MEDICAID EXPANSION: DEPARTMENT OF HEALTH & SOCIAL SERVICES DOCUMENTS

<TARGET><BILL></BILL><SUBJECT>MEDICAID EXPANSION
DEPARTMENT OF HEALTH and SOCIAL SERVICES
DOCUMENTS</SUBJECT><COMM>SHSS29</COMM></TARGET>

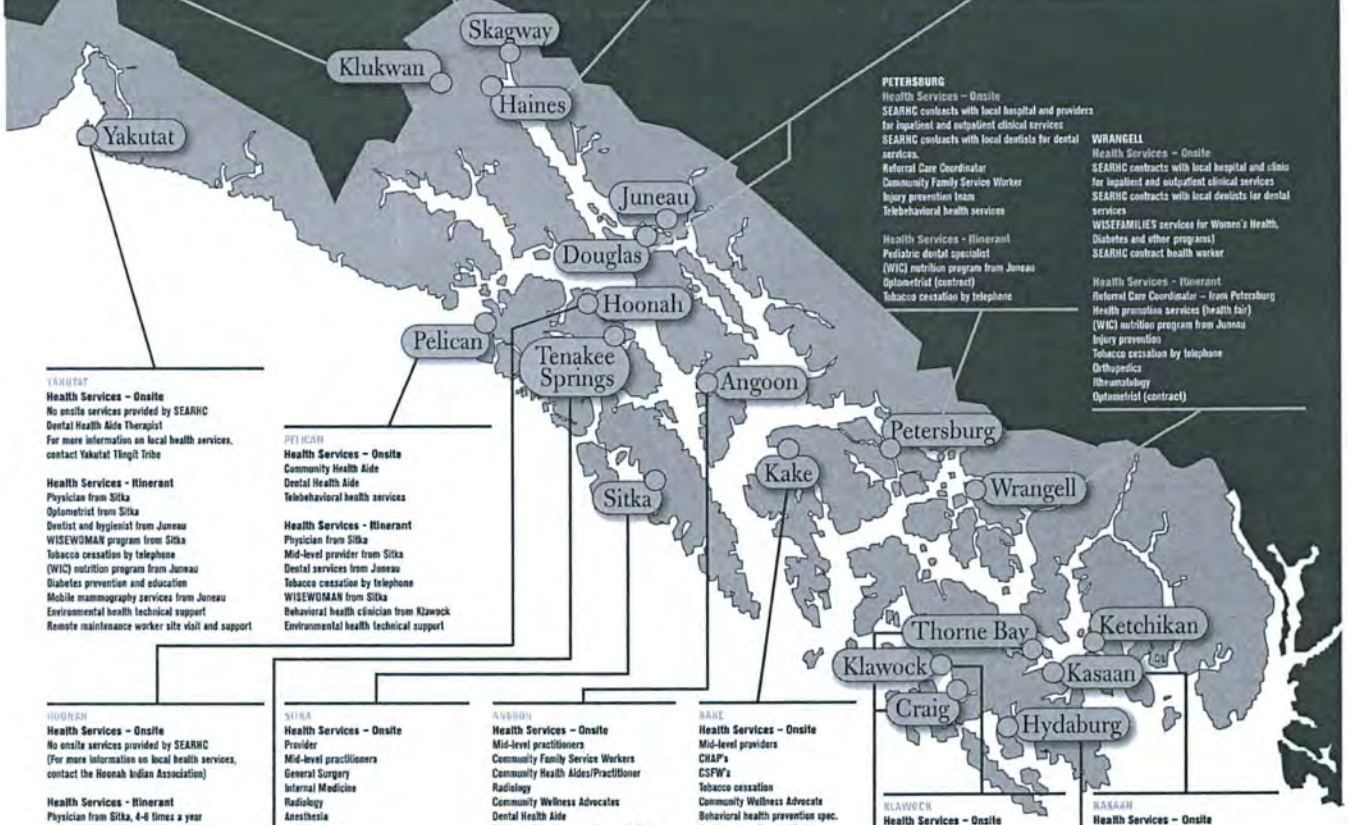
MEDICAID EXPANSION & REFORM TIMELINE

*Savings indeterminate at this time.

Learn more at www.dhss.alaska.gov/healthyalaska

Revised 4-2-15

Health Services in SEARHC Communities



KLUKWAN

Health Services – Onsite
Community Health Aide
Behavioral health prevention specialist
Dental Health Aide
Telebehavioral health services
WISEWOMAN program
Tobacco cessation

Health Services – Itinerant
Physician from Haines – weekly
Mid-level provider from Haines – weekly
Dentist and hygienist from Haines
Community Family Service Worker staff from Haines
(WIC) nutrition program from Juneau
Registered dietitian from Juneau
Health promotion services from Haines
Tobacco cessation
Injury prevention
Environmental health technical support
Remote maintenance worker site visit & support

SKAGWAY

Health Services – Onsite
SEARHC provides medical services through contract health agreements with the local clinic
Behavioral health services
Telebehavioral health services

Health Services – Itinerant
Mobile mammography services from Juneau
(WIC) nutrition program from Juneau
Tobacco cessation by telephone

HAINES

Health Services – Onsite
Family medicine physicians
Mid-level providers
Pharmacist & pharmacy technician
Physical therapist
Dentist, hygienist
Laboratory
Radiology and teleradiology
Frontier Extended Stay Clinic
WISEWOMAN Program
Breast and Cervical Health Program
Behavioral health clinician
Community Family Service Workers
Behavioral health prevention specialist
Youth community coordinator
Telebehavioral health services
Community Wellness Advocates
Diabetes prevention and education
Tobacco cessation
Injury prevention
Injury prevention
Tobacco cessation
Injury prevention

Health Services – Itinerant
Mobile mammography from Juneau
ENT/audiology from
Mt. Edgecumbe Hospital (MEH)
(WIC) nutrition program from Juneau
Internal medicine from MEH
Registered dietitian from Juneau
Optometry from Juneau
Ultrasound from MEH & Juneau
Pediatrics from Sitka
Rheumatology
Podiatry – contracted
Orthopedics – contracted

JUNEAU/DOUGLAS

Health Services – Onsite
Family medicine physicians
Pediatrician
Mid-level providers
Pharmacists & pharmacy techs
Physical therapist
Optometrist
Social Worker & Social Services Coordinator
Radiology (x-ray, ultrasound, mammography)
Laboratory services
Dietician
Clinical case managers
Dentists & dental hygienists
Psychiatrists
Psychologist
Child family therapist
Community Family Service Workers
WISEWOMAN Program
Breast and Cervical Health Program
Diabetes prevention & education
Tobacco cessation services
Injury prevention & safety shop
Literacy promotion
Physical activity promotion
(WIC) nutrition program
Telebehavioral health services

Health Services – Itinerant
Hepatology
Cardiology
Orthopedics
Gynecology
Neurology
Dermatology
Otolaryngology
Rheumatology
Urology
Dental specialists

PETERSBURG

Health Services – Onsite
SEARHC contracts with local hospital and providers for inpatient and outpatient clinical services
SEARHC contracts with local dentists for dental services.
Referral Care Coordinator
Community Family Service Worker
Injury prevention team
Telebehavioral health services

Health Services – Itinerant
Pediatric dental specialist
(WIC) nutrition program from Juneau
Optometrist (contract)
Tobacco cessation by telephone

WRANGELL

Health Services – Onsite
SEARHC contracts with local hospital and clinic for inpatient and outpatient clinical services
SEARHC contracts with local dentists for dental services
WISEFAMILIES services for Women's Health, Diabetes and other programs)
SEARHC contract health worker

Health Services – Itinerant
Referral Care Coordinator – from Petersburg
Health promotion services (health fair)
(WIC) nutrition program from Juneau
Injury prevention
Tobacco cessation by telephone
Orthopedics
Rheumatology
Optometrist (contract)

YAKUTAT

Health Services – Onsite
No onsite services provided by SEARHC
Dental Health Aide Therapist
For more information on local health services, contact Yakutat Tlingit Tribe

Health Services – Itinerant
Physician from Sitka
Optometrist from Sitka
Dentist and hygienist from Juneau
WISEWOMAN program from Sitka
Tobacco cessation by telephone
(WIC) nutrition program from Juneau
Diabetes prevention and education
Mobile mammography services from Juneau
Environmental health technical support
Remote maintenance worker site visit and support

PELICAN

Health Services – Onsite
Community Health Aide
Dental Health Aide
Telebehavioral health services

Health Services – Itinerant
Physician from Sitka
Mid-level provider from Sitka
Dental services from Juneau
Tobacco cessation by telephone
WISEWOMAN from Sitka
Behavioral health clinician from Klawock
Environmental health technical support

HOONAH

Health Services – Onsite
No onsite services provided by SEARHC
(For more information on local health services, contact the Hoonah Indian Association)

Health Services – Itinerant
Physician from Sitka, 4-6 times a year
Mobile mammography services from Juneau
Optometry services from Juneau
Breast and Cervical Health Program
Tobacco cessation by telephone
Diabetes prevention and education from Juneau
(WIC) nutrition program from Juneau
Dentist and hygienist from Juneau
Environmental health technical support
Remote maintenance worker site visit & support
Injury prevention team

TENAKEE SPRINGS

Health Services – Onsite
No clinic staff or onsite operations

Health Services – Itinerant
Tobacco cessation by telephone
Dentist from Sitka

SITKA

Health Services – Onsite
Provider
Mid-level practitioners
General Surgery
Internal Medicine
Radiology
Anesthesia
Otolaryngology
Pediatrics
Obstetrics/Gynecology
Psychiatry
Optometry
Dental
Dental hygiene
Dental Health Aide Therapist
Psychology
Child family therapy
Respiratory therapy
Occupational therapy
Pharmacists & pharmacy techs
Physical therapy services
Laboratory services
Radiology services (x-ray, MRI, CT, bone density, ultrasound, echocardiography, mammography)
Dietary & nutrition
Social work services
Breast and Cervical Health Program
WISEWOMAN program
Diabetes prevention & education
Tobacco cessation program
Injury prevention
(WIC) nutrition program
Teen clinic

Health Services – Itinerant
Rheumatology
Orthopedics
Ophthalmology
Dermatology
Cardiology
Neurology
Hepatology
Geriatrics
Urology
Pediatric neurology
Pediatric cardiology

ANGOON

Health Services – Onsite
Mid-level practitioners
Community Family Service Workers
Community Health Aides/Practitioner
Radiology
Community Wellness Advocates
Dental Health Aide
Behavioral health prevention specialist
Injury prevention team
Telebehavioral health services
WISEWOMAN services
Health promotion services

Health Services – Itinerant
Physician from Sitka
Dentist & hygienist
Pediatric dental specialist
Behavioral health clinician from Sitka
Optometrist from Juneau
Audiologist from Sitka
Registered dietitian from Juneau
Tobacco cessation by telephone
Health promotion program from Sitka
(WIC) nutrition program
Mobile mammography services from Juneau
Breast and Cervical Health Program
WISEWOMAN Program
Environmental health technical support
Remote maintenance worker site visit & support

CRAIG

Health Services – Onsite
Public health nurse in Craig
Injury prevention team
No onsite services provided by SEARHC in Craig. (See Klawock profile)

Health Services – Itinerant
Tobacco cessation by telephone
Environmental health technical support
Remote maintenance worker site visit & support (See Klawock profile)

KAKE

Health Services – Onsite
Mid-level providers
CHAP's
CSFW's
Tobacco cessation
Community Wellness Advocate
Behavioral health prevention spec.
Youth community coordinator
Dental health aide
Radiology
Tele-behavioral health services
WISEWOMAN services
Health promotion services
WISEFAMILIES

Health Services – Itinerant
Physician from Sitka
Dentist & hygienist from Sitka
Pediatric dental specialist
Behavioral health clinician from Sitka
Tobacco cessation by telephone
Audiologist from Sitka
Optometrist from Juneau
Registered dietitian from Juneau
Health promotion program from Sitka
Injury prevention from Sitka
(WIC) nutrition program
Mobile mammography services - Juneau
Breast and Cervical Health Program
WISEWOMAN Program from Sitka
Environmental health technical support
Remote maintenance worker site visit & support

THORNE BAY

Health Services – Onsite
Mid-Level Provider
Nurse
Dental Health Aide
Community Health Aide

KLAWOCK

Health Services – Onsite
Family practice physicians
Mid-level practitioner
Telepharmacist (1, based in Sitka) & pharmacy technician (1, based in Klawock)
Physical therapist
Laboratory
Teleradiology
Referral case manager
Frontier Extended Stay Clinic
Dentist and dental hygienist
Dental Health Aide Therapist
Behavioral health clinicians
Community Family Service Worker
Telebehavioral health services
Community Wellness Advocate
Breast and Cervical Health Program
WISEWOMAN Program
Diabetes prevention and education
Tobacco cessation
Injury prevention team

