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THE PACIFIC HEALTH POLICY GROUP

State of Alaska

Department of Administration

Medicaid Technical Assistance

HEALTH CARE AUTHORITY FEASIBILITY STUDY

FINAL REPORT

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CONTENTS

EXECUTIVE SUMMARY

REPORT OVERVIEW

The Pacific Health Policy Group (PHPG) was retained by the Commissioner's Office of the Department of Administration to provide input regarding Medicaid-specific considerations for the development of a Health Care Authority (Authority).

This report addresses and is organized as follows:

- ***Section 1*** – Provides an overview of the Medicaid program administration responsibilities performed at the federal and state levels as well as the regulatory structure used to accomplish these functions.

- ***Section 2*** – Presents an overview of the Alaska Medicaid program's organizational structure and administrative functions as well as the populations and benefits covered, expenditures and current reform initiatives.

- ***Section 3*** – Summarizes states' approaches to the administration of public payer health care programs. This includes states' efforts to coordinate and/or integrate purchasing strategies, control costs of the Medicaid expansion populations and consolidate administrative functions and regulatory operations into an Authority.

- ***Section 4*** – Discusses considerations and approaches intended to facilitate discussion and help the State identify areas for further evaluation to assess the potential feasibility of having an Authority coordinate and/or integrate purchasing efforts with Medicaid, develop a common benefit design across public payer programs and Medicaid, and integrate the Medicaid program as part of the Authority (i.e., designation of Authority as the Medicaid Single State Agency).

- ***Section 5*** – Presents a summary of key decision considerations of the policy options presented in Section 4. In addition, this section presents a provisional model that describes the structure, role and responsibilities of an Authority as well as a potential approach for transitioning Medicaid to an Authority. The provisional model represents a starting point and is intended to illustrate the design elements based on other states' experience and the policy options discussed in Section 4. Further evaluation, supported by stakeholder input, will be required to develop an approach that best meets the State's policy objectives related to administration of publicly-funded health benefits.

The following highlights the content of each section.

Section 1 – Medicaid Program Requirements and Funding

Established in 1965 under Title XIX of the Social Security Act, the Medicaid program is an entitlement program that provides medical and health-related services for the nation's low-income populations. Individuals eligible for Medicaid have the right to payment for medically necessary health care services as defined in federal statute, and states that operate their programs within federal guidelines are entitled to federal reimbursement for a share of total program costs.[1]

In addition to financing the program jointly, the federal government and states administer Medicaid together. Each state describes how it would administer its Medicaid program through a State Plan. The State Plan is a contract between the state and the federal government that specifies the state's administrative structure and activities/processes, identifies and describes the groups of individuals and services that the state would cover and requirements for program eligibility, gives an assurance that the state would abide by federal rules to claim federal matching funds for program activities and describes the provider reimbursement methodologies that would be utilized by the state. [2]

The entity tasked with administration of a state's Medicaid program is known as the Single State Agency. Although each state is required to designate a Single State Agency to administer the state's Medicaid program, Medicaid agencies have the authority to delegate or outsource certain administrative functions to other state agencies and/or contractors.[3] However, the Medicaid agency may not delegate, to other than its own officials, the authority to supervise the Medicaid State Plan or to develop or issue policies, rules and regulations on program matters.[4]

Section 2 – Alaska Medicaid Program

Under Alaska's Medicaid State Plan, the Department of Health and Social Services (DHSS) is designated as the Single State Agency responsible for administering the State's Medicaid program. Today, Medicaid covers nearly one in four Alaskans. As of May 2017, Alaska has 185,139 individuals enrolled in Medicaid and CHIP.[5] Approximately half of those enrolled are children.

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[1] Medicaid and CHIP Payment and Access Commission (MACPAC) Medicaid 101: Financing, available at https://www.macpac.gov/medicaid-101/financing/. The federal government matches state Medicaid expenditures based on a statutory formula, the Federal Medical Assistance Program (FMAP). A share of Medicaid expenditures is paid based on each state's per capita income (PCI) relative to the national average; the federal government pays a larger portion of the costs in states with lower per capita incomes.

[2] See https://www.medicaid.gov/state-resource-center/medicaid-state-plan-amendments/medicaid-state-plan-amendments.html for more information about specific State Plans and amendments.

[3] 42 CFR § 431.10. *See also* DHHS OIG, Memorandum Report: Offshore Outsourcing of Administrative Functions by State Medicaid Agencies, OEI-09-12-00530 (April 11, 2014), available at https://oig.hhs.gov/oei/reports/oei-09-12-00530.pdf.

[4] 42 CFR § 431.10(e).

[5] Data obtained from http://dhss.alaska.gov/HealthyAlaska/Pages/dashboard.aspx.

Between May 2016 and May 2017, Medicaid enrollment has grown by 23 percent in the State. While half of that growth is attributed to coverage of the expansion adult population, a driver has been the recession which technically began 2015. Alaska has a current unemployment rate of seven percent, compared to approximately four percent nationally. The recession is expected to continue through mid-2020 for the state.[6]

The Alaska Medicaid program paid more than $1.65 billion during SFY 2016 to provide health care coverage to eligible Alaskans. Alaska's Medicaid program expenditures per enrollee are among the highest in the country.[7] Several factors may contribute to the high cost, such as Alaska's unique rural and remote geography, high cost of living, limited competition among providers, healthcare workforce shortages and reliance on fee-for-service reimbursement.

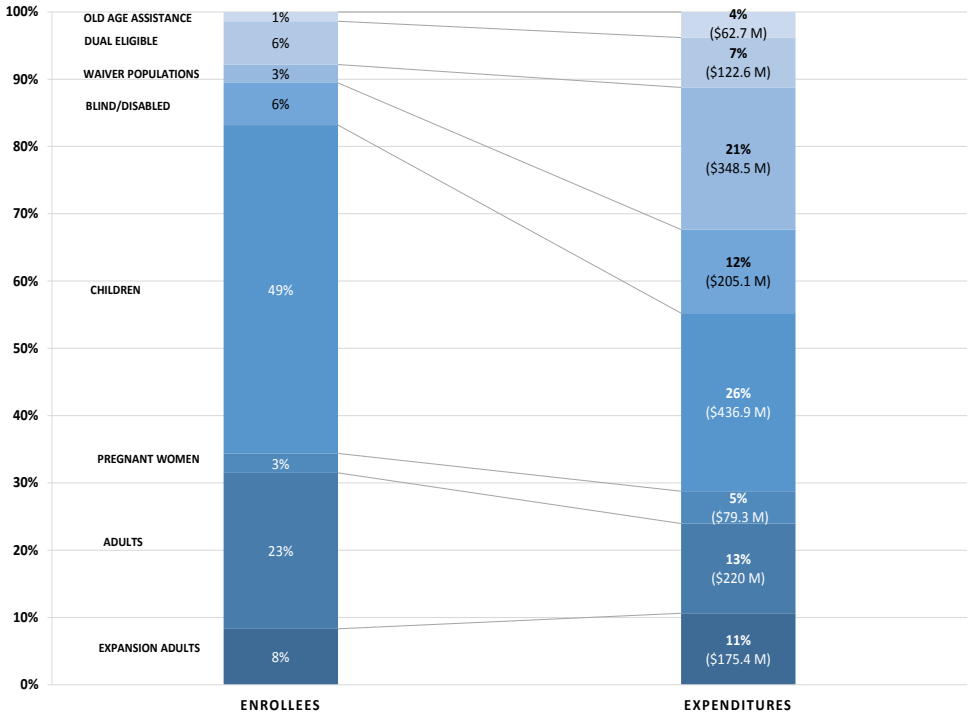
Although Alaska's general Medicaid match rate and administrative match rate are 50 percent, several enhanced federal match rates are available for certain populations, providers, services and administrative functions. As a result, the federal government funds approximately 65 percent of Alaska's Medicaid program.

As illustrated in Exhibit ES-1 on the following page, the percentage of total enrollees by subgroup is not necessarily proportional to the subgroup's percentage of total Medicaid expenditures. Individuals in the old age assistance, dual eligible (eligible for both Medicaid and Medicare), waiver populations and blind/disabled categories accounted for 16 percent of total enrollment but 44 percent of total expenditures.

[6] For additional information about Alaska's recession, see http://www.alaskapublic.org/2017/02/24/understanding-alaskas-recession/.

[7] *See* Kaiser Family Foundation, Data Note: Variation in Per Enrollee Medicaid Spending, available at http://www.kff.org/medicaid/fact-sheet/data-note-variation-in-per-enrollee-medicaid-spending/.

Exhibit ES-1 – SFY 2016 Medicaid Enrollees and Corresponding Percentage of Total Expenditures[8]



Average expenditures per enrollee vary by eligibility group. Expenditures per enrollee are higher among the aged and individuals with disabilities due to the higher use of complex acute services and long term supports and services. In contrast, expenditures are lower for expansion adults and children. Exhibit ES-2 below provides the SFY 2016 Medicaid expenditures per member per month (PMPM) by enrollee population.

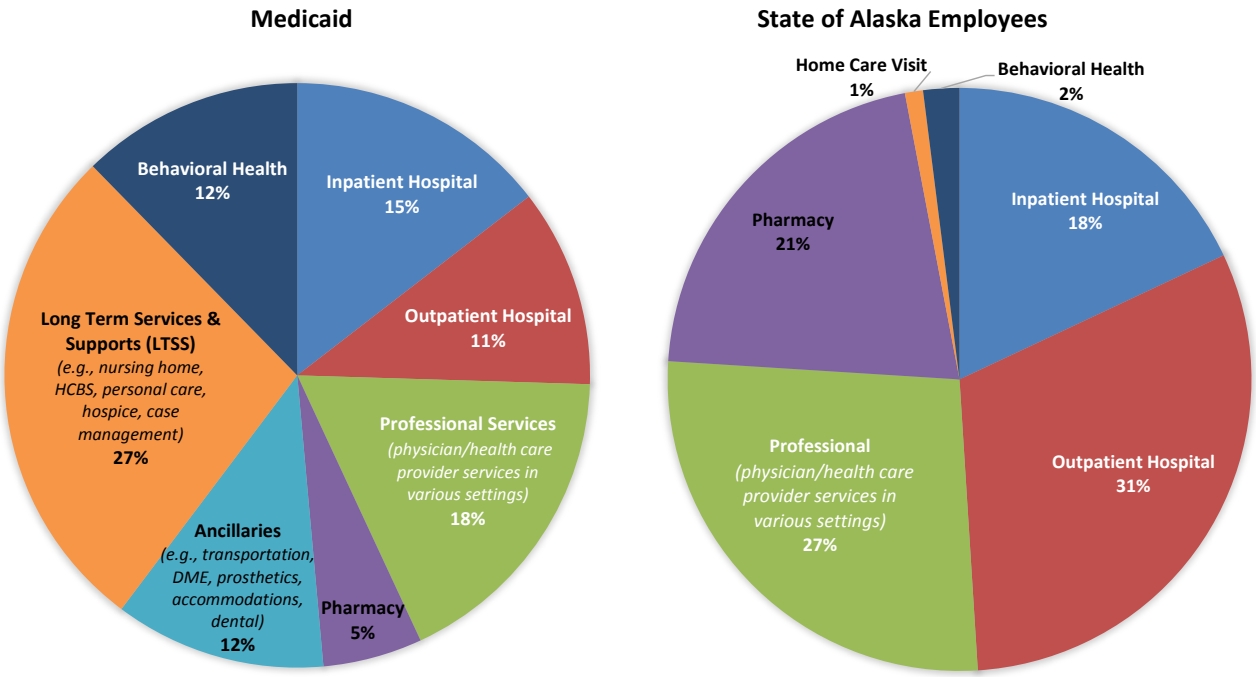
Exhibit ES-2 – SFY 2016 PMPM Expenditures by Medicaid Enrollee Population[9]

Medicaid Enrollee Population	SFY 2016 PMPM
Old Age Assistance	$ 2,476
Dual Eligible (Medicaid + Medicare)	$ 1,045
Waiver Populations	
Managed Care Optional	$ 1,102
TEFRA	$ 881
Section 1915(c)	$ 6,993
Blind/Disabled	$ 1,874
Children	$ 450
Pregnant Women	$ 1,499
Adults	$ 520
Expansion Adults	$ 1,156

[8] SFY 2016 Medicaid enrollee and expenditure data presented were obtained from the "Alaska Medicaid Data Book SFY 2015 and SFY 2016" and accompanying appendices prepared by Milliman on behalf of DHSS.
[9] *Id.*

Over one-fourth of total expenditures in SFY 2016 were for long term services and supports (LTSS) (see Exhibit ES-3 below). LTSS includes hospice, nursing home, home and community-based services (HCBS), case management and personal care services. Professional services includes medical/surgical-related services provided by physicians and other health care practitioners in settings such as office, hospital, emergency room, delivery room, clinic, etc. Professional services accounted for the next largest segment of spending at 18 percent, followed by inpatient hospital services (physician and hospital claims) at 15 percent.

Exhibit ES-3 – Expenditures by Category of Service – Medicaid vs. State of Alaska Employees[10]



In comparing Alaska's Medicaid expenditures to medical expenses of State of Alaska Employees, the distribution of expenditures differs. In contrast to Medicaid, 58 percent of State Employee health care expenditures are for two categories – professional services and outpatient hospital services – and pharmacy accounts for 21 percent of costs.

Senate Bill (SB) 74, passed by the Alaska Legislature in April 2016 and signed into law in June 2016, focuses on improved efficiency and outcomes in Medicaid usage, billing and delivery. It directs DHSS to undertake a series of Medicaid reforms intended to improve quality, increase value and control spending while building upon initiatives already underway. Areas of focus include payment system reform; expanded use of telehealth; enhanced fraud prevention, enforcement and recovery; primary

[10] *Id.* State Employee data comes from the Consultative Analytic Impact Report for Alaska Care, State of Alaska Employees for 2016.

care case management; coordinated care demonstration projects; home and community based services; behavioral health reform; and exploring privatization.[11]

SECTION 3 – OVERVIEW OF STATES' APPROACHES TO ADMINISTRATION OF PUBLIC PAYER HEALTH CARE PROGRAMS

Public Payer Coordination and Integration Approaches

States and their Medicaid agencies have identified coordinated purchasing strategies as an opportunity to leverage purchasing power to reduce health care costs, increase administrative efficiency and improve quality of care. Different approaches have been taken to reorganizing administrative/structural frameworks to support coordination of purchasing efforts. For example, informal inter-departmental collaborations and staff-level interactions may be used for coordinated purchasing. States also may create an executive committee to assist with purchasing coordination. At the other end of the continuum, agencies may be consolidated under the direction of a Health Care Authority formally created by legislation.

Creating a single Authority with responsibility for health benefit administration or coordination across payers may provide a more stable foundation for advancing integration. However, states also have created Authorities but have not succeeded in coordinating administrative functions or health care purchasing across public programs. Factors that impact states' abilities to successfully coordinate and integrate operations across publicly-funded programs include:

- ***Program administration***:
  - Commonality between the populations, benefit packages, service needs, provider network and provider rates for the populations covered under each program
  - What and how do federal and/or state legal authorities govern program administration
  - Appropriate and sufficient resources to support coordination efforts as well as ongoing operations
  - Willingness of vendors/contractors to participate and effectively perform functions across different programs

- ***Priorities and values***:
  - Awareness that changes in executive/administration leadership (governor or key staff) which may shift the direction of program administration
  - Availability of funding to support initial and sustained coordination efforts
  - Understanding the differences in agency culture, values and mission

[11] *See* http://dhss.alaska.gov/HealthyAlaska/Pages/Redesign/Redesign_news.aspx.

Coordination across payers for service delivery and payment models, such as coordinated care and value-based purchasing, have garnered support from CMS and been actively explored and implemented by states in recent years. States also have pursued approaches to use health information technology across payers to measure and improve quality of care. States also have implemented common provider management requirements such as network adequacy and program integrity monitoring for managed care entities.

Some states have designated directors or chief medical officers across agencies to facilitate coordination of quality, provider management and medical management. In addition, some states have consolidated or coordinated provider contracts and related activities.

Although examples of integration and coordination exist, they are limited. Whether the approaches achieve success is largely dependent on the administrative or structural framework to support coordination. As mentioned earlier, some states have the capacity to centralize management and contracted services policies for multiple programs because designated directors and chief medical officers play a key role across all programs. This is particularly the case for states utilizing an Authority or Authority-like governance structure.

Medicaid Expansion Populations and Common Benefit Design

Currently, 31 states, including Alaska, and the District of Columbia provide Medicaid coverage to most low-income adults with income up to 138 percent of the federal poverty level (FPL). Some states have used Section 1115 waivers to implement demonstrations to control costs of care associated with the Medicaid expansion adult group.

For example, Arkansas provides premium assistance to support beneficiaries' purchase of coverage from qualified health plans (QHPs) offered through the individual Federally Facilitated Marketplace. To be eligible for participation, the individual must be an expansion adult or parent. Enrollees receive the state's alternative benefits plan, as defined in the State Plan. Wrap-around services in the plan not covered by Employer Sponsored Insurance (ESI) or QHPs are provided by the state through its fee-for-service Medicaid program.

Indiana offers a benefit package that is more consistent with commercial plan benefits but excludes chiropractic and non-emergency transportation services. However, the Medicaid State Plan benefit package, which includes these two benefits, is provided to Section 1931 parent/caretakers, low-income 19 and 20 year old dependents, individuals eligible for transitional medical assistance and individuals identified as medically frail. Except for members receiving the State Plan benefit package, vision and dental services are only available if regular monthly contributions are made to a health savings-like account.

Health Care Authorities

Successful consolidation and integration of multiple health agencies, including state employee health coverage and the state's Medicaid agency, into a single collective Authority are limited but currently operational in Oregon and Washington. Other states have established Authorities, however, many of Authorities in these states serve a limited role or are no longer operating. The Oklahoma legislature envisioned moving the state employee health plan to the Health Care Authority (OHCA), which did not occur. Today, the OHCA primarily operates the Medicaid program with different divisions having specified responsibilities and administers the state-funded insurance program for small businesses and uninsured employees. Hawaii's effort to create a centralized, policy-making Authority faltered, where competing legislation is now pending to both fund and abolish the Authority.

Alaska has experience with quasi-governmental boards and commissions. Examples include the Alaska Permanent Fund (APF), Alaska Mental Health Trust Authority (AMHTA), Alaska Housing Finance Corporation (AHFC). Alaska Gasline Development Corporation (AGDC), Alaska Energy Authority (AEA) and Alaska Industrial Development and Export Authority (AIDEA), Regulatory Commission of Alaska (RCA) and North Pacific Fisheries Management Council (NPFMC).

SECTION 4 – CONSIDERATIONS FOR ALASKA'S MEDICAID PROGRAM

As Alaska considers whether to create an Authority to centralize the administration of public payer health care programs, including Medicaid, Alaska should recognize that few states have contemplated and even fewer have implemented an operational Authority. Direct cost savings attributed to the formation of an Authority also are not available; information about cost savings are generally attributed to delivery system and payment reforms. In addition, the experiences (successes or failures) of other states may not reflect that of Alaska's potential initiatives.

The considerations and approaches presented in this report are intended to facilitate discussion and help the State identify areas for further evaluation to assess the potential feasibility of having an Authority coordinate and/or integrate purchasing efforts with Medicaid, develop a common benefit design across public payer programs and Medicaid, and integrate the Medicaid program as part of the Authority (i.e., designation of Authority as the Medicaid Single State Agency). Further evaluation and refinement of these approaches would require additional analysis and collaboration with DHSS.

Coordinated/Integrated Program Administration and Purchasing

As the Authority considers opportunities for coordination and/or integration of functions and purchasing across the Authority and Medicaid, the following considerations should be taken into account:

- ***Differences in Program Requirements*.** Medicaid has specialized program requirements and obligations related to federal compliance, including populations and services that must be covered.

- ***Cost Allocation Plan*.** There is risk of reduced federal match funds for certain administrative functions. In general, most Medicaid administration-related expenditures are reimbursed at 50 percent for amounts expended by the State. Certain administrative costs may be matched at a higher rate. To receive match funding, costs must not duplicate payment for activities that are already being offered or should be provided by other entities or paid through other programs. Costs must be supported by a Cost Allocation Plan that describes the procedures DHSS would use to identify and measure costs.

- ***Current Reform Initiatives*.** DHSS is engaged in several Medicaid reform initiatives, including those at the direction of SB 74, such as evaluating options for coordinated care, value-based purchasing and provider payment. Components of these models have been utilized by both Medicaid programs and other public/private payers as mechanisms for improving quality of care while managing costs. Unlike other programs, State Plan Amendments or waiver authorities would be required for Medicaid.

