THE STATE of ALASKA
GOVERNOR BILL WALKER

Department of
Health and Social Services

ALASKA MENTAL HEALTH BOARD
ADVISORY BOARD ON ALCOHOLISM
AND DRUG ABUSE

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March 11, 2016

Jeff Jessee, Chief Executive Officer
Alaska Mental Health Trust Authority BY EMAIL ONLY
3745 Community Park Loop
Anchorage, Alaska 99508

Re: Recommendations for Use of MHTAAR to Support Medicaid Reform Activities in FY2017

Dear Jeff,

Thank you for asking the Alaska Commission on Aging, the Governor's Council on Disabilities and Special Education, the Advisory Board on Alcoholism and Drug Abuse, and the Alaska Mental Health Board ["Partner Boards"] to provide recommendations of Medicaid Reform activities that would benefit from support from the Alaska Mental Health Trust Authority in FY2017. The Partner Boards offer the following recommendations for consideration by trustees of the Alaska Mental Health Trust Authority (AMHTA) on March 16, 2016.

Our understanding is that AMHTA staff has identified available funds of approximately $2,000,000 available MHTAAR, and the Partner Boards support authorization of up to $2,000,000 MHTAAR for activities to support Medicaid Reform in FY2017. However, if trustees authorize spending more than $2,000,000 MHTAAR for such activities in FY2017, necessitating review and adjustment of the previously approved FY17 Mental Health Budget, we ask that such review and adjustment be made in direct and active consultation with the Partner Boards (among others). Also, recognizing that beneficiaries could expect to be significantly affected by the proposed 50% reduction to the Adult Dental Medicaid program, the Partner Boards recommend that trustees authorize an amount certain to be used to mitigate the negative impacts (should they occur) and preserve beneficiaries' access to medically necessary dental services.

The Partner Boards – informed by input from the stakeholder engagement processes related to Medicaid Reform, the Alaska Behavioral Health Association, and others – recommend trustees consider funding these activities:

- Technical assistance, procured by contract(s) with an entity or entities (other than the Department of Health and Social Services) with current expertise in behavioral health, senior, and disability Medicaid coding, billing, and documentation (to include treatment

planning) as well as assessing and mitigating audit risk, for providers needing to increase capacity to effectively and accurately bill Medicaid for services delivered to beneficiaires. [$250,000-$300,00, depending on the number of provider agencies included in the contract]

- Funding for providers of Medicaid services to beneficiaries that need assistance to "onboard" to the Health Information Exchange (A-eHN). (*This project was presented by DHSS and AMHB and ABADA last year. There may be potential for the project to extend to providers of services to beneficiaries through the Division of Senior and Disabilities Services, but the extent of that potential is unknown at this time.)* [$5,000-$15,000/per agency, up to $100,000]

- Funding for outreach and assistance to enroll beneficiaries eligible for Medicaid, whether through Medicaid Expansion or traditional Medicaid, to ensure that all eligible beneficiaries and the organizations that serve them (home and community based services providers, assisted living facilities, Aging and Disability Resource Centers, health care providers, homeless shelters, etc.) understand how and have help to apply successfully for benefits. [$40,000-$50,000 per community]

- Fund development of data analytics structures to uniformly track and analyze service outcomes (during treatment/services, at discharge, and over time) and service utilization for beneficiaries receiving services from Medicaid providers. (*This would address the need identified by ABHA for data about recovery outcomes after discharge, as well as the need for uniformity in data collected about senior and disability services, and support the long-term goal of shifting the system to pay for outcomes (value) instead of outputs (volume)*). [$500,000]

We appreciate that you approached the Partner Boards for recommendations on activities that would help move forward our shared efforts related to Medicaid Reform, and look forward to the conversation next week.

Sincerely,

J. Kate Burkhart
Executive Director, AMHB and ABADA

cc: Denise Daniello, Executive Director, ACOA
Patrick Reinhart, Executive Director, GCDSE

AADD
ALASKA ASSOCIATION ON DEVELOPMENTAL DISABILITIES
P.O. Box 241742
Anchorage, Alaska 99524

To facilitate a united provider voice for best practices, advocacy, partnerships and networking.

Jeff Jessee
3475 Community Park Loop, #200
Anchorage, AK 99508

March 11, 2016

Dear Jeff,

AADD appreciated both your presentation at our face to face meeting in Juneau and your request to consider ways in which the Trust might be of assistance to the provider system supporting Trust beneficiaries who experience intellectual and developmental disabilities. We have identified the following primary needs 1) Analyze business needs under Medicaid reform, 2) Increase AADD's national presence and 3) Enhance workforce development.