Health Services – Itinerant
Optometrist from Sitka
ENT & audiologist from Sitka
(WIC) nutrition program from Ketchikan
Registered dietitian
Mobile mammography services from Juneau
Environmental health technical support
Remote maintenance worker site visit & support

KASAAN

Health Services – Onsite
Community Health Aide

Health Services – Itinerant
Mid-level provider from -Thorne Bay
Dentist and hygienist from ARMC – Klawock
Tobacco cessation by telephone
Women, Infants & Children (WIC) nutrition program from Ketchikan
Environmental health technical support
Remote maintenance worker site visit & support

HYDABURG

Health Services – Onsite
Physician Assistant
Community Health Aide/Practitioner
Community Family Service Worker
Dental Health Aide
Community Wellness Advocate
Telebehavioral health services

Health Services – Itinerant
Physician from ARMC – Klawock
Dentist and hygienist from ARMC – Klawock
Behavioral health staff from ARMC
WISEWOMAN Program from ARMC
Registered dietitian from ARMC
Women, Infants & Children (WIC) nutrition program from Ketchikan
Tobacco cessation by telephone
Environmental health technical support
Remote maintenance worker site visit & support

SEARHC
Your Partner in Health

Better Care, Smarter Spending, Healthier People: Improving Our Health Care Delivery System

Date

2015-01-26

Title

Better Care, Smarter Spending, Healthier People: Improving Our Health Care Delivery System

Contact

press@cms.hhs.gov

Better Care, Smarter Spending, Healthier People: Improving Our Health Care Delivery System

Updated January 26, 2015

Improving the quality and affordability of care received by Americans is, alongside increasing access to it, a core pillar of the Affordable Care Act. The Administration is working to ensure that Americans receive better care; that we spend our health care dollars more wisely; and that we have healthier communities, a healthier economy, and ultimately, a healthier country. This means finding better ways to deliver care, pay providers, and share and utilize information.

The Affordable Care Act offers many tools to improve the way providers are paid to reward quality and value instead of quantity, to strengthen care delivery by better integrating and coordinating care for patients, and to make information more readily available to consumers and providers. Doing so will improve the coordination and integration of health care, engage patients more deeply in decision-making and improve the health of patients – with a priority on prevention and wellness.

It is our role and responsibility to lead this change, and we will lead. At the same time, we understand the importance of engaging partners who are also committed to improving our health care system. Patients, physicians and other providers, government, and businesses all have a stake in this effort.

Significant progress has already been made, thanks to the Affordable Care Act, and other efforts are underway.

Health care cost growth has slowed

The United States is in the midst of a sustained, historic slowdown in the growth of health care costs. The years 2011, 2012, and 2013 saw the slowest growth in real per capita national health expenditures on record, spurred by slow growth in per-beneficiary spending throughout our health care system, including Medicare, Medicaid, and private insurance. Slow growth in the cost of health care continued in 2014, even as millions gained coverage. The average premium for employer-based family coverage increased just 3 percent in 2014,

according to the Kaiser Family Foundation, tied for the smallest increase since the Kaiser survey began in 1999. Medicare spending per beneficiary was approximately flat in fiscal year 2014, and from 2010 to 2014, Medicare spending per beneficiary grew at a rate that was 2 percentage points per year less than growth in GDP per capita. Looking forward, due primarily to the persistent slowdown in health care costs, the Congressional Budget Office now estimates that Federal spending on Medicare and Medicaid in 2020 will be $188 billion below what it projected as recently as August 2010.

Health outcomes are improving and adverse events are decreasing

Since 2011, patient safety has improved dramatically, thanks in part to the Partnership for Patients (see below). Patient harm has fallen by 17%, saving 50,000 lives and billions of dollars. As one example, clinicians at some hospitals have reduced their early elective deliveries to close to zero, meaning fewer at-risk newborns and fewer admissions to the neonatal intensive care units.

In 2012, we implemented an Affordable Care Act program that ties Medicare payment for hospitals to readmission rates for certain conditions, i.e. the percentage of patients that have to return to the hospital within 30 days of being discharged. After holding constant at 19 percent from 2007 to 2011 and decreasing to 18.5 percent in 2012, the Medicare all-cause 30-day readmission rate has further decreased to approximately 17.5 percent in 2013. This translates into an 8 percent reduction in the rate and an estimated 150,000 fewer hospital readmissions among Medicare beneficiaries between January 2012 and December 2013.

Providers are engaged

The Innovation Center is charged with testing innovative payment and service delivery models to reduce expenditures in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP), and at the same time, preserving or enhancing quality of care. Already the Innovation Center is engaged in projects with more than 60,000 health care providers to improve care, and an estimated 2.5 million Medicare, Medicaid and CHIP beneficiaries are receiving care through the Innovation Center's payment and service delivery models.

For example, in 2012, Medicare Accountable Care Organizations (ACOs) began participating in the Medicare Shared Savings Program and the Pioneer ACO. These programs encourage providers to invest in redesigning care for higher quality and more efficient service delivery, without restricting patients' freedom to go to the Medicare provider of their choice.

There are 424 organizations currently participating in the Medicare ACOs, serving over 7.8 million Medicare beneficiaries. As existing ACOs choose to add providers and more organizations join the Shared Savings

Program, participation in ACOs is expected to grow. Medicare ACOs participating in the Shared Savings Program and the Pioneer ACO Model combined generated over $417 million in savings for Medicare.

Medicare beneficiaries are shopping for coverage according to quality

The Affordable Care Act ties payment to private Medicare Advantage plans to the quality ratings of the coverage they offer. Since those payment changes have been in effect, more seniors are able to choose from a broader range of higher quality Medicare Advantage plans, and more seniors have enrolled in these higher quality plans as well.

Approximately 40 percent of Medicare Advantage contracts received four or more stars in 2015, which is an increase from 6 percent in 2013. About 60 percent of Medicare Advantage enrollees are currently enrolled in plans with four or more stars for 2015, an increase of approximately 31 percentage points compared to the percentage in four or five star plans for the 2012 ratings.

Below are specific examples of reforms and investments that help build a health care delivery system that better serves all Americans.

INCENTIVES: PAYING FOR VALUE:

- *Hospitals.* Two important programs that reward hospitals based on the quality of care they provide to patients began in 2012, and a third was initiated in 2014.
  - *Hospital Value-Based Purchasing Program.* This program links a portion of hospitals' Medicare payments for inpatient acute care to their performance on important quality measures. Examples of measures include whether a patient received an antibiotic before surgery, and how well doctors and nurses communicate with patients. For FY 2015, as directed by the law, CMS increased the applicable percent reduction, the portion of Medicare payments available to fund the value-based incentive payments under the program, from 1.25 to 1.5 percent of the base operating DRG payment amounts to all participating hospitals.
  - *Hospital Readmissions Reduction Program.* This program reduces Medicare payments to hospitals with excess readmissions beginning October 2012 to encourage patient safety and care quality. In FY 2015, the maximum reduction in payments under the Hospital Readmissions Reduction Program increased from 2 to 3 percent of base discharge amounts, as required by law. CMS will assess hospitals' readmissions penalties using five readmissions measures endorsed by the National Quality Forum.
  - *Hospital-Acquired Condition Reduction Program.* This program, authorized by the Affordable Care Act, began in October 2014 and reduces Medicare payments for some hospitals that rank in the worst performing quartile with respect to hospital-acquired conditions (HACs), which is determined based on the hospital's performance

on three quality measures (Patient Safety Indicator 90 composite, central-line associated bloodstream infection and catheter associated urinary tract infection). Additional safety measures for measures such as surgical site infections and methicillin resistant staph aureus infections have been added for future years.

- *Dialysis Facilities*. The End-Stage Renal Disease (ESRD) Quality Incentive Program ties Medicare payments directly to facility performance on quality measures, resulting in better care at lower cost for over 503,000 Medicare beneficiaries with end stage renal disease. In addition, a new comprehensive care model announced in January 2013 will test a new payment and service delivery approach to improve care for ESRD beneficiaries, by coordinating primary care with care for their special health needs.
- *Testing New Payment Models*: The Innovation Center is testing innovative payment and service delivery models that are already seeing results.
  - *Pioneer Accountable Care Organization Model*. Nineteen ACOs are currently participating in the Pioneer ACO Model, which is designed for health care organizations and providers that are already experienced in coordinating care for patients across care settings. Preliminary results from the independent evaluation of the Pioneer ACO Model show that Pioneer ACOs have generated gross savings of $147 million in their first year. During the second performance year, Pioneer ACOs generated estimated total model savings of over $96 million and savings to the Medicare Trust Funds of approximately $41 million. Pioneer ACOs also outperformed published quality benchmarks in year one and improved in almost all quality and patient experience measures in year two. When combined with ACOs in the Medicare Shared Savings Program, there are 424 organizations currently participating in the Medicare ACOs, and these two programs combined generated over $417 million in savings for Medicare since 2012.
  - *Bundled Payments for Care Improvement initiative*. The initiative currently has 105 Awardees in Phase 2 (risk-bearing), including 38 conveners of health care organizations, representing 243 Medicare organizational providers. Additionally within Phase 1 of the initiative are 870 participants, including 138 conveners of health care organizations, representing 6,424 Medicare organizational providers. They are testing how bundling payments for episodes of care can result in more coordinated care for Medicare beneficiaries and lower costs for Medicare. Bundling payment for services that patients receive across a single episode of care, such as heart bypass surgery or a hip replacement, is one way to encourage doctors, hospitals and other health care providers to work together to better coordinate care for patients, both when they are in the hospital and after they are discharged.
  - *Health Care Innovation Awards*. The Health Care Innovation Awards Round One are funding up to $1 billion in awards to 107 organizations across the country that are implementing the most compelling new ideas to deliver better health, improved care and lower costs to people enrolled in Medicare, Medicaid and CHIP. The Health Care Innovation Awards Round Two are funding up to $360 million to 39 organizations to test new payment and service delivery models.

CARE DELIVERY: PROMOTING BETTER CARE AND PROTECTING PATIENT SAFETY:

- *Comprehensive Primary Care Initiative.* The Innovation Center is currently testing the Comprehensive Primary Care Initiative (CPC), which is a multi-payer partnership between Medicare, Medicaid private health care payers, and primary care practices in four states (Arkansas, Colorado, New Jersey and Oregon) and three regions (New York's Capital District and Hudson Valley, Ohio and Kentucky's Cincinnati-Dayton region, and Oklahoma's Greater Tulsa region). This initiative includes providing care management for those at greatest risk; improving health care access; tracking patient experience; coordinating care with hospitals and specialists; and using health information technology to support population health. Practices receive non-visit based care management fees from the participating payers, and the opportunity to share in savings. Results from the first year suggest that CPC has generated nearly enough savings in Medicare health expenditures to offset care management fees paid by CMS, with hospital admissions decreasing by 2% and emergency department visits by 3%. Results should be interpreted cautiously as effects are emerging earlier than anticipated, and additional research is needed to assess how the initiative affects cost and quality of care beyond the first year.
- *Multi-Payer Advanced Primary Care Initiative.* The Innovation Center is currently testing the Multi-Payer Advanced Primary Care Practice (MAPCP), which is a multi-payer initiative in which Medicare is participating with Medicaid and private health care payers in eight advanced primary care initiatives in Maine, Michigan, Minnesota, New York, North Carolina, Pennsylvania, Rhode Island, and Vermont. Under this demonstration, participating practices and other auxiliary supports (e.g., community health teams) receive monthly care management fees from the participating payers and additional support (e.g., data feedback, learning collaboratives, practice coaching). More than 3,800 providers, 700 practices, and 400,000 Medicare beneficiaries participated in the first year. Unlike CPC, the eight states participating in MAPCP convene the participants and administer the initiatives rather than CMS. During the first year, the demonstration produced an estimated $4.2 million in savings. Also, the rate of growth in Medicare FFS health care expenditures was reduced in Vermont and Michigan, driven largely by reduced growth in inpatient expenditures.
- *Partnership for Patients.* The nationwide Partnership for Patients initiative, launched in April 2011 with funds provided by the Affordable Care Act, aims to save 60,000 lives by averting millions of hospital acquired conditions over three years by reducing complications and readmissions and improving the transition from one care setting to another. At the core of this initiative are 26 Hospital Engagement Networks, which work with 3,700 hospitals (representing 80% of the American population), working with health care providers and institutions, to identify best practices and solutions to reducing hospital acquired conditions and readmissions. As of December 2014, an HHS report shows an estimated 50,000 fewer patients died in hospitals and approximately $12 billion in health care costs were saved as a result of a reduction in hospital-acquired conditions from 2010 to 2013. Preliminary estimates show that in total, hospital patients experienced 1.3 million

fewer hospital-acquired conditions from 2010 to 2013. This translates to a 17 percent decline in hospital-acquired conditions over the three-year period.

