

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES
OFFICE OF THE COMMISSIONER

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July 27, 2007

The Honorable Lyman Hoffman
Senate Finance Committee Co-Chair
Mail Stop 3100, State Capitol
Juneau, AK 99801

Dear Senator Hoffman:

As you requested in your letter of June 21, 2007, this is the first report to you and Legislative leadership on the implementation progress the Department of Health & Social Services (DHSS) is making under Senate Bill 61. The following bullets are in the same order as work tasks developed by your staff.

- **Study a tiered pharmacy pricing model where reimbursement tiers are available for rural and urban pharmacies - No new resources**

DHSS is working out the final contract details with the Department of Law for work is to be completed by the Oklahoma School of Pharmacy. The Oklahoma School of Pharmacy was chosen because it has completed similar cost of dispensing surveys for the states of Oklahoma and Nebraska. DHSS is slated to review all costs of dispensing pharmaceuticals statewide, as well as the wholesale costs of medications. With this survey DHSS intends to determine the optimal reimbursement methodology for the Medicaid program and the individual providers in order to maintain access and receive economies of scale for urban pharmacies. The Department plans to fully involve the pharmacy community in the survey to encourage the most accurate results. During the next quarter the RFP process should be complete and work begun on the survey.

- **Implement additional medications under Pharmacy Prior Authorization - No new resources**

DHSS implemented prior authorization for additional medications beginning July 18, 2007. This includes all long acting and some short acting narcotics where utilization of medications is high. Additional medications will be added for prior authorization as they are determined to be appropriate for utilization control.

- **Level of Care Controls in Personal Care Assistant program – No new resources**

Since April 2006 DHSS implemented and utilizes the Personal Care Assessment Tool (PCAT) to determine the appropriateness and scope of care authorized for persons requesting

PCA services. The PCAT is administered by licensed RN's who are under contract with DHSS and DHSS approves and authorizes all provider prior authorizations (PA) and monitors resultant billing activity as a means of utilization management for subsequent service plan review. The impact of these two measures substantially reduced the costs of the PCA program. Additional controls will be considered as part of this work through a contractor selected by the RFP process. During the next quarter the RFP requirements will be completed

- **Alternate Reimbursement Methodology for DD services – No new resources**

DHSS has entered a contract with Meyers and Stauffer June 30, 2007 to conduct a review and analysis of the Medicaid Program reimbursement methods and to propose three rate methodologies for consideration. DHSS will pilot the proposed methodologies and select one for adoption into regulation and implementation over FY09, or as appropriate based on utilization of the proposed contractors transition plan and timeline. Until such implementation of a standard rate methodology, DHSS continues to hold rates firm under the current regulatory freeze, and only approves increases based upon health and safety concerns, that if unaddressed, could place the individual at greater risk and result in a more costly form of institutionalized care. The contractor and DHSS should have this work well under way during the next quarter.

- **Implement Disease Management Program \$80.0**

Disease Management (DM) is an organizational system designed to coordinate health care interventions and communication for certain populations with chronic conditions. DM strategies are aimed at increasing the use of evidence-based practice guidelines. DM should improve the health status of many Medicaid clients with chronic health problems while slowing cost increases.

To date expenditures on DM development have been limited to staff support, 1.25 FTEs. In the next quarter, the DM steering committee/staff will develop a program design and budget request for the DHSS FY2009 budget. If approved, a DM contracting expert will be retained to assist DHSS with the development of an RFP with conditions that bidders' proposals offer both guaranteed savings and improved clinical outcomes.

Implementation challenges include completing the development of a complex DM program, recruiting primary care physicians to support DM contractor services, offering a RFP that is attractive to experienced Medicaid DM contractors, and deploying a new care management program in the Alaska health care environment. Staff is currently studying other states' programs to take advantage of their 'lessons learned.' Final information development leading to a possible budget proposal will be completed during the next quarter.

