ALASKA MENTAL HEALTH TRUST AUTHORITY

PLANNING COMMITTEE

November 17, 2015

1:30 p.m.

Taken at:

Alaska Mental Health Authority
3745 Community Park Loop, Suite 200
Anchorage, Alaska 99508

OFFICIAL MINUTES

Trustees present:

Mary Jane Michael, Chair
Paula Easley
Larry Norene
Russ Webb

Trust staff present:

Jeff Jessee
Steve Williams
Miri Smith-Coolidge
Valette Keller
Carley Lawrence
Amanda Lofgren
Mike Baldwin
Luke Lind
Katie Baldwin-Johnson

Also participating:

Heidi Wailand; Kathy Craft; Donna Mong; Tawny Buck; Thea Bemben; Monique Martin; Patrick Reinhart; Nancy Burke; Chris Cook; Denise Daniello; Tracey Sparks-Campbell; Jared Kosin; Shaun Wilhelm; Beth Davidson; Karen Forrest.

PROCEEDINGS

CHAIR MICHAEL calls the Planning Committee meeting to order and asks for any announcements. There being none, she moves to approval of the agenda.

TRUSTEE WEBB makes a motion to approve the agenda.

CHAIR MICHAEL asks for the people on-line to introduce themselves. She then states that the first item on the agenda is regarding Medicaid expansion and redesign. She asks Mr. Baldwin to introduce the guests.

DEPARTMENT OF HEALTH AND SOCIAL SERVICES/AGNEW:BECK

MR. BALDWIN introduces Monique Martin from the Department of Health and Social Services, and the contractors from Agnew::Beck, Thea Bemben and Heidi Wailand.

MS. MARTIN states that she is a healthcare policy adviser in the Office of the Commissioner in the Department of Health and Social Services. She begins with an update on Medicaid expansion and the reform efforts underway at the Department. She states that Commissioner Davidson is traveling for a conference for the National Prevention Network in Seattle and thanks the Trust for all the support and funding dedicated to the Department, especially the assistance in getting the expansion population enrolled. She states that, as of November 16, 2015, there are about 4300 people that have been determined eligible for Medicaid under expansion in the state. She continues that the electronic applications are picking up speed, which is really helpful for the DPA staff to get in electronic format. She adds that about 20,000 Alaskans are anticipated to enroll in healthcare coverage for Medicaid expansion in the first year. She gives a short report on the progress of this process. She states that healthcare.gov will screen applicants when they attempt to make a determination of eligibility. An update was received and, as of November 6, about 574 applications were received. Of those 574 applications in the first six days of open enrollment, a little over half of them received a determination right away. She adds that all are pleased with this progress. She continues that there is a trend of more applications coming into the Division of Public Assistance with a need to focus on that volume of work. She explains and states the need to ramp up reporting back to Alaskans. Those dashboards will be on the Web site soon. She states that Thea Bemben and Heidi Wailand will talk about the Medicaid redesign and expansion technical assistance contract which was funded with the Trust's generous support. The contract was awarded to Agnew::Beck and Health Management Associates, who will provide the national perspective. She turns the presentation over to Heidi Wailand.

MS. WAILAND states that this presentation is essentially a state peek of Thursday's webinar that will be broadcast to the public. She continues that the Trust provided the funding for this ambitious project. The scope of work included an environmental assessment, which is on the DSS's Web site, and is available to the public. It looked at what the states are doing in the realm of Medicaid redesign, their experiences, what is and is not working, and provides a baseline to proceed with thinking about what initiatives might be possible for Alaska. She continues that the scope of work also included identifying two to three alternative models for the expansion population, which are coverage models; analyzing the implications of those models from an implementation and a financial standpoint. She adds that five to ten Medicaid reform initiative options were looked at, which she explained. She states that the scale and intensity of the work is very impressive. There are three parallel tracks that are happening now: Extensive stakeholder engagement, extensive policy analysis, implementation analysis, and then actuarial analysis. She turns the presentation over to Thea Bemben who will talk more about the roadmap for reform that is starting to take shape.

MS. BEMBEN states that one of the things heard strongly from the key partners last week is that people really need a clear vision of where this redesign effort is going. She continues that the Department is working on the redesign. This presentation is part of trying to look at some additional reform options and coverage for the expansion population. She states that the goals the Department set for Medicaid redesign and expansion are consistent with the triple aim of health care reform across the country. She continues that the focus is on improving outcomes for enrollees and optimizing access to care. This process is trying to navigate the balance between moving towards value and keeping all the providers engaged as that is being done. She goes into greater detail of cost containment; coordination of care, which is key for both improving health outcomes and cost containment; rising rates of chronic disease; the geography of Alaska; and the private insurance market, which has a strong influence on the types of reforms. She moves on to the vision of a high-functioning health system and explains it in greater detail. She talks about the need to share responsibility for promoting health and well-being, which includes the participants, the enrollees, as well as the payers, the providers and the communities; a shared process. She asks for any questions.