- *Supporting practice transformation.* In October 2014, CMS announced the Transforming Clinical Practice Initiative (TCPI), which is designed to help clinicians achieve large-scale health transformation through an over $800 million investment. Specifically, the initiative is designed to support 150,000 clinician practices over the next four years in sharing, adapting and further developing comprehensive quality improvement strategies. TCPI is one of the largest federal investments uniquely designed to support clinician practices through nationwide, collaborative, and peer-based learning networks that facilitate large-scale practice transformation.
- *Healthy infants.* The Strong Start for Mothers and Newborns initiative, announced in February 2012, aims to reduce early elective deliveries as well as test models to decrease preterm births among high-risk pregnant women in Medicaid and the Children's Health Insurance Program (CHIP). The initiative builds on the work of the Partnership for Patients, testing ways to support providers in reducing early elective deliveries. It also provides over $11.7 million to 27 awardees to test enhanced prenatal care interventions to lower the risk of preterm birth among pregnant women with Medicaid or CHIP. As part of this initiative, clinicians at some hospitals have reduced their early elective deliveries to close to zero, meaning fewer at-risk newborns and fewer admissions to the neonatal intensive care unit. From 2010 to 2013, there was a reduction of 64.5 percent in early elective deliveries, reflecting the collaborative efforts of providers, private sector organizations, and government toward the shared goal of improved birth outcomes.
- *Better coordination of care for beneficiaries with multiple chronic conditions.* Under this year's rulemaking, the Medicare Physician Fee Schedule will include a new chronic care management fee beginning next year. This separate payment for chronic care management will support physician practices in their efforts to coordinate care for Medicare beneficiaries with multiple chronic conditions. This helps improve the way care is provided by supporting clinicians coordinating care for patients, including outside of regular office visits.
- *Providing states with additional flexibility and resources to enhance care.* The State Innovation Models Initiative aims to help states deliver high-quality health care, lower costs, and improve their health system performance. Together with awards released in early 2013, over half of states (34 states and 3 territories and the District of Columbia), representing nearly two-thirds of the population are participating in efforts to support comprehensive state-based innovation in health system transformation aimed at finding new and innovative ways to improve quality and lower costs. Seventeen states are currently implementing comprehensive state-wide health transformation plans (Arkansas, Colorado, Connecticut, Delaware, Idaho, Iowa, Maine, Massachusetts, Michigan, Minnesota, New York, Ohio, Oregon, Rhode Island, Tennessee, Vermont and Washington).
- *Integrating care for individuals enrolled in Medicare and Medicaid.* Many of the ten million Medicare-Medicaid enrollees suffer from multiple or severe chronic conditions. Total annual spending for their care is approximately $300 billion. Twelve states (California, Colorado, Illinois, Massachusetts, Michigan, Minnesota, New York, Ohio, South Carolina, Texas, Virginia and Washington) have entered into agreements with CMS to

integrate care for Medicare-Medicaid enrollees. Enrollees participating in the Financial Alignment Initiative may have access to coordinated services, and some states offer services that were not available outside of this demonstration, like dental, vision, and community-based behavioral health services. These demonstrations are designed to provide enrollees with person-centered, integrated care that provides a more easily navigable and seamless path to accessing and using services covered by Medicare and Medicaid.

- *Greater independence for Americans with disabilities and long-term care needs.* The Affordable Care Act includes a number of policies to promote non-institutional long-term care programs that will help keep people at home and out of institutions:
  - *Money Follows the Person Program.* The Money Follows the Person Program helps states rebalance their long-term care systems in part by transitioning Medicaid beneficiaries from institutions to the community. As of December 2013, over 40,650 individuals with chronic conditions and disabilities have transitioned from institutions back into the community through Money Follows the Person Program. The 44 participating States and DC have proposed to transition an additional 25,816 individuals out of institutional settings through 2016.
  - *Balancing Incentive Program.* Nineteen states are participating in the Balancing Incentive Program, which gives states incentives to increase access to non-institutional long-term services and supports and provides new ways to serve more Medicaid beneficiaries in home and community-based settings.
  - *Health Home State Plan Amendments.* Sixteen states have approved Health Home State Plan Amendments to integrate and coordinate primary, acute, behavioral health, and long term services and supports for Medicaid beneficiaries.
  - *Promoting care at home.* An Affordable Care Act demonstration, Independence at Home, tests whether providing chronically ill beneficiaries with primary care in the home will help them stay healthy and out of the hospital. Fourteen primary care practices and three consortia of physician practices are participating in the Independence at Home Demonstration.

INFORMATION: IMPROVING THE AVAILABILITY OF INFORMATION TO GUIDE DECISION-MAKING

- *Electronic Health Records (EHRs).* Adoption of electronic health records continues to increase among physicians, hospitals, and others serving Medicare and Medicaid beneficiaries helping to evaluate patients' medical status, coordinate care, eliminate redundant procedures, and provide high-quality care. The proportion of U.S. physicians using EHRs increased from 18% to 78% between 2001 and 2013, and 94% of hospitals now report use of certified EHRs. Electronic health records likely will help speed the adoption of many other delivery system reforms, by making it easier for hospitals and doctors to better coordinate care and achieve improvements in quality.
- *Access to Cost, Charge, and Quality Data*: Cost and charge data for hundreds of services (inpatient, outpatient, and physician services) and quality scores for hundreds of thousands of hospitals, physicians, nursing homes,

and other providers are now available on the Medicare website. These websites are part of an Administration-wide effort to increase the availability and accessibility of information on quality, utilization and costs for effective, informed decision-making.

- *Physician Compare.* Physician Compare, a website created by the Affordable Care Act, helps consumers make informed choices about the health care they receive from Medicare physicians and other health care professionals. Currently, users have the ability to compare the general information for up to three group practices on Physician Compare. This includes names, addresses, distance from the search location, specialty, Medicare assignment, and affiliated health care professionals. The first quality measures were added to Physician Compare in February 2014, and since then, the number of groups reporting quality data through the Physician Quality Reporting System (PQRS) has doubled. In 2015, CMS plans to expand Physician Compare to include quality performance results for all physician groups.
- *Hospital Compare.* Hospital Compare helps consumers make informed choices about the health care they receive from hospitals. Hospital Compare has information about the quality of care at over 4,000 Medicare-certified hospitals- across the country and includes measures such as access to timely and effective care, readmissions, and patient experience, among many others. Beneficiaries also can now find information on the incidence of serious hospital-acquired conditions in individual hospitals. In FY 2015, hospitals with high rates of hospital-acquired conditions will see their Medicare payments reduced.
- *Charge Data for Hospital and Physician Services.* In May 2013, HHS released for the first time new data showing variation across the country and within communities on what hospitals charge for common inpatient services. The data posted on CMS's website include information comparing the charges for services that may be provided during the 100 most common Medicare inpatient stays. Hospitals determine what they will charge for items and services provided to patients and these "charges" are the amount the hospital generally bills for an item or service. The website also includes data on outpatient charges. In April 2014, CMS updated the hospital data and released for the first time comprehensive data on physician utilization and charges in the Medicare program.
- *Qualified Entity Program.* The Qualified Entity (QE) Program, created by the Affordable Care Act, allows organizations approved as qualified entities (QEs) access to Medicare data to produce public performance reports on physicians, hospitals, and other providers. These reports combine private sector and/or Medicaid claims data with the Medicare data to identify which hospitals and doctors provide the highest quality, cost-effective care. QEs must protect the privacy and security of the Medicare claims data and may use it only for purposes of the QE Program. To date, CMS has certified 12 regional QEs and one national QE. Two of the regional QEs, Q-Corp and Health Insight, released public reports using the combined Medicare and other payer data in 2014.

The Healthy Alaska Plan: A Catalyst for Reform

Healthy Alaskans – Healthy Economy – Healthy Budgets

Alaska Department of Health and Social Services
February 2015

"This evening there are tens of thousands of Alaskans with no health insurance who could be covered at no cost to the state. These are mothers and fathers, sons and daughters; entire families who will go to bed tonight in fear. Fear that despite their best efforts, they are just one injury or diagnosis away from losing everything. That's wrong. It's unacceptable. And we're going to put an end to that on my watch."

Governor Bill Walker, *State of the State address,* January 2015

THE STATE
of ALASKA
GOVERNOR BILL WALKER

Department of
Health and Social Services

Office of the Commissioner

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Anchorage, Alaska 99503-5924
Main: 907.269.7800
Fax: 907.269.0060

February 6, 2015

Dear Alaskans,

Governor Walker and I have heard from so many Alaskans about their inability to get the health care they need. We all have an interest in ensuring that Alaskans are as productive as possible and can contribute to our communities and economy. But people can't work, hunt, or fish when they are not healthy.

Medicaid expansion is our opportunity to invest in the health of Alaskans and the health of our economy. Over 41,000 of our family members, friends and neighbors have the opportunity for health coverage.

Medicaid expansion will serve as a catalyst for meaningful Medicaid reform. Leveraging the federal resources that come with expansion is our biggest opportunity to finance our reform efforts.

I look forward to working with Alaskans to redesign our Medicaid system to meet our current fiscal challenges while ensuring that our most vulnerable Alaskans have access to wellness and prevention programs.

Quyana (thank you).

Valerie Davidson
Commissioner
Department of Health & Social Services

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The Healthy Alaska Plan: A Catalyst for Reform

Table of Contents

GOALS FOR IMPROVING HEALTH CARE IN ALASKA

The Walker/Mallott Transition Team recommended the following goals for improving health care in Alaska[i]:

- Implement Medicaid expansion without delay as a catalyst for Medicaid reform
- Maximize federal revenue and minimize unrestricted general fund expenditures
- Recognize that those eligible for Medicaid through expansion can move to self-sufficiency
- Engage interagency and interdepartmental collaborations to leverage human and financial resources
- Ensure the transparency of data and information
- Decrease the percent of state residents without health insurance
- Hold increases in the cost of healthcare to the rate of inflation in Alaska
- Increase the number of healthcare providers in Alaska

The Healthy Alaska Plan: A Catalyst for Reform, serves as the path to Medicaid expansion and the reform efforts for the State's current Medicaid program. This report outlines how Medicaid expansion functions as the catalyst for meaningful Medicaid reform. This report includes the benefits for our fellow Alaskans who would gain access to health care coverage with expansion, as well as the positive impacts to Alaska's economy and the associated savings to the State budget.

I. Healthy for Alaskans

Many low-income Alaskan adults will be able to access health coverage through Medicaid expansion. Currently, adult Medicaid is limited to residents who must not only be low-income, but also be in a certain category such as disabled, pregnant or caretakers of dependent children. The importance of access to health care cannot be understated.

Access to health care means improved health outcomes and increased productivity and independence. With Medicaid expansion:

- The number of uninsured Alaskans would be reduced by half;[ii]
- More Alaskans would receive preventative and primary care, including behavioral health services and help in managing costly chronic diseases;
- Business owners would benefit because of less turnover and fewer lost work days due to employees with unattended illnesses and injuries; and,
- Alaska's statewide mortality rate would drop.[iii]

The bottom line is ***— health care coverage saves lives***. A recent analysis of the impacts of health insurance coverage was conducted by health economists at Harvard University comparing mortality rates for adults in Massachusetts for the five years prior to and five years following the date health reform took effect in that state, versus a control group with similar demographics and economic conditions. The analysis found that for every 830 adults who gained health insurance, one death per year was prevented.[iv]

Access to health care coverage means Alaskans will receive more preventative and primary health care that can prevent death, disability and costly health services.[v, vi]

- Uninsured adults are less likely than insured adults to receive preventive services or screening, such as mammograms, Pap smears, or prostate screening.
- Inadequate prevention and screening increase the likelihood of preventable illness, missed diagnoses and delays in treatment.
- Chronic diseases — such as cancer, heart disease, stroke, arthritis, asthma, diabetes, and behavioral health conditions — are among the most prevalent, costly, and preventable or controllable of all health problems.

- The five most common causes of death in Alaska are cancer, heart disease, unintentional injuries, stroke and chronic lower respiratory disease. Of those, four are either preventable or treatable if caught early (cancer, heart disease, stroke, COPD).

- In 2014, diabetes was the seventh leading cause of death in Alaska — 106 Alaskans died from diabetes mellitus.