- **Personal Care Assistants (PCA) Waiver –No new resources**

The Pacific Health Policy report suggested that Alaska could move its personal care program to a home and community-based waiver to ensure the same comprehensive screening as in existing waivers services. DHSS will investigate that idea, however, DHSS has already implemented an assessment process that uses the same comprehensive assessment for waivers and personal care and has consolidated and coordinated the assessment for individuals who receive both types of services, thus linking the services together and eliminating any duplication of services and further controlling costs. The department intends to continue this coordination of assessment and service planning, but will look for any additional benefits from further changes to the PCA program through the RFP process being developed during the next quarter.

- **Federal Financial Participation in Pioneer Homes - \$50.0**

One method to gain additional federal funding for the Pioneer Homes is to develop a Medicaid Alzheimer's waiver, thus expanding Medicaid eligibility for Pioneer Home residents. In determining the feasibility of creating an Alzheimer's Medicaid waiver in Alaska, the Pioneer Home section researched other states with such waivers and determined that there are only five such waivers operating in Delaware, Florida (2), Mississippi, and Virginia. We are currently determining which of these states have similar issues to Alaska and which states have a program that would work best in Alaska. We have determined that 60% of Pioneer Home residents have Alzheimer's and related disorders (ARD). Some such residents may already be Medicaid eligible. A Medicaid waiver should expand the number that can be funded through Medicaid. A contractor will be secured to help determine the best way to implement an ARD Medicaid waiver in Alaska. Other options that could increase federal funding will also be explored.

A cost of care study is being proposed to assist in exploring a rate increase for the Pioneer Homes based on cost. DHSS will secure a contractor to analyze the cost study and recommend an appropriate rate. Any proposed rate increase will require consultation with a variety of stakeholder groups and a regulation revision. Such a rate increase also increases federal funding for those eligible for waiver services. Completion of RFP requirements will be completed during the next quarter.

- **Address Wait List of DD services - \$20.0**

DHSS currently draws 25 persons per quarter from the SDS Registry, previously identified as the "DD Waitlist". There has been substantial review and development of policy and practice related to the screening and removal of persons from the registry over the past 18 months. A legislative appropriation for \$3M specific to removing people from the registry by placing them into service was approved during the previous legislative session. New screening tools and processes related to monitoring, assessing, removing and placing persons on the registry into service have been implemented. Throughout FY07 134 people were selected for service.

Currently, data analysis using the piloted screening tool and review of persons on the registry suggests 900 persons would meet level of care for services, of which, approximately 775 would be waiver eligible.

There are several options under consideration at present to address those persons who would not meet level of care eligibility for the waiver, and methods to place persons into service regardless of criteria that would designate supports for them based upon a "tiered" system.

Use of existing grant funding and matching federal funding with existing grants are among the options being considered. Assigning recipients that are removed from the registry to state care coordinators is part of the continuing pilot project, which is continuing under the advisement and support of stakeholder groups. The savings realized in the care coordination pilot project thus far warrant its continuance. These continued savings could be utilized to provide services and remove additional recipients from the registry.

During the next quarter RFP requirements will be developed to obtain a contractor to investigate other options to gain additional federal funding and further reduce or eliminate the need for a Registry.

- **Federal Funds Participation for CAMA - \$20.0**

The Chronic and Acute Medical Assistance (CAMA) program serves as a payer of last resort for individuals with certain chronic or life-threatening conditions who do not meet Medicaid eligibility standards. There may be some opportunity to cover CAMA recipients under a Medicaid 1115 demonstration waiver or under a Medicaid Medically Needy state plan.

The department will use \$20.0 to hire a contractor to evaluate the opportunities to include the CAMA population under Medicaid and determine if the overall effect on the state general funds budget would be positive. In addition, the contractor will evaluate whether it would be more cost effective to provide disease management support or assist CAMA recipients with SSI/SSDI disability claims, as alternatives to an 1115 waiver. RFP requirements will be determined during the next quarter.