- ***Consultation and Coordination with Tribal Health.*** Nearly 40 percent of Alaska's Medicaid clients are American Indian/Alaska Native (Al/AN). The Tribal Health System is a vital part of Alaska's health care delivery system. Due to the government-to-government relationship between Tribal entities and the State, federal law and regulations and guidance issued by CMS require state Tribal consultation processes to be followed.[12] States must obtain advice and input from Tribal entities on a regular and ongoing basis prior to submission of any State Plan Amendments, waiver request or proposal for a demonstration project that is likely to have a direct effect on American Indian/Alaska Native (AI/AN) and Tribal health care providers. Consultation is required and further exploration is warranted with regard to how the Tribal Health System would be impacted by the possible integration of Medicaid into an Authority. In addition, SB 74 requires DHSS to fully implement changes in federal policy on Tribal Medicaid Reimbursement that authorizes 100 percent federal funding for services provided to AI/AN individuals eligible for Medicaid.[13] The new federal policy allows the state to claim 100 percent federal reimbursement for Medicaid services provided to AI/AN Medicaid recipients in non-Tribal facilities if the recipients' Tribal Health Organization has a care coordination agreement

[12] *See* Centers for Medicare & Medicaid Services Tribal Consultation Policy available at https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Downloads/CMSTribalConsultationPolicy2015.pdf. *See also* Revised CMS Tribal Consultation Policy (effective December 10, 2015) available at https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Downloads/TribalLeaderLetter2015.pdf.

[13] CMS State Health Official Letter #16-002, dated February 26, 2016, regarding federal funding for services "received through" an IHS/Tribal Facility and furnished to Medicaid-eligible American Indians and Alaska Natives: https://www.medicaid.gov/federal-policy-guidance/downloads/sho022616.pdf

established with the non-Tribal facility. Changes to the Medicaid program should be analyzed to ensure DHSS's ability to optimize savings from this policy is not negatively impacted. In state fiscal year 2018, it is anticipated DHSS will save more than $40 million as a direct result of this federal policy.

- ***Clinical/Quality*.** Collaboration between Medicaid and other public payer programs may foster development of a uniform set of evidence-based strategies to reduce costs and improve outcomes for common high-utilization services.

- ***Information Technology (IT).*** Any changes to IT-related projects would require federal approval in order to secure federal match. The approval process requires significant resources and time to complete.

- ***Administrative Burden for Providers***. Creation of common utilization management criteria and processes, reporting requirements and provider monitoring activities potentially reduces providers' administrative burden and therefore reduces overall health system costs.

Common Benefit Package

The Authority could establish a common benefit package that would be made available to all individuals receiving state-funded health care. This common benefit package would define the State's obligation for state-purchased health care. The Authority could also define a set of premium benefit options beyond the basic benefit package would be the financial responsibility of the employer and/or program participant. The common benefit package could be made available to some Medicaid populations such as expansion adults. Other populations, such as non-disabled adults, pregnant women or children, could be considered for transition to the common benefit package because the needs of these populations may be similar to Public Employees/Retirees. However, the federal Medicaid requirements for administering benefits for these groups may create additional challenges and may result in duplicative functions across the Authority and DHSS.

Transition of the Medicaid expansion adult population contemplates offering a benefit package that more closely resembles a commercial benefit than what is offered under Medicaid. This approach is supported by the following considerations:

- The federal government has indicated states have greater latitude in designing programs made available to the expansion adult population. The Authority would administer the benefit but DHSS would retain responsibility for federal claiming.
- Transitioning this group to the Authority increases its purchasing power.
- Provider reimbursement at rates above the current Medicaid rates would increase provider revenues for this population and better align payment rates for Alaska's providers. Because of the enhanced matching rate for the expansion adult population, payments are largely funded

by federal dollars and the increased payment rates would represent a modest increase in State matching funds.

- Administration of benefits for the expansion adult group could create the opportunity for the Authority to develop alternative coordination approaches, such as risk-based managed care, and alternative delivery models in a more flexible manner than would be available under the traditional Medicaid program.

The common benefit model would include defined cost sharing obligations, such as premiums, copayments or deductibles. However, the cost sharing obligations may not be affordable for the Medicaid expansion adult group. Also, absent a federal waiver, CMS limits or prohibits cost sharing for certain Medicaid recipients, income levels and for certain services.[14] Therefore, the model design would need to reduce individual out-of-pocket costs. Potential approaches for addressing this issue would include establishing different cost sharing obligations for the expansion adult group or development of a health savings account (HSA)-approach to fund cost sharing.

If the HSA-approach is considered, HSAs for the expansion adult group could be funded by the Medicaid program and monthly enrollee premiums. Monthly premium amounts would be based on a percentage of annual income. If there is a balance in the HSA at the end of the year, a portion of the member's contributions to the HSA would roll over to the subsequent year and could be used to reduce monthly premiums.

The HSA approach could enable the Authority to establish the same benefits, including cost sharing, across all program participants. However, establishing HSAs for the Medicaid population would be administratively burdensome and likely would be administered by a third party vendor. States that had or are currently utilizing HSA-like arrangements for the Medicaid expansion adult population include Arkansas and Indiana, respectively.[15] The State will need to determine whether the administrative investment in HSA-like accounts for the expansion adult population is warranted to advance consumer decision making and responsibility. For example, Arkansas phased out HSA-like accounts due to administrative burdens and associated costs of the program along with the determination that the accounts were an inefficient way of promoting consumer choice and personal responsibility.

Integration of Medicaid as Part of the Authority

Prior to transitioning Medicaid to the Authority, a detailed assessment would be necessary to validate whether the transition is in the best interest of the State to fully realize any goals for health care purchasing. Policy considerations include the following:

[14] *See* https://www.medicaid.gov/medicaid/cost-sharing/index.html.

[15] Information on the Arkansas Works and Healthy Indiana Plan (HIP) 2.0 programs is presented in Section 3 of this report.

- ***Differences in Program Requirements*.** Medicaid has specialized program requirements and obligations related to federal compliance, including populations and services that must be covered. These requirements may make it difficult to centralize administration and purchasing across public programs. Ultimately, Medicaid could continue to operate independently even if it were under the Authority.

- ***Staffing/Cost Allocation Plan*.** DHSS has a little over 3,400 funded permanent positions. DHSS provides general administrative support to Medicaid and receives federal reimbursement for providing these services under a Cost Allocation Plan. DHSS would need to retain staffing to administer existing social service programs and a detailed staffing analysis would need to be undertaken to fully assess the potential impact of transitioning the Medicaid program from DHSS to the Authority. This analysis also would examine whether certain Medicaid administrative functions should remain with DHSS while other functions transition to the Authority while ensuring there is not a loss of federal reimbursement for the administration of the Medicaid program. For example, the State may determine that DHSS should retain eligibility functions and responsibility for administration of the HCBS waiver programs.

  In the case of Washington, the state needed to increase its staffing to accommodate federal requirements for administering/supervising the administration of the Medicaid program. Although the Authority is the designated entity in Washington, it delegated to the Department of Social and Health Services (DSHS) the management and oversight of Medicaid services such as mental health and substance abuse, private duty nursing for children and adults and nursing homes. For the state, reassigning staff was not an option because it would require the Authority to remove staff from other necessary activities to maintain a viable Medicaid program and assigning partial full-time staff would not provide the capacity to exercise the level of oversight necessary.

- ***Information Technology (IT).*** Any changes to IT-related projects would require federal approval in order to secure federal match. The approval process requires significant resources and time to complete. If Medicaid transitions to the Authority, certain IT-related functions, such as claims processing, may be able to support only the Medicaid program.

- ***Timeline*.** Administrative changes impacting the Medicaid State Plan and the Cost Allocation Plan will require time to secure federal approval.

- ***Transition*.** The need for a transition period, possibly two years or longer, could be required to allow time to determine staffing, contracts, equipment and physical space that would be moved or affected by changes in the administrative structure of the Medicaid program. In addition to existing workloads, committees and workgroups would need to be organized to assist with mapping out processes. Funding and/or dedicated staff for transition tasks may be necessary.

SECTION 5 – SUMMARY OF KEY DECISION CONSIDERATIONS AND PROVISIONAL MODEL

Section 5 presents a summary of key decision considerations of the policy options presented in Section 4 (see Exhibit ES-5 beginning below).

Exhibit ES-5 – Summary of Decision Considerations

Policy Option	Potential Opportunities	Potential Challenges
Coordinated/ Integrated Purchasing	• Strengthens the ability of the State to leverage its purchasing power for both administrative support services and health services • Coordination and/or consolidation of administrative functions could reduce administrative expenses • Development of consolidated analytic capabilities and uniform measures could promote quality and access to care • Streamline provider reporting and monitoring could reduce administrative burden on providers and therefore reduce overall health system costs • Strengthens the ability of the State to leverage its purchasing power to advance delivery reform models, such as value-based purchasing and community-based models (e.g., provider-led delivery systems)	• Medicaid has specialized program requirements and obligations related to federal compliance; adherence to these requirements across other public programs could be more costly • Federal funding for Medicaid administrative functions potentially could be reduced • Changes to how Medicaid is administered require federal approval • DHSS currently is engaged in several Medicaid reform initiatives that place a demand on its administrative resources; engagement in coordination with other public programs potentially requires additional resources • Program changes that impact Tribal Health will need to be carefully considered and developed with appropriate Tribal consultation • Any changes to IT-related projects would require federal approval in order to secure federal Medicaid match. The approval process requires significant resources and time to complete.
Common Benefit Package	• Enhances State's ability to leverage its purchasing power to control program costs and advance health reform • Creates a benefit that defines the State's contribution toward health care • Provides flexibility to establish benefits based on available resources • Centralized administration of common benefit potentially reduces administrative costs	• Inclusion of Medicaid expansion population would require federal approval • Health needs of Medicaid expansion population may increase overall costs • Benefit design may be not fully address health needs of the Medicaid expansion group • Cost sharing obligations for Medicaid expansion population would need to be addressed such as cost sharing limitations and restrictions by CMS and other states

Policy Option	Potential Opportunities	Potential Challenges
	• Contributes to provider reimbursement parity	have experienced challenges with use of HSAs to fund cost sharing
Integration of Medicaid as Part of the Authority	• Maximizes the State's purchasing power • Reduces costs for health benefit administration • Purchasing power and designation of a single entity supports system-wide health reform • Streamlines contracting, claims processing and utilization management functions • Assigns responsibility to a single entity to ensure a sustainable, high-quality health system	• Medicaid operates under complex regulatory framework that may require certain functions to operate independently • Alaskans' health and social needs may best be met by a department that administers both health and social services • DHSS would need to retain staffing to administer existing social service programs and transitioning health services to a separate entity could increase staff resource needs and impact federal Medicaid funding • If certain Medicaid administrative functions remain with DHSS, overall Medicaid program administration potentially could be less coordinated if divided across two agencies • Administrative changes impacting the Medicaid State Plan and the Cost Allocation Plan will require time to secure federal approval. • A transition period, possibly two years or longer, could be required to allow time to determine staffing, contracts, equipment and physical space; funding and/or dedicated staff for transition tasks may be necessary • The potential impact on the current Tribal Health System would need to be evaluated and consultation with Tribal Health Organizations would be necessary

Section 5 also presents a provisional model that describes the structure, role and responsibilities of an Authority. The model also describes a potential approach for transitioning Medicaid to an Authority. The provisional model represents a starting point and is intended to illustrate the design elements based on other states' experience and the policy options discussed in Section 4. Further evaluation, supported by stakeholder input, will be required to develop an approach that best meets the State's policy objectives related to administration of publicly-funded health benefits.

SECTION 1 – MEDICAID PROGRAM REQUIREMENTS AND FUNDING

A. MEDICAID: PROGRAM ADMINISTRATION/REGULATORY STRUCTURE

The following provides an overview of Medicaid program administration responsibilities performed at the federal and state levels as well as the regulatory structure used to accomplish these functions. Unlike other public purchasers, Medicaid is subject to federal requirements (e.g., coverage of populations and services, administration, consultation and reporting). These federal requirements must be taken into consideration when determining the role of Medicaid within Alaska's Authority and opportunities for integrated/coordinated purchasing. Waiver approval would be required to restructure Alaska's Medicaid program operations and funding.

JOINT FEDERAL-STATE ADMINISTRATION

Established in 1965 under Title XIX of the Social Security Act, the Medicaid program is an entitlement program that provides medical and health-related services for the nation's low-income populations. Individuals eligible for Medicaid have the right to payment for medically necessary health care services as defined in federal statute, and states that operate their programs within federal guidelines are entitled to federal reimbursement for a share of total program costs.[16]

In addition to financing the program jointly, the federal government and states administer Medicaid together. At the federal level, Medicaid is administered primarily by the U.S. Department of Health and Human Services (HHS), the Centers for Medicare and Medicaid Services (CMS) and CMS regional offices.[17] Other federal departments and agencies also partake in various oversight roles of Medicaid such as systems, privacy, and program integrity/fraud, waste and abuse. Exhibit 1-1 on the following page provides an overview of the Medicaid administrative functions performed by CMS.

[16] Medicaid and CHIP Payment and Access Commission (MACPAC) Medicaid 101: Financing, available at https://www.macpac.gov/medicaid-101/financing/. The federal government matches state Medicaid expenditures based on a statutory formula, the Federal Medical Assistance Program (FMAP). A share of Medicaid expenditures is paid based on each state's per capita income (PCI) relative to the national average; the federal government pays a larger portion of the costs in states with lower per capita incomes.

[17] MACPAC Chapter 4: Building Capacity to Administer Medicaid and CHIP (June 2014), available at https://www.macpac.gov/wp-content/uploads/2015/01/Building_Capacity_to_Administer_Medicaid_and_CHIP.pdf.

Exhibit 1-1 – CMS Medicaid Administrative Functions

Administrative Functions Performed by CMS
✓ Develop and issue regulations to codify policies based on statutory provisions of the Social Security Act, including the following: • Notice of Proposed Rulemaking (NPRM) – proposes policy approaches to implementing provisions of statute and solicits public comments • Interim Final Rule with Comment (IFC) – provision goes into effect when published but open for public comment to allow for potential revisions and issue as Final Rule • Final Rule – formally codifies policies proposed in the NPRM or IFC
✓ Develop guidance to communicate with states and stakeholders through: • State Medicaid Director and State Health Official Letters • Center for Medicaid and CHIP Services (CMCS) Informational Bulletins • Frequently Asked Questions (FAQs)
✓ Review and approve State Plans, State Plan Amendments and waiver/demonstration requests
✓ Oversee states' Medicaid program implementation and operations
✓ Process state claims for federal reimbursement of program expenditures

States perform the day-to-day program operations and have flexibility within broad federal rules to administer the program (see Exhibit 1-2 below). The entity tasked with administration is known as the Single State Agency. Although each state is required to designate a Single State Agency to administer the state's Medicaid program, Medicaid agencies have the authority to delegate or outsource certain administrative functions to other state agencies and/or contractors.[18] However, the Medicaid agency may not delegate, to other than its own officials, the authority to supervise the Medicaid State Plan or to develop or issue policies, rules and regulations on program matters.[19]

Exhibit 1-2 – State Medicaid Administrative Functions

Administrative Functions Performed by the Single State Agency
✓ Define covered populations and benefits
✓ Determine program eligibility
✓ Provide/manage member services, materials and communications
✓ Enroll providers
✓ Set payment rates
✓ Adjudicate claims
✓ Oversee contractors
✓ Manage information systems
✓ Monitor access to and quality of services
✓ Ensure program integrity
✓ Manage utilization
✓ Establish administrative and operating policies and procedures

[18] 42 CFR § 431.10. *See also* DHHS OIG, Memorandum Report: Offshore Outsourcing of Administrative Functions by State Medicaid Agencies, OEI-09-12-00530 (April 11, 2014), available at https://oig.hhs.gov/oei/reports/oei-09-12-00530.pdf.

[19] 42 CFR § 431.10(e).

Each state describes how it would administer its Medicaid program through a State Plan. The State Plan is a contract between the state and the federal government that: [20]

- Specifies the state's administrative structure and activities/processes, including identification and organization of the Single State Agency
- Identifies and describes the groups of individuals and services that the state would cover and requirements for program eligibility
- Gives an assurance that the state would abide by federal rules to claim federal matching funds for program activities
- Describes the provider reimbursement methodologies that would be utilized by the state

A state seeking to change its State Plan utilizes the State Plan Amendment process. Amendments may be submitted to revise program policies, operational approaches or coverage contained in the State Plan, and also may be submitted to update information. CMS also utilizes this process in the event of a federal statutory or regulatory change that globally impacts the Medicaid program.

Medicaid Program Conditions

Federal law under Section 1902 of the Social Security Act imposes the following three basic conditions on all state Medicaid programs:

- ***Statewideness.*** Medicaid State Plans must be in effect throughout the state, in all political subdivisions. States cannot limit Medicaid services by geographic location and must provide all medically necessary covered services without regard to the community of residence of the Medicaid enrollee seeking health care services.
- ***Comparability.*** Medicaid services must be comparable in amount, duration and scope for each eligible population.
- ***Freedom of Choice.*** Medicaid enrollees may obtain services from any qualified Medicaid provider.

When a state wants greater flexibility to design and improve their Medicaid program, a formal waiver of certain statutory requirements must be submitted to the Secretary of HHS for review and approval. Waivers allow states to be exempt from provisions of federal Medicaid regulation. Section 1115 of the

[20] See https://www.medicaid.gov/state-resource-center/medicaid-state-plan-amendments/medicaid-state-plan-amendments.html for more information about specific State Plans and amendments.

Social Security Act gives the Secretary authority to approve experimental, pilot or demonstration projects that promote the objectives of Medicaid.

As described in Exhibit 1-3 below, Medicaid delivery systems can take a number of forms and can be implemented under several different federal legal authorities. Certain authorities provide states with flexibility regarding compliance with the three requirements noted above.

Exhibit 1-3 – Federal Authorities for Restructuring State Medicaid Health Care Delivery or Payment[21]

Federal Authority	Description
§ 1115 Demonstrations	Renewable, broad waiver authority to approve projects that test policy innovations likely to further objectives of the Medicaid program. Demonstration populations may be provided with different health benefits or have different service limitations than are specified in the State Plan.
§ 1932(a) State Plan Amendment Authority	State Plan authority for mandatory and voluntary managed care programs. Allows for inclusion of dual eligible (Medicare and Medicaid) members as part of broader managed care authority. Once approved, the state may run its managed care program without needing a renewal on a periodic basis by CMS. However, this authority is limited in that it does not allow states to require dual eligible, American Indian/Alaska Native (AI/AN) or children with special health care needs to enroll in a managed care program.
§ 1915(a) Exception to State Plan Requirements for Voluntary Managed Care	To authorize voluntary managed care programs. Prohibits mandatory enrollment or selective contracting; passive enrollment with an opt-out is permitted.
§ 1915(b) Waivers	Two-year (or five-year, if serving dual eligible), renewable waiver authority for mandatory enrollment in managed care. Must not substantially impair beneficiary access to medically-necessary services of adequate quality. Allows states to require dual eligible, AI/AN and children with special health care needs to enroll in a managed care delivery system. States may implement a managed care delivery system using one of four 1915(b) waivers: • (b)(1) Freedom of Choice – restricts Medicaid enrollees to receive services within the managed care network • (b)(2) Enrollment Broker – utilizes a "central broker" • (b)(3) Non-Medicaid Services Waiver – uses cost savings to provide additional services to beneficiaries • (b)(4) Selective Contracting Waiver – restricts the provider from whom the Medicaid eligible may obtain services
§ 1915(c) Home and Community-Based Services (HCBS) Waivers	Three-year (or five-year) renewable waiver authority to provide long term services and supports delivered in community settings as an alternative to institutional settings. Must specify target population/sub-populations being served.
§ 1915(a)/(c) Authority	To implement voluntary managed care program, including HCBS in managed care contract. Option to use passive enrollment with an opt-out.

[21] *See* CMS Technical Assistance Tool "At-a-Glance" Guide to Federal Medicaid Authorities Useful in Restructuring Medicaid Health Care Delivery or Payment (April 2012), available at https://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/At-a-glance-medicaid-Authorities.pdf.

Federal Authority	Description
Concurrent § 1915(b)/(c) Waivers	To implement a mandatory or voluntary managed care program that includes waiver HCBS in managed care contract. 1915(c) allows for targeted eligibility and HCBS services. 1915(b) allows mandated enrollment in managed care plans providing these HCBS services and to exercise other options such as selective contracting with providers. Waivers must be applied for concurrently and comply with requirements of each.
§ 1915(i) HCBS State Plan Option	State Plan Amendment to offer HCBS as State Plan optional benefit statewide.
§ 1915(j) Self Directed Personal Assistance Services (PAS)	To enable individuals or their representatives to exercise decision-making authority in accessing, managing and purchasing personal assistant services. Must already have an operational 1915(c) program. May be implemented statewide or on a limited geographic basis.
§ 1915(k) Community First Choice	To provide HCBS attendant services and supports for beneficiaries. Must cover assistance and maintenance with activities of daily living and health-related tasks, ensure continuity of services and supports, and provide voluntary training on how to select, manage and dismiss staff.
§ 1937 Benchmark/ Benchmark-Equivalent Benefit Plans	To offer more limited Medicaid benefits, modeled on one of three commercial benefit plans: federal employees health benefit plan, state employee coverage or health maintenance organization (HMO) plan with the largest enrollment in the state. Coverage also may be offered through Secretary-approved plan. Certain benefits must be included. Benefits may be tailored to the population being covered. (Certain populations exempt.)
§ 1945 Health Home State Plan Option	To offer enhanced integration and coordination of primary, acute, behavioral health and long term services and supports for individuals with chronic illness by adding specific services to the State Plan.