Health care access also helps address some of Alaska's most pressing social issues.

- For our prisoner and parole population, access to behavioral health care, including substance abuse treatment and mental health services, reduces offender recidivism.[vii]

- Alaska leads the country in high rates of domestic violence and sexual assault. Many survivors do not have health coverage, or lose it when they leave their abuser. Improved health care access through insurance coverage will make a positive difference in health behaviors and outcomes for victims of domestic violence and sexual assault in Alaska.

- Access to Medicaid coverage is already showing a positive difference for the homeless population in other states. According to a recent Kaiser Family Foundation report, Medicaid expansion is contributing to improved access to care as well as broader benefits for homeless individuals, such as the improved capability to gain employment.[viii]

Access to health care and insurance coverage impacts everything from prevention of disease and disability, quality of life, life expectancy, and the ability of people to work and become self-sufficient.

WHO WILL BE ELIGIBLE FOR COVERAGE THROUGH EXPANSION?

Medicaid expansion will increase access to health insurance for an estimated 41,910 low-income Alaskans.[ix] These are adults from 19 to 64 years of age who are currently not eligible for Medicaid — those not caring for dependent children, not disabled or pregnant, and who earn at or below 138% of the Federal Poverty Level (FPL) for Alaska. The Alaskans who will be eligible for Medicaid through the expansion live in all areas of the state.

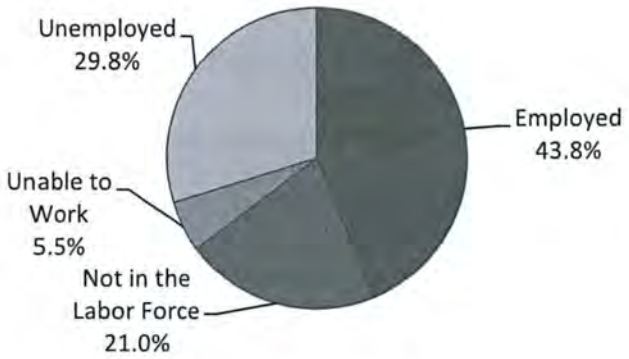
Geographic Distribution of Alaskans Eligible for Medicaid through Expansion

Those in the expansion population include individuals who are not currently offered affordable health insurance coverage by their employer, may not be eligible for subsidized plans on the Health Insurance Marketplace, and cannot afford to purchase an individual health insurance plan on their own.

Expansion will benefit single Alaskans without dependent children earning up to $20,314 a year, and married couples without dependent children earning up to $27,490 per year. Once these Medicaid recipients in the expansion population achieve a higher income they will be able to transition to the Health Insurance Marketplace and receive a subsidy to help afford coverage until their income reaches 400% FPL.

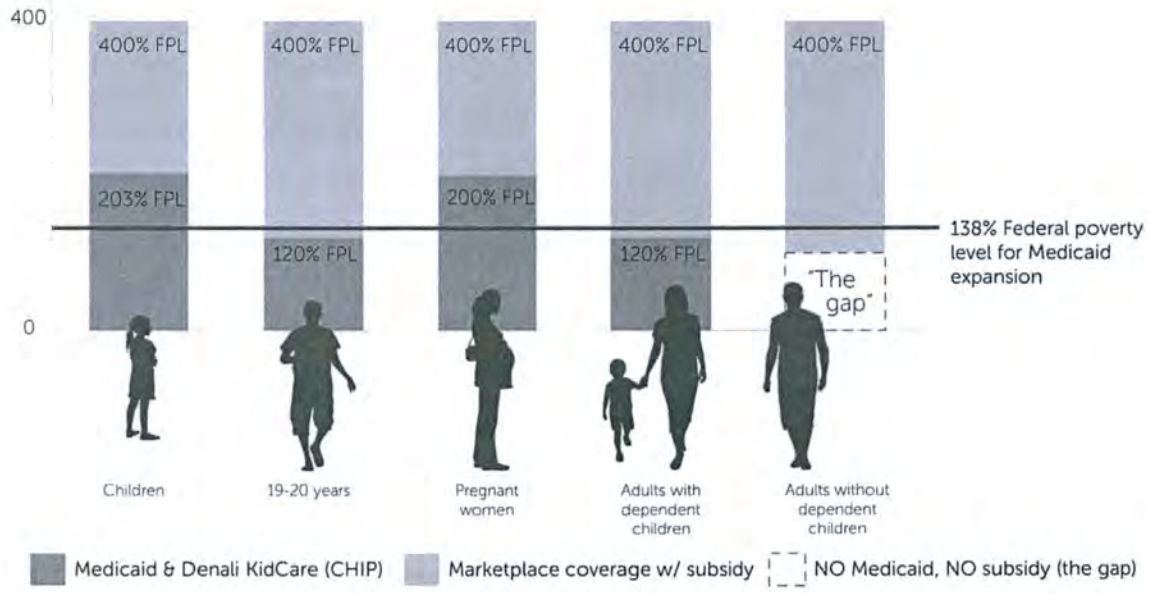
Nearly 20,100 of those eligible are expected to enroll in the first year of expansion, increasing to over 26,500 by the year 2021. Many are employed. Those who are unemployed are Alaskans who are not currently working but are looking for work, and include seasonal employees not currently working. Those identified as not in the labor force have no job and are not currently seeking employment because they are retired, in school, have family responsibilities, are incarcerated, or have other circumstances that preclude them from seeking employment.

Employment Status of Alaska's Medicaid Expansion Population



Approximately 24,000 of Alaskans (55% of the expansion population) have an annual income below 100% FPL. People earning less than 100% FPL do not qualify for a subsidy to purchase health insurance through the Health Insurance Marketplace and fall in "The Gap" for access to coverage.

Income Eligibility for Health Coverage



The Affordable Care Act limits eligibility for subsidies to those with incomes between 100% and 400% FPL. The Act as passed by Congress in 2010 required states to expand Medicaid eligibility as a condition of participation in the Medicaid program, providing guaranteed access to coverage for these lowest income Americans. However, a ruling by the U.S. Supreme Court in 2012 made Medicaid expansion optional for states. The result of this court decision left low-income Americans earning less than 100% FPL who live in states that did not expand Medicaid eligibility in "The Gap." This means they are not eligible for Medicaid and are also not eligible for a subsidy to purchase health insurance.

II. Healthy for the Economy

Alaska is currently facing a serious fiscal challenge. The rapid and steep decline in oil prices not only affects state government revenue levels, but has a ripple effect throughout our petroleum-dependent economy. At this time, when our state economy is particularly threatened with a potential recession, additional federal revenue and the accompanying job creation could help cushion the blow until oil prices begin climbing again and our economy stabilizes.

Medicaid expansion will bring more than one billion new federal dollars into Alaska's economy over the first five years, and create 4,000 new jobs.[x] The benefits of expansion will affect all populations, regions and sectors as measured in improved health, job opportunities and short and long term medical care cost savings. By expanding Medicaid, the state will make a vital investment in Alaskans and Alaska while paving the way to meaningful Medicaid reform.

Studies project that over the next seven years Medicaid expansion in Alaska would likely yield:[xi, xii]

- 40,000 uninsured Alaskans eligible for basic health care coverage
- $1.1 Billion in new federal revenue for Alaska
- 4,000 new jobs
- $1.2 Billion more in wages and salaries paid to Alaskans
- $2.49 Billion in increased economic activity throughout the state

Moreover, accessing these federal funds that our economy needs and Alaskans are due corrects an inequity in federal policy. The federal Medicaid expansion policy benefits Americans living in certain states, the expansion states, at the expense of those Americans living in non-expansion states. Expansion will bring Alaska tax dollars back to Alaska and drive needed economic activity across the state.

Expanding Medicaid also helps reduce State general Fund expenditures because the federal funds will cover certain health services the state currently provides with general fund dollars. For example, the Alaska Department of Corrections is obligated to provide health care for incarcerated individuals and does so with State general fund dollars. Under expansion, federal Medicaid funds would pay for some of those services and save the state an estimated $4.1 million the first year and about $7 million each year following. This and additional areas of state savings are explained further in the next section.

Another challenge for Alaska's economy and Alaskan employers is the high price of health insurance premiums and the underlying prices for medical services in our state. One driver of higher prices is uncompensated care, which is care provided for individuals who are unable to or otherwise do not pay their medical bills. These unpaid bills translate into higher prices for commercially purchased health insurance and for self-insured employers. Arizona hospitals reported a decrease in uncompensated care of 31% during the first four months after Medicaid expansion was implemented there.[xiii] In 2011, Alaska non-tribal hospitals provided $91 million in uncompensated care. A significant drop in the level of uncompensated care similar to Arizona's experience could assist in controlling health care cost growth in our state.

III. Healthy for the State Budget

It may seem counterintuitive that giving more people health care will result in state budget savings, but the new federal revenue that comes with expansion enables savings of state general fund dollars currently obligated in other programs. These savings completely offset the state's share of the associated administrative costs ***and*** enable additional general fund reductions.

MEDICAID EXPANSION GENERATES NEW REVENUE AND SAVES STATE MONEY

Providing access to health care for more Alaskans will both improve the quality of life for thousands of Alaskans while increasing state revenues and generating savings to the state general fund.

In FY 2016, the State of Alaska has the opportunity to provide access to health care coverage for over 41,000 Alaskans while reducing the general fund budget by $6.1 million.

Not all 41,000 potentially eligible Alaskans are expected to enroll in Medicaid. People don't enroll for a number of reasons: they don't think they will need health care; don't want to sign up with the government; or just never get around to it. During the first year of expansion, over 20,000 people are expected to enroll, with the number increasing each year before leveling at about 63% of eligible Alaskans, or nearly 27,000 enrollees.[xiv]

Increase in Enrollees and Revenue

Currently, the federal government funds 50% of most Medicaid expenses. Under expansion, the federal government will pay Alaska 100% of the health care expenses associated with the newly covered population for calendar years 2015 and 2016. The federal government will then transition its match over several years to 90% of health care expenses for the new population. Starting in 2020, the federal match remains at 90%. The state is not required to continue the expansion coverage beyond the 90% match.

	2016	2017	2018	2019	2020	2021
New Enrollees	20,066	23,273	26,492	26,535	26,580	26,623
Cost Per Enrollee	$7,248	$7,495	$7,752	$8,018	$8,293	$8,433
Costs Below are in Thousands of Dollars						
Total Health Care Spending for New Enrollees	**$145,435**	**$174,438**	**$205,368**	**$212,747**	**$220,433**	**$224,514**
Federal Share	**$145,435**	**$170,633**	**$195,514**	**$200,683**	**$204,087**	**$204,928**
State Share	**$0**	**$3,804**	**$9,854**	**$12,064**	**$16,346**	**$19,587**

Source: Analysis by Evergreen Economics[xv]

Savings to State General Fund

While the federal government is obligated to pay the state for the vast majority of costs associated with covering the Medicaid expansion population, the state will still bear some new costs. However, the state will be able to offset those costs by reducing or eliminating general fund contributions to programs that provide health care to the newly eligible people in Medicaid. Initial offsets include:

- The Chronic and Acute Medical Assistance program (CAMA) that provides limited state funded coverage for the lowest income Alaskans for certain serious medical conditions. A large portion of this population will qualify for and be covered under the expanded Medicaid program, which means that the state can immediately cut $1 million in state general fund payments.

- The state is required to provide health care for incarcerated individuals in the corrections system. In Alaska, these services are currently provided with state general fund dollars. Incarcerated inmates are not eligible for Medicaid when inside the correctional institution. However, when receiving inpatient hospital services outside the institution, those services can be covered by Medicaid if the individual is otherwise eligible. The Department of Corrections has estimated savings based on what they paid for these inpatient services in 2014 and the projected in-state population. An additional benefit of expansion is many of these people will be eligible for Medicaid upon release and thus able to access health services, including substance abuse treatment, which is expected to reduce recidivism.

- Savings are expected in behavioral health grants as the number of Medicaid eligible Alaskans they serve is increased through expansion. While Medicaid will not replace all of the cost of these services, a significant amount can be refinanced.

- Similar cuts will occur in other Department of Health & Social Services programs as well as other state agencies as additional potential savings are identified. These cuts will significantly increase year after year as expansion enrollment ramps up to full capacity.