- **Substance Abuse/Mental Health Waiver - \$35.0**

A contractor will be engaged to investigate in detail the potential for expanding Medicaid coverage for behavioral health treatment to provide a cost effective method to partially address the need for increased, effective treatment. Currently Medicaid eligibility categories exclude from coverage most men and women between ages 22 and 64, even if they meet the income and resource requirements. Substance abuse treatment for these Alaskans, if available at all, is funded with local funds or state general funds. Federal Medicaid funds are simply not available under the current Medicaid eligibility criteria unless waived or somehow incorporated into a DRA state plan for a unique benefit package. However, this segment of

the population costs Alaska hundreds of millions of dollars in lost work, increased health care, education and criminal justice costs. Additional populations to be considered for coverage include parents of children receiving Medicaid behavioral health services and uninsured children in need behavioral health services who do not meet current eligibility criteria for Medicaid or Denali KidCare.

The department anticipates hiring a contractor familiar with Medicaid waiver law and policy to evaluate the feasibility of expanding the Medicaid program to provide services to this targeted group of Alaskans in need of behavioral health services.

Expected outcomes of the contract include: identify eligibility criteria for accessing benefits; propose an appropriate array of tailored services to address the health needs of the population; evaluate the benefits of offering additional appropriate services, such as prevention, early intervention services, screenings or brief counseling services; identify opportunities for increasing the treatment capacity where it is currently lacking; propose a service delivery model for insuring access to appropriate care; propose criteria for evaluating improvements in health status and cost savings.

During the next quarter the RFP requirements will be finalized and the RFP potentially out for solicitation.

- **Long Term Care Planning - \$250.0**

This work will parallel and coordinate with the work description noted in #2 under rural providers. Different service definitions and service arrays will be investigated. For example, we are not making use of the advances in technology that could be applied to community settings. Cameras, computers and sensors may be cost effective and permit someone to remain safely in their own home longer.

Currently there are little or no services for people 65 years of age or older with mental illness. Alaska Pioneer Homes are not licensed to accept or serve residents with chronic mental illness and structurally configured to meet the needs of such people. A contractor will be engaged to investigate the possibility of different forms of congregate care to meet the needs of elders with mental illness and to develop or recommend reimbursement methods to meet the cost of care for these services. RFP requirements will be finalized during the next quarter.

- **Increase Rural Providers Federal Funds participation:**

There are significant issues to address if the capture of additional federal funds is to be successful. These can generally be categorized as: strategic planning \$50.0, specific service planning and service definition \$700.0 and \$214.0, and cost development, reporting and billing infrastructures \$250.0 and \$138.0

1 - Strategic Planning: Managed Care Assessment - There are significant challenges to developing a viable Tribal managed care model. Any managed care arrangement would have to conform to both federal Medicaid and Indian Health Service law and regulation. Should it become law, Section 208 of the pending Indian Health Care Improvement Act reauthorization provides some flexibility for Indian managed care entities. Additionally, history has shown that traditional managed care plans have the potential to put participating organizations at both financial and legal risk. Further study is necessary to broadly define the parameters for a Tribal managed care arrangement and to identify the significant legal and financial considerations. This study, to be led by Alaska Native Tribal Health Consortium (ANTHC), will be done in close partnership and collaboration with the DHSS and Yukon Kuskokwim Health Corporation (YKHC). As a partner in this managed care assessment YKHC may be able to provide concrete examples of strengths and barriers in achieving a workable managed care model.

2 - Specific Service Planning and Service Definitions: There are a variety of barriers that may preclude the tribal health provider from offering a particular service, including reimbursement, nature of the service, legal requirements and staffing. Some of these barriers can be addressed in the short term while others will take longer to resolve.

Further study is needed to identify services the tribal health programs could provide, identify the barriers to providing the service and develop work plans to eliminate these barriers. Implied in this process is a prioritization which first identifies and addresses those services that will have the largest impact in the short term (within one year) on the Medicaid budget. This will be the first phase of this effort.