The Trust has been such a valuable ally for AADD. The funding supplied by the Trust to produce the report: "Impacts of the Health Enterprise MMIS Conversion on Home & Community Based Service Providers" was invaluable for providers. With Medicaid reform taking place there is a need for a report to provide greater clarity around the mandatory infrastructure requirement for agencies to be in compliance with Medicaid reform and existing regulations and compliance requirements.

As Alaska moves into Medicaid Reform the need for knowledge of other states' implementation increases in value. There is now a great need for the provider association to increase its national connectedness. This can be accomplished through the implementation of National Core Indicators in Alaska and the opportunity for leadership to attend key training and networking opportunities with other states.

The Trust's funding assistance for the Leadership Consortium has and will continue to provide a deeper view of person-centered services, systems change tools, emerging leadership training and participatory management skills. Our attached request continues to grow those skills and opportunities in Alaska and to support providers through training of direct service professionals.

The first page of our request is an overview of the funding request. The following pages articulate the specific tasks tied to each funded item. The activities are listed in the order of priority importance to AADD.

AADD recognizes the funding issues facing the State of Alaska currently and is working proactively with the state divisions to maintain services to the Trust beneficiaries. Thank you for this

opportunity to work with the Mental Health Trust Authority to implement our vision of quality of life services in the community.

Sincerely,

Lizette Stiehr
Executive Director, AADD

ALASKA MENTAL HEALTH TRUST AUTHORITY REQUEST

Alaska Association on Developmental Disabilities

ANALYZE BUSINESS NEEDS UNDER MEDICAID REFORM

1. Report to analyze business needs under Medicaid Reform $50,000

There is need to create transparency around the mandatory infrastructure requirements that agencies must have in place to comply with both the current plethora of regulations and compliance mandates as well as those required under Medicaid Reform. Other states implementing the 1915 (i) and (k) waivers have experienced increased infrastructure needs not currently reflected in the cost study data to be collected this fiscal year. The study needs to analyze the minimum infrastructure required by programs to comply with the Medicaid system.

2. Study to examine the economic impact of IDD programs $50,000

Providers supporting Trust beneficiaries who experience intellectual and developmental disabilities have a significant economic impact in Alaska. A report documenting the economic contribution and impact to the business community both at a state and local level will inform conversations around reform and long-term care sustainability.

INCREASE NATIONAL CONNECTEDNESS

3. National Core Indicators FY17-90,000, FY18-$40,000, FY19-90,000

National Core Indicators (NCI) is a uniform national dataset utilized to gather vital information on service outcomes. The information collected via surveys of recipients addresses the quality of their service outcomes. This focus on quality addresses Medicaid's Final Rule requirements for person centered services and would allow Alaska to identify which areas most need to be addressed. Alaska is one of a handful of states currently that do not participate. The funding in FY 17 and 19 would provide face-to-face interviews for a statistically significant number of service recipients. FY 18 would support family surveys.

4. Attendance at national systems conference $4,000 annually

To increase awareness of best practices, coming trends and Medicaid changes the Executive Director and President of AADD request funding to attend a national systems conference (i.e. The National Association of State Directors of Developmental Disabilities Services or National Association of States United on Aging and Disability). The conferences typically address Medicaid reform with offerings on changes in other states and information from CMS.

5. Small group to view best practices $10,000 annually

In order to implement cost savings recommended in Medicaid Reform it would be of great value for a small group of key providers to have the opportunity to see first-hand how other states are implementing:

a. assistive technology to supervise or complete visits remotely
b. smart homes where technology replaces direct staff
c. supported employment
d. innovative group homes (one of system's most expensive costs)

6. Join ANCOR Board $6,000 annually

ANCOR is the American Network of Community Options and Resources. It serves as the nationwide association for all providers and associations serving home and community based waivers. There is an opening on the ANCOR board and Alaska has been encouraged to join. There are three mandatory board meetings each year, paid by the board member. As agencies experience slimmer margins, this cost is not feasible for a small or medium sized provider. Participation at that level informs Alaska of national trends as well as state-level activities.