TRUSTEE WEBB points out some concerns that should be targeted as an upfront way to fix some serious problems and asks the direction that may be taking.

MS. BEMBEN replies that the emergency room physicians are engaged and very interested in participating. She states that the emergency department is providing a full-service, 24/7 place to receive healthcare. She continues that there is a need to develop a system that has some of the same qualities as the emergency department has, but not in the emergency department.

TRUSTEE WEBB states that his key issue is how to change the system so that the system is not creating those emergencies.

A discussion ensues.

MS. WAILAND states that there is a multi-pronged approach that starts to address some of the complications that have been highlighted. She begins with the most vulnerable, most needy folks, and states that health homes are one of the major tools available to identify that group of individuals and get them intensive care management. She continues that health homes could be the kind of vehicle needed when somebody exits the Department of Corrections to get them off the ground. She explains health homes in greater detail. She moves on to the need to have greater access to services with a full continuum so that both sides of the spectrum can be addressed. The third prong is looking at the gaps in the continuum of care; trying to identify the key gaps that are the failures of the system, that break down.

MS. BEMBEN continues the presentation, looking at the package of reforms.

MS. LOFGREN asks to explain the three tiers for the primary-care initiative.

MS. BEMBEN states that the draft report is in the process of being developed. She continues that in terms of the foundational reforms, it is the primary-care initiative, behavioral health access and data analytics that have to be done to be ready to do any further reform. She explains

this in greater detail. She moves on, stating that business process improvement is really important, and she has heard from providers that they are dying under the burden of administration. She states a draft on an initiative for telemedicine has started and explains this in detail. She moves to the primary-care initiative, explaining that when someone enrolls in Medicaid, if this initiative comes into being, would receive education and orientation on how to use their benefits. She goes through the process in selecting a primary-care provider, and then moves to the criteria of the tiers.

MS. WAILAND states the need to start thinking about the risks associated with the enrollees and the level of care management that would be helpful to them. One of the first key features is removing the requirement to be a DBH grantee to bill Medicaid for behavioral health services. This is a big deal, which she explains. She states the possibility of pursing a waiver for the Institute of Mental Diseases, IMD, exclusions; and establishing behavioral health aides as rendering providers for early-intervention services for mild and moderate individuals. She adds that this would be set up in the same way that the CHAP program is set up where services are provided under the supervision of a physician or a licensed behavioral health professional. She continues that different reimbursement structures that would pay for services at a higher level are also being looked at. She talks about the issue of data, the data analytics and IT infrastructure initiative is one of those foundational initiatives where none of these are going to be successful unless the infrastructure and ability to work with data is increased. The key feature is making sure that the health information exchange is being supported. In looking at the sustainability of the health information exchange is not just submitting information, but also using the information in practice. She states that AKAIMS could potentially be folded into the health information exchange which could serve as a super level data exchange within the state. She moves on, talking about other reporting needs, adding that the data analytics and IT infrastructure initiative is continuing to build out. She asks for any questions.

A discussion ensues on the hospitals and staff developing the interfaces for all the providers to benefit from the health information exchange.

MR. BALDWIN states that there is a circular reasoning problem in that some clinics will not sign on because they cannot get information from the system because the big hospitals that they want the information from are not on board yet.

The discussion continues.

MS. BALDWIN-JOHNSON states that another piece of this is looking at the cost of bringing behavioral health providers into AHEN, and also the substantial costs to community health centers of meeting the meaningful-use criteria before they are eligible to be part of the exchange. She continues that the technology infrastructure, the electronic record, has to be in place.

MS. WAILAND states that another opportunity is to fold in the prescription drug monitoring data base, which is not real-time. She explains this more fully.

MS. BEMBEN moves on to the emergency room, which is a great example of where data sharing is so important. People who are seeking opiates will show up at the emergency

department to get prescriptions. She continues that opiates is a huge issue because emergency physicians do not have the information that there may be a pain contract with a primary-care provider or that the patient has been kicked out of multiple primary-care practices. This is key to the heroin epidemic, which is a key piece of this initiative. The main elements of it are to be able to track users and be able to link up with follow-up care.

TRUSTEE EASLEY asks if the percentage of providers that have gone to electronic health records is known and if everyone is going to be on the computer all the time inputting data.

MS. BEMBEN replies that the hard part of the question about percentage is understanding what percentage of federally qualified health centers have HRs. She states that there are a lot of different entities and small practices making it difficult to define provider.