GENERAL FUND COSTS AND OFFSETS IDENTIFIED TO DATE:

	2016	2017	2018	2019	2020	2021
			General Fund Costs			
Health Care Costs	$0	$3,804	$9,854	$12,064	$16,346	$19,587
Administrative Costs for Medicaid expansion	$0*	$1,392	$1,478	$1,499	$1,600	$1,625
			General Fund Offsets			
Chronic & Acute Medical Assistance (CAMA)	$1,000	$1,300	$1,400	$1,500	$1,500	$1,500
Corrections	$4,100	$7,000	$7,000	$7,000	$7,000	$7,000
Behavioral Health Grants	$1,000	$5,000	$9,000	$13,000	$16,000	$16,000
TOTAL SAVINGS	($6,100)	($8,104)	($6,068)	($7,937)	($6,554)	($3,288)

* FY16 Administrative Cost is being funded by the Alaska Mental Health Trust Authority

IV. Catalyst for Reform

Alaska's Medicaid program is unsustainable as currently designed and needs reform in order to best serve the health of Medicaid beneficiaries, operate more efficiently for Medicaid providers, turn the cost curve, and improve value. Medicaid expansion is required to provide the federal funding and the flexibility needed to facilitate fundamental reform. As demonstrated in Section III, expanding Medicaid eligibility even without enacting reforms will save the State of Alaska general fund dollars. Greater savings and improved quality and outcomes in the program can be achieved with meaningful Medicaid reforms.

As private health insurance becomes increasingly expensive in our state, Medicaid expansion provides opportunities to decrease employer health benefit costs and private insurance premiums. Medicaid reform can jump-start private sector health care reform.

According to the Alaska State Hospital & Nursing Home Association, non-tribal hospitals[1] in our state provided $91 million in uncompensated care in 2011.[xvi] Based on the experience in other states that have already expanded Medicaid, an estimated reduction in uncompensated care of 20% - 30% could be achieved in Alaska, which could amount to a decrease of between $18 and $27 million in lost revenue at non-tribal hospitals and translate into lower hospital prices for private payers.

New, innovative models of care and other reforms can create efficiencies in the health care delivery system and reduce waste in the form of unnecessary or ineffective services. Reforms aimed at ensuring Medicaid patients are receiving the right care, at the right time, in the right place and at the right price will improve patient satisfaction and outcomes and free up capacity in the health care system.

The building blocks for achieving meaningful Medicaid Reform for our state will include:

I. **Payment Reform:** Reimbursement methodologies from fee-for-service payment structures that incentivize higher service volume and rewards inefficiencies in the delivery system, to alternative payment mechanisms that can drive improved value.

II. **Strengthened Primary Care:** A high-performing health care system rests on a foundation of access to primary care providers who are adequately supported to manage and coordinate care for their patients.

III. **Care Management:** Improvements in medical management of Medicaid services will ensure appropriate utilization of services.

IV. **Workforce Innovation:** Design of new provider types that can work as members of health care teams and allow clinicians to work at the top of their licenses and function more efficiently with more support for patient care.

[1] Differences in cost reporting requirements between tribal and non-tribal hospitals make calculations and comparisons between the two difficult.

V. **Maximizing federal matching fund opportunities:** Medicaid waiver opportunities that allow delivery and payment for services outside of the traditional Medicaid program will be thoroughly explored. Those identified as saving state general funds and improving care will be pursued. Working with other state agencies and with systems such as the statewide community health centers may provide support to leverage federal financing. Partnerships with the tribal health system and our ability to receive 100% federal reimbursement for Medicaid services provided in that system could result in additional state general fund savings.

VI. **Improved Telehealth Capability:** Identification of barriers to service delivery through telehealth to improve access, address health care system capacity, and reduce travel requirements for rural Alaskans.

These reforms will strengthen and incorporate program improvements already underway in Alaska's Medicaid Program, which include:

- An initiative to control overutilization of hospital emergency room services;
- Increased fraud and abuse prevention and control efforts;
- Activities to reduce waste, i.e., unnecessary or ineffective services, through improved medical management;
- Home and community-based service improvements for seniors and Alaskans with disabilities with a focus on person-centered planning and conflict-free services;
- Coordination with Patient-Centered Medical Home initiatives;
- Coordination with the Alaska tribal health system to increase community resources and strengthen systems of care across the state; and,
- Investigating methods for refinancing Medicaid through waiver options.

The reform effort will also evaluate potential strategies for increasing prevention and shared responsibility, for example through:

- Cost-sharing requirements for certain enrollees, such as those between 100% and 138% FPL;
- Cost-sharing for certain services, such as non-emergency use of hospital emergency department services;
- Support for Health Savings Accounts (HSAs) for certain enrollees;
- Choice restrictions for certain enrollees and services to direct patients to the appropriate level of care;
- Incentives for healthy behaviors;

- Increased access to preventative services shown to improve health outcomes and decrease health care costs; and,

- Work assistance benefits for the expansion group, such as access to job search websites, resume assistance and skills-to-job matching services, job training, vocational rehabilitation and other work supports.

The Medicaid reform plan will be based in part on recommendations from the Alaska Health Care Commission and the Medicaid Reform Advisory Group. The department will be supported in this effort with funding from the Alaska Mental Health Trust Authority for a technical assistance contract. The contractor will assess and recommend various options for reform, and support the department to draft the plan with input from national and local experts and feedback from the public. Their work will include an in-depth analysis of different types of benefit packages, and will consider the applicability of innovations from other states to Alaska's Medicaid program and health care market.

End Notes

[i] Walker/Mallott Transition Team Reports: http://gov.alaska.gov/Walker/transition-2014.html

[ii] *Medicaid in Alaska Under the ACA*. Health Policy Center, the Urban Institute. February 2013. Available on http://dhss.alaska.gov/healthyalaska/

[iii] Sommers, BD, Long, SK, Baicker, K. Changes in Mortality after Massachusetts Health Care Reform. *Ann Intern Med.* 2014; 160(9):585-593. Doi:10.7326/M13-2275.

[iv] *Ibid.*

[v] *Medicaid in Alaska Under the ACA*. Health Policy Center, the Urban Institute. February 2013. Available on http://dhss.alaska.gov/healthyalaska/.

[vi] *Chronic Disease in Alaska: 2014 Brief Report*. Alaska Department of Health & Social Services. http://dhss.alaska.gov/dph/Chronic/Documents/Publications/assets/2014_CDBriefReport.pdf

[vii] DiPietro, B., & Klingenmaier, L. (2013). Achieving Public Health Goals through Medicaid Expansion: Opportunities in Criminal Justice, Homelessness, and Behavioral Health with the Patient Protection and Affordable Act. *American Journal of Public Health*, 25-29.

[viii] *Early Impacts of the Medicaid Expansion for the Homeless Population.* Kaiser Family Foundation. Nov 2014. http://kff.org/uninsured/issue-brief/early-impacts-of-the-medicaid-expansion-for-the-homeless-population/

[ix] *Projected Population, Enrollment, Service Costs and Demographics of Medicaid Expansion Beginning in FY 2016.* Evergreen Economics analysis for the Alaska Department of Health & Social Services. February 4, 2015. Available on http://dhss.alaska.gov/healthyalaska.

[x] *Ibid.* And, *Fiscal and Economic Impacts of Medicaid Expansion in Alaska.* Northern Economics. February 2013. Both reports are available on http://dhss.alaska.gov/healthyalaska.

[xi] *Projected Population, Enrollment, Service Costs and Demographics of Medicaid Expansion Beginning in FY 2016.* Evergreen Economics analysis for the Alaska Department of Health & Social Services. February 4, 2015. Available on http://dhss.alaska.gov/healthyalaska.

[xii] *Fiscal and Economic Impacts of Medicaid Expansion in Alaska.* Northern Economics. February 2013. Available on http://dhss.alaska.gov/healthyalaska.

[xiii] *Impact of Insurance Expansion on Hospital Uncompensated Care Costs in 2014.* Office of the Assistant Secretary for Planning & Evaluation, US Department of Health & Human Services. http://aspe.hhs.gov/health/reports/2014/uncompensatedcare/ib_uncompensatedcare.pdf

[xiv] *Projected Population, Enrollment, Service Costs and Demographics of Medicaid Expansion Beginning in FY 2016.* Evergreen Economics analysis for the Alaska Department of Health & Social Services. February 4, 2015. Available on http://dhss.alaska.gov/healthyalaska.

[xv] *Ibid.*

[xvi] http://d2vx0b949pmiku.cloudfront.net/wp-content/uploads/2012/11/Uncompensated-care-Talking-Points-Final-1-29-15.pdf

① Medicaid ~~@current~~ system @ current levels is so very broken that it simply cannot deliver anything that resembles quality health care to an expanded population

② no workforce development plan that describes where all doctors, nurses, phlebotomists and techs to handle all the new people will come from.

③ We cannot afford this. We are facing billions in shortfalls for the next several years

④ Feds cannot afford this.

ALASKA MEDICAID REDESIGN + EXPANSION TECHNICAL ASSISTANCE

NOTES FROM ROUND 1 JOINT STAKEHOLDER AND DHSS LEADERSHIP WORK SESSION, AUGUST 18, 2015

Thank you for participating in our first breakout discussion about Medicaid Redesign and Expansion in Alaska. The following notes capture the feedback we gathered during the joint stakeholder and DHSS leadership work session on Tuesday, August 18th. These notes are the starting point for feedback that we hope to collect about Medicaid redesign priorities and what a high functioning health system in Alaska should look like. We will be adding to these notes over the months to come and incorporating all feedback into the final report.

What does a high functioning health system in Alaska look like?

- **Whole person, Coordinated Care**
  - Coordinated care – helping people access the most appropriate services; care coordination across settings (not just emergency care)
  - Coordinated care in an integrated environment (common definition and clear vision for care coordination/case management)
  - Greater use of primary care and other providers to coordinate care
  - Patient at the center of care
- **Prioritizes Prevention**
  - Prevention as mainstay
  - Incentives for wellness; partnership between patients and provider team
- **Patient education and shared responsibility**
  - Knowledgeable patients
  - Navigation support
- **Access to care, including the appropriate type and level of care**
  - There would be no overutilization
  - Access is rational and coordinated
  - No one falls through the cracks
  - Integration between behavioral health and physical health – people are getting their behavioral health needs addressed
  - Effective assessments and referral systems
- **Care Close to Home**
  - Increase access, reduce travel required
  - Opportunity to be in their homes and home communities at end of life
  - Regional approach is important for meeting local needs and tailoring to cultures; flexibility in structure

What does a high functioning health system in Alaska look like?

  - Retain our identity – value in delivering services in rural Alaska; access to blended services (specialty and primary, dosed with reality/striking the right balance for cost effectiveness)
- **Leverages all Resources to Contain Costs and Drive Value**
  - Providers who tap into third party billing
  - Cost of care is actively managed
  - Affordable at all levels
  - Use payment reform to drive value from services
  - Leveraging the resources we do have available, as well as our buying power (e.g. agreements out of state); working together we have tremendous potential
- **Information infrastructure for sharing health information and analyzing data**
  - Sophisticated telecommunications system
  - Timely data – need for real time systems (providers can see coverage, etc)
  - Single payer system
  - Widespread Telehealth use
- **Easier to Manage**
  - Simple and flexible; reduction of administration burden
- **Innovation and Strategic Alignment**
  - Workforce alignment
  - Policy alignment
  - System that fosters local innovation and shares savings
  - Payment models that recognize community need; providers are rational actors in the market; in an ideal system, we are paying for the services that residents need
  - Reimbursement models follow the services required
- **Strong Workforce Development and Retention**
  - Access, availability and provider recruitment - need to be able to get providers and keep them
  - Developing workforce from an early age
  - Access to education and training for those who wish to pursue careers in health care; have the infrastructure for training across all areas
  - Need to use everyone's full potential – leverage the people we have in the system
- **Quality Care**
  - Quality of care has to be the center of our system; our measure of success
  - Continuous quality improvement: quality, effectiveness and efficiency

What are your priorities for health system changes to achieve that vision?