7. Attend national State Association Executives Conference $1,000 annually

ANCOR sponsors a gathering of state association executives that address issues associations of DD providers are experiencing. This professional training and networking opportunity has great value for AADD, for example learning how other states are making their Medicaid systems sustainable.. AADD considers this to be the primary professional development opportunity for its Executive and will cover half of the costs. In FY 17 the Executive Director will utilize her personal mileage to attend the meeting.

WORKFORCE DEVELOPMENT

8. Collective training for direct service professionals (DSPs) $100,000 annually

Medicaid and state regulations require an increasing number of trainings for DSPs (First Aid, HIPAA, blood borne pathogens). The Alaska Training Cooperative is currently a cornerstone of training in Alaska with the development and offering of the Core Competencies. They could be a significant additional support for provider agencies if they could provide three additional services for the providers:

a) Compile the basic trainings required and offer them periodically
b) Offer scholarships for DSPs interested in working in the field to take core competencies prior to being hired by a program
c) Utilize the Learning Management System data to provide documentation of above trainings completed and reminder of training expiring

9. Training for Emerging Leadership/Participatory Management $15,000 annually

Invite national expert (i.e. Lynne Seagle) to Alaska to work with an Alaskan provider agency to assure full compliance with Medicaid's person centered services.

10. Assistive Technology $50,000 to $75,000 annually

Medicaid reform includes cost savings through the use of assistive technology which providers strongly support. There is need for an environmental scan of the DD system to analyze what assistive technology options best fit Alaskan services, maximize cost saving and recommend steps for implementation.

a) Year 1 – Study to identify best use of assistive technology in Alaska
b) Year 2 – Pilot site(s) to implement a recommendation
c) Year 3 – Focus on rural pilot project implementing assistive technology

ALASKA MENTAL HEALTH TRUST AUTHORITY REQUEST

Alaska Association on Developmental Disabilities - March 11, 2016

	FY 17	FY 18	FY 19
ANALYZE BUSINESS NEEDS UNDER MEDICAID REFORM			
1. Report analyzing the IDD business system	50,000	50,000	
2. Report analyzing economic significance of IDD system	50,000	0	
INCREASE NATIONAL PRESENCE			
3. National Core Indicators (NCI)	90,000	40,000	90,000
4. AADD President and Executive Director attend national systems conference (i.e. NASDDDS Conference or NASUD Conference)	4,000	4,000	4,000
5. Small group (3 to 5) travel to see best practice (i.e.) In assistive technology, smart homes, innovative model group homes, supported employment	0	10,000	10,000
6. Alaskan Join ANCOR Board (3 trips per year)	6,000	6,000	6,000
7. Executive Director attend national gathering of State Association Executives	700	1,000	1,000
WORKFORCE DEVELOPMENT			
7. Training DSPs	50,000	100,000	100,000
8. Emerging leadership/person centered training in Alaska	15,000	15,000	15,000
9. Assistive Technology Environmental scan of assistive technology utilization for Alaska	50,000	75,000	75,000
	Total	Total	Total
	315,700	301,000	301,000

Further explanation of each item by number is contained on following pages

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11 March 2016

Jeff Jessee
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Re: Grant to Medicaid – Transition Support from the Trust

Jeff –

First, let me thank you for presenting at last week's behavioral health provider meeting. Our agenda was filled with very timely discussions and presentations, such as yours, and I know the members appreciated your guidance as always. Along with public comment, behavioral health providers had many conversations with their legislators on a variety of issues. The Behavioral Health Association strives to ensure that members have the best, most up to date, and comprehensive information available for those discussions. Your presentation helped us achieve that goal.

As you are aware, we also used the provider meeting to hold an important discussion about what it will take to help successfully transition services from grants to Medicaid. The Alaska Behavioral Health Association shares the Trust's goal of ensuring Medicaid expansion and reform is a success for our clients and their families, the service delivery system, and the State. We recognize the important opportunity to help Alaskans access healthcare as well as the need to reform our system of care to ensure greater sustainability and quality service delivery. We appreciate the Trust's commitment to this and your interest in supporting the behavioral health providers as we all work toward our shared goal.

The overall risk we are trying to manage stems from a change to the provider's revenue cycle and source of revenue. The task immediately ahead of us is to, where possible, shift the reliance from forward funded grants that allow for a more holistic approach to providing behavioral healthcare to a reimbursement, fee-for-service payment model that is predicated on medical necessity. The goal is to accomplish this without disruption to the continuity of care or limiting access to quality, cost-effective behavioral health treatment services for Alaskans in need.