Federal law also includes provisions to protect the choice and consultation of individuals who are American Indian/Alaska Native (AI/AN) enrolled in Medicaid managed care and Indian Health Care Providers (IHCPs) who provide services to these populations (see Exhibit 1-4 on the following page).[22]

[22] CMCS Informational Bulletin, Indian Provisions in the Final Medicaid and Children's Health Insurance Program Managed Care Regulations (December 14, 2016), available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib121416.pdf.

Exhibit 1-4 – Summary of Federal Managed Care Protections for AI/AN

Requirement	Description of Requirement
Enrollees	
Network Sufficiency Standards and Provider Choice	Demonstrate sufficient IHCPs participating in the network to ensure timely access to services available under the contract from IHCPs for AI/AN enrollees who are eligible to receive services. If timely access cannot be guaranteed due to few or no network participating IHCPs, the sufficiency standard is satisfied if enrollees are permitted to access out-of-state IHCPs or this circumstance is deemed a good cause reason under the contract for enrollees to disenroll from the state's managed care program into fee-for-service. Any AI/AN who is enrolled in a managed care plan not controlled by Indian Health Service (IHS)/Tribe and eligible to receive services from a network IHCP may choose that IHCP as his/her primary care provider (PCP), as long as that provider has the capacity to provide the services.
Auto-assignment	Managed care entities should review their auto-assignment algorithm to ensure than an appropriate logic is used to accomplish the most appropriate PCP assignment. Criteria could include an enrollee's historical relationship with a PCP. Plans should ensure that information on the process for changing PCPs is easily accessible and, at a minimum, be described in the enrollee handbook and on the plan's website.
Providers	
Payment and Contracting	An IHCP enrolled in Medicaid or CHIP as a federally qualified health center (FQHC) but is not a participating provider with the managed care entity must be paid the FQHC payment rate under the State Plan, including any supplemental payment due from the state. When an IHCP is not enrolled in Medicaid or CHIP as a FQHC, and regardless of whether the IHCP participates in the managed care entity's network, the IHCP receives the applicable encounter rate published annually by the Federal Register by IHS, or in the absence of a published encounter rate, the amount it would receive if services were provided under the State Plan's fee-for-service payment methodology. States must make a supplemental payment to the IHCP to make up the difference if the amount received by the IHCP from the managed care entity is less than the applicable encounter or fee-for-service rate.
Indian Managed Care Entity (IMCE) Enrollment Restriction	An IMCE may restrict its enrollment to AI/AN in the same manner as IHCPs may restrict the delivery of services to AI/AN.
Avoiding Duplicate Visits for Referrals	Managed care entities must permit an out-of-network IHCP to refer an AI/AN enrollee to a network provider for covered services.

CONSULTATION REQUIREMENTS

Federal law requires each state to establish a Medical Care Advisory Committee (MCAC)[23] to advise on health and medical services. MCAC members are appointed and must include board-certified physicians and other health profession representatives, members of consumers' groups, and director of the state's public welfare or health department who does not head the Medicaid agency.

[23] 42 CFR § 431.12.

In addition, federal law and regulations and guidance issued by CMS require state Tribal consultation processes to be followed.[24] States must obtain advice and input on a regular and ongoing basis prior to submission of any State Plan Amendments, waiver request or proposal for a demonstration project that is likely to have a direct effect on AI/AN and IHCPs. Consultation is required at least 60 days before the state intends to submit a waiver request or renewal or follow the Tribal Consultation Requirements described within the Medicaid State Plan.

B. MEDICAID: FUNDING

As mentioned earlier, Medicaid is funded jointly by the federal and state governments. The following provides an overview of federal reimbursement of state expenses related to providing Medicaid coverage and administering the program.

FEDERAL MEDICAL ASSISTANCE PERCENTAGE (FMAP)

The federal government provides match funds to states for qualifying Medicaid expenditures using the FMAP financing arrangement. The FMAP rate varies by state and is determined by a formula set in federal statute based on multiple criteria including per capita income. The formula is designed so that the federal government pays a larger portion of Medicaid costs in states with lower per capita incomes relative to the national average. States with lower incomes receive higher reimbursement, with a statutory maximum of 83 percent; states with higher incomes receive a lower reimbursement, with a statutory minimum of 50 percent. For FY 2017, the average state FMAP is 57 percent, with rates ranging from 50 percent to 74.63 percent. This formula-derived FMAP is referred to as the "regular" FMAP.

In lieu of the regular FMAP rate, exceptions have been added in federal statute and regulations. These exceptions create complexity and require an understanding of state and federal contributions. Enhanced match rates are available based on populations, providers and services.

ENHANCED MATCH BASED ON POPULATION

Eligible populations include CHIP-eligible children, expansion adults, certain women with breast or cervical cancer and Medicare beneficiaries eligible for the Qualifying Individuals program (see Exhibit 1-5 on the following page).

[24] *See* Centers for Medicare & Medicaid Services Tribal Consultation Policy available at https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Downloads/CMSTribalConsultationPolicy2015.pdf. *See also* Revised CMS Tribal Consultation Policy (effective December 10, 2015) available at https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Downloads/TribalLeaderLetter2015.pdf.

Exhibit 1-5 – Exceptions to the Standard FMAP Rates for Medicaid Populations

Population	Overview	CY 2017 Federal Match
Children & Pregnant Women Covered under CHIP	• Congress created an enhanced FMAP for CHIP (E-FMAP) • The Affordable Care Act extended CHIP participation and increased the E-FMAP for states by 23 percentage points (but not to exceed 100 percent) through September 30, 2019	State's E-FMAP + 23 percentage points
Expansion Adults	• Under the Affordable Care Act, federal match is: CY 2014 through CY 2016 = 100%, CY 2017 = 95%, CY 2018 = 94%, CY 2019 = 93% and CY 2020+ = 90%[25] • Proposed federal legislation could change the enhanced match rate	95%
Women Served through Breast & Cervical Cancer Program	• Optional coverage group for women under age 65 with breast or cervical cancer who do not qualify for Medicaid under a mandatory coverage group, meet income eligibility criteria and are otherwise uninsured/have insurance that does not cover preventive screening services • Cost of breast and cervical cancer treatment services for eligible women are matched at the state's CHIP E-FMAP	State's E-FMAP
Qualifying Individuals (QI)	• States pay Medicare Part B premiums for Medicare beneficiaries with income between 120% and 135% of the FPL and limited assets • States receive 100% federal reimbursement for these costs	100%

Enhanced Match Based on Provider

States receive 100 percent federal reimbursement for Medicaid services provided to Medicaid-eligible individuals who are AI/AN through an Indian Health Service (IHS)/Tribal facility. IHS/Tribal facilities may enter into written care coordination agreements with non-IHS/Tribal providers to furnish certain services for their patients who are AI/AN Medicaid beneficiaries. The amounts paid by the state for services requested by the providers in accordance with the care coordination agreement would be eligible for 100 percent federal reimbursement. (See Exhibit 1-6 on the following page.)

[25] Some states provided health coverage for non-elderly, non-pregnant low-income individuals prior to the Affordable Care Act's Medicaid expansion so they did not qualify for the "newly eligible" federal matching rate. To address this issue these states received an increased federal matching rate that varied based on the states' standard FMAP from CY 2014 through CY 2018 and 93% in CY 2019, with 90% CY 2020 and ongoing.

Exhibit 1-6 – Exceptions to the Standard FMAP Rates for IHS/Tribal Facility and Providers with a Coordination Agreement

Provider	Overview	CY 2017 Federal Match
Indian Health Service (IHS)/Tribal Facility[26]	• States are eligible for 100% federal reimbursement for any Medicaid service covered by the Medicaid State Plan for AI/AN patient that the IHS or Tribal facility is authorized to provide and when an IHS/Tribal facility requests services for an AI/AN patient from a non-IHS/Tribal provider under a care coordination agreement	100%

Enhanced Match Based on Service

Services that are eligible for a higher FMAP include certain preventive services and immunizations, smoking cessation for pregnant women, family planning, health homes and Community First Choice Option (see Exhibit 1-7 beginning below).

Exhibit 1-7 – Exceptions to the Standard FMAP Rates for Medicaid Services

Service	Overview	CY 2017 Federal Match
Preventive Services and Immunizations	• Optional coverage of all the preventive services recommended by the United States Preventive Services Task Force (USPSTF) and adult immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) with no cost sharing • Participating states receive a one percentage point increase in their FMAP rate for these services	State's FMAP + 1 percentage point
Smoking Cessation for Pregnant Women	• In addition to covering – with no cost sharing – all the USPSTF and ACIP preventive/immunization services noted above participating states receive a one percentage point increase in their FMAP rate for smoking cessation services mandatory for pregnant women	State's FMAP + 1 percentage point
Family Planning	• States receive 90% federal reimbursement for family planning services and supplies	90%

[26] *See* SHO #16-002, Re: Federal Funding for Services "Received Through" an IHS/Tribal Facility and Furnished to Medicaid-Eligible American Indians and Alaska Natives (February 26, 2016), available at https://www.medicaid.gov/federal-policy-guidance/downloads/SHO022616.pdf. This update in payment policy is intended to help states, the IHS and Tribes to improve delivery systems for AI/AN by increasing access to care, strengthening continuity of care and improving population health.

Service	Overview	CY 2017 Federal Match
Health Homes	• Optional coverage of health home and associated services to eligible individuals • States receive 90% federal reimbursement for these services for the first 8 quarters that the health home option is in effect in the state	90% for 1st 8 quarters the state's health home is in effect
Community First Choice Option	• Optional coverage of home and community-based attendant services and supports for eligible individuals at or below 150% of the FPL or a higher income level applicable to those requiring institutional level care • States receive a 6 percentage point increase in their regular FMAP rate for these services	State's FMAP + 6 percentage points

Federal Match for Administrative Expenses

In addition to reimbursement of care-related expenditures, the federal government reimburses states for Medicaid program administrative costs. Medicaid administrative costs in general represent five percent or less of total Medicaid spending nationally. Most administrative costs incurred by states are matched by the federal government at 50 percent. There are some administrative functions which are matched at higher rates such as activities that require medically trained personnel, operation of information systems for eligibility and claims processing, fraud control activities and CHIP administrative services (see Exhibit 1-8 beginning on the following page).

To receive federal matching funds for Medicaid administrative expenditures, costs being claimed must:

- Be proper and efficient for the state's administration of its Medicaid State Plan
- If related to multiple programs, be allocated in accordance with the benefits received by each participating program. States are required to develop a method to assign costs based on the relative benefit to the Medicaid program and other government or non-government programs
- Be supported by an allocation methodology that:
    - Includes a narrative description of the procedures that the state agency uses in identifying and measuring costs; and
    - Appears in the state's approved Public Assistance Cost Allocation Plan (PACAP). The PACAP includes all costs incurred by an agency, with the possible exception of expenditures for financial assistance, medical vendor payments, food stamps and payments for services and goods provided directly to program recipients. It must reference methodologies, claiming mechanisms, interagency agreements and other relevant issues that are used when claiming and appropriately allocating costs
- Be supported by adequate source documentation
- Not duplicate payment for activities that already are being offered or should be provided by other entities, or paid through other programs

- Not include funding for a portion of general public health initiatives that are made available to all persons (e.g., public health education campaigns)
- Not include the overhead costs of operating a provider facility
- May not supplant funding obligations from other federal sources

For states that contract with managed care organizations under a risk contract, any amounts paid to the managed care plan to cover administrative functions are matched as a medical assistance cost at the applicable FMAP and *not* as an administrative cost.[27] Under a risk-based contract, the managed care plan assumes financial risk for the cost of covered services and plan administration.

Exhibit 1-8 – Federal Match Rate for Medicaid Administrative Activities[28]

Administrative Area	Overview	CY 2017 Federal Match
General Medicaid Administration	• Activities necessary for proper and efficient administration of the Medicaid State Plan	50%
General CHIP Administration	• Limited to 10 percent of the state's annual federal CHIP spending	State's E-FMAP
Eligibility Determination and Redetermination	• General determination and redetermination processes	50%
	• Determining presumptive eligibility and providing services for children	50%
	• Costs incident to eye or medical exam to determine disability/blindness eligibility	50%
	• Operation of approved updated system for eligibility determinations	75%
	• Implementation and operation of immigration status verification system	100%
Skilled Professional Medical Personnel Activities	• Activities conducted by skilled professional medical personnel (and direct support staff), including training	75%
Related to Long Term Services & Supports (LTSS)	• Preadmission screening and resident review (PASRR) for individuals with mental illness or mental retardation admitted to nursing facility	75%
	• Survey and certification of nursing facilities	75%
Translation and Interpretation	• Translation and interpretation services for children in families for whom English is not the primary language	75%
Medicaid Management Information System (MMIS)	• Operation of approved Medicaid management information system (MMIS) for claims and information processing	75%
	• Implementation of an MMIS	90%

[27] 42 CFR § 438.812.

[28] Information obtained from https://www.macpac.gov/federal-match-rates-for-medicaid-administrative-activities/.

Administrative Area	Overview	CY 2017 Federal Match
	• MMIS modifications necessary for collection and reporting on child health measures	State's FMAP
Quality/Utilization Review	• Medical and utilization review activities performed by an external quality review organization (EQRO) or quality improvement organization (QIO)	75%
	• Quality review of Medicaid managed care organizations performed by EQRO	75%
Fraud Control	• Operation of state Medicaid fraud control unit (MFCU)	75%
	• Implementation of state MFCU	90%
Family Planning	• Administration of family planning services	90%
Electronic Health Records (EHR)	• Administration of incentive payment programs for adoption of electronic EHR	90%
	• Incentive payments to eligible providers for adoption of EHR	100%

C. MEDICAID: ELIGIBILITY GROUPS

In order to receive federal funding, states must cover certain categorically eligible groups:

- Children (age 18 and under)
- Pregnant women
- Parents/caregiver relatives (adults in families with dependent children)
- Individuals with disabilities
- Aged (age 65 and older)

States may choose to cover other groups such as children in foster care who are not otherwise eligible for Medicaid, individuals receiving home and community-based services (HCBS); uninsured women under age 65 in need of treatment for breast or cervical cancer; and the medically needy (individuals who fall within one of the categorically needy populations but whose incomes make them ineligible for cash assistance and those whose medical expenses would be deducted when determining countable income for eligibility purposes).

The Children's Health Insurance Program (CHIP) was signed into federal law under Title XXI of the Social Security Act in 1997. CHIP serves uninsured children up to age 19 in families with incomes too high to qualify them for Medicaid. This provided states with an opportunity to use CHIP funds to create a separate CHIP program, expand their Medicaid program or adopt a combined approach.

The Patient Protection and Affordable Care Act of 2010, often shortened to the Affordable Care Act, expanded Medicaid coverage to adults under the age of 65 with income at or below 138 percent of the federal poverty level (FPL).[29,30] It also required coverage of former foster care children up to age 26. As for children, it increased children's health coverage by transitioning coverage for all children with household income up to 138 percent FPL to Medicaid. Also, it required states to maintain eligibility and enrollment standards, referred to as maintenance of eligibility (MOE), for Medicaid and CHIP. These MOE provisions prohibited states from eliminating their CHIP program or reducing Medicaid and CHIP income eligibility thresholds to make fewer children eligible. In order to receive federal Medicaid funding, states must maintain the eligibility levels in place as of March 23, 2010. The MOE provisions are in effect through September 30, 2019.

The Affordable Care Act also provided states with the option to extend CHIP eligibility to children of state employees who lack access to affordable dependent coverage in the state employee health plan. Of the states with a separate CHIP, 17 have elected to extend coverage.

Under the Medicare Savings Programs, states are required to offer Medicare premium and cost sharing assistance for Medicare beneficiaries with income and resources within qualifying limits. There are four kinds of programs: Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), Qualifying Individual (QI) and Qualified Disabled and Working Individuals (QDWI).

Exhibit 1-9, presented on the following page, provides a high level overview of current mandatory and optional Medicaid populations (based on categorical and income qualification) eligible for federal match funding.

[29] Prior to the Affordable Care Act Medicaid expansion, some states provided coverage for non-elderly, non-pregnant low-income individuals using Medicaid waivers.

[30] Currently, 31 states (including Alaska) and the District of Columbia provide coverage to expansion adults. Kaiser Family Foundation, "Where Are States Today? Medicaid and CHIP Eligibility Levels for Children, Pregnant Women, and Adults", available at http://www.kff.org/medicaid/fact-sheet/where-are-states-today-medicaid-and-chip/.

Exhibit 1-9 – Overview of Current Federal Mandatory and Optional Medicaid Populations

Population	Mandatory States *must* cover persons in category with income:	Optional States *may* cover persons in category with income:
Children	States must be in compliance with Affordable Care Act MOE provisions so some states may have higher income eligibility limits in place	States may elect to expand beyond the Affordable Care Act's MOE provisions
Pregnant Women	≤ 138% of the FPL	> 138% of the FPL
Adults		
Former Foster Care	At any level – no income test for this category	
Parents/Caregiver Relatives	Within the state's eligibility limit for cash assistance prior to welfare reform	Above the state's eligibility limit for cash assistance prior to welfare reform
Expansion Adults	≤ 138% of the FPL[31]	> 138% of the FPL
Working Disabled	Within the SSA published state-specific threshold for annual gross income established for Qualified Severely Impaired Individuals	≤ 250% of the FPL
Breast and Cervical Cancer		≤ 250% of the FPL
Medically Needy		Standard set by state - individual may "spenddown" to eligibility by deducting incurred medical expenses from income
Persons with Disabilities	From cash assistance through SSI	Above the SSI limit
Aged	From cash assistance through SSI	Above the SSI limit
HCBS Waiver Populations		(State-defined for each program)
Medicare Savings Programs		
Qualified Medicare Beneficiary (QMB)	≤ 100% of the FPL	
Specified Low-Income Medicare Beneficiary (SLMB)	Between 100% and 120% of the FPL	
Qualifying Individual (QI)	Between 120% and 135% of the FPL	
Qualified Disabled and Working Individuals (QDWI)	≤ 200% of the FPL (and eligible for Medicare Part A)	

[31] The Affordable Care Act expanded access to health coverage through the expansion of eligibility for Medicaid benefits. The expansion, which began in 2014, authorized states to cover childless adults who have incomes at or below 138 percent of the FPL. "Childless adults" refers to people who are under age 65, not pregnant, not entitled to Medicare, and not described in any existing mandatory coverage group. Twenty-six states filed a constitutional challenge to the Affordable Care Act's Medicaid expansion (*National Federation of Independent Business (NFIB) v. Sebelius*). On June 28, 2012, the U.S. Supreme Court issued its decision. The majority found the penalty provision related to Medicaid expansion unconstitutional because states did not have adequate notice to voluntarily consent to the program changes, and declining to participate placed states' existing federal Medicaid funds potentially at risk for non-compliance. Additionally, a different majority of the Court held that this issue was fully remedied by limiting the U.S. HHS Secretary's enforcement authority, thus leaving the Medicaid expansion intact.

D. MEDICAID: COVERED SERVICES

As illustrated in Exhibit 1-10 below, states are required to cover certain mandatory benefits and have the flexibility and federal match opportunity to cover optional benefits. Together these mandatory and optional benefits create a comprehensive package of services that is often referred to as traditional Medicaid State Plan coverage. These benefits include a range of primary and preventive care, acute medical services and long term services and supports. Within broad federal guidelines, states define specific features of each covered benefit such as the amount, duration and scope.

