be any changes to selection and training of individuals to administer the tools?

To the extent that the functional assessment tool changes, staff will be trained on new features of the tool.

16. How does the State propose to meet the conflict-free case management requirement of 1915(k) in remote areas of Alaska where there are no or limited independent case managers?

Conflict-free case management is the provision of case management services by an independent entity, one that does not have a conflict of interest in either the assessment or care plan. For example, case managers cannot be employed by providers of State plan home and community-based services for an individual. However, exceptions may be made if the provider is the only willing and qualified entity in the area. In this case, the State must develop additional safeguards including an alternative dispute resolution process. The State of Alaska is currently in dialogue with the Centers for Medicaid and Medicare Services about this exception in rural Alaska; the State will communicate the result of its discussions at the appropriate time.

Efficiencies

17. How will the State avoid duplication between waiver programs and the state plan option services?

[1]CMS Fact Sheet: Summary of Key Provisions of the Home and Community-based Services Settings Final Rule. January 10, 2014. http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/downloads/hcbs-setting-fact-sheet.pdf

[2]Medicaid.gov. Home and Community Based Services, Q and A. May 7, 2012. http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/downloads/final-q-and-a.pdf

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