Behavioral health providers offer the following for consideration as the Trust develops its support strategy.

Question: What do YOU need to help make the transition from grants to Medicaid? How can the Trust help ensure efficient and effective delivery of Medicaid services?

1. The reimbursement rates have to be sufficient for this to work. Any help/support to make sure the rates get fixed is paramount.

2. We tried the technical assistance resource pool a few years ago. We had a lot of folks identify that they were subject matter experts on a variety of topics but some providers seemed reluctant to share their weaknesses and needs with other providers (especially because they are in many ways, their competitors). Although a few providers did take advantage of the resources, we did not end up using this to its maximum potential. Melissa Stone and I talked a few years ago about the TA Resource Pool and came to the realization that delivering the information to providers in a webinar or group format might be a better approach. This discussion predated DBH's TA teleconferences (I know that a lot of providers have found those helpful) as well as the formation of a couple of workgroups (both of which ran their course and provided some good benefit).

   SUGGESTION: Make a small amount of money available to help support travel and SME's time.

   SUGGESTION: Make webinar software/support available to provider groups and workgroups to assist in technical assistance and support.

3. We do have examples of providers offering technical assistance and support to one another right now. Typically, providers come to know each other through ABHA. With a mutual understanding of similarities and a developed relationship, they feel more comfortable approaching one another.

4. Providers cannot typically afford a professionally trained medical coder or biller. We asked if a contract with an itinerant coder/biller would help. Providers suggested that it would be more helpful to have access to the person who sets up the system that feeds the coder/biller the information they need. These people have titles like Revenue Cycle Manager, Medicaid Billing Specialist, etc.

   SUGGESTION: Make funding available for contract consulting (either per hour or on a project basis). Report common challenges and recommendations and disseminate findings.

5. There was some discussion about services that providers have to do to help their clients but that are not reimburseable. I asked for more clarification and detail. It appears that we might want to invest resources in helping to better identify these services to either correct the misconception that they cannot be billed or to take actions to make these necessary services reimburseable. As an example, I know travel to a client to deliver services has been discussed in the past as a necessary service but one that is not reimburseable.

   SUGGESTION: The Division of Behavioral Health has been able to offer limited, but very helpful support. Make funding/resources available for DBH and/or contract consulting. Verify consultant recommendations with DBH, HCS, and auditors to ensure accurate information. Report services that are currently unreimbursed (either to correct the misconception and start billing or for policy work to find a way to reimburse the necessary service).

6. Providers asked to re-visit the value of a follow-back study. Our system for data collection after treatment is practically non-existent. Providers feel that there would be value in knowing what was working (and what was not) and cost-savings associated with success. The discussion highlighted that we might soon be able to better quantify relapse and readmission, but that we needed to put something in place to help better understand what was happening.

   SUGGESTION: Work with treatment providers to develop a study to examine and report impact after treatment (particularly important for substance abuse treatment providers).

7. Providers had a couple of guys from Foraker present a few years ago at an ABHA conference. The presentation was focused on spotting risks and opportunities in financial statements. The providers felt both the format and content was incredibly helpful.

   SUGGESTION: Make resources available; coordinate with ABHA to host discussions with key speakers and subject matter experts. This could also potentially happen at the Change Agent Conference or as a standalone conference/meeting

8. There was some interest in expanding how peers could bill. Right now, peer support services are tied directly to a client's treatment plan. There was a feeling that that was underutilized but also that we might try to find a way for them to be reimbursed for more general support and outreach.

9. There was pretty wide agreement that transforming a practice to one more reliant on Medicaid involved not just the types of services that could be billed, the ability to deliver those services (clinical capacity), but that the reimbursement process itself required a certain level of expertise. Providers were looking for support to make that process easier (ex. eliminate the service authorization, reduce process management focus, and reduce paperwork/admin burden). They were also interested in technical assistance on submitting required paperwork, specifically standardized training from the Department or whoever was in charge of program oversight and audits. There was some discussion about the risks inherent in a system that separates Medicaid program auditors from trainers. There was also some discussion about practices drifting from a standard and the risks involved therein.

10. There was a request to try to promote education for the prevention of errors that might be understood as fraud over building a system only focused on policing. The audit risks involved in billing Medicaid are significant and the providers (especially those making the transition or involved in some other practice transformation) don't have capital reserves to survive an honest mistake. There is considerable concern over audit risk (especially from folks who are less familiar with Medicaid).