Exhibit 1-10 – Mandatory and Optional – Traditional Medicaid State Plan Covered Services

Mandatory	Optional
• Inpatient and outpatient hospital services • Early and periodic screening, diagnostic and treatment (EPSDT) services for children under age 21 • Nursing facility services • Home health services • Physician services and, when licensed or otherwise recognized by the state, midwife and certified nurse practitioner services • Rural health clinic/federally qualified health center (FQHC) services • Laboratory and x-ray services • Family planning services and supplies • Freestanding birth center services (when licensed or otherwise recognized by the state) • Transportation to medical care • Tobacco cessation counseling for pregnant women	• Prescription drugs • Clinic services • Physical therapy, occupational therapy and speech, hearing and language disorder services • Respiratory care services • Other diagnostic, screening, preventive and rehabilitative services • Chiropractic services • Podiatry services • Optometry/vision services, including eyeglasses • Dental services • Prosthetics and dentures • Other practitioner services • Private duty nursing services • Personal care • Hospice • Case management • Services for individuals age 65 and older in an institution for mental disease (IMD) • Services in an intermediate care facility for individuals with intellectual disability (ICF/ID) • State Plan home and community based services (§1915(i)), self-directed personal care assistance services (§1915(j)), community first choice option (§1915(k)) and health homes for enrollees with chronic conditions (§1945) • Inpatient psychiatric services for individuals under age 21 • Other services approved by the HHS Secretary

In lieu of traditional coverage, states may offer alternative benefit plans. States may offer these plans to all enrollees but some groups are excluded from mandatory enrollment such as certain parents, pregnant women, individuals dually enrolled in Medicaid and Medicare, those who qualify for Medicaid on the basis of blindness or disability, enrollees receiving hospice care, individuals who are medically frail or have special medical needs, and children enrolled through child-welfare involved pathways. However, states are required to enroll the expansion adults in alternative benefit plans. Alternative

benefit plans are benchmark and benchmark-equivalent benefit packages based on one of the following:[32]

- Federal employees health benefit plan
- State employee coverage
- Health maintenance organization plan with the largest enrollment in the state
- Plan approved by the HHS Secretary

In addition to the benefits covered under the benchmark option, states must assure access to Federally Qualified Health Center (FQHC) services, family planning services, mental health services that comply with parity standards, EPSDT services for children under age 21 and transportation to and from medically-necessary Medicaid-covered services either through these packages or as additional benefits provided by the state.[33] The Affordable Care Act required that these plans also cover the ten essential health benefits which form the basis of coverage for plans offered on the Marketplace (see Exhibit 1-11).[34]

Exhibit 1-11 – Essential Health Benefits Covered under the Affordable Care Act

Essential Health Benefits
• Ambulatory patient services • Emergency services • Hospitalization • Maternity and newborn care • Mental health and substance use disorder services, including behavioral health treatment • Prescription drugs • Rehabilitative and habilitative services and devices • Laboratory services • Preventive and wellness services and chronic disease management • Pediatric services, including oral and vision care

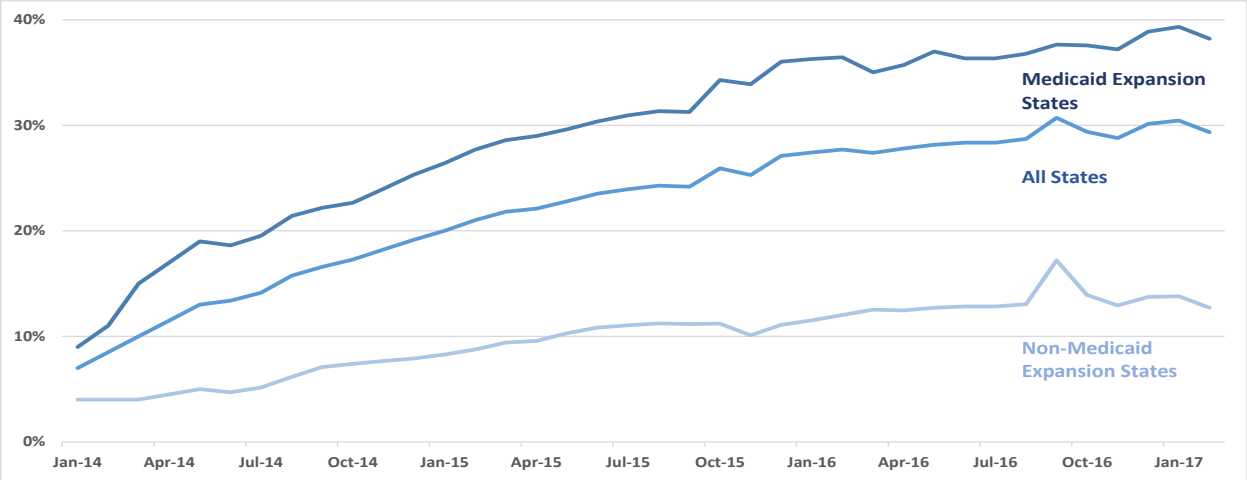
The Medicaid and CHIP Payment and Access Commission (MACPAC) reports that most states providing coverage to expansion adults are offering Secretary-approved benefit packages that align with their traditional Medicaid benefit package with some modifications.[35]

[32] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, State Medicaid Director Letter, SMDL 312-003, ACA #21, Essential Health Benefits in the Medicaid Program (November 20, 2012), available at https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-003.pdf.
[33] 42 CFR § 440.335, 42 CFR § 440.390, 42 CFR § 440.395.
[34] 42 CFR § 440.347.
[35] 42 CFR § 440.305(b). *See* MACPAC, "Federal Requirements and State Options: Benefits Fact Sheet" (March 2017) available at https://www.macpac.gov/wp-content/uploads/2017/03/Federal-Requirements-and-State-Options-Benefits.pdf.

E. MEDICAID: NATIONAL TRENDS

Medicaid enrollment has increased following implementation of the Affordable Care Act.[36] As of February 2017, nearly 74.5 million individuals are enrolled in Medicaid and CHIP across the nation.[37] In states reporting data, this accounts for a 29 percent increase over the last three and a half years. Although variation across states exists, states that expanded Medicaid to cover expansion adults show the largest overall growth in enrollment – 38 percent compared to nearly 13 percent for non-expansion states (see Exhibit 1-12).[38]

Exhibit 1-12 – Cumulative Change in Enrollment Compared to Summer 2013



Expansion adults made up a relatively small share of total enrollment at 18 percent.[39] This group represents a relatively small share (12 percent) of total Medicaid spending across all states.[40] The vast majority of Medicaid spending was for the traditional population.

Enhanced federal match funds are available to states covering expansion adult populations. Under the Affordable Care Act, states covering this population for the first time received 100 percent federal match funds through 2016. The federal match rate decreased to 95 percent in 2017. Under current law, matching funds would decline slightly each year until it reaches 90 percent in 2020, where it would

[36] Medicaid: Key Issues Facing the Program, U.S. Government Accountability Office, Report to Congressional Addressees (July 2015), available at https://www.gao.gov/assets/680/671761.pdf.
[37] CMS, Medicaid and CHIP Enrollment Data Report Highlights, February 2017, available at https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html (accessed April 28, 2017). CMS has defined the period between July and September 2013 as its baseline period; this also is the timeframe before the first open enrollment period under the Affordable Care Act.
[38] *Id*. See also the Kaiser Commission on Medicaid and the Uninsured, Two Year trends in Medicaid and CHIP Enrollment Data: Finding from the CMS Performance Indictor Project (June 2016), available at http://files.kff.org/attachment/Issue-Brief-Two-Year-Trends-in-Medicaid-and-CHIP-Enrollment-Data.
[39] Medicaid Enrollment Data collected through MBES.
[40] Medicaid CMS-64 Adult Expansion Group Expenditures Data collected through MBES.

remain. Federal law potentially could change the enhanced match rate for expansion adults. As an example, the House legislative language for the American Health Care Act (AHCA), passed on May 4, 2017, would continue offering enhanced federal matching funds in 2020 and later for those already enrolled as of December 31, 2019, and only for as long as they maintain continuously covered under Medicaid. Starting January 1, 2020, states would only receive the standard federal match for any new expansion enrollees. The enhanced federal match would not be available to any states that adopt the expansion after February 28, 2017. Similar legislation is being considered in the Senate.

In addition to an increase in enrollment, states are observing higher rates of care utilization per enrollee.[41] People are accessing health care because coverage is available to them. Another contributing factor to utilization is that the U.S. population is aging.[42] This change is driven by the aging baby boomers who began turning 65 in 2011 and a projected increase in overall life expectancy. The older population – persons age 65 years or older – represents 14.5 percent of the nation's population but is expected to grow to be nearly 22 percent of the population by 2040.[43] Older adults have a higher prevalence of chronic conditions that require care and need for long term services and supports than younger populations.

Delivery and Payment Reform

In response to increasing Medicaid expenditures and declining state revenues, states have pursued various efforts to reduce Medicaid program costs or control the rate of growth. States often initially pursue cutting provider rates and eliminating enrollee benefits in an effort to achieve cost savings. However, restricting access to certain services can drive vulnerable populations to access care from the emergency room or delay seeking out care until the situation worsens. Both CMS and states are exploring initiatives in an effort to curb the increasing costs of health care without reducing access to care and the quality of care provided.

In recent years, both CMS and states have taken different approaches to move away from reliance on traditional fee-for-service reimbursement. With fee-for-service, providers are paid based on the number of services they deliver. Payment is tied to volume rather than whether the services provided demonstrate an improvement in care. Value-based payment approaches are viewed as a solution to address rising health care costs by removing a financial structure that incentivizes volume and eliminating clinical inefficiencies and service duplication. Under these approaches, providers are paid to deliver care in a manner that keeps people healthy and demonstrates improvement.

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[41] Rudowitz, R., Valentine, A. & Smith, V., Kaiser Family Foundation Issue Brief: "Medicaid Enrollment & Spending Growth: FY 2016 & 2017", available at http://www.kff.org/report-section/medicaid-enrollment-spending-growth-fy-2016-2017-issue-brief-8931/.

[42] Ortman, J., Velkoff, V. & Hogan, H., "An Aging Nation: The Older Population in the United States," available at https://www.census.gov/prod/2014pubs/p25-1140.pdf.

[43] U.S. Department of Health and Human Services, Administration on Aging, Aging Statistics, available at https://aoa.acl.gov/Aging_Statistics/Index.aspx.

This section highlights recent delivery system and consumer-driven initiatives undertaken by states, including an overview of three common delivery systems utilized by Medicaid programs – managed care, accountable care organizations (ACOs) and patient centered medical homes/health homes – followed by an overview of value-based purchasing.

Delivery System Initiatives

Managed Care

Managed care is a delivery system organized with the goal to manage cost, utilization and quality. Health benefits are delivered through contracted arrangements between states and the entity providing care. As presented in Exhibit 1-13, entities may include managed care organizations, primary care providers or prepaid health plans. Depending on the arrangement, these entities may provide comprehensive Medicaid benefits, additional benefits or a specific subset of benefits.

Exhibit 1-13 – Medicaid Managed Care Delivery Models

Model	Entity	Services Provided	Payment	Entity Bears Financial Risk
Managed Care Organization (MCO)	Health plans	May offer comprehensive benefits or exclude benefits carved out by state depending on arrangement (e.g., prescription drugs or behavioral health)	Monthly capitated payment or per member per month (PMPM) premium	Yes
Prepaid Health Plan (PHP)	Health plans	Only provides certain services (i.e., not comprehensive)	Typically paid on a risk or capitated basis	Varies
Managed Long Term Services and Supports (MLTSS)	Health plans (MCO/PHP)	Long term services and supports, often including institutional and home and community-based services	Depends on the arrangement	Varies
Primary Care Case Management (PCCM)	Primary care providers	Provide, locate, coordinate and monitor primary care services. Providers may serve as medical home	Paid a case management fee in addition to regular fee-for-service (FFS) payments	Varies

Based on information available, all states except three – Alaska, Connecticut and Wyoming – use managed care delivery systems for at least part of their Medicaid populations.[44]

[44] See Smith, V., Gifford, K., Ellis, E., Rudowitz, R. and Snyder, L., Kaiser Family Foundation: Medicaid in an Era of Health & Delivery System Reform: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2014 and 2015, available at http://www.kff.org/report-section/medicaid-in-an-era-of-health-delivery-system-reform-delivery-system-reforms/. Wyoming has one 1915(b) managed care waiver that provides wraparound care management entity benefits for children with serious emotional disorders, as well as a Program of All-Inclusive Care for the elderly (PACE) program that is only available in one county.

Accountable Care Organizations (ACOs)

An ACO is a network of health care providers (generally physicians and hospitals or a regional entity) that share financial and medical responsibility for providing coordinated care to patients with the goal of limiting unnecessary spending. Accountability is achieved through states': [45]

- Implementation of a value-based payment structure through use of a shared savings arrangement or global budget model
- Measurement of quality improvement through use of quality metrics to track patient outcomes and ensure providers are not withholding health services to retain savings
- Timely collection and analysis of accurate data through establishment and maintenance of data infrastructure to adequately support ACOs and identification of data ownership

As of January 2017, 10 states have active Medicaid ACO programs and at least 11 more are pursuing them.[46]

Patient Centered Medical Homes and Health Homes

Patient centered medical homes (PCMHs) focus on whole person care through a care team led by a physician that is collectively responsible for coordinating care. Some states have adopted these initiatives to serve their most costly populations such as individuals with chronic conditions.

As an extension of the PCMH model, Section 2703 of the Affordable Care Act allows states to design and implement health homes to provide comprehensive care coordination for Medicaid beneficiaries with chronic conditions. The Medicaid Health Home State Plan Option provides participating states with 90 percent federal reimbursement for health home and associated services during the first eight quarters that the health home option is in effect in the state. A state is eligible for more than one period of enhanced reimbursement but may only claim it for a total of eight quarters for one enrollee. (The enhanced reimbursement does not apply to the underlying Medicaid services also provided to persons enrolled in a health home.)

States have flexibility in designing their health home models but must meet federal requirements with respect to:

- Target populations eligible for participation
- Mandated core health home services
- Service providers eligible for participation

The health home option waives the Medicaid State Plan requirements for statewide implementation and comparability of services among populations. This allows states to target health home enrollment

[45] CHCS, Medicaid Accountable Care Organizations: State Update, Fact Sheet (January 2017), available at http://www.chcs.org/media/ACO-Fact-Sheet-01-30-17.pdf.
[46] *Id.*

by condition, geography and individuals with particular qualifying conditions. States, however, are prohibited from targeting enrollment by age, delivery system or dual eligibility status. To participate, states submit a State Plan Amendment to CMS for review and approval.

CMS reports that as of November 2016, 20 states and the District of Columbia have a total of 29 approved Medicaid health home models.[47]

Payment Reform

Value-Based Purchasing

States are pursuing value-based purchasing efforts to create opportunities for alignment around payment, reporting and infrastructure for Medicaid, Medicare and commercial programs. These initiatives are intended to support the movement from a fee-for-service, volume-based payment system towards value-based payment systems. Alignment is thought to allow value-based payment systems to be more viable for providers because it allows providers to capture revenue lost when shifting from volume to value.

CMS also is encouraging alignment through several federally-funded multi-payer alignment initiatives, including the State Innovation Models (SIM), Financial Alignment Initiative for Medicare-Medicaid Enrollees, Comprehensive Primary Care Initiative and the Health Care Payment Learning and Action Network.

The following provides an overview of three multi-payer purchasing programs that have gained national attention.

***Maryland All-Payer Model*.** The state's All-Payer Model converted hospital payments from fee-for-service to a global system in which hospital total revenue for all payers is set at the beginning of the year.[48] Initially, the state and hospitals experienced challenges in implementing the model. However, hospitals began adopting the global payments and expanded efforts to transition patients after discharge. Under the model, hospital spending per Medicare beneficiary rose less rapidly than nationwide but not necessarily in the private sector. The state committed to limiting growth in the per capita hospital revenues for all payers to the long-term growth rate of 3.58 percent per year. The actual growth was lower (1.47 percent in 2014 and 2.31 percent in 2015). To date, the state has reported an estimated $429 million in total Medicare savings, which was partially offset by an additional $110 million in non-hospital spending, resulting in a net savings of $319 million in Medicare total cost of care.

[47] For more information, see https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/health-home-information-resource-center.html.

[48] Sabatini, N., Antos, J., Haft, H., and Kinzer D., "Maryland's All-Payer Model – Achievements, Challenges, And Next Steps" (January 31, 2017), available at http://healthaffairs.org/blog/2017/01/31/marylands-all-payer-model-achievements-challenges-and-next-steps/.

Vermont Blueprint for Health. The Blue Print is a multi-payer program that combines state-level direction with local health care administration and service delivery through medical homes, along with practice facilitators and community health teams.[49] The program showed a reduction in hospital expenditures and utilization; the participant group's expenditures were reduced by $482 relative to the comparison group. The lower costs were driven primarily by inpatient and outpatient hospital expenditures, with associated changes in utilization. Medicaid participants had a relative increase in expenditures for dental, social and community-based services.

Washington State Heath Care Authority (HCA). The HCA, as directed by the Legislature, has pledged that 80 percent of its provider payments under its Medicaid and Public Employees Benefits Board (PEBB) programs would be linked to quality and value by 2019.[50] The HCA's ultimate goal is to reduce health care cost growth to two percent less than the national health expenditure trend. In 2016, the HCA offered three new medical plan options for enrollees in its PEBB Program to test an accountable care plan approach. The HCA issued a purchaser's toolkit to provide an overview of the principles behind value-based purchasing, links to tools and resources and a series of downloadable documents to facilitate the contracting process.

[49] Jones, C. et al., Population Health Management, Vermont's Community-Oriented All-Payer Medical Home Model Reduces Expenditures and Utilization While Delivering High-Quality Care, (vol. 19, number 3, 2016) available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4913508/pdf/pop.2015.0055.pdf.
[50] *See* https://www.hca.wa.gov/assets/program/vbp_roadmap.pdf.

SECTION 2 – ALASKA MEDICAID PROGRAM

The following presents an overview of the Alaska Medicaid program's organizational structure and administrative functions as well as the populations and benefits covered, expenditures and current reform initiatives. Medicaid has specialized program requirements and obligations related to federal compliance, including populations and services that must be covered.

A. ALASKA MEDICAID: ORGANIZATIONAL STRUCTURE

Under Alaska's Medicaid State Plan, the Department of Health and Social Services (DHSS) is designated as the Single State Agency responsible for administering the State's Medicaid program. In addition to the DHSS Commissioner, the Office of the Commissioner includes two Deputy Commissioners (Medicaid and Health Care Policy, and Family, Community and Integrated Services), Assistant Commissioner (Finance and Management Services), Chief Medical Officer, supporting staff and Offices and programs, such as Rate Review and Tribal Health Program. The Office of the Commissioner is responsible for providing department leadership and direction.

DHSS has a little over 3,400 funded permanent positions staffing the following divisions and agencies:

- Division of Public Health
- Division of Public Assistance
- Division of Health Care Services
- Division of Senior and Disabilities Services
- Alaska Pioneer Homes
- Office of Children's Services
- Division of Juvenile Justice
- Division Behavioral Health
- Division of Finance and Management Services

The Deputy Commissioner for Medicaid and Health Care Policy oversees the Divisions of Health Care Services, Senior and Disabilities Services, Public Assistance and Pioneer Homes. The Deputy Commissioner for Family, Community and Integrated Services oversees the Office of Children's Services and the Divisions of Juvenile Justice and Behavioral Health. Each Division has its own director and program support staff. The Chief Medical Officer of DHSS also serves as the Director of the Division of Public Health.

Finance and Management Services provides financial, administrative, facilities and technology services to DHSS through several program support sections and is overseen by the Assistant Commissioner.

Various boards and commissions act in an advisory capacity. In particular, the Medical Care Advisory Committee (MCAC) advises DHSS on Medicaid policy and program changes. Members are appointed by the DHSS Commissioner and include providers, consumers, advocates and Medicaid recipients.

In addition, CMS requires states to ensure that Tribal Health Organizations are consulted prior to making changes in Medicaid programs that may have a direct impact on AI/AN, Tribal health programs, or the Indian Health Service (IHS). DHSS has a CMS-approved Tribal consultation process documented in their Medicaid State Plan, and has an agreement with Alaska's Tribal Health Organizations to send letters of consultation to them at least 60 days in advance of submission of a Medicaid State Plan Amendment to CMS.[51]

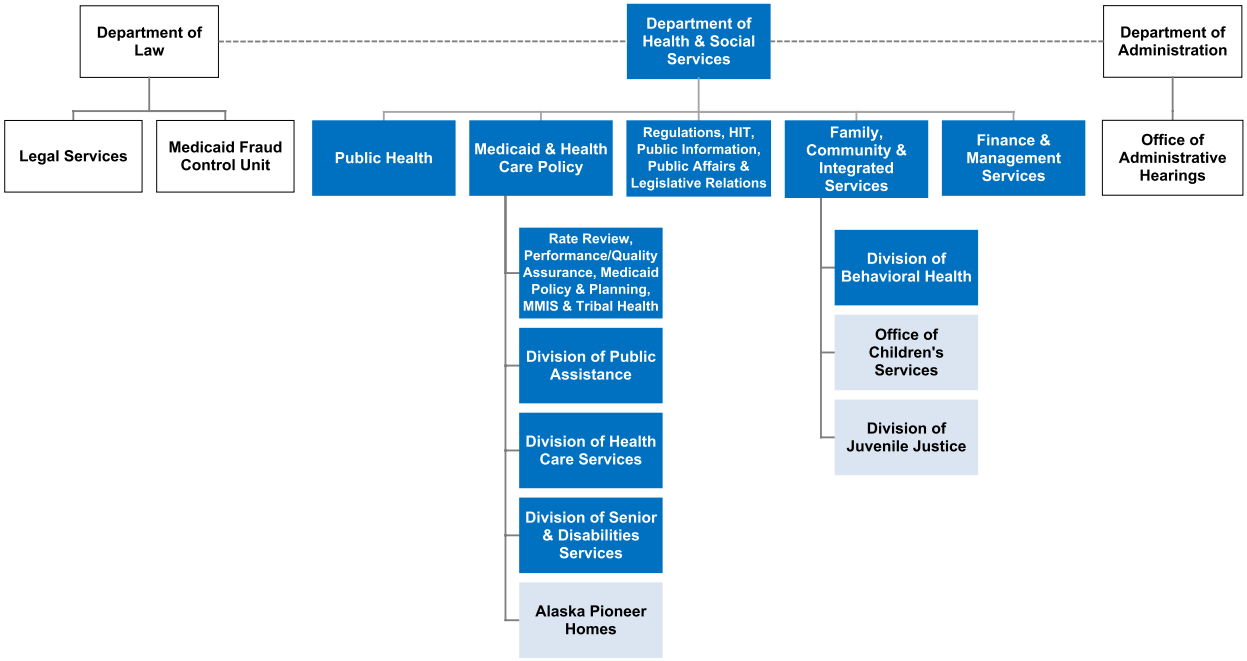
State partner agencies support DHSS including the Department of Administration, Department of Law, Department of Commerce and Economic Development, Department of Education and Early Development and Department of Public Safety.