MS. WAILAND clarifies that provider information could have the electronic health record that is used within their organization. She continues that electronic health record would have an interface to the health information exchange. She adds that if the organization has an electronic health record that is not AKAIMS, that information would have to be entered, and the client enrolled into AKAIMS, as well.

A short discussion ensues.

MS. WAILAND states that the last initiative is accountable care organizations, which would be a pilot issue with three or four providers. She continues that this model is one that has been in practice within the Medicare and the Medicaid system. She gives a brief overview of what that means.

MS. BEMBEN goes through the coverage models.

CHAIR MICHAEL thanks all for the presentation and calls a five-minute break.

(Break.)

BEHAVIORAL SYSTEMS ASSESSMENT

MR. BALDWIN states that Heidi Wailand will give an overview of the behavioral health systems assessment.

MS. WAILAND thanks the Trust for the opportunity to talk about the behavioral systems assessment. She states that there was an opportunity to share some of the regional reports at the Change Agent Conference recently that was very exciting and very well received. She states that the behavioral systems assessment was focused on five goals: the first goal was to describe the system; the second was to assess the need of Alaskans for behavioral health systems; the third was to assess the capacity of the system to meet the goal; the fourth goal was to address the framework for ongoing monitoring; and the fifth was to identify barriers and make recommendations for systems improvements. She continues that the final report was framed around a series of questions: What are the state-funded and tribal behavioral health systems;

what forces are influencing their capacity; what the prevalence of behavioral health issues in Alaska were; who the current users are; where clients are being serviced and by whom; what services do clients use; are services effective, who pays, and how much does it cost; how do current utilization trends compare to behavioral health needs of Alaskans; and what was learned from behavioral health aides as well as from providers about improving the system's capacity. She explains more fully and then goes through the data with Mr. Baldwin's help. She states that it is important to talk about the different data sources. The behavioral health system assessment is three parallel analyses that are woven together to tell a story. The first data set talks about prevalence data, which is the rate of behavioral health issues in Alaska. She explains in greater detail.

MR. BALDWIN adds that this data is taken on Alaskan responses, which is a step forward. He continues going through the data and the presentation. He states that in talking about services within the Medicaid redesign effort the gap is in who is served around mild and moderate mental illness.

MS. WAILAND continues the presentation on the assessment and the data collected, explaining as she and Mr. Baldwin go through the slides.

TRUSTEE WEBB states that as part of this project was creating an ongoing capacity to assess the behavioral health system. He asks how that relates to this presentation and can the health information exchange be utilized as a source of information that would enable this to continue.

MS. WAILAND replies yes, this system brings a tremendous skill set to the issue. She states that one of the challenges facing the Division is making sure that every piece of information collected is the right piece of information. The infrastructure piece is critical and sees that next phase being a continuation of the dialogue that was started with providers at the Change Agent Conference.

CHAIR MICHAEL thanks Ms. Wailand and moves on to the Office of Rate Review. She asks Mr. Baldwin for an update.

OFFICE OF RATE REVIEW

MR. BALDWIN introduces Jared Kosin from the Office of Rate Review who will talk about some of the current issues around some of the home- and community-based rate processes and projects that they are working on.

MR. KOSIN states that he is executive director of the Office of Rate Review in the Department of Health and Social Services. He explains that his office will set the price Medicaid will pay for services. He goes through the different exercises that have been done to date that are important. He explains in greater detail as he goes along. He states that there is a new methodology that will take all of the services and identify the top five providers for each service. Those top providers will be asked to do cost surveys and provide a financial audit. He explains that the top providers in the service, in almost all circumstances, are providing around 90 percent of those units of that service. The foundation can be built from the price from a very small group of

providers, leaving the burden off the others. The federal government has said that service has to be provided in a conflict-free manner. He explains this further.

TRUSTEE EASLEY asks how people can be attracted to take some of the jobs with regard to home-based community projects.

MR. KOSIN replies to that question by going through behavioral health.

MS. LOFGREN asks if there is a time line for the behavioral health rates.

MR. KOSIN replies that they are trying to overhaul the entire system and will try to get them in place by July 1st.

A short question-and-answer period ensues, followed by a short discussion.

MR. BALDWIN states that at the last Planning Committee meeting, Kate Burkhart had brought forward a proposal to look at trying to onboard some behavioral health providers into the health exchange network. He continues that Shaun Wilhelm and Beth Davidson are here to respond to the request for more information.