- Access to appropriate level of care as close to one's home and home community as possible
  - Services need to come to the person rather than person going to the services
  - Addressing levels of care and integrating services across settings and region; avoiding duplication and filling gaps
  - Integration of physical and behavioral health – thinking about who best to provide which services
  - Long term supports as close to home as possible
  - Increasing use of Specialty clinics in regions
  - Planning for the continuum of care; planning tends to occur in isolation; today we miss too many

What are your priorities for health system changes to achieve that vision?

intersections

- Excellent patient information and support
  - Patient education and responsibility
  - Navigation support
  - Simplification of the system – during transition providing universal navigation services and eventually not needing navigation
- Efficient and effective care that produces value for payers and consumers
  - Payment mechanisms that align with the outcomes we want to see
  - State is a major purchaser of health care – needs to really examine its management and the opportunity to look at entirety of state health care spending
  - Incentivizing collaboration
  - Utilization management
  - Fully capitalizing on the resources we have within the Tribal and VA systems
  - Integrating the health care system from a structural perspective -- delivery of services is more efficient (e.g. single payer, nurses crossing different patient groups)
  - Streamlining data reporting requirements or practices
  - Primary care case management – the pathway to operationalizing our vision
  - Use of the marketplace
  - Increased use of data locally and statewide to drive improvements in quality
  - Movement toward bundled payments and away from the 15-minute increment
- Contain Medicaid costs
  - Management of long-term costs within the state
  - Honest conversation about cost of care within communities
  - Addressing the payment structure; adjusting rates and incentivizing providers; addressing cost of care

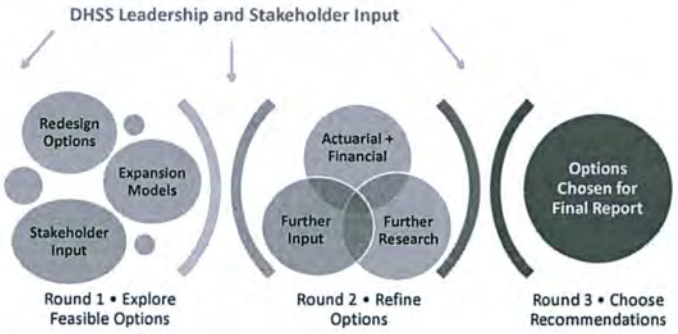
Healthy Alaska Plan MEDICAID REDESIGN AND EXPANSION IN ALASKA

Stakeholder Meeting • August 18, 2015

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

Timeline	Tasks + Deliverables
August	• Conduct an environmental scan of options for Medicaid Redesign + Expansion • First round consultation with key partners and DHSS leaders to review environmental scan findings and select options for actuarial analysis
September	• First round of actuarial analysis, additional investigation • Stakeholder meetings and constituent engagement on options under consideration • Presentations at fall meetings
October	• Second round consultation with key partners and DHSS leaders to review analysis, stakeholder feedback and weigh feasibility of options • Second round of actuarial analysis • Presentations at fall meetings
November	• Final round consultation with key partners and DHSS leaders to produce recommendations
December	• Contract team produces report of recommended expansion and reform options
January	• Webinar of contract team's findings • Report published on January 15, 2016
January – April	• Legislative Hearings to share findings and recommendations • Action plan for recommended options • Evaluation plan for recommended options

Iterative Process for Selecting Recommendations



Research and Analysis of Options

- Environmental Scan
  - Reform and expansion efforts in other states
  - Current and recent Medicaid redesign/expansion experiences in Alaska
  - Federal context, including Centers for Medicare & Medicaid Services (CMS) perspective
  - Alaska context (politics, geography, health care system)
- Input and Discussion
  - Ensuring options meet state goals, are sustainable
  - Understanding barriers, benefits and trade-offs involved in various proposals
- Refine Options
  - Fiscal and regulatory analysis
  - How reform proposals could fit together

Stakeholder Engagement Throughout the Project

Stakeholder Engagement	Timeline
Project Introduction Webinar	July 27
Presentation and Partner Work Session, Round 1	August 18
Partner organizations engage constituents DHSS presents at fall meetings, conferences	August – November 2015
Presentation and Partner Work Session, Round 2	October 9
Presentation and Partner Work Session, Round 3	November 10
Project Findings Webinar	January 2016
Legislative Hearings in Session	January – April 2016

Ways to Stay Informed about the Project

DHSS Healthy Alaska Plan
http://dhss.alaska.gov/healthyalaska

E-mail medicaid.redesign@alaska.gov

Sign up for the DHSS Medicaid Redesign listserv
https://public.govdelivery.com/accounts/AKDHSS/subscriber/new?topic_id=7

Healthy Alaska Plan
MEDICAID REDESIGN AND EXPANSION IN ALASKA

Environmental Assessment

Stakeholder meeting • August 18, 2015

Agnew::Beck Consulting
Health Management Associates
Nora Leibowitz
Ian Randall
Lee Repasch

Project Goal

To engage the Alaskan stakeholder community & Department of Health & Social Services/Alaska Mental Health Trust Authority leadership to develop strategies and recommendations for Medicaid redesign and expansion

Deliverable 1: Environmental Assessment

Present the spectrum of potential and feasible health reform options available to Alaska

Today's Agenda

- Status of Department of Health & Social Services Medicaid projects and other reform efforts
- Context on available reform options and mechanisms
- Feedback via audience response
- Conversation among participants focused on a few key questions

Stakeholder Response

Please use your remote to answer the following questions.

Audience Response Instructions

- Press the number of your answer and SEND after each selection
- To change your answer, press CLEAR and enter your new selection
- Results are shared live in the presentation

Practice Question

Click + Send

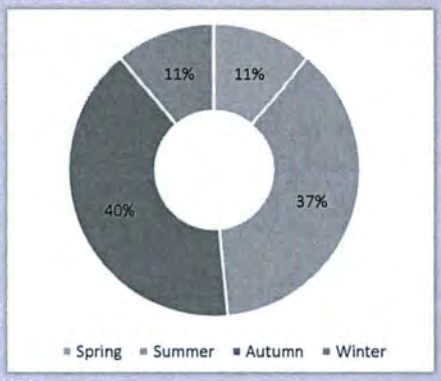
What is your favorite season?

1. Spring
2. Summer
3. Autumn
4. Winter

Practice Question

Results

What is your favorite season?



Stakeholder Response

Click + Send

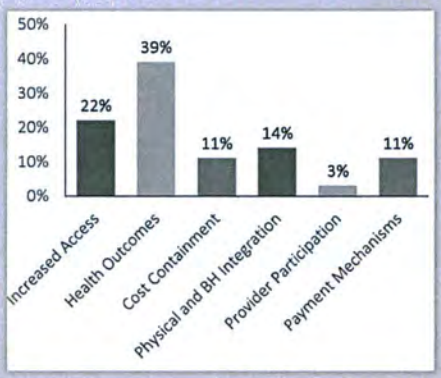
Q1. Which of the following goals of health reform is most important to you?

1. Increased access to care
2. Improved health outcomes
3. Medicaid cost containment
4. Increased integration of behavioral health and physical health
5. Improved provider participation
6. Innovative payment mechanisms

Stakeholder Response

Results

Q1. Which of the following goals of health reform is most important to you?



Stakeholder Response

Click + Send

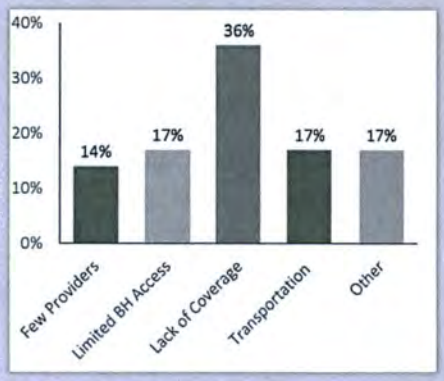
Q2. What is the biggest barrier to health care in Alaska?

1. Limited providers, generally
2. Limited access to behavioral health providers
3. Lack of insurance coverage (including Medicaid and other sources)
4. Transportation
5. Other

Stakeholder Response

Results

Q2. What is the biggest barrier to health care in Alaska?



Key Factors Shaping Alaska's Health Care System

- Reliance on a fee-for-service delivery system
- Fragmented care delivery
- Rising rates of chronic disease & co-morbidities
- Social determinants of health
- Lack of cost and quality data/transparency
- Complex legal & regulatory environment
- Provider shortages & high provider rates
- Geographical challenges
- Insurance market flux

Health Reform – Current Efforts

- **Patient Centered Medical Home Pilot for Children & Adolescents**
- **Care Management "super-utilizer" pilot**
- **Utilization/Cost Management Initiatives**
  - Medically necessary transportation
  - Vision, pharmaceuticals, and durable medical equipment
- **Planning for Tribal Health System Partnership (1115 waiver)**
  - Transportation
  - Expand American Indian/Alaska Native Medicaid-reimbursable services & enhance referral coordination
- **Provider tax feasibility study**
- **1915(i) & 1915(k) Options**

Health Reform – Opportunity

The Patient Protection & Affordable Care Act

- Provides **Opportunity & Funding** to continue to reform and improve Medicaid
  - Delivery System Innovation
  - Align Public and Private Markets
  - Increase Access: Medicaid Expansion
  - Benefit Package Redesign
  - Wellness Incentives & Shared Responsibility Models
  - Insurance Market Reform

Health Reform – Financing Authority

- 1115 Waiver
  - Including Delivery System Reform Incentive Pool
- 1915 (b) & (c)Waivers
- 1916 (f) Waiver
- State Plan Amendment & Options
  - 1915 (i) & (k)
- 1332 Waiver ["Wyden Waiver" (ACA)]

Health Reform: Financing Authority 1115 Demonstration Waiver

- Waive provisions of the Social Security Act
- Must be "likely to assist in promoting the objectives of" Medicaid
- Must demonstrate budget neutrality
- In practice:
  - Expand eligibility
  - Provide services not typically covered by Medicaid
  - Use innovative service delivery systems that improve care, increase efficiency, and reduce costs

How are States using 1115s?

- To implement Premium Assistance Models
  - AR, IA, IN, NH, UT
- To Implement Member Cost Sharing & Premium Contributions
  - AR, IA, IN, MI
- To waive and reshape required benefits
  - AR, IN
- To implement wellness incentives
  - IA, IN, MI, PA

1115: What is CMS Denying?

- Premiums for individuals with incomes <100% federal poverty level if payment is required to maintain eligibility
- Elimination of EPSDT (Early & Periodic Screening, Diagnosis and Treatment) services for newly eligibly 19 and 20 year olds
- Elimination of family planning provider free choice for newly eligible adults

Other Denied State 1115 Proposals

- Imposition of penalties for non-emergency Emergency Department visits after the first visit that are higher than those approved in Indiana
- Work requirements as a condition of eligibility
- *Cost sharing: waiting on data from state pilots*

1115 Waiver- Delivery System Reform Incentive Pool (DSRIP)

- Reform health care delivery and funding methods for safety net systems
- Incentive payments to hospitals and other safety-net providers for reaching milestones that improve quality and cost of care.
- CA, CO, MA, NY, OR, VT
- No formal CMS guidance issued

Health Reform Financing Authority 1915 & 1916 Waivers

- Waive provisions of the Social Security Act
- **1915 Waivers**
  - **1915(b)**:
    - Implement managed care delivery systems that limit the number and type of providers enrollees can see
    - Allow states to use savings to offer additional services
  - **1915(c)**: Provide long-term care services in home and community-based settings

Health Reform Financing Authority 1915 & 1916 Waivers

- Waive provisions of the Social Security Act
- **1916** Waivers
  - 1916 (f): Implement cost-sharing requirements greater than otherwise allowable amounts
  - Test a unique *and previously untested* use of copayments
  - Restricted to 2 years
  - Indiana is using § 1916(f) authority to test graduated co-payments for non-emergency Emergency Room use of up to $25

Health Reform Financing Authority: State Plan Amendments & Options

- **State Plan Amendment (SPA)**: Medicaid Expansion
- **Home and Community Based Services (HCBS)** options under State Plan authority

Requires: "individuals receiving services and supports through Medicaid's HCBS programs have full access to the benefits of community living and are able to receive services in the most integrated setting"

HCBS Continued

- **1915 (i) State Plan HCBS**
  - Establish separate needs-based criteria and allow HCBS services to be self-directed
- **1915 (k) Community First Choice**
  - Provide HCB attendant services and supports to eligible Medicaid enrollees

Health Reform Financing Authority State Plan Amendments & Options

- State Plan Option
- Flexibility in establishing alternative benefit packages (ABP) for Medicaid beneficiaries
- Benefits modeled on specified commercial insurance products or HHS-approved coverage option
- Newly eligible individuals must receive benefits thru ABP
  - Can extend to children > 6 years of age
- Must include the ACA's 10 Essential Health Benefits

Health Reform: Coordinated Care & Value Based Care

Partial Risk/Partial Capitation

- Accountable Care Organizations and Bundled Payments
- Pre-Paid Inpatient Health Plans and Pre-Paid Ambulatory Health Plans

Payment Incentives

- Primary Care Case Management (PCCM)
- Patient Centered Medical Homes (PCMH) & Health Homes

Full Risk/Managed Care

Coordinated Care and Value-Based Purchasing

- **Reward value and create financial incentives for health care providers to focus on primary and preventive care**
- **Improve access, and adopt more effective, efficient models of care delivery to improve quality and reduce costs**

Coordinated Care and Value-Based Purchasing

Accountable Care Organizations (ACOs)

- Provider-run organization
- Participating providers are collectively responsible for the care of an enrolled population, and may share in any savings associated with improvements in the quality and efficiency of car

Medicaid ACOs

- Colorado Accountable Care Collaborative
- Oregon Coordinated Care Organizations

Health Reform Tools

Experience with Bundled & Global Payments

- **Medicare:** Bundled Payments for Care Improvement (BPCI) Initiative
- **Medicaid:** Arkansas Health Care Payment Improvement Initiative

  Medicaid and commercial payers for 5 episodes:
  1) perinatal;
  2) attention deficit hyperactivity disorder;
  3) upper respiratory infection;
  4) total joint replacement for both hips and knees; and
  5) congestive heart failure.