B. ALASKA MEDICAID: ADMINISTRATIVE FUNCTIONS

DHSS protects and promotes the health of Alaskans through health and social service programs of many divisions. Divisions within the Department of Law provide legal services and investigate/prosecute Medicaid fraud and the abuse, neglect or financial exploitation of individuals in Medicaid-funded facilities. The Office of Administrative Hearings within the Department of Administration is responsible for Medicaid recipient case hearings and provider rate appeals. Exhibit 2-1 on the following page provides an overview of the agencies and divisions primarily responsible for the day-to-day administrative functions supporting Alaska's Medicaid program.

[51] *See* http://dhss.alaska.gov/Commissioner/Pages/TribalHealth/Tribal-Health-Consultation.aspx.

Exhibit 2-1 – DHSS Organization Structure



NOTE: DHSS divisions primarily responsible for the administration of Alaska's Medicaid program are in dark blue. Other DHSS divisions are in light blue.

The Alaska Medicaid Program contracts with several entities to perform various program functions. Conduent State Healthcare, LLC (formerly Xerox State Healthcare) serves as the program's Medicaid Management Information System (MMIS) developer and fiscal agent. Qualis Health provides utilization management services along with case management, quality of care reviews and provider education. Magellan Medicaid Administration provides pharmacy benefits administration services. MedExpert International, Inc. provides case management services to care coordination program participants.

Exhibit 2-2 on the following page outlines primary Medicaid administrative functions and identifies the entities responsible for them. Similar functions also are present in the administration of public employee benefit plans. Where applicable, this exhibit also identifies the functions performed by the Department of Administration and its contractors.

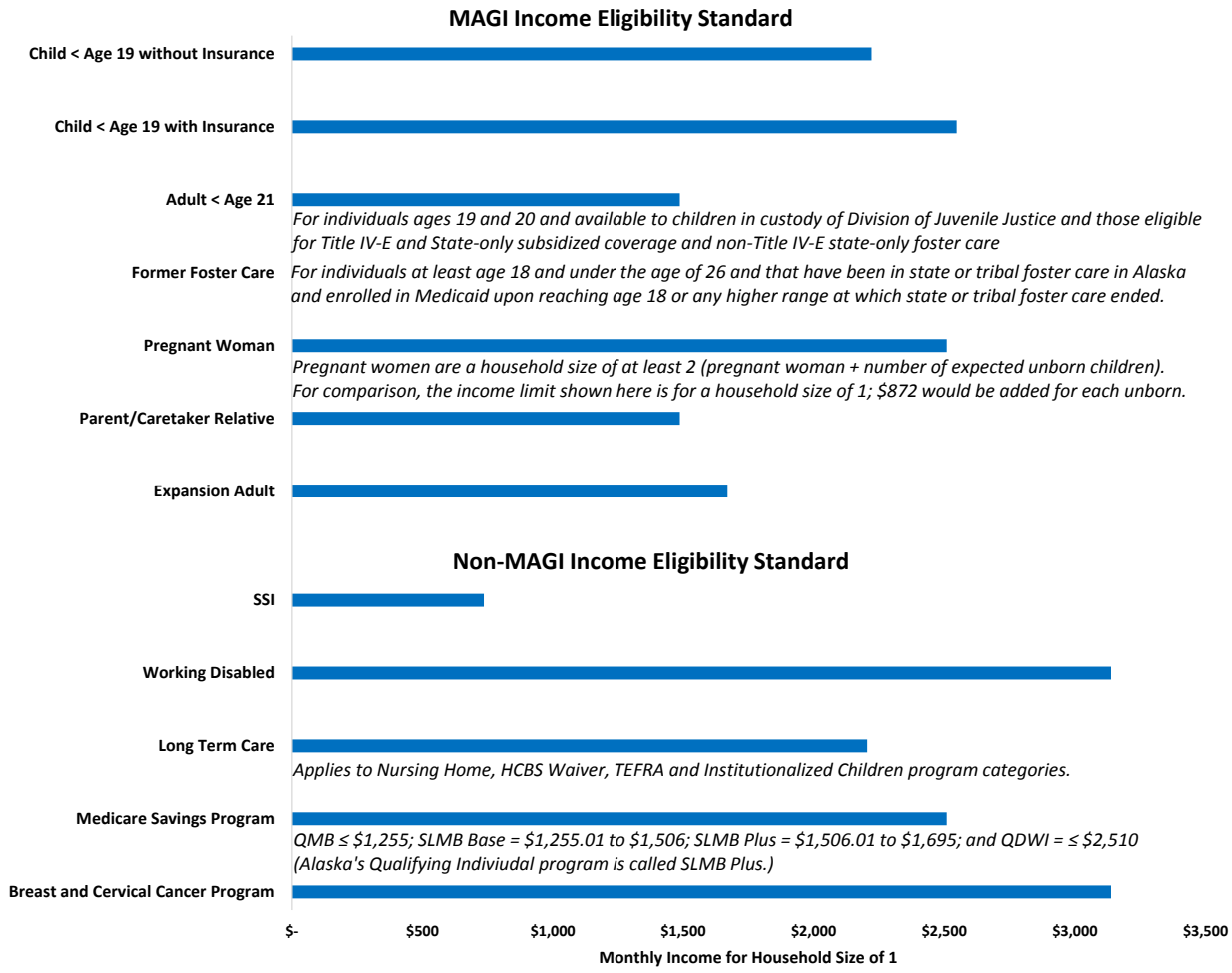
Exhibit 2-2 – Alaska Medicaid Program and Employee Benefit Program Administrative Functions

	Department of Health and Social Services		Department of Administration	
Administrative Functional Areas & Activity Examples	**Staff**	**Contractor**	**Staff**	**Contractor**
Utilization Management	• Eligibility determination • Service authorization • Care coordination	• Service authorization • Care coordination • Care management	• Eligibility determination • Transfer eligibility data	• Service authorization • Care management
Network Management	• Provider recruitment • Provider contract management • Provider performance monitoring	• Provider recruitment • Provider enrollment • Provider contract management • Provider performance monitoring	• Vendor management and oversight	• Provider recruitment • Provider enrollment • Provider contract management • Provider performance monitoring
Quality Management	• Access and service standards development, implementation and review • Incident/complaint investigation	• Incident/complaint investigation • Satisfaction monitoring	• Incident/complaint investigation • Vendor management and oversight	• Access and service standards development, implementation and review • Incident/complaint investigation • Satisfaction monitoring
Data Management	• Collect/report data on quality metrics • Generate systematic reports • Data file exchange	• Collect/report data on quality metrics • Generate systematic reports • Data file exchange	• Monitor claims trends • Perform analytics work	• Provide claims data warehouse • Collect/report data on quality metrics • Generate systematic reports
Claims Processing	• Process claims and adjustments • Receive, verify and log claims and adjustments • Perform edits	• Process claims and adjustments • Receive, verify and log claims and adjustment • Perform edits	• Incident/complaint investigation • Appeals functions • Vendor management and oversight	• Process claims and adjustments • Receive, verify and log claims and adjustments • Perform edits
Enrollment Services	• Member outreach, education and issue resolution	• Member outreach, education and issue resolution • Create and distribute member materials	• Member outreach, education and issue resolution • Create and distribute member materials • Electronic enrollment	• Create and distribute member materials

C. ALASKA MEDICAID: POPULATIONS

Alaska Medicaid provides coverage to one in four Alaskans. In addition to serving all mandatory groups, Alaska has extended coverage to certain optional groups.[52,53] Alaska's coverage of expansion adults went into effect on September 1, 2015. Exhibit 2-3 describes the current income eligibility standards applicable for each population group covered under Alaska's Medicaid program. Note that for comparison purposes, the monthly income amounts listed below are for a household size of one.

Exhibit 2-3 – Alaska Medicaid Monthly Income Eligibility Standards (for Household Size of One)[54]



NOTE: Monthly Income Limit values reflect Modified Adjusted Gross Income (MAGI)-converted income standards and include a disregard equal to five percentage points of the FPL. This applies only to the population groups shown under "MAGI Income Eligibility Standard".

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[52] Alaska Medicaid eligibility categories are described at 7 AAC 100. *See also* Alaska's Medicaid State Plan.

[53] The Alaska Medicaid program provides limited medical assistance under the Chronic and Acute Medical Assistance (CAMA) which is a State-funded program designed to help adults who do not qualify for Medicaid, have very limited financial means and meet diagnosis requirements. Expenditures for this program are not eligible for federal matching funds.

[54] Income eligibility standards available at http://dpaweb.hss.state.ak.us/POLICY/PDF/Medicaid_standards.pdf.

D. ALASKA MEDICAID: COVERED SERVICES

Alaska Statutes define the services covered under Alaska's Medicaid program. In addition to the mandatory Medicaid services required under the Social Security Act, the State provides for certain optional services as well as benefits identified as cost saving measures. Expansion adults receive the standard benefits offered to other Medicaid eligible individuals in the State. Exhibit 2-4 provides an overview of benefits covered by Alaska's Medicaid program and the number of states that also cover these benefits.

Exhibit 2-4 – Overview of Benefits Covered by Alaska's Medicaid Program

Benefit	Federal Medicaid Coverage	Covered by Alaska Medicaid	Number of States Covering Benefit[55]
Institutional & Clinical Services			
FQHC services	Mandatory	Yes	All
Freestanding ambulatory surgery center	Mandatory	Yes	All
Freestanding birth centers	Mandatory	Yes	All
Inpatient hospital services	Mandatory	Yes	All
Outpatient hospital services	Mandatory	Yes	All
Public health or mental health clinic	Mandatory	Yes	All
Rehabilitation services, mental health or substance abuse	Optional	Yes	All
Rural health clinic services	Mandatory	Yes	All
Practitioner Services			
Chiropractor	Optional	No	26
Dental services	Optional	Yes	47
Medical/surgical services by dentist	Mandatory	Yes	All
Nurse midwife	Mandatory	Yes	All
Nurse practitioner	Mandatory	Yes	All
Optometrist	Optional	Yes	All
Physician	Mandatory	Yes	All
Podiatrist	Optional	No	45
Psychologist	Optional	Yes	35
Prescription Drugs	Optional	Yes	All
Therapy Services			
Occupational therapy services	Optional	Yes	34
Physical therapy services	Optional	Yes	36
Therapy services for speech, language and hearing disorders	Optional	Yes	36
Products & Services			
Dentures	Optional	Yes	33

[55] Data was obtained from the Kaiser Family Foundation State Health Facts, available at http://kff.org/state-category/medicaid-chip/medicaid-benefits/, which includes the 50 states and the District of Columbia as of 2012. Where applicable, the counts have been updated to reflect coverage requirements under the Affordable Care Act.

Benefit	Federal Medicaid Coverage	Covered by Alaska Medicaid	Number of States Covering Benefit[55]
Eyeglasses	Optional	Yes	42
Hearing aids	Optional	Yes	31
Medical equipment and supplies	Optional	Yes	All
Prosthetics and orthotics	Optional	Yes	50
Transportation Services			
Ambulance	Mandatory	Yes	All
Non-emergency transportation	Mandatory	Yes	All
Other Services			
EPSDT, under age 21	Mandatory	Yes	All
Diagnosis, screening and preventive services	Optional	Yes	45
Lab and x-ray	Mandatory	Yes	All
Targeted case management	Optional	Yes	49
Tobacco cessation for pregnant women	Mandatory	Yes	All
Long Term Care – HCBS			
HCBS waiver	Optional	Yes	47
Home health (nursing services, home health aides, medical supplies and equipment)	Mandatory for those entitled; optional for others	Yes	All
Hospice	Optional	Yes	41
Personal care	Optional	Yes	31
Private duty nursing	Optional	Yes	23
Long Term Care – Institutional Care			
Inpatient hospital and nursing facility services in institutions for mental diseases, age 65 and older	Optional	Yes	46
Inpatient psychiatric, under age 21	Optional	Yes	All
Intermediate care facility for intellectual and/or developmental disabilities	Optional	Yes	48
Skilled nursing facility services	Mandatory	Yes	All

E. ALASKA MEDICAID: EXPENDITURES

ENROLLMENT

Today, Medicaid covers nearly one in four Alaskans. As of May 2017, Alaska has 185,139 individuals enrolled in Medicaid and CHIP.[56] Approximately half of those enrolled are children.

Between May 2016 and May 2017, Medicaid enrollment has grown by 23 percent in the State. While half of that growth is attributed to coverage of the expansion adult population, a driver has been the recession which technically began in 2015. Alaska has a current unemployment rate of seven percent, compared to approximately four percent nationally. The recession is expected to continue through mid-2020 for the state.[57]

EXPENDITURES BY MEDICAID ENROLLMENT GROUP

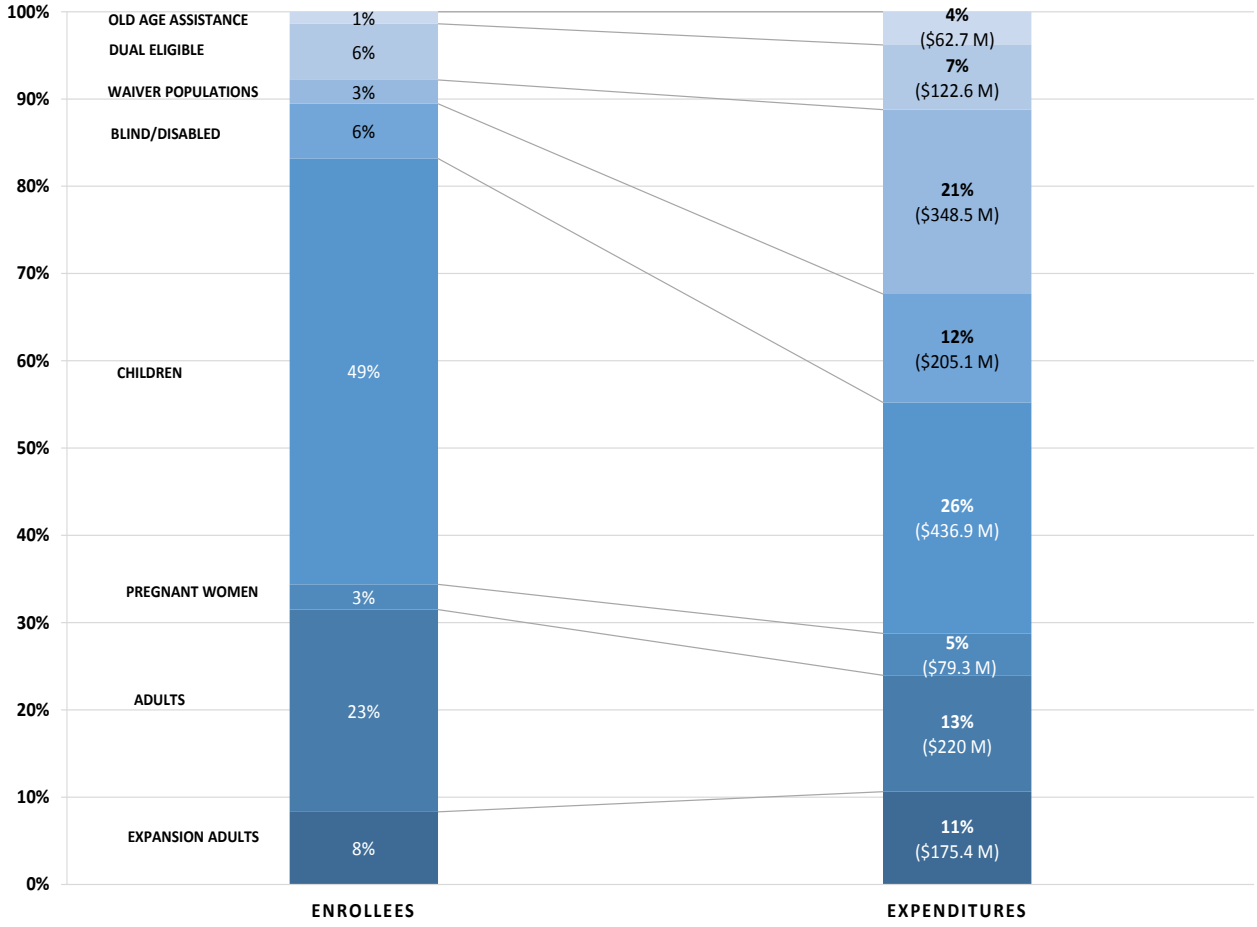
The Alaska Medicaid program paid more than $1.65 billion during SFY 2016 to provide health care coverage to eligible Alaskans. Alaska's Medicaid program expenditures per enrollee are among the highest in the country.[58] Several factors may contribute to the high cost, such as Alaska's unique rural and remote geography, high cost of living, limited competition among providers, healthcare workforce shortages and reliance on fee-for-service reimbursement.

Although Alaska's general Medicaid match rate and administrative match rate are 50 percent, several enhanced federal match rates are available for certain populations, providers, services and administrative functions. As a result, the federal government funds approximately 65 percent of Alaska's Medicaid program.

As illustrated in Exhibit 2-5 on the following page, the percentage of total enrollees by subgroup is not necessarily proportional to the subgroup's percentage of total Medicaid expenditures. Individuals in the old age assistance, dual eligible (eligible for both Medicaid and Medicare), waiver populations and blind/disabled categories accounted for 16 percent of total enrollment but 44 percent of total expenditures.

[56] Data obtained from http://dhss.alaska.gov/HealthyAlaska/Pages/dashboard.aspx.
[57] For additional information about Alaska's recession, see http://www.alaskapublic.org/2017/02/24/understanding-alaskas-recession/.
[58] *See* Kaiser Family Foundation, Data Note: Variation in Per Enrollee Medicaid Spending, available at http://www.kff.org/medicaid/fact-sheet/data-note-variation-in-per-enrollee-medicaid-spending/.

Exhibit 2-5 – SFY 2016 Medicaid Enrollees and Corresponding Percentage of Total Expenditures[59]



Average expenditures per enrollee vary by eligibility group. Expenditures per enrollee are higher among the aged and individuals with disabilities due to the higher use of complex acute services and long term supports and services. In contrast, expenditures are lower for expansion adults and children. Exhibit 2-6 on the following page provides the SFY 2016 Medicaid expenditures per member per month (PMPM) by enrollee population.

[59] SFY 2016 Medicaid enrollee and expenditure data presented were obtained from the "Alaska Medicaid Data Book SFY 2015 and SFY 2016" and accompanying appendices prepared by Milliman on behalf of DHSS.

Exhibit 2-6 – SFY 2016 PMPM Expenditures by Medicaid Enrollee Population[60]

Medicaid Enrollee Population	SFY 2016 PMPM
Old Age Assistance	$ 2,476
Dual Eligible (Medicaid + Medicare)	$ 1,045
Waiver Populations	
Managed Care Optional	$ 1,102
TEFRA	$ 881
Section 1915(c)	$ 6,993
Blind/Disabled	$ 1,874
Children	$ 450
Pregnant Women	$ 1,499
Adults	$ 520
Expansion Adults	$ 1,156

As discussed earlier in this section, the Medicaid program uses the Federal Medical Assistance Percentage (FMAP) to determine the share of the cost of covered services that the federal government pays each state. Alaska's FMAP is 50 percent. However, there are several exceptions to the regular FMAPs for specific populations and providers/services that allow for an enhanced federal match, including: children and pregnant women under the Children's Health Insurance Program (CHIP), AI/AN enrollees served through federal or Tribal facilities, women receiving care through the breast and cervical cancer program and expansion adults. Exhibit 2-7 below provides an overview of current enhanced FMAPs for Alaska.