    SUGGESTION: Promote education for prevention (maybe a quarterly bulletin to Medicaid providers).

    SUGGESTION: Make funding available to contract with an audit risk management consultant.

    SUGGESTION: Ensure resources are available for quick, accurate responses to billing questions.

11. A lot of the providers spoke about difficulty recruiting staff to provide the services necessary. They suggested that the Trust might help with some sort of centralized recruiting practice or developing some way to help subsidize recruitment. There was some discussion of SHARP and providers recognized this was helping. More highly trained providers are expensive and they are in short supply. Lower credentialed individuals turnover quickly and they are also in short supply. Providers understood that a large part of this problem was that the rates don't cover the cost of care.

    SUGGESTION: Consider developing centralized recruitment services focused on behavioral health.

    SUGGESTION: Continue support for the SHARP loan repayment program.

12. There was some discussion about developing EHRs and onboarding the EHR onto AeHN. Providers recognized that this would be helpful. It didn't seem like there were many that didn't have some EHR in place (if not only AKAIMS), but many of them recognized that resources and support to help them integrate their records with AeHN would be helpful.

    SUGGESTION: Make funding available to help providers develop their EHRs and to support connectivity.

13. Providers working with populations that have/are involved with DOC and the Courts need better clarification and support to help provide care for their populations. It's clear that there is some confusion around what resources are available to individuals that are pretrial, referred to treatment from the courts, and furloughed as well as the new process and policy involved in reinstating Medicaid benefits. DOC and DHSS need to work together to help resolve this. There was a comment about an ongoing conversation with the Feds on this topic and that there might be clarification coming from that level.

    SUGGESTION: Establish an online verification system so Medicaid beneficiaries and providers can enter a beneficiary number to immediately verify eligibility.

14. Providers continue to struggle with some of the barriers to Medicaid program enrollment we spoke about earlier. In addition to some more technical challenges, providers struggle to provide care for people who are eligible for Medicaid but refuse to sign up. Providers also commented that people are not signing up for Medicaid until they need it.

    SUGGESTION: Support with public education/media campaign addressing specific concerns (privacy, IHS/VA or other entitlements vs. the benefit program, etc.)

15. Providers asked DHSS for help with model language between IHS providers and non-IHS providers on serving IHS beneficiaries in a non-IHS setting.

16. Grant-based services are forward funded; Medicaid reimburses for services after the fact. This change will put a lot of pressure on available cash and cash flow. If there is any disruption to the service or payment systems, providers will need funds to draw from to help. In the past, the Department has used advances on provider's grant disbursements to help. Grant funds are spent down by the end of the period and Medicaid does not

provide for an operating margin. Paying particular attention to startup costs/transition costs, revenue projections, and tracking accounts receivable (both amount and Days A/R) will be important.

SUGGESTION: Consider establishing a source of funding/preserving grant funding to help with system transformation and any system disruption.

17. As the 1115 waiver develops and any alternative to the restriction to bill in an IMD setting becomes available, providers may need additional support transforming their clinical practice and treatment modalities to conform to the new alternative. These providers will also likely need technical assistance and support to help ensure accurate, efficient, and effective billing practices.

    SUGGESTION: Ensure resources are available to providers to help implement the change.

18. While it's not specific to Medicaid, providers also spoke about the need for technical assistance and support to bill Medicare and private insurance. There was also some discussion on what to do with clients whose income grew to exceed the income eligibility for Medicaid, but either could not afford the premium/copay/deductible with a private plan or had a private plan that did not cover the behavioral health services the individual needed.

    SUGGESTION: Convene Div. of Insurance, Private Insurance reps on the issue of plan benefits re: behavioral health (what they are, required staffing, etc.), on parity, on network adequacy, and on becoming a network provider.

Jeff, we sincerely appreciate that you are asking the behavioral health providers what is needed to help ensure continuity of cost-effective, quality services. We hope that some of the preceding discussion helps as you formulate how best to support our collective efforts toward our shared goal. As you can see, not all of the challenges identified include corresponding suggestions. Also, some of the suggestions address part, but maybe not all, of the corresponding challenge. We hope this feedback provides some initial information that can help foster further discussion and look forward to collaborating with you and your team.

Please feel free to contact me if you would like any additional detail or have any questions.

Thank You –

Tom Chard
Alaska Behavioral Health Association (ABHA)