Little data yet on success in achieving aims

Health Reform Tools

Primary Care Case Management (PCCM)

- Primary Care Providers are responsible for approving and monitoring beneficiary care by ensuring appropriate access to specialists, high-cost imaging, expensive medications, and inpatient hospitalizations
- No waiver needed!
- Many states, such as Colorado, use PCCMs because full-risk managed care is not practical

Patient Centered Medical Homes

- Whole person care
  - More team-based approach to integrated care than PCCM
  - Includes additional care coordination supports & services
- Recognition standards
  - Conducting comprehensive health assessments for all new patients
  - Proactively managing and reducing barriers for high-risk patients
  - Ensuring after-hours access
  - Maintaining electronic health records (EHRs) and tracking quality metrics
- Often utilizes Federally Qualified Health Center (FQHC) Model of Care

Health Homes Model

- Variant of the Patient Centered Medical Home (PCMH) model
- Integrates physical and behavioral health services
- Targets enrollees with specified high-risk behavioral health and chronic conditions
- Care coordination services include social and community supports
- States are experimenting with shared savings, risk-adjusted payments, bundled payments, and capitated payments for Health Homes
- Can target geographic areas without a waiver
- 90% FMAP (Federal Medical Assistance Percentage)!

1332 "Wyden" Waivers

- Allows state to waive provisions of the Affordable Care Act (ACA):
  - Individual Mandate, Employer Mandate, Benefits and Subsidies, Exchanges and QHPs
- Must preserve ACA's coverage and financial rules:
  - Scope and comprehensiveness of coverage, affordability, impact on federal deficit
- Not all reforms require a waiver. Without a Waiver, states can:
  - Tie Qualified Health Plan certification to quality goals, payment reform
  - Eliminate bronze or platinum level plans
  - Add state subsidies
  - Merge individual and small group markets
  - Modify Essential Health Benefits

PAHPs and PIHPs

States pay the plan a monthly per member rate for a defined set of services

- Prepaid Ambulatory Health Plans (PAHP)
  - Provide medical services to enrollees under contract with a state
  - Do not provide or arrange any inpatient hospital or institutional services for enrollees
- Prepaid Inpatient Health Plans (PIHP)
  - Provide or arrange for inpatient hospital or institutional services for enrollees
- Both have components of a full-risk capitated plan but neither have a comprehensive risk contract

Full Risk Capitated Managed Care

- Medicaid Managed Care Organizations (MCOs)
  - Deliver a set of Medicaid benefits to a specific Medicaid population
  - Receive a set per member per month (PMPM) rate
  - Used by 39 States and the District of Columbia
- Less popular in Rural and Frontier states
  - Networks are more difficult to build
  - Infrastructure requirements are lacking
- No evidence of aggregate savings

Other Tools: Thinking Outside the Office

- Telehealth & Telemedicine
  - Monitoring Chronic Conditions
  - Behavioral Health
- Enhanced patient communication platforms (e.g., physician messaging)
- Remote tele-diagnostics
- Smart Phone Applications

Stakeholder Response

Please use your remote to answer the following questions.

Stakeholder Response

Click + Send

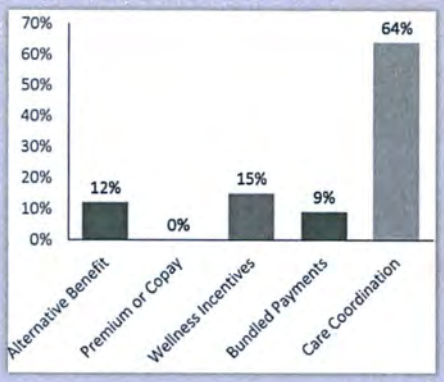
Q3. Which of the following reforms is most promising for use in Alaska?

1. Alternative benefit structure
2. Consumer premiums or copayments
3. Wellness + healthy behavior incentives
4. Bundled payments
5. Care coordination incentives

Stakeholder Response

Results

Q3. Which of the following reforms is most promising for use in Alaska?



Stakeholder Response

Click + Send

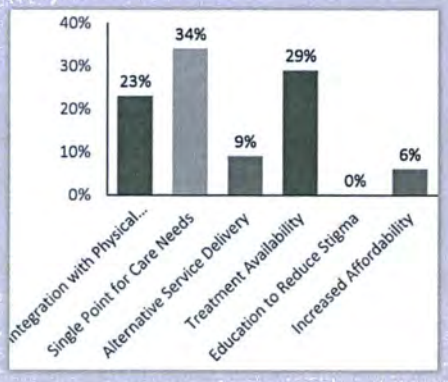
Q4. How could behavioral health care be improved?

1. Increased provider-level integration with physical health
2. Single point of accountability for ensuring behavioral health and physical health care needs are met
3. Alternative service delivery options
4. Increased availability of treatment (providers, medication)
5. Education to reduce stigma of seeking care for behavioral health issues
6. Increased affordability

Stakeholder Response

Results

Q4. How could behavioral health care be improved?



Where do we go from here?

- Health Reform Goals
- Recommendations
- Action

Stakeholder Questions + Key Issues

Small Group Discussion

If Alaska had a really high functioning health system, what would it look like?

What do you hope Medicaid redesign and expansion will do for Alaska's Medicaid system?

What are your priorities for health system changes to achieve that vision?

Stakeholder Response

Please use your remote to provide some feedback on today's session.

Feedback on the Session

Click + Send

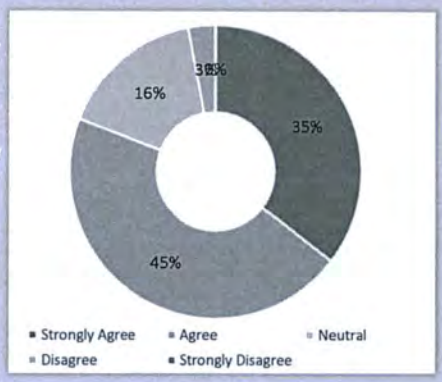
This session introduced excellent information.

1. Strongly Agree
2. Agree
3. Neutral
4. Disagree
5. Strongly Disagree

Feedback on the Session

Results

This session introduced excellent information.



Feedback on the Session

Click + Send

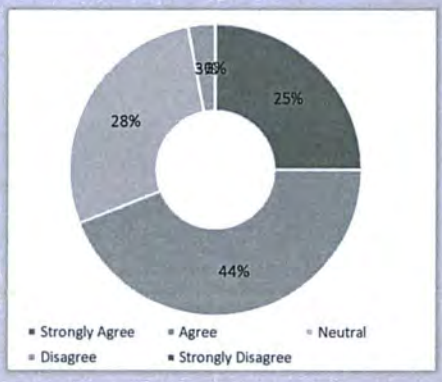
I feel more informed about the current status of this project.

1. Strongly Agree
2. Agree
3. Neutral
4. Disagree
5. Strongly Disagree

Feedback on the Session

Results

I feel more informed about the current status of this project.



Feedback on the Session

Click + Send

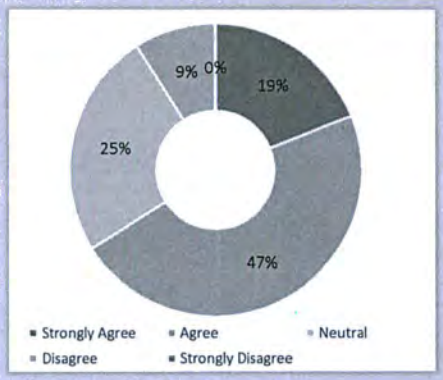
This format is an effective way for stakeholders to learn and engage with the project.

1. Strongly Agree
2. Agree
3. Neutral
4. Disagree
5. Strongly Disagree

Feedback on the Session

Results

This format is an effective way for stakeholders to learn and engage with the project.



Ways to Stay Informed about the Project

DHSS Healthy Alaska Plan
http://dhss.alaska.gov/healthyalaska

E-mail medicaid.redesign@alaska.gov

Sign up for the DHSS Medicaid Redesign listserv
https://public.govdelivery.com/accounts/AKDHSS/subscriber/new?topic_id=7

Thank You!

Please enjoy lunch, and provide any additional feedback you have on the yellow comment cards.

Comments can also be sent via e-mail to medicaid.redesign@alaska.gov.

MEDICAID REDESIGN + EXPANSION TECHNICAL ASSISTANCE

TABLE OF ACRONYMS AND ABBREVIATIONS

The Medicaid Redesign and Expansion project is one of several initiatives the Department of Health and Social Services has undertaken to improve Alaska's health care delivery system. As with any complex topic, there is a great deal of acronyms, abbreviations, jargon and technical language associated with Medicaid and the health care system. Below is a working list of acronyms and abbreviations stakeholders may encounter throughout the project, ranging from Medicaid and the national health care system to institutions or concepts specific to Alaska.

The project team will be adding to this list regularly, and welcomes your input on what acronyms and abbreviations would be helpful to include!

MEDICAID AND FEDERAL

ABP	Alternative Benefit Package	IMD	Institutions for Mental Diseases (exclusion)
ACA / PPACA	Patient Protection and Affordable Care Act ("Affordable Care Act")	MCO	Managed Care Organization
ACO	Accountable Care Organization	MMIS	Medicaid Management Information System
AHRQ	Agency for Healthcare Research and Quality	PAHP	Prepaid Ambulatory Health Plan
BPCI	Bundled Payments for Care Improvement	PCCM	Primary Care Case Management
CMS	Centers for Medicare & Medicaid Services	PCMH	Patient Centered Medical Home
DHHS	(U.S.) Department of Health and Human Services	PFP	Pay for Performance
DSH	Disproportionate Share Hospital	PIHP	Prepaid Inpatient Health Plan
DSRIP	Delivery System Reform Incentive Pool	PMPM	Per Member, Per Month (payment)
EHB	(10) Essential Health Benefits	QHP	Qualified Health Plan
FMAP	Federal Medical Assistance Percentage	QI	Quality Improvement
FPL	Federal Poverty Line	RCCO	Regional Coordinated Care Organization
GPRA	Government Performance and Results Act	SAMHSA	Substance Abuse and Mental Health Services Administration
HCBS	Home and Community Based Services	SPA	State Plan Amendment
HRSA	Health Resources and Services Administration	SSA	Social Security Act
HSA	Health Savings Account	UCR	Usual, Customary, and Reasonable

HEALTHCARE RELATED

ANP	Advanced Nurse Practitioner	FQHC	Federally Qualified Health Center
ASAM	American Society of Addiction Medicine (levels 0.5 to 4)	HMIS	Health Management Information System
BH	Behavioral Health	LTC	Long Term Care
DES/DET	Designated Evaluation and Stabilization/ Designated Evaluation and Treatment (hospitals)	LTSS	Long Term Services and Supports
DRG	Diagnosis-Related Group	SBIRT	Screening, Brief Intervention, and Referral to Treatment
DSM(-5)	Diagnostic and Statistical Manual of Mental Disorders	SDS	Senior and Disability Services
ED	Emergency Department	SED	Severe Emotional Disturbance (youth)
EHR	Electronic Health Record	SMI	Serious Mental Illness
EPSDT	Early and Periodic Screening, Diagnosis and Treatment	SUD	Substance Use Disorder (adult)
FFS	Fee for Service (payment model)		

ALASKA'S SYSTEM

AEHN	Alaska E-Health Network	DHAT	Dental Health Aide Therapist
AMHTA	Alaska Mental Health Trust Authority	DHSS	Department of Health and Social Services
API	Alaska Psychiatric Institute	DJJ	Division of Juvenile Justice
ASAP	Alcohol Safety Action Program	DOC	Department of Corrections
BHA/P	Behavioral Health Aide/Practitioner	HCC	Health Care Commission
CBHC	Certified Behavioral Health Center	HIE	Health Information Exchange
CHA/P	Community Health Aide/Practitioner	OCS	Office of Children's Services
CHC	Community Health Center	SOA	State of Alaska
DBH	Division of Behavioral Health	THO	Tribal Health Organization

HEALTHY ALASKA PLAN

AGENDA

- Healthy Alaskans
  - Medicaid Expansion Update
- Catalyst for Reform
  - Reforms Underway
  - 1915 (i) and (k) Contract
  - Tribal Transportation & Referral Policy
  - Provider Tax Contract
  - Medicaid Redesign & Expansion Technical Assistance Contract

HEALTHY ALASKANS

Who is covered by expansion?