Exhibit 2-7 – Enhanced FMAPs Available for Alaska's Medicaid Program Populations/Providers

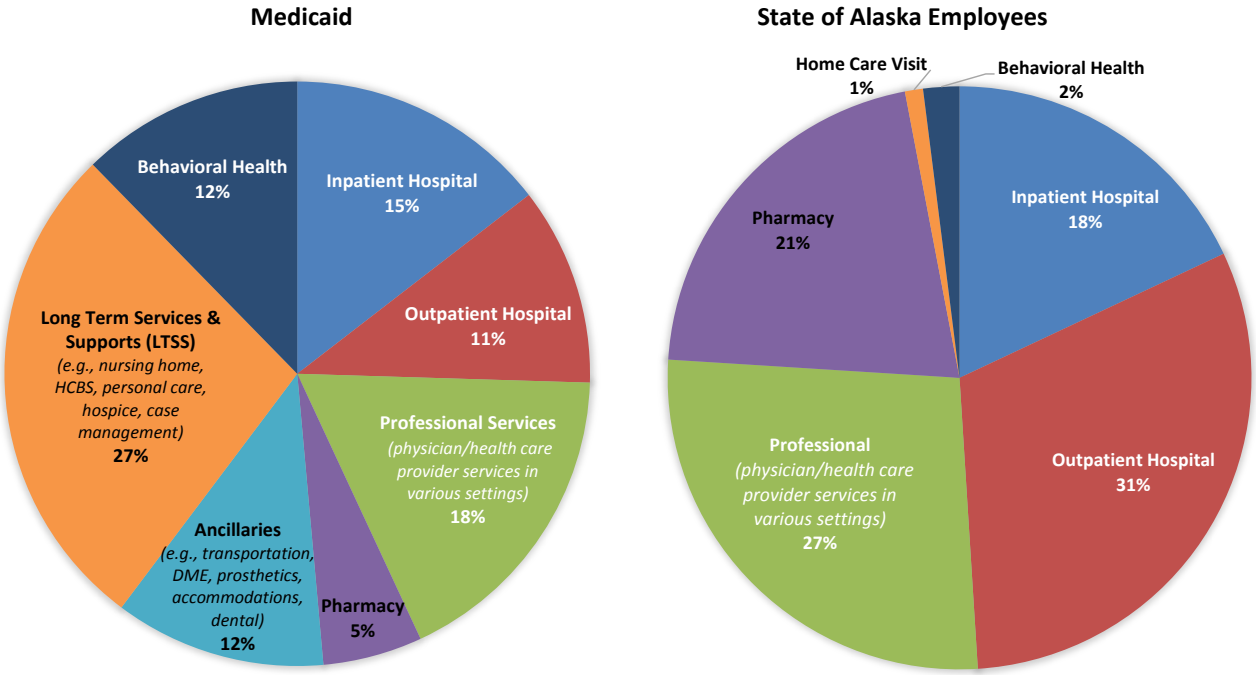
Population/Providers	CY 2017 Federal Match for Alaska
Children and Pregnant Women under CHIP	88%
AI/AN Enrollees Served through IHS/Tribal Facilities	100%
Women Served through the Breast and Cervical Cancer Program	65%
Expansion Adults	95%

[60] *Id.*

EXPENDITURES BY SERVICE CATEGORY

Over one-fourth of total expenditures in SFY 2016 were for long term services and supports (LTSS) (see Exhibit 2-8). LTSS includes hospice, nursing home, home and community-based services (HCBS), case management and personal care services. Professional services includes medical/surgical-related services provided by physicians and other health care practitioners in settings such as office, hospital, emergency room, delivery room, clinic, etc. Professional services accounted for the next largest segment of spending at 18 percent, followed by inpatient hospital services (physician and hospital claims) at 15 percent.

Exhibit 2-8 – Expenditures by Category of Service – Medicaid vs. State of Alaska Employees[61]



In comparing Alaska's Medicaid expenditures to medical expenses of State of Alaska Employees, the distribution of expenditures differs. In contrast to Medicaid, 58 percent of State Employee health care expenditures are for two categories – professional services and outpatient hospital services – and pharmacy accounts for 21 percent of costs.

Nearly 40 percent of Medicaid clients are AI/AN. Tribal providers are a critical source of care for AI/AN, and some rural Medicaid clients, and represent approximately 20 percent of total Medicaid expenditures for SFY 2016. States are eligible for 100% federal reimbursement for any Medicaid service covered by the Medicaid State Plan for AI/AN patients that the IHS or Tribal facility are authorized to provide and when an IHS/Tribal facility requests services for AI/AN patients from a non-IHS/Tribal

[61] *Id. State Employee data comes from the Consultative Analytic Impact Report for Alaska Care, State of Alaska Employees for 2016.*

provider under a care coordination agreement. (This is one of the Medicaid initiatives currently being undertaken by Alaska to take advantage of the 100 percent federal match rate).

Exhibit 2-9 provides a summary of expenditures by category of service, broken down by provider type.

Exhibit 2-9 – Distribution of Expenditures by Category of Service[62]

Alaska Medicaid SFY 2016				
Category of Service	**Examples**	**Non-Tribal Providers Expenditures (in millions)**	**Tribal Providers Expenditures (in millions)**	**Total Expenditures (in millions)**
Inpatient Hospital	• Hospital and provider claims for inpatient hospital medical, surgical, delivery and non-delivery	$ 177.5	$ 62.2	$ 239.7
Outpatient Hospital	• Hospital and provider claims for outpatient emergency room, surgery, radiology and pathology/lab	$ 109.0	$ 71.9	$ 180.9
Professional Services	• Medical/surgical-related services provided by physicians and other health care practitioners in settings such as office, hospital, emergency room, delivery room, clinic, etc.	$ 189.6	$ 100.8	$ 290.4
Pharmacy	• Prescription drugs	$ 76.1	$ 14.5	$ 90.7
Ancillaries	• Ground/air transportation • DME/prosthetics • Accommodations • Dental	$ 162.4	$ 30.3	$ 192.7
Long Term Services and Supports (LTSS)	• Nursing home • HCBS • Personal care • Hospice • Case management	$ 436.5	$ 16.5	$ 453.0
Behavioral Health	• Inpatient/outpatient general and psychiatric hospital • Therapies • Substance abuse residential • Children's residential • Psychosocial rehabilitation services	$ 157.0	$ 46.1	$ 203.1
	Total	**$ 1,308.1**	**$ 342.4**	**$ 1,650.5**

[62] SFY 2016 Medicaid enrollee and expenditure data presented were obtained from the "Alaska Medicaid Data Book SFY 2015 and SFY 2016" and accompanying appendices prepared by Milliman on behalf of DHSS.

As noted in Exhibit 2-10 below, the 10 services with the highest costs account for 67 percent of all service expenditures. Many of these services (e.g., HCBS, nursing home, personal care) are not typically covered in a commercial benefit package.

Exhibit 2-10 – SFY 2016 Top 10 Service Expenditure Categories[63]

Alaska Medicaid SFY 2016			
Top 10 Service Expenditure Categories	**Non-Tribal Providers Expenditures (in millions)**	**Tribal Providers Expenditures (in millions)**	**Total Expenditures (in millions)**
HCBS	$ 259.4	$ 0.6	$ 260.0
Inpatient Hospital Medical/Surgical (excluding maternity/delivery)	$ 155.9	$ 52.8	$ 208.7
Nursing Home	$ 100.7	$ 15.6	$ 116.3
Dental	$ 60.4	$ 28.7	$ 89.1
Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC)/Tribal Clinic	$ 13.4	$ 68.9	$ 82.3
Pharmacy	$ 65.9	$ 13.4	$ 79.3
Personal Care	$ 73.3	$ 0.2	$ 73.5
Outpatient Emergency Room	$ 50.3	$ 20.2	$ 70.5
Psychosocial Rehabilitation Services	$ 50.8	$ 18.1	$ 68.9
Air Transportation	$ 58.9	$ 1.6	$ 60.5
Total Expenditures for SFY 2016 Top 10 Services	**$ 889.0**	**$ 220.0**	**$ 1,109.0**

F. ALASKA MEDICAID: CURRENT REFORM INITIATIVES

Senate Bill (SB) 74, passed by the Alaska Legislature in April 2016 and signed into law in June 2016, focuses on improved efficiency and outcomes in Medicaid usage, billing and delivery. It directs DHSS to undertake a series of Medicaid reforms intended to improve quality, increase value and control spending while building upon initiatives already underway. Areas of focus include payment system reform; expanded use of telehealth; enhanced fraud prevention, enforcement and recovery; primary care case management; coordinated care demonstration projects; home and community based services; behavioral health reform; and exploring privatization.[64]

[63] *Id.*

[64] *See* http://dhss.alaska.gov/HealthyAlaska/Pages/Redesign/Redesign_news.aspx.

Exhibit 2-11 provides an overview of current Alaska Medicaid reform initiatives.

Exhibit 2-11 – Alaska Medicaid Reform Initiatives

Initiative	Description
Delivery System Reforms	
Coordinated Care Demonstration Project	Contract to implement one or more demonstrations to assess the efficacy of various health care delivery modes with respect to cost, access and quality of care.
Primary Care Case Management (PCCM)	Establish PCCM system or managed care organization contract to increase use of appropriate and preventive care and decrease unnecessary use of specialty care and hospital emergency department services.
Health Homes (Section 2703 of the Affordable Care Act)	Implement Health Homes under Medicaid State Plan options.
Behavioral Health Managed System of Care and 1115 Waiver	Development and management of comprehensive and integrated behavioral health program that uses evidence-based, data-driven practices to achieve outcomes for people with mental health or substance abuse disorders and children with severe emotional disturbances. Application for Section 1115 waiver to establish demonstration project.
Section 1915(i) and 1915(k) Home and Community Based Services	Implement home and community-based services.
Criminal Justice Reform (SB 91 Integration)	Link potential DHSS programs with Department of Corrections (DOC) inmates, including support for prisoners reentering the community to access Medicaid and public assistance benefits.
Emergency Department Improvement Project	Collaborate with state hospital association to establish hospital-based project to reduce use of emergency department services.
Delivery System Infrastructure	
Telemedicine	Identify and develop recommendations to address barriers to telemedicine and set annual targets for quality and cost-effectiveness.
Health Information Infrastructure	Develop plan to strengthen health information infrastructure to support reform, including data analytics.
Tribal Medicaid Reimbursement	Collaborate with Alaska Tribal Health Organizations and HHS to implement changes in federal policy on Tribal Medicaid reimbursement that authorizes 100% federal funding for services provided to AI/AN individuals eligible for Medicaid.
Medicaid Reform Program	Focus on initiatives to improve effectiveness and efficiency of health care expenditures while improving the quality of care received by Medicaid recipients, including working with stakeholders to help identify quality and cost effectiveness measures and targets for the Medicaid program that can be monitored and reported to help improve the overall quality of the Medicaid program and the services received by Medicaid recipients.
Prescription Drug Monitoring Program	Database registry.
Internal Systems Improvements	
Eligibility Verification System	Establish an enhanced computerized income, asset and identity eligibility verification system to verify eligibility, eliminate duplication of public assistance payments and deter waste and fraud.

Initiative	Description
Fraud & Abuse Prevention Enhancement	Allows for assessment of interest and penalties on identified overpayments, requires providers to conduct self-audits, and use of a fraud and abuse inter-department committee.
Exploring Options	
Privatization Studies	Procure studies to analyze feasibility of: (1) privatizing services delivered at the Alaska Psychiatric Institute, in conjunction with the Alaska Mental Health Trust Authority; (2) privatizing select facilities of the Division of Juvenile Justice; and (3) privatizing pharmacy services delivered at Alaska Pioneer Homes.
Health Care Authority Feasibility Study	Procure a study to determine the feasibility of creating a Health Care Authority to coordinate health care plans and consolidate purchasing effectiveness for all state employees, retired state employees, retired teachers, Medicaid recipients, University of Alaska employees, employees of state corporations and school district employees.

SECTION 3 – OVERVIEW OF STATES' APPROACHES TO ADMINISTRATION OF PUBLIC PAYER HEALTH CARE PROGRAMS

The following section provides an overview of some states' approaches to the administration of public payer health care programs. This includes efforts to coordinate and/or integrate purchasing strategies, control costs of the Medicaid expansion populations and consolidate administrative functions and regulatory operations into an Authority. This section also provides a brief overview of Alaska's experience with quasi-governmental boards and commissions.

A. PUBLIC PAYER COORDINATION AND INTEGRATION APPROACHES

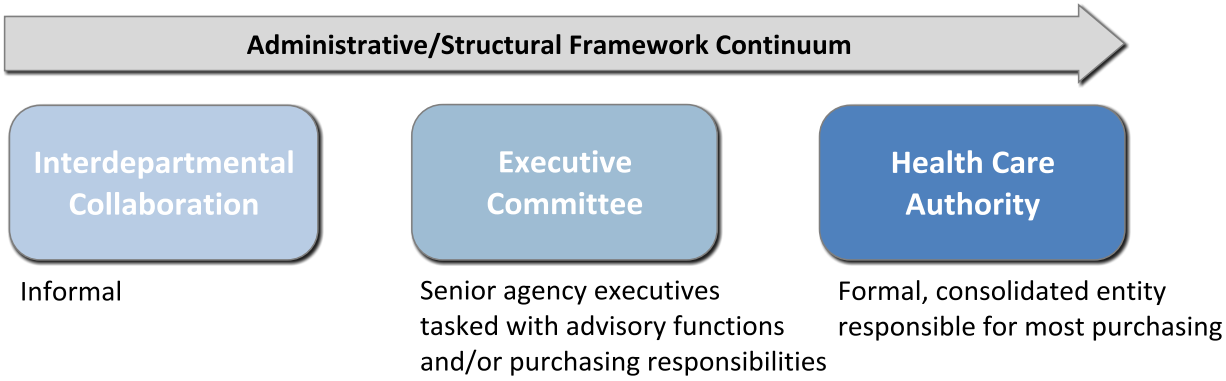
Attempts have been made to coordinate/integrate administrative activities and purchasing strategies among state agencies or other public purchasers (e.g., Medicaid, state employees). However, coordinated purchasing is not without its challenges. For example, there may be a reluctance to coordinate without formal governmental mandate and changes in administration leadership can hinder progress. Purchasers also may differ significantly in their program goals, covered populations and services, regulatory frameworks and operations which further complicates alignment. In addition, program savings results have been mixed. The following highlights the framework states have used to support coordination and states' efforts.

ADMINISTRATIVE/STRUCTURAL FRAMEWORK TO SUPPORT COORDINATION

States and their Medicaid agencies have identified coordinated purchasing strategies as an opportunity to leverage purchasing power to reduce health care costs, increase administrative efficiency and improve quality of care. Different approaches have been taken to reorganizing administrative/structural frameworks to support coordination of purchasing efforts (see Exhibit 3-1 on the following page). For example, informal inter-departmental collaborations and staff-level interactions may be used for coordinated purchasing. States also may create an executive committee to assist with purchasing coordination. At the other end of the continuum, agencies may be consolidated under the direction of a Health Care Authority formally created by legislation.

Authorities may be responsible for most or all state health care purchasing, which generally encompasses programs that provide Medicaid and health plan coverage for state employees and educators (university/college or school district). While these programs generally operate independently of each other, an Authority may offer supports such as shared resources (staff, financing, technology) across a variety of administrative functions that can be utilized by the division operating the program.

Exhibit 3-1 – Administrative/Structural Framework to Support Coordination



Creating a single Authority with responsibility for health benefit administration or coordination across payers may provide a more stable foundation for advancing integration. However, states also have created Authorities but have not succeeded in coordinating administrative functions or health care purchasing across public programs. Factors that impact states' abilities to successfully coordinate and integrate operations across publicly-funded programs include:

- ***Program administration***:
  - Commonality between the populations, benefit packages, service needs, provider network and provider rates for the populations covered under each program
  - What and how do federal and/or state legal authorities govern program administration
  - Appropriate and sufficient resources to support coordination efforts as well as ongoing operations
  - Willingness of vendors/contractors to participate and effectively perform functions across different programs

- ***Priorities and values***:
  - Awareness that changes in executive/administration leadership (governor or key staff) which may shift the direction of program administration
  - Availability of funding to support initial and sustained coordination efforts
  - Understanding the differences in agency culture, values and mission

Types of Coordinated Purchasing

Coordination across payers for service delivery and payment models, such as coordinated care and value-based purchasing, have garnered support from CMS and been actively explored and implemented by states in recent years. States also have pursued approaches to use health information technology across payers to measure and improve quality of care. States also have implemented common provider management requirements such as network adequacy and program integrity monitoring for managed care entities.

Some states have designated directors or chief medical officers across agencies to facilitate coordination of quality, provider management and medical management. In addition, some states have consolidated or coordinated provider contracts and related activities.

Although examples of integration and coordination exist, they are limited. Whether the approaches achieve success is largely dependent on the administrative or structural framework to support coordination. As mentioned earlier, some states have the capacity to centralize management and contracted services policies for multiple programs because designated directors and chief medical officers play a key role across all programs. This is particularly the case for states utilizing an Authority or Authority-like governance structure.

The following are examples from states engaged in coordinated purchasing across public payers:

Georgia Department of Community Health (DCH). The DCH is one of the state's four health agencies. It serves as the lead agency for Medicaid and also oversees the State Health Benefit Plan. DCH contracted with Express Scripts, Inc. (ESI) to serve as the state's single pharmacy benefits manager (PBM). ESI manages pharmacy services for the Medicaid and CHIP managed care programs, State Health Benefit Plan and Board of Regents. The state transitioned to a single PBM to improve quality of care and efficiency by consolidating services previously performed by a variety of vendors.

Maryland All-Payer Model. The state's All-Payer Model focuses on limiting total per capita hospital spending and improving quality and health. The state converted its hospital payment system from traditional fee-for-service to a global system: the hospital's total revenue for all payers is set at the beginning of the year allowing the hospital flexibility to invest in care and health improvement activities that reduce avoidable utilization and improve value for purchasers and consumers.

New York State Department of Health (NYSDOH). The NYSDOH developed the QARR measurement staff to monitor quality in managed care plans. It consists of over 70 measures from NCQA's HEDIS®, CAHPS® and state-specific measures. QARR focuses on health outcomes and process measures, and includes clinical data relating to prenatal care, preventive care, acute and chronic illness and mental health and substance abuse. All managed care organizations and Medicaid managed care plans (including HIV special needs plans and health and recovery plans (HARP)) certified by the NYSDOH must report applicable QARR measures to the Office of Quality and Patient Safety. All PPO/EPO plans licensed by the New York State Department of Financial Services who meet member thresholds must complete all measures. Certain plan types are excluded from QARR: managed long term care-Medicaid Advantage and Medicaid Advantage Plus plans, fully-integrated dual Advantage (FIDA) plans, dental-only, vision-only, catastrophic-only and student coverage-only.

Oregon Health Authority (OHA). The OHA provides oversight of most of the state's health care programs. The Health Policy and Analytics Division (HPA) of the OHA houses the Office of Clinical Services Improvement (CSI) which has a key role in developing and staffing OHA's internal, cross-agency Quality Council as well as agency-wide policy development, strategic planning and clinical leadership. The Office provides the structure for clinical, behavioral and population health leadership of the OHA to analyze clinical trends in quality compliance and system performance; development of integrated strategies to improve quality; ensure the Quality Council's work is integrated and shared with the medical directors of the Coordinated Care Organizations, public employee boards and contracted plans, and other OHA programs; sponsors performance improvement projects; and oversees the Transformation Center to coordinate and support efforts based on the Quality Council's recommendations. The OHA Chief Medical Officer oversees the Office as well as the Pharmacy and Therapeutics Committee and the Oregon Prescription Drug Program.

Vermont Blueprint for Health. Blueprint for Health is a state-led, multi-payer program dedicated to achieving coordinated and seamless health services, with an emphasis on prevention and wellness through use of medical homes along with practice facilitators and community health teams. The Blueprint for Health combines state level direction with local health care administration and service delivery. Grants are provided to a local health care agency (e.g., FQHC or hospital) to serve as an administrative entity in each of the state's 14 health service areas (HSAs) with responsibility of hiring project managers to lead implementation and engage community partners, staffing of community health teams and financial management. Key stakeholders in each HSA must agree upon and identify at least one administrative entity accountable for leading implementation and ongoing operations of the Multi-Payer Advanced Primary Care Practice (MAPCP) model in their HSA. Lead administrative entities receive multi-insurer payments, including Medicare and Medicaid, to support hiring of local community health teams.

Washington State Health Care Authority (HCA). The HCA's clinical collaboration and initiatives program is led by the HCA's chief medical officer and supports several initiatives to help persons receiving coverage through Medicaid and the Public Employees' Benefit Board. Initiatives include identifying and recommending evidence-based strategies to reduce cost and improve outcomes in health care, educate individuals about proper use of emergency rooms, work with providers to improve mother and child outcomes and decrease non-medically induced C-sections and inductions, among others.

Other models that have been considered by states for integration and coordination across public payers are claims processing and health plan contracting. A limited number of states, including Maine, have contemplated implementing a single unified claims system. However, at the time of this report, PHPG did not identify any states with a consolidated processing system. Federal requirements for Medicaid Management Information Systems (MMIS) are extensive and not applicable to other types of public payer programs which may make coordination across programs burdensome.

West Virginia and Nevada considered coordinated strategies for purchasing managed health care services for Medicaid and public employees to improve access, encourage a more integrated health care delivery system and manage costs. Ultimately, West Virginia's approach did not sustain due to differences in priorities among agencies. Although Nevada released a request for proposals, they did not receive any offers from managed care entities electing to provide services for public employees.

Member eligibility and enrollment services may be coordinated across public assistance programs. Because of the unique requirements, it may not be feasible to coordinate eligibility and enrollment services with other public payer programs. However, states have developed or coordinated with the Federally Facilitated Marketplace to modify existing or implement new platforms to determine subsidy/cost sharing reduction eligibility and enroll individuals in qualified health plans or redirect to the state for Medicaid (and other public assistance programs) eligibility determinations and enrollment.

B. MEDICAID EXPANSION POPULATIONS AND COMMON BENEFIT DESIGN

Currently, 31 states, including Alaska, and the District of Columbia provide Medicaid coverage to most low-income adults with income up to 138 percent of the federal poverty level (FPL). Some states, notably Arkansas, Indiana and Kentucky, have used Section 1115 waivers to implement demonstrations to control costs of care associated with the Medicaid expansion adult group. The following provides a high level overview of the demonstrations implemented in these states, including successes and challenges encountered.