MS. WILHELM states that she is with the Division of Behavioral Health and Beth Davidson is the IT coordinator for the department. She continues that the Division is in the process of just starting the scope of work for this process of onboarding. She adds that they can onboard AKAIMS into the health information exchange and also need to have providers onboard to the health information exchange so data can be gathered. She states that discussed was the streamlining process the Division has gone through with stakeholders to find out what are some of the main ways the Division can help relieve the burden of reporting for providers. She continues that what came through loud and clear is dual entry. This is an effort that is a vehicle for the Division to reduce the burden of providing information and to leverage both primary-care information and behavioral health information. She states that one of the questions asked was who owns the data. The data is truly at the provider level. Whoever has authorized access to the health information exchange can develop reports that could help the analysis of this information. She agrees to the proposal of having an infrastructure building, but to leverage that information analytical capacity is needed. This would allow a better picture of what the system is doing. She goes into detail of a proposed schedule, outlining some of the stuff already done and can start looking about what is needed to develop a minimal data set, and being able to develop that conduit. She states that a few providers approached us at the Change Agent Conference that are ready and willing to start. She continues that the concern is how to pay for the change which can cost anywhere from $13,000 to $30,000 just to onboard. This means taking their data and mapping it to a schema or data elements that is within AKAIMS that require a data set. Some providers will be able to afford this; other smaller providers may not. She states that AHEN has the capacity of taking funding from the federal government, OMC, and using that funding to help providers onboard. It would not have to be an issue of the Trust actually managing each individual grant for each of the providers. She continues that perhaps the Trust would be able to give a certain dollar amount to AHEN on an annual basis, and adds that this plan is in the works. She states that another thing that they would like to approach the Trust about is doing a survey of

providers to find out how many providers would be onboarding to the HIE. She continues that some providers are doing clinical records and some are thinking about transitioning from AKAIMS to their own EHR. She adds that they may collectively approach their vendor which may defray some of the costs.

TRUSTEE WEBB states that he is all about developing the infrastructure needed in order to have the data needed for Medicaid expansion and everything else. He continues that his concern is how to get there from here and if there is a rational way rather than a scattershot way to do that without incurring extra time and money.

MS. WILHELM replies that there are two solutions. One, within the health information exchange, is an option to use an EHR within AHEN. Within that Orion platform is a behavioral health platform. If there are small providers not currently using an EHR, the option would be for them to use an EHR that would directly feed them into AKAIMS. She explains this more fully.

A short discussion ensues.

CHAIR MICHAEL asks if a requirement of their grant agreement could be that they must participate and that financial assistance would be provided.

MS. WILHELM replies that has been considered and would be very beneficial to have providers compelled to somehow provide or utilize data through the health information exchange.

CHAIR MICHAEL states that this seems to be the direction the State wants to take, and recommendations from consultants are for a letter to go out pretty quickly to providers so that they are not investing in systems that will not help with the transition.

MS. WILHELM agrees, and states that there is a lot of interest with concern on the cost for onboarding.

A short discussion ensues.

MR. BALDWIN states that, if the Trust is supportive, that is an initial scope that Ms. Wilhelm has brought for potential requests for some sort of funding.

MS. WILHELM states that there are three pilot agencies that have already put aside funding on their own. She continues that funding may be needed for one or two providers in 2017.

MR. BALDWIN states that one of the activities in 2016 is the survey of providers to scope out what the layout of the EHR is, and it is moving towards that direction of preparing something toward 2017.

TRUSTEE WEBB states that he is supportive of getting good and useful data that can then be turned into actual information that can lead to useful decisions and investments on the part of the Trust and others.

TRUSTEE EASLEY asks when CMS required all the providers to go to electronic health records.

MS. WILHELM replies that there are differing answers based on what type of provider it is.

MS. DAVIDSON explains this in greater detail.

A short question-and-answer ensues on the entities and the criteria for being considered one of those entities.

TRUSTEE EASLEY states that the Trustees are very interested in this topic and asks if there is a requirement to operate under the 20,000 minimum for reporting from areas around the state.

MS. WILHELM replies that the HIPAA guidelines are there to protect the anonymity of individuals within given regions. So the Division did this as a means to meet that requirement.

TRUSTEE WEBB introduces Karen Forrest, the deputy commissioner of Health and Social Services. He congratulates her on her appointment and welcomes her.

MS. FORREST thanks all and states appreciation for all the work the Trust has done over the years for the Department.

CHAIR MICHAEL states that it is a great partnership and enjoys working with her.

MS. WILHELM thanks everyone for taking the time to listen to this information.

CHAIR MICHAEL thanks all and asks for a motion to adjourn.

TRUSTEE NORENE makes a motion to adjourn the meeting.

TRUSTEE WEBB seconds.

There being no objection, the meeting is adjourned.

(Planning Committee adjourned at 4:57 p.m.)