- Adults Ages 19 – 64
  - Not otherwise eligible for Medicaid or Medicare
- Earning up to 138% of the Federal Poverty Level (FPL)
  - Single adults earning up to $20,328 per year
    - $1,694 per month
  - Two-person family earning up to $27,492 per year
    - $2,291 per month

HEALTHY ALASKANS

How many have signed up?

- Estimates for year one = 20,666
- As of December 14th:
  - 7,010 determined eligible for Medicaid Expansion
- Chronic & Acute Medical Assistance enrollees transitioned to Medicaid
  - CAMA is fully funded by general funds
  - In August: 436 open CAMA
  - In December: 2 open CAMA

HEALTHY ALASKANS

Where can people apply?

Apply one of the following ways:

- www.healthcare.gov
  - "No Wrong Door"
- ARIES Self Service Portal
  - Uses your myAlaska Account
- Paper application

CATALYST FOR REFORM

Reforms Underway

- Medicaid Coordinated Care Initiative ("SuperUtilizers")
- Utilization Management:
  - Pharmacy
  - Transportation Policy
  - Dental and Audiology Benefits
  - Durable Medical Equipment
- Tribal Health System Partnerships:
  - Patient Housing (Anchorage)
  - Long Term Care Facilities (Bethel and Kotzebue)
- Home & Community Based Services
  - Increased Eligibility Requirements for PCA Services (from 1 to 2 ADLs)
  - New Acuity-Based Tiered Rating System

CATALYST FOR REFORM

1915 i/k Implementation Contract

- Contract Awarded to Health Management Associates
- Alaska currently provides HCBS to 4,000 individuals under four 1915(c) Medicaid waiver programs:
  - Children with Complex Medical Conditions (CCMC)
  - Adults with Physical and Developmental Disabilities (APDD)
  - Alaskans Living Independently (ALI)
  - Individuals with Intellectual and Developmental Disabilities (IDD)

CATALYST FOR REFORM

1915 i/k Implementation Contract

- 1915(i): For people who do not meet nursing level of care, but meet other criteria
  - Alzheimer's, traumatic brain injury, severe mental illness, or individuals with developmental or intellectual disabilities
- Section 1915(k) improve savings on home and community-based services
- Implementation: July 1, 2017
- Stakeholder Process
  - "Development and Implementation Council"
  - In person forums: Anchorage, Barrow, Bethel, Fairbanks, Mat-Su Valley, Juneau, Kenai, Ketchikan, Nome

CATALYST FOR REFORM

Tribal Transportation & Referral Policy

- Increase to 100% FMAP (federal match) for:
  - Transportation
  - Services referred by Tribal health to providers outside the Tribal health system
- Originally proposed by Governor Walker as an 1115 Waiver
- CMS issued new federal policy instead – nationwide benefit

CATALYST FOR REFORM

Provider Tax Contract

- Feasibility Study & Recommendation
  - Contract Awarded to Myers & Stauffer
- No tax can be imposed without legislation
- Every state in the union, except Alaska, has one or more health care provider taxes
- 19 classes of health care services and providers can be taxed
  - Nursing facility services and inpatient hospital services are most common taxed classes

CATALYST FOR REFORM

Provider Classes Currently Under Study

(As of December 1st)

1. Inpatient hospital
2. ~~Outpatient hospital~~
3. Nursing facility
4. Intermediate care facility services for individuals with intellectual disabilities
5. Physician services
6. ~~Home health services~~
7. ~~Outpatient prescription drugs~~
8. Services of managed care organizations
9. ~~Ambulatory surgical center services~~
10. Dental services
11. Podiatric services
12. Chiropractic services
13. Optometric/Optician
14. Psychological services
15. Therapist services
16. Nursing services
17. Lab and x-ray services
18. Emergency ambulance services
19. ~~Other~~
    - ~~RPTCs~~
    - ~~PCAs~~
    - ~~HCBS Waiver~~
    - ~~Behavioral Health~~

12/21/2015

CATALYST FOR REFORM

Medicaid Redesign & Expansion Technical Assistance Contract

- Contract Awarded to Agnew::Beck
  - Subcontractors: Health Management Associates (HMA) and Milliman (actuarial firm)
- Contract Amendment: Additional Stakeholder Process
  - Sector engagement sessions
    - Alaska State Hospital & Nursing Home Association; Alaska Primary Care Association; Long Term Service & Supporters Providers; Alaska Behavioral Health Association; Physicians; Tribal Health Organizations; Change Agent Conference
  - Webinars follow each Key Partners Work Session
- Contract and Amendment are posted online
  - dhss.alaska.gov/HealthyAlaska/Pages/Medicaid_Redesign.aspx

CATALYST FOR REFORM

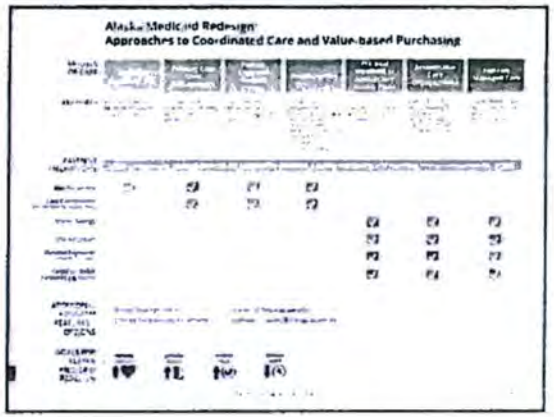
Meetings Held: 1st Session

- **July 27: Kick-Off Webinar**
- **August 18: Key Partners Work Session**
- **September 2: Project Update Webinar**
  - Draft Environmental Assessment
    - Alaska's current system
    - Models of care; provider reimbursement
    - Medicaid financing mechanisms to support systems change
  - Brainstormed shared vision and priorities for Medicaid redesign

CATALYST FOR REFORM

Key Partner Organizations

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



CATALYST FOR REFORM

Meetings Held: Round 2

- **October 9: Key Partners Work Session**
- **October 21: Project Update Webinar**
  - Review of Initiatives
    - Alternative Models for the Expansion Population
    - Medicaid Reform Initiative Options
  - Evolving working document
    - Description; key features; federal requirements; IT needs; rate structure and/or payment mechanism; statutory and/or regulatory changes; actuarial analysis

CATALYST FOR REFORM

Meetings Held: Round 3

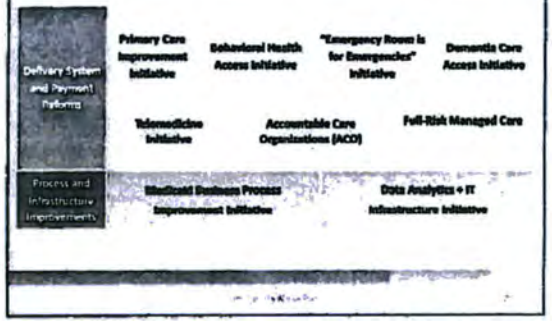
- November 10: Key Partners Work Session
  - Presentation on Actuarial Analysis
    - Overview of the Approach
  - Review of Medicaid Reform Initiatives
  - Potential alternative coverage models for expansion population
- November 19: Project Update Webinar
  - Review of Preliminary Package of Reforms

CATALYST FOR REFORM

Reform Initiatives: All Presented

CATALYST FOR REFORM

Reform Initiative: 2nd Review



CATALYST FOR REFORM

1) Primary Care Improvement Initiative

Offer primary care case management for all enrollees; Health Homes for people with behavioral health and chronic conditions

Key Features

- Primary Care Improvement, including:
  - Enrollee education and orientation
  - Assignment to Primary Care Provider upon enrollment
  - Early detection of physical and behavioral health needs through a health risk assessment and risk assignment to one of three tiers
  - Referrals for non-emergent specialty and inpatient services
- Health Homes, including:
  - Care coordination for individuals with multiple chronic conditions
  - A team-based approach to clinical care
  - Linkage to community supports and resources
  - Integration of primary and behavioral health care
- Targeted case management for other high risk groups

CATALYST FOR REFORM

2) Behavioral Health Access Initiative

Move away from crisis-driven care by developing mild to moderate mental health services, expanding in-state access to substance use disorder services, addressing key gaps in the continuum of care

Key Features

- Remove requirement to be a DBH grantee to bill Medicaid for behavioral health services
- Expand provider types that can bill Medicaid for behavioral health services, regardless of settings (LPC, LMFT, Psychologists, LCSW)
- Pursue waiver of Institute for Mental Diseases exclusion to increase access to residential treatment services
- Establish Behavioral Health Aides as rendering providers of early intervention services to individuals with mild to moderate behavioral health issues
- Establish a value based reimbursement structure with tiered payments
- Address key gaps in the current continuum of care (e.g. mental health screening, assertive community treatment services)

CATALYST FOR REFORM

3) Data Analytics + IT Infrastructure

Increase State's capacity to use the data it collects, support providers' patient data and reporting needs and support Alaska's ability to implement the health care payment and delivery reform initiatives

Key Features

- Improve capacity of IT systems and architecture to better support access to required and desired data and reduce redundancy in reporting
- Improve ability to produce Federally required and other reports and advanced analytics
- Explore strategies to maintain a productive and sustainable statewide Health Information Exchange to support appropriate use of patient information; interfaces to support exchange of data
- Make data accessible from a warehouse or repository

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4) "ER is for Emergencies" Pilot Initiative

Reduce emergency visits, coordinate patient care, promote prescription monitoring, and improve healthcare for homeless and individuals with chronic behavioral health issues who are high utilizers of the Emergency Departments

Key Features

Based on key elements of WA program:

- Tracking frequent Emergency Room users
- Patient education about appropriate care settings
- Designated personnel to receive and share Medicaid client information
- Contact primary care provider for follow-up visits
- Implement narcotics guidelines to direct patients to Primary Care Providers or pain management services
- Physician participation in Prescription Drug Monitoring Program
- Emergency physician provides review and feedback

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5) Accountable Care Organizations Pilot

An ACO is a group of health care providers that agrees to share responsibility for the cost and quality of health care for a defined group of people. In this model, a projection is established for the total cost of care and the ACO is eligible for a portion of the savings or responsible for a portion of the overrun.

Key Features

- State would contract with ACOs as entities accountable for a set of services for a population of enrollees.
- ACOs would provide physical care, behavioral health care, and long-term supports and services.
- ACOs would work across their provider networks to align efforts to improve care and achieve quality goals and cost-saving targets.
- Care management would be shared between the ACO and the providers.
- The model would be regional (all providers and all enrollees), potentially starting with 2-3 pilot regions. If interest, could also consider in urban areas using a subset of interested providers and enrollees.
- Would include shared savings and, after transition period, shared losses

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Preliminary Package of Reforms

Foundational System Reforms	• Primary Care Improvement Initiative • Behavioral Health Access Initiative • Data Analytics + IT Infrastructure Initiative
Paying for Value Pilot Projects	• "ER is for Emergencies" Pilot • Accountable Care Organizations Pilot
Workgroups to Support Reform Efforts	• Medicaid Redesign Ongoing Dialogue • Continuous Medicaid Business Process Improvement • Telemedicine Licensing + Regulations

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Alternative Coverage Models for the Expansion Population

1 Current Medicaid Benefit Package

2 Alternative Benefit Package based on Qualified Health Plan
Administered by Medicaid

3 Private Coverage Option based on Qualified Health Plan
Administered by private insurer

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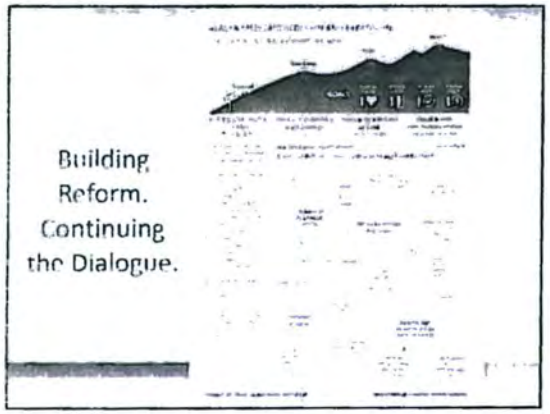
Remaining Work

- Actuarial Analysis and drafting the Final Report
- DHSS will continue presentations as requested
- January 15: Final Report due to DHSS
- January 21: Final Project Webinar (tentative)



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How can you stay informed?

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- **1915 i/k Implementation**
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