Arkansas Works Program.[65] Arkansas was the first state to receive approval to expand Medicaid under the Affordable Care Act through a Section 1115 waiver. Under the Arkansas Works program, effective January 2014, Arkansas provides premium assistance to support beneficiaries' purchase of coverage from qualified health plans (QHPs) offered through the individual Federally Facilitated Marketplace. To be eligible for participation, the individual must be an expansion adult or parent. Enrollees receive the state's alternative benefits plan, as defined in the State Plan. Wrap-around services in the plan not covered by Employer Sponsored Insurance (ESI) or QHPs are provided by the state through its fee-for-service Medicaid program. As of 2017, enrollees with incomes at or below 100 percent of the FPL do not pay premiums or cost sharing. Enrollees with higher incomes pay monthly premiums and point-of-service cost sharing. In addition, there is a mandatory cost-effective small group ESI program for expansion adults that has an offer of coverage from a qualified small group employer.

The demonstration implemented HSA-like accounts, which required monthly contributions based on income. By 2015 the state began phasing out this program with complete program termination by 2016 due to administrative burdens and costs and determination that the accounts were an inefficient way of

[65] Arkansas Works (originally called Arkansas Health Care Independence Program or the Private Option) Section 1115 Demonstration (Project No. 11-W-00287/6) Fact Sheet (extension approved December 8, 2016).

promoting consumer choice and personal responsibility.[66,67] For CY 2018, the state proposes to cap financial eligibility at the federal poverty level and transition the population from Medicaid to other coverage, including the Marketplace and ESI.[68] Other changes include instituting work requirements for able-bodied adults that would roughly mirror the requirements found in the Supplemental Nutrition Assistance Program (SNAP).

Healthy Indiana Plan (HIP) 2.0.[69] Indiana's HIP 2.0 offers low-income adults a high deductible consumer-driven health plan paired with a HSA-like account (POWER account) which contains contributions made by the state as well as a required monthly contribution by the recipient. Members who consistently make the required contributions to their POWER account are enrolled in HIP Plus which includes enhanced benefits such as dental, vision and bariatric surgery. Members with income below 100 percent of the FPL who do not make monthly contributions are placed in the HIP Basic plan, which is more limited in covered services and has cost sharing. HIP 2.0 also includes the HIP Link which provides enrolled individuals with a defined contribution to help pay for the costs of ESI.

The benefit package is more consistent with commercial plan benefits but excludes chiropractic and non-emergency transportation services. However, the Medicaid State Plan benefit package, which includes these two benefits, is provided to Section 1931 parent/caretakers, low-income 19 and 20 year old dependents, individuals eligible for transitional medical assistance and individuals identified as medically frail. Except for members receiving the State Plan benefit package, vision and dental services are only available if regular monthly contributions are made to the POWER account. To date, program results have been mixed, and critics question whether the state has made achievements on HIP 2.0's stated goals, including whether POWER accounts are promoting personal responsibility in health care.[70]

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[66] Buntin, M., Graves, J. & Viverette, N., Health Affairs Blog: "State Medicaid Lessons for Federal Health Reform," available at http://healthaffairs.org/blog/2017/06/07/state-medicaid-lessons-for-federal-health-reform/.

[67] Arkansas Health Reform Legislative Task Force, Final Report (December 15, 2016), available at http://www.arkleg.state.ar.us/assembly/2017/Meeting%20Attachments/836/I14805/Final%20Approved%20Report%20from%20TSG%2012-15-16.pdf

[68] Hardy, B., "Trump administration likely to approve work requirements for Arkansas Medicaid expansion and shift 60,000 to marketplace," Arkansas Times (March 6, 2017), available at http://www.arktimes.com/ArkansasBlog/archives/2017/03/06/trump-administration-likely-to-approve-work-requirements-for-arkansas-medicaid-expansion-and-shift-60000-to-marketplace. *See also* Davis, A., "4-year savings put at $66M if state cuts Medicaid roles," Arkansas Online (April 27, 2017), available at http://www.arkansasonline.com/news/2017/apr/27/4-year-savings-put-at-66m-if-state-cuts/.

[69] *See* https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/in-healthy-indiana-plan-support-20-pa4.pdf.

[70] Harper, J., "Indiana's Claims About Its Medicaid Experiment Don't All Check Out," available at http://www.npr.org/sections/health-shots/2017/02/24/516704082/indiana-s-claims-about-its-medicaid-program-dont-all-check-out. *See* Health Indiana Plan §1115 Demonstration Waiver Extension (Project No. 11-W000296/5), available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/in-healthy-indiana-plan-support-20-pa4.pdf and Lewin Group, "Indiana Health Indiana Plan 2.0: Interim Evaluation Report, available at https://www.medicaid.gov/Medicaid-CHIP-Program-

***Kentucky HEALTH Program*.**[71] Similar to Indiana's HIP 2.0, the Kentucky HEALTH program, as proposed, offers high deductible health plans with commercial market benefits and access to health savings-like member managed accounts (with monthly premium contributions) to fund the deductible and enhanced health care benefits (such as vision, dental, over the counter medications and gym memberships). Premium assistance is available for individuals with access to ESI coverage. The Kentucky HEALTH program would target the Medicaid expansion populations, particularly adults with income up to 138 percent of the federal poverty level. However, Kentucky HEALTH also would include children and all non-disabled adults currently covered under traditional Medicaid. Kentucky submitted its demonstration application in April 2016. As of the date of this report, the application remains in pending status with CMS. Program critics raise concerns similar to those of Indiana's program.

Exhibit 3-2 on the following page summarizes the 1115 demonstration programs of Arkansas, Indiana and Kentucky.

Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-interim-evl-rpt-07062016.pdf.

[71] *See* https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/ky-health-pa.pdf.

Exhibit 3-2 – Summary of 1115 Waiver Demonstrations in Arkansas, Indiana and Kentucky

Overview	Premium/Cost-Sharing Obligations	ESI Premium Assistance	Work Incentive Program	Status/Outcomes
Arkansas Works				
Implemented in 2014 with approved extension through 2021. State supports purchase of coverage of QHPs offering coverage on the Marketplace with premium assistance from Medicaid ("private option"). Targets expansion adults. AI/AN are not required to enroll in QHPs or ESI but can choose to opt in.	• HSA-like account eliminated for all enrollees due to administrative burden/costs and ineffectiveness for enrollees. • No premium obligation if below 100% FPL. If more than 100% FPL: (1) pay monthly premium capped at 2% of income; (2) if premium is not paid by end of grace period, beneficiary does not lose eligibility but accrues debt to the state; and (3) subject to point-of-service cost sharing (premiums and cost sharing would be no more than 5% of quarterly household income).	Mandatory ESI program with Medicaid paying employee contribution and covering any benefits not covered by Medicaid. Premium payment paid to the carrier or employer if in an ESI.	Voluntary program for unemployed beneficiaries to receive information about job training.	To achieve savings, the state plans to submit a waiver for changes beginning 2018, including to cap financial eligibility at federal poverty level rather than 138% FPL (eliminates coverage for 60,000), institute work requirements that mirror SNAP and raise premiums.
Healthy Indiana Plan (HIP) 2.0				
Program implemented in 2014. Medicaid plan features high deductible health plan with POWER account (HSA-like). Targets expansion adults.	• HIP Plus includes enhanced benefits such as vision, dental and bariatric. Requires monthly HSA-like POWER contributions based on FPL; amounts roughly equivalent to 2% of income. If income >100% FPL, failure to pay premium by end of grace period results in program termination for 6 months. • Income ≤100% FPL: failure to pay premium by end of grace period results in transfer to HIP Basic. HIP Basic provides minimum coverage and is for income <100% FPL who do not make account contributions. • AI/AN and pregnant women exempt from POWER contributions and cost-sharing.	HIP Link is an employer plan premium assistance paired with health savings-like account. Enhanced POWER account is used to pay for premiums, deductibles and copays.	Gateway to Work program is a voluntary program for all individuals who complete application for HIP coverage. It connects applicants to job training and job search program.	Program goal achievement results mixed with reported data discrepancy concerns. Waiver extension submitted January 2017 and amended in June to restructure monthly contributions and ask about tobacco usage to determine account contribution and application of use surcharge.
Kentucky HEALTH				
High deductible health plan paired with health care spending accounts. Targets expansion adults and children and all non-disabled adults currently covered by Medicaid.	• Monthly premium, increasing on a sliding scale based on family income, ranging from $1 to $15 per month. • Pregnant women and children exempt from cost-sharing.	May enroll entire family with optional participation in 1st year. Mandatory participation for adults in 2nd year if employed at least 1 year. Premium deducted from payroll and is reimbursed.	After 3 months of program eligibility, participation would be condition of eligibility for all able-bodied adults without dependents. Non-compliance results in benefit suspension until satisfied for 1 month.	Program critics raise concerns about use of HSA-like accounts. Waiver to implement program, submitted in August 2016, is pending approval.

C. HEALTH CARE AUTHORITIES

OTHER STATES' AUTHORITIES AND GOVERNANCE STRUCTURES

Successful consolidation and integration of multiple health agencies, including state employee health coverage and the state's Medicaid agency, into a single collective Authority are limited but currently operational in Oregon and Washington.

Key features supporting the Authority structure within these states include:

- ***Delegation of Certain Medicaid Functions.*** Although the Authority serves as the Single State Agency in Oregon and Washington, some administrative functions are delegated to other state agencies outside of the Authority.[72] In Oregon the Office of Administrative Hearings and the Department of Human Services (DHS) are involved in the fair hearing process. In addition, DHS performs eligibility determinations for all Medicaid programs. Prior to July 2017, DHS's responsibility for eligibility determinations was limited to specialized populations such as adoption assistance, child welfare, foster children and aged, blind and disabled (ABD). Several factors contributed to the transition of Medicaid enrollment from the Oregon Health Authority to DHS.[73] In Washington, the Department of Social and Human Services (DSHS) is responsible for eligibility determinations and fair hearings as well as certain program functions for specialized programs, including LTSS, HCBS, intermediate care facilities for individuals with intellectual disability (ICF/ID), waivers, certain chronic care management services, mental health and alcohol and substance abuse.

- ***Legislation*.** Legislation that establishes the Authority with clear principles and responsibilities to provide oversight functions for all health related divisions/units and have the power to exercise discretion in the administration, supervision and operational functions to carry the state's Medicaid program.

- ***Governing Board***. Creation of a governing board to support the Authority. The board consists of members with qualified skills, experience and training related to health care and represents diversity in geographic, ethnic, gender, racial and economic interests. Advisory bodies, including standing and ad hoc committees and task forces, support the board and allow for stakeholder outreach and involvement as well as provide research and evidence-based information to make recommendations to and support the board in policy-making responsibilities/initiatives.

[72] Delegation could be documented through a memorandum of understanding or interagency/intergovernmental agreement between the agencies. (Some states also mandate certain agency relationships through state law and thus eliminate the need for an agreement.) In addition, states report delegation information to CMS via the State Plan Amendment process to obtain approval of the arrangement.

[73] Gray, C., "State Quietly Pulls Medicaid Enrollment from OHA and Gives it to DHS", available at: https://www.thelundreport.org/content/state-quietly-pulls-medicaid-enrollment-oha-and-gives-it-dhs.

- ***Agency Alignment with Priorities and Values.*** Entities in and outside the Authority share the same program priorities, mission and values.

Other states have established Authorities, however, many of these states serve a limited role or are no longer operating. The Oklahoma legislature envisioned moving the state employee health plan to the Health Care Authority (OHCA), which did not occur. Today, the OHCA primarily operates the Medicaid program with different divisions having specified responsibilities and administers the state-funded insurance program for small businesses and uninsured employees. Hawaii's effort to create a centralized, policy-making Authority faltered, where competing legislation is now pending to both fund and abolish the Authority.

Some states have elected to create Authorities to oversee discrete health care programs or administrative functions. For example, the New Mexico Retiree Health Care Authority (NMRHCA) provides for and administers medical plans for state agencies and eligible participating public entities. The Maryland Health Services Cost Review Commission (HSCRC) is an independent state agency that sets rates for the state's 51 hospitals, but does not regulate physician fees. Vermont's Green Mountain Care Board is an independent agency that regulates the state's health insurance rates, hospital budgets and major capital expenditures.

The following is a brief description of the administrative/structural framework and responsibilities of entities currently performing health care purchasing activities in the states of Maryland, New Mexico, Oklahoma, Oregon, Vermont and Washington. Exhibit 3-3, which follows these descriptions, provides a summary of the governance structures and responsibilities of these entities. (Additional detail on each state is presented in *Attachment I – Authority/Governance Models*.)

Maryland Health Services Cost Review Commission (HSCRC). Founded in 1971 by the Maryland Legislature, the HSCRC is governed by seven volunteer Commissioners appointed by the Governor. Commissioners serve four-year staggered terms. The HSCRC is an independent state agency that sets rates for the state's 47 acute general, three specialty and three private psychiatric hospitals. The HSCRC's rate regulatory authority applies to inpatient services and outpatient emergency services at a hospital; physician fees are not regulated by the HSCRC. The HSCRC created data infrastructure that includes a uniform accounting and reporting system and collects and analyzes data on hospital operations. Examples of available databases include but are not limited to annual revenue, expenses and volume data, audited financial statements, wage and salary survey, and patient level case mix data.

New Mexico Retiree Health Care Authority (NMRHCA). Formed in 1990 as an independent statutory agency, the NMRHCA provides medical plans for New Mexico state agencies and eligible participating public entities, including cities, counties, universities and charter schools. The NMRHCA is governed by an 11 member Board of Directors, consisting of representation by participating entities, retirees, active employees and one member appointed by the Governor. NMRHCA staff administer the program and provide customer service to enrollees.

Oklahoma Health Care Authority (OHCA). The OHCA is a state agency created in 1993 by the Oklahoma Legislature to convert the state's Medicaid program to a managed care system. The OHCA is governed by a seven member Board of Directors who represent experience in either medical care, health care services, delivery, finance, managed care or health insurance. The OHCA and its Board are served by the Behavioral Health Advisory Council, Drug Utilization Review Board, Living Choice Advisory Committee, Medical Advisory Committee and State Plan Amendment Rate Committee. Primary duties of the OHCA include administration of SoonerHealth (Oklahoma's Medicaid program) and Insure Oklahoma (an employer sponsored insurance plan that assists small business owners in providing health coverage to employees with low to moderate incomes through premium subsidies that offset coverage costs).

Oregon Health Authority (OHA). Established by the Oregon Legislature in 2009, the OHA is a state government agency which oversees the administration of most of the state's health-related programs/divisions such as public health, mental health, Oregon Health Plan (Oregon's Medicaid program), Oregon Educators Benefit Board and Public Employees' Benefit Board. The OHA is governed by the nine member Oregon Health Policy Board (OHPB) which serves as the policy-making and oversight body for the OHA. OHPB members are nominated by the Governor and must be confirmed by the Oregon Senate. The OHA and OHPB primarily are served by over 30 advisory bodies and committees.

Vermont Green Mountain Care Board (GMCB). Created in 2011, the GMCB is structured as an independent group of Vermonters. The GMCB has been assigned three main responsibilities: regulation, innovation and evaluation. It regulates health insurance rates, hospital budgets, Accountable Care Organizations and major capital expenditures. The GMCB tests new ways to pay for and delivery health care and evaluates innovation projects and proposals for benefit inclusion and funding sources. Members of the GMCB are appointed by the Governor upon nomination by the GMCB Nominating Committee and confirmed by the Vermont Senate. Members include a board chair and four members. The GMCB Advisory Committee and Primary Care Advisory Group support the GMCB. Members serve a staggered six-year term.

Washington State Health Care Authority (HCA). The HCA was created by the Washington Legislature in 1988. The HCA purchases health care for Washington Apple Health (Medicaid) and the Public Employees Benefits Board (PEBB) Program. Although the HCA has oversight responsibility for Apple Health and PEBB, both operate independently under the HCA structure. The HCA delegates certain activities to the Department of Social and Health Services (DSHS). The Public Employees Benefits (PEB) Board, created within the HCA, sets eligibility requirements, approves premium contributions for eligible employees and approves benefits of all participating health insurance plans. The PEB Board consists of nine members appointed by the Governor.

Exhibit 3-3 – Summary of Governance Structures and Responsibilities

	Maryland Health Services Cost Review Commission	New Mexico Retiree Health Care Authority	Oklahoma Health Care Authority	Oregon Health Authority	Vermont Green Mountain Care Board	Washington State Health Care Authority
Date Created	1971	1990	1993	2009	2011	1988
Structure	Independent State Agency	Independent Statutory Agency	State Agency	State Agency	Independent Group/Board	State Agency
Governance	7 Commissioners appointed by Governor	12 member (maximum, with 11 currently) Board appointed by Governor with approval by various officials	7 member Board appointed by Governor, Senate President and House Speaker with approval by appointing party	9 member Board appointed by Governor with approval by Senate	5 member Board appointed by Governor on nomination by GMCB Nominating Committee with approval by Senate	9 member Board appointed by Governor
Medicaid Responsibilities	None	None	Serves as the Medicaid Single State Agency. Units within OHCA perform various Medicaid administrative functions. OHCA has delegated eligibility determinations and fair hearings for aged, blind, disabled (ABD) and LTSS groups to the Department of Human Services	Serves as the Medicaid Single State Agency. Units within OHA perform various Medicaid administrative functions, excluding for specialty programs (e.g., mental health, LTSS). OHA has delegated fair hearings to the Office of Administrative Hearings and Department of Human Services (DHS). As of July '17, DHS does all Medicaid eligibility determinations (prior limited programs)	None	Serves as the Medicaid Single State Agency. Units within HCA perform various Medicaid administrative functions. HCA has delegated eligibility determinations, fair hearings and certain program administration functions for specialty programs (e.g., LTSS, mental health) to the Department of Social and Health Services
Public Employee Health Plan Coverage Responsibilities	None	Administers coverage to retirees of state agencies and eligible participating public entities (including cities, counties, universities and charter schools)	Administers the state-funded insurance program Insure Oklahoma for small businesses and uninsured employees	The Public Benefit Employees' Board is a division within the OHA	None	The Public Employees Benefits (PEB) Board, created within the HCA, sets eligibility requirements, approves premium contributions and approves benefits
Rate Setting Responsibilities	Sets rates for hospitals but does not regulate physician fees	None	Sets provider rates for the Medicaid program	Rate setting/ development for Mental Health Organizations and CCOs	Reviews hospital budgets and oversees ACO All-Payer Model	Rate setting authority and oversight for FQHC/RHC and Medicaid providers

GOVERNANCE MODELS IN ALASKA

Alaska has experience with quasi-governmental boards and commissions. The following provides a brief description of each entity's responsibilities and governance structure. Additional information is presented in *Attachment II – Alaska Governance Models.*

- ***Alaska Permanent Fund (APF).*** The APF is a governmental endowment funded annually through a 25 percent deposit from Alaska's oil sale revenues. In 1980, the Alaska Legislature created the Alaska Permanent Fund Corporation (APFC) to manage APF assets as a semi-independent, state-owned corporation. Before APFC's creation, APF fund assets were managed by the Treasury Division of Alaska's Department of Revenue. The Board is governed by APFC policies and charters, through which its Audit and Governance Committees are established.

- ***Alaska Mental Health Trust Authority (AMHTA).*** The AMHTA is a public corporation established within the Department of Revenue to act as trustee for the Alaska Mental Health Trust Fund, ensure an integrated comprehensive mental health program for Alaskans and administer the Office of the Long Term Care Ombudsman established by statute. The AMHTA is managed by a seven member Board and committees. The AMHTA's stated statutory obligations are to: enhance and protect the trust; provide leadership in advocacy, planning, implementing and funding of a Comprehensive Integrated Mental Health Program; propose a budget for Alaska's Comprehensive Integrated Mental Health Program; coordinate with state agencies on programs and services that affect beneficiaries; and report to the Legislature, the Governor and the public about the Trust's activities.

- ***Alaska Housing Finance Corporation (AHFC)***. Created in 1972, the AHFC is a public corporation with the stated mission of providing Alaskans access to safe, quality, affordable housing through low-cost mortgage financing. The AHFC is a government instrumentality housed within the Department of Revenue, yet maintains a separate legal existence independent of the State. In 1992, the Alaska State Housing Authority (ASHA) merged into AHFC, resulting in AHFC's assumed management of Alaska's public housing and rural loan and energy programs. AHFC now provides complete state housing services to Alaskans by offering housing vouchers, issuing bonds to raise capital, offering mortgages and loans, promoting energy efficiency, offering grants and administering federal tax credits for affordable and special needs housing. The AHFC's legislative authorities and responsibilities include: administration of the Alaska Housing Finance Revolving Fund, insuring veteran's loans and purchasing other mortgage loans, and administration of subsidiary corporations.