As noted, it is anticipated that some barriers identified above can be addressed in the short term but that others will take a longer time to resolve. Therefore, there needs to be a second phase to this project that identifies longer-term barriers that need to be addressed. This is especially applicable to the long-term care service array that will be necessary to serve elders and/or the disabled at home and their communities in rural Alaska. As part of this process YKHC will evaluate and determine what long term care service array(s) will be necessary in order to effectively and efficiently meet the long term care needs of their members, whether in rural or urban Alaska. This service array will be described not exclusively in terms of current Medicaid waiver and state plan services, but in terms of the actual services that will efficiently and effectively allow Medicaid elders and disabled to remain safely in their homes and communities

3 - Cost Development, Reporting and Billing Infrastructures: In many cases existing reimbursement methodologies do not work for rural tribal health provider programs because the health care delivery system is so different and rural costs are much higher. However, it may be possible to develop more relevant reimbursement systems that will provide sustainability for the redefined service array that is to be developed as part of this process.

Before this can be done, however, the State and the rural tribal providers must first undergo a process of determining the true cost of care for the services provided. This cost determination is necessary before Centers for Medicare and Medicaid services will approve alternate reimbursement methodologies and it is also necessary to ensure that the rural tribal health providers programs are earning sufficient revenue to pay for and sustain services.

As with most planning, the larger regional tribal providers are further ahead on cost analysis than are other, smaller tribal providers. Therefore, the cost identification effort will include a component to enhance the effort of YKHC. YKHC will then be able to share its experience and knowledge with others. ANTHC will assist other tribal providers in undertaking their cost analysis.

Current reimbursement methodologies are a combination of IHS determined encounter rates or daily rate, fee for service rate schedules and varying versions of cost based reimbursement. The current methodologies appear to sometimes hinder tribal ability to maintain and especially expand Medicaid services by not fully reimbursing tribal providers the costs of providing the services. ANTHC and YKHC will investigate and analyze Tribal health program cost identification, capture, allocation, and reporting to support each service or groups of services to maximize the tribal ability to expand service capacity and/or service array to more fully serve Medicaid members.

DHSS has had extensive discussion with the leadership of ANTHC and YKHC. The statement of work and description of deliverables for these grants is almost finished. DHSS expects to have signed grant agreements with both by the end of July.

During the next quarter ANTHC, YKHC and DHSS will strive to determine the scope of work to be contracted out versus performed internally, strive to have statements of work and deliverable fleshed out and will have an overall plan, structure and processes developed to insure a thorough assessment of the many components of this project does occur expeditiously.

- **DHSS - \$508.0**

DHSS is in the process of hiring additional expertise to engage in the reimbursement methodology work; to do the significant coordination between multiple contractors, grantees and DHSS staff; drafting RFP requirements to obtain additional Medicaid expertise in multiple areas of study; and outlining the overall structure necessary to engage in this major Medicaid reform initiative. Current staff is also engaged in this work. We intend to have the reimbursement methodology positions advertised and possibly hired during the next quarter.

DHSS intends to combine most of the contractor work into just two RFP solicitations, with flexibility for the selected contractor to sublet work, if necessary, to obtain the necessary expertise. As described earlier, it is our intent to have those out for solicitation during the next quarter.

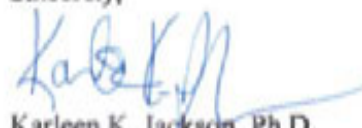
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Thank you for your encouragement and support of this Medicaid reform initiative. We do believe changes can be made to slow the general fund cost increases and thus make Alaska Medicaid more sustainable. The work from this project should provide the direction and tools to let this happen.

The next report due before October 1st will include more detail and separate sections from YKHC and ANTHC on the status of their work, plus information on any initial findings or potential recommendations, basically to provide a 'heads up' on the direction a particular part of this work might be taking.

If you have any questions about this first report or wish to discuss any aspects of Medicaid reform please contact Jerry Fuller, the Medicaid director at 907-269-7380 or Renee Gayhart, our Tribal liaison at 907-465-1619.

Sincerely,



Karleen K. Jackson, Ph.D.
Commissioner

cc: Senate President Green
House Speaker Harris
Senate Finance Committee Co-Chair Stedman
House Finance Committee Co-Chair Chenault
House Finance Committee Co-Chair Meyer
Senator Olson, Operating Budget Subcommittee Chair
Representative Hawker, Operating Budget Subcommittee Chair
OMB Director Karen Rehfeld, Office of the Governor
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