- ***Alaska Gasline Development Corporation (AGDC)***. The AGDC was formed in 2010 under HB 369 as an independent, public corporation of the State with the purpose of determining the feasibility of developing an in-state North Slope natural gas pipeline. In 2014 under SB 13, the Legislature provided the AGDC $69.8 million to fund the State's equity participation and expanded AGDC's mission and responsibility to develop an in-state liquefied natural gas (LNG) project on the State's

behalf. AGDC's responsibilities broadly include the development, construction and marketing of the Alaska Stand Alone Pipeline (ASAP) and LNG projects. The AGDC is structured as a public corporation and government instrumentality administered within the Department of Commerce, Community and Economic Development.

- ***Alaska Energy Authority (AEA) and Alaska Industrial Development and Export Authority (AIDEA)***. The AEA is an independent state public corporation within the Department of Commerce, Community and Economic Development. The AEA serves as the State's energy office and lead agency for statewide energy policy and program development by using one agency as a clearinghouse in managing the Alaska's energy-related functions. The AIDEA was created in 1967 by the Legislature to encourage economic growth and diversification in Alaska by providing financing to industrial, manufacturing, energy, infrastructure, commercial real estate and business interests within the State. The AEA receives state funding, and the AIDEA is self-funded; both the AEA and AIDEA generate revenues from corporate and agency holdings. By statute, the AEA and AIDEA share the same seven member Board of Directors. Membership includes the Commissioner of Revenue and the Commissioner of Commerce, Community and Economic Development, and five public members possessing demonstrated leadership skills and private sector business or industry experience. Public members are appointed by the Governor and serve two-year terms.

- ***Regulatory Commission of Alaska (RCA)***. The RCA is an independent agency of the State with broad authority to regulate utilities and pipeline carriers throughout Alaska. It monitors active certificates for public utilities and pipelines, which includes regulation of water and wastewater systems, fully regulated telecommunications and electric and natural gas monopolies. The RCA is governed by five Commissioners who are appointed by the Governor and confirmed by the Legislature for six-year terms. Annually, the Commissioners elect a Chairman for a one-year term. The Chairman assumes responsibility for the RCA's administrative functions; serves as the RCA's policy spokesperson and liaison to the Legislative and the Executive branches; assigns dockets; coordinates public meeting activities; and is ultimately responsible for the RCA's adjudication process.

- ***North Pacific Fisheries Management Council (NPFMC)***. The NPFMC is nonprofit governmental organization and one of eight regional councils established by the Magnuson-Stevens Fishery Conservation and Management Act in 1976 to manage fisheries in the 200-mile Exclusive Economic Zone. It prepares and amends fishery management plans and regulations for fisheries occurring in federal waters. The NPFMC works closely with the Alaska Department of Fish and Game and the Alaska Board of Fisheries to coordinate management programs in federal and state waters. Staff support the Council and include an Executive Director, Deputy Director, technical staff and support staff; staff are not federal government employees. The NPFMC assigns tasks that are carried out by the Executive Director, who, along with the Deputy Director, directs and oversees staff. The NPFMC operates using a council system composed of Council members and staff, advisory bodies and the public. There are 11 voting members and four non-voting members. When reviewing potential rule changes the Council draws upon the services of people from Alaska and federal agencies, universities and the public who serve on panels and committees. Information is provided to the

public about Council activities and helping the public participate in the process, including holding open meetings of various advisory bodies to the public.

SECTION 4 – CONSIDERATIONS FOR ALASKA'S MEDICAID PROGRAM

Currently, Alaska uses State dollars to purchase and administer health benefits across several state and local governmental agencies. The current approach enables each responsible agency to structure its program that takes the following into consideration:

- The health needs and coverage preferences of the enrolled population
- The agency's need to manage competing priorities for resources
- Federal and state regulatory requirements
- Opportunities to coordinate health benefits with other benefits and services
- The mission, values and culture of the agency

Although agencies may be subject to substantial oversight and may be directly or indirectly dependent on State appropriations, each agency has a certain level of autonomy. Because agencies are not under common leadership and health programs are separately administered, it may be very difficult for Alaska to realize potential benefits of centralized or coordinated purchasing and administration.

As Alaska considers whether to create an Authority to centralize the administration of public payer health care programs, including Medicaid, Alaska should recognize that few states have contemplated and even fewer have implemented an operational Authority. Direct cost savings attributed to the formation of an Authority also are not available; information about cost savings are generally attributed to delivery system and payment reforms. In addition, the experiences (successes or failures) of other states may not reflect that of Alaska's potential initiatives.

The following considerations and approaches are intended to facilitate discussion and help the State identify areas for further evaluation to assess the potential feasibility of having an Authority coordinate and/or integrate purchasing efforts with Medicaid, develop a common benefit design across public payer programs and Medicaid, and integrate the Medicaid program as part of the Authority (i.e., designation of Authority as the Medicaid Single State Agency). Further evaluation and refinement of these approaches would require additional analysis and collaboration with DHSS.

A. COORDINATED/INTEGRATED PROGRAM ADMINISTRATION AND PURCHASING

Administrative functions have the potential to be coordinated across state agencies responsible for administration of benefits for State of Alaska employees and retirees, university employees, school district employees and individuals enrolled in Medicaid. Examples of potential opportunities for coordinated and/or integrated administrative functions across public payers implemented by other states include the following:

- ***Integrated Utilization Management (UM)*** – Common/uniform prior authorization policies and procedures and single Medical Director
- ***Quality/Provider Oversight*** – Development of uniform clinical best practices, common performance measures and uniform provider reporting
- ***Population Health/Wellness Initiatives –*** Development of statewide education and outreach programs
- ***Data Warehouse and Analytics –*** Access to data and analytical tools to support program management

Other areas for evaluation and implementation for coordinated purchasing strategies could include:

- Contracting for specific health care services (e.g., pharmacy) or coordinated service providers (e.g., managed care or provider-sponsored initiatives)
- Contracting for administrative services (e.g., call center, actuarial services)

Attachment III – Coordination/Integration Models and Alaska Medicaid Considerations identifies coordination/integration models explored by states that may be of interest to Alaska. In addition, this attachment provides a preliminary framework for the areas that Alaska could evaluate in consideration of its Medicaid program.

Although coordinating and/or integrating administrative functions among public payers may produce efficiencies, documented evidence from states of cost savings is limited. In addition, few states have explored these options and even fewer have actually implemented these initiatives. Challenges cited include a reluctance to coordinate without a formal governmental mandate; changes in administrative leadership; and significant differences in purchaser's program goals, covered populations and services, regulatory frameworks and operations.

If primary responsibility for program administration is retained by departments, coordinated purchasing could be accomplished through inter-departmental collaboration or through an Authority. Absent an Authority to serve as a lead agency, development of new approaches and strategies across departments could create challenges due to the availability of resources and conflicting objectives.

In response to these challenges, the Legislature could delegate broad flexibility to the Authority to achieve clear goals and objectives. As an example, the Authority would evaluate coordination opportunities and be responsible for leading coordination efforts.

ALASKA MEDICAID CONSIDERATIONS

As the Authority considers opportunities for coordination and/or integration of functions and purchasing across the Authority and Medicaid, the following considerations should be taken into account:

- ***Differences in Program Requirements*.** Medicaid has specialized program requirements and obligations related to federal compliance, including populations and services that must be covered.

- ***Cost Allocation Plan*.** There is risk of reduced federal match funds for certain administrative functions. In general, most Medicaid administration-related expenditures are reimbursed at 50 percent for amounts expended by the State. Certain administrative costs may be matched at a higher rate. To receive match funding, costs must not duplicate payment for activities that are already being offered or should be provided by other entities or paid through other programs. Costs must be supported by a Cost Allocation Plan that describes the procedures DHSS would use to identify and measure costs.

- ***Current Reform Initiatives*.** DHSS is engaged in several Medicaid reform initiatives, including those at the direction of SB 74, such as evaluating options for coordinated care, value-based purchasing and provider payment. Components of these models have been utilized by both Medicaid programs and other public/private payers as mechanisms for improving quality of care while managing costs. Unlike other programs, State Plan Amendments or waiver authorities would be required for Medicaid.

- ***Consultation and Coordination with Tribal Health.*** Nearly 40 percent of Alaska's Medicaid clients are American Indian/Alaska Native (AI/AN). The Tribal Health System is a vital part of Alaska's health care delivery system. Due to the government-to-government relationship between Tribal entities and the State, federal law and regulations and guidance issued by CMS require state Tribal consultation processes to be followed.[74] States must obtain advice and input from Tribal entities on a regular and ongoing basis prior to submission of any State Plan Amendments, waiver request or proposal for a demonstration project that is likely to have a direct effect on AI/AN and Tribal health care providers. Consultation is required and further exploration is warranted with regard to how the Tribal Health System would be impacted by the possible integration of Medicaid into an Authority. In addition, SB 74 requires DHSS to fully implement changes in federal policy on Tribal Medicaid Reimbursement that authorizes 100

[74] *See* Centers for Medicare & Medicaid Services Tribal Consultation Policy available at https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Downloads/CMSTribalConsultationPolicy2015.pdf. *See also* Revised CMS Tribal Consultation Policy (effective December 10, 2015) available at https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Downloads/TribalLeaderLetter2015.pdf.

percent federal funding for services provided to AI/AN individuals eligible for Medicaid.[75] The new federal policy allows the State to claim 100 percent federal reimbursement for Medicaid services provided to AI/AN Medicaid recipients in non-Tribal facilities if the recipients' Tribal Health Organization has a care coordination agreement established with the non-Tribal facility. Changes to the Medicaid program should be analyzed to ensure DHSS's ability to optimize savings from this policy is not negatively impacted. In state fiscal year 2018, it is anticipated DHSS will save more than $40 million as a direct result of this federal policy.

- ***Clinical/Quality*.** Collaboration between Medicaid and other public payer programs may foster development of a uniform set of evidence-based strategies to reduce costs and improve outcomes for common high-utilization services.

- ***Information Technology (IT).*** Any changes to IT-related projects would require federal approval in order to secure federal match. The approval process requires significant resources and time to complete.

- ***Administrative Burden for Providers***. Creation of common utilization management criteria and processes, reporting requirements and provider monitoring activities potentially reduces providers' administrative burden and therefore reduces overall health system costs.

B. COMMON BENEFIT PACKAGE

Pooling covered lives and coordinated purchasing could enable Alaska to pool its purchasing power to increase competition and secure/negotiate more favorable rates among providers/practitioners. The common benefit package approach envisions the centralized administration of a basic benefit package that would be made available to all individuals receiving state-funded health care (but potentially would include only a subset of the Medicaid population).

The Authority could be responsible for establishing a common benefit package that would be made available to all individuals currently receiving state-funded health care and a subset of the Medicaid population. The Authority could administer the common benefit package, including enrollment and member services, financial management (provider rates and cost sharing) and administration of benefits.

The common benefit package could enable the State to create a single funding stream to define the State's commitment for Public Employee coverage. Under this approach, State funding would be tied to the cost of the basic benefit package. Enhanced benefit packages and Health Saving Accounts (HSAs)

[75] *See* CMS State Health Official Letter #16-002, dated February 26, 2016, regarding federal funding for services "received through" an IHS/Tribal Facility and furnished to Medicaid-eligible American Indians and Alaska Natives: https://www.medicaid.gov/federal-policy-guidance/downloads/sho022616.pdf.

also would be available; additional costs of these plans would be the responsibility of the employer or employee.

As an example, the Legislature could appropriate funding to support school district employee health care directly to the Authority. School districts could use their residual health care budget to make payments to the Authority for enhanced benefits or the districts could use these funds to better compensate employees who could then choose individually to purchase enhanced benefits.

Alaska Medicaid Considerations

The common benefit package could be made available to some Medicaid populations such as expansion adults. Other populations, such as non-disabled adults, pregnant women or children, could be considered for transition to the common benefit package because the needs of these populations may be similar to Public Employees/Retirees. However, the federal Medicaid requirements for administering benefits for these groups may create additional challenges and may result in duplicative functions across the Authority and DHSS.

Transition of the Medicaid expansion adult population contemplates offering a benefit package that more closely resembles a commercial benefit than what is offered under Medicaid. This approach is supported by the following considerations:

- The federal government has indicated states have greater latitude in designing programs made available to the expansion adult population. The Authority would administer the benefit but DHSS would retain responsibility for federal claiming.
- Transitioning this group to the Authority increases its purchasing power.
- Provider reimbursement at rates above the current Medicaid rates would increase provider revenues for this population and better align payment rates for Alaska's providers. Because of the enhanced matching rate for the expansion adult population, payments are largely funded by federal dollars and the increased payment rates would represent a modest increase in State matching funds.
- Administration of benefits for the expansion adult group could create the opportunity for the Authority to develop alternative coordination approaches, such as risk-based managed care, and alternative delivery models in a more flexible manner than would be available under the traditional Medicaid program.

The common benefit model would include defined cost sharing obligations. However, the cost sharing, such as premiums, copayments or deductibles obligations may not be affordable for the Medicaid expansion adult group. Also, absent a federal waiver, CMS limits or prohibits cost sharing for certain

Medicaid recipients, income levels and for certain services.[76] Therefore, the model design would need to reduce individual out-of-pocket costs. Potential approaches for addressing this issue would include establishing different cost sharing obligations for the expansion adult group or development of a HSA-approach to fund cost sharing.

If the HSA-approach is considered, HSAs for the expansion adult group could be funded by the Medicaid program and monthly enrollee premiums. Monthly premium amounts would be based on a percentage of annual income. If there is a balance in the HSA at the end of the year, a portion of the member's contributions to the HSA would roll over to the subsequent year and could be used to reduce monthly premiums.

The HSA approach could enable the Authority to establish the same benefits, including cost sharing, across all program participants. However, establishing HSAs for the Medicaid population would be administratively burdensome and likely would be administered by a third party vendor. States that had or are currently utilizing HSA-like arrangements for the Medicaid expansion adult population include Arkansas and Indiana, respectively.[77] The State will need to determine whether the administrative investment in HSA-like accounts for the expansion adult population is warranted to advance consumer decision making and responsibility. For example, Arkansas phased out HSA-like accounts due to administrative burdens and associated costs of the program along with the determination that the accounts were an inefficient way of promoting consumer choice and personal responsibility.

C. INTEGRATION OF MEDICAID AS PART OF THE AUTHORITY

An Authority would have the following responsibilities:

- Strong analytic capacity to support objective analysis and capability to access health care data to complete these objectives
- Fiscal management and administration of health benefits of public payers
- Integration and coordination of certain administrative functions
- Development of approaches that ensure access to care for all Alaskans (e.g., value-based purchasing, contracting to enhance provider network capacity, determining appropriate payment rates)
- Monitoring and enhancement of the Alaska health care delivery system

However, the Authority's responsibilities with respect to the Medicaid program requires additional evaluation as identified below.

[76] *See* https://www.medicaid.gov/medicaid/cost-sharing/index.html.
[77] Information on the Arkansas Works and Healthy Indiana Plan (HIP) 2.0 programs is presented in Section 3 of this report.

ALASKA MEDICAID CONSIDERATIONS

The Medicaid program would not immediately transition to the Authority for the following reasons:

- ***Medicaid operates under a complex regulatory framework.*** Other states have contemplated the inclusion of Medicaid and other state-funded health programs within a single regulatory structure. Currently, Oregon and Washington are the only states that operate Authorities which oversee their Medicaid programs along with other public payer health programs. However, both of these Authorities delegate certain functions (e.g., fair hearings, eligibility determinations) or administration of specialized programs (e.g., LTSS, behavioral health) to agencies outside of the Authority.[78]

  DHSS administers the Alaska Medicaid program within a specifically-defined set of federal laws, regulations and policies.[79] These requirements address all facets of the program's operations, including member eligibility and enrollment, member services, provider oversight, utilization management, claims processing, reporting and financial management. Any programmatic changes require federal review and approval.

  The Authority will have an extensive set of implementation tasks to become operational. The transition of Medicaid following implementation would significantly contribute to the complexity of start-up activities. Additionally, the Authority will be responsible for identifying and implementing approaches for coordinating administrative functions early on and in cooperation with DHSS; this exercise will be helpful to better understand the opportunities created by transitioning Medicaid to the Authority and to identify specific Medicaid administrative functions that should be retained by DHSS.

- ***DHSS is organized to address health and social needs.*** There is an increased recognition of the impact that social determinants have on health care costs.[80] DHSS administers Alaska's Medicaid program, health-related programs and social service programs. DHSS currently is organized to address both the social and health needs of the populations it serves. The creation of an Authority that manages and oversees only health care services would move the State away from a structure intended to integrate health and social services to address the needs of vulnerable populations. The continued integration of health and social services should be carefully analyzed, especially regarding the administration of certain specialized programs, such

[78] Additional detail about these Authorities and their responsibilities related to Medicaid is presented in Section 3 and *Attachment I – Authority/Governance Models* of this report.
[79] Additional information regarding federal Medicaid requirements and Alaska's Medicaid program is presented in Sections 1 and 2 of this report.
[80] McGovern, L., Miller, G. & Hughes-Cromwich, P., Health Affairs, "The Relative Contribution of Multiple Determinants to Health Outcomes," available at http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_123.pdf.

as home and community based (HCBS) waiver programs. In addition, current behavioral health reform efforts are underway at DHSS that must be taken into consideration.

Prior to transitioning Medicaid to the Authority, a detailed assessment would be necessary to validate whether the transition is in the best interest of the State to fully realize any goals for health care purchasing. Policy considerations include the following:

- ***Differences in Program Requirements*.** Medicaid has specialized program requirements and obligations related to federal compliance, including populations and services that must be covered. These requirements may make it difficult to centralize administration and purchasing across public programs. Ultimately, Medicaid could continue to operate independently even if it were under the Authority.

- ***Staffing/Cost Allocation Plan*.** DHSS has a little over 3,400 funded permanent positions. DHSS provides general administrative support to Medicaid and receives federal reimbursement for providing these services under a Cost Allocation Plan. DHSS would need to retain staffing to administer existing social service programs and a detailed staffing analysis would need to be undertaken to fully assess the potential impact of transitioning the Medicaid program from DHSS to the Authority. This analysis also would examine whether certain Medicaid administrative functions should remain with DHSS while other functions transition to the Authority while ensuring there is not a loss of federal reimbursement for the administration of Alaska's Medicaid program. For example, the State may determine that DHSS should retain eligibility functions and responsibility for administration of the HCBS waiver programs.

  In the case of Washington, the state needed to increase its staffing to accommodate federal requirements for administering/supervising the administration of the Medicaid program. Although the Authority is the designated entity in Washington, it delegated to the Department of Social and Health Services (DSHS) the management and oversight of Medicaid services such as mental health and substance abuse, private duty nursing for children and adults and nursing homes. For the state, reassigning staff was not an option because it would require the Authority to remove staff from other necessary activities to maintain a viable Medicaid program and assigning partial full-time staff would not provide the capacity to exercise the level of oversight necessary.

- ***Information Technology (IT).*** Any changes to IT-related projects would require federal approval in order to secure federal match. The approval process requires significant resources and time to complete. If Medicaid transitions to the Authority, certain IT-related functions, such as claims processing, may be able to support only the Medicaid program.

- ***Timeline*.** Administrative changes impacting the Medicaid State Plan and the Cost Allocation Plan will require time to secure federal approval.

- ***Transition*.** The need for a transition period, possibly two years or longer, could be required to allow time to determine staffing, contracts, equipment and physical space that would be moved or affected by changes in the administrative structure of the Medicaid program. In addition to existing workloads, committees and workgroups would need to be organized to assist with mapping out processes. Funding and/or dedicated staff for transition tasks may be necessary.

If Alaska determines that integration of Medicaid into the Authority should occur, the transition could occur under two organizational approaches:

- ***Medicaid established as a separate Division within the Authority*** – this organization model serves to recognize the complexity of Medicaid program requirements and the transition would be potentially less disruptive to current operations.

- ***Existing Medicaid program functions become the responsibility of the three Divisions (Health Care Transformation, Operations and Finance)*** – this model promotes a more integrated and streamlined approach to managing state-purchased health care.

Currently, only two states, Oregon and Washington, have a legislatively-mandated Authority that purchases health care coverage for both the Medicaid program and public employees benefit program. And, as discussed in Section 3 of this report, certain administrative functions (e.g., eligibility determinations and enrollment) and administration of specialized programs (e.g., LTSS, mental health) remain with the states' department of social services. If the State elects to move forward with transition of Medicaid to the Authority, it may determine that certain Medicaid functions should be retained by DHSS as in the case of Oregon and Washington. Examples include the following:

- ***Eligibility Determinations and Enrollment***[81] – Given the complexity of Medicaid eligibility systems, its linkage to other assistance programs, and extensive involvement of field staff to support families, it may be most feasible for eligibility and enrollment to continue to be a DHSS function.

- ***Specialized Programs*** – Administration of specialized programs frequently requires extensive member support, given the complex health and social needs of these populations. And, DHSS staff oversee administration of non-Medicaid programs and grants in conjunction with administration of specialized health services (e.g., LTSS and behavioral health). Therefore, it may be most efficient to retain administration of specialized programs within DHSS. If these specialized health services remain with DHSS, the Authority and DHSS must work together closely to ensure the integration of care for Alaska's most vulnerable residents. During the Medicaid Redesign process in 2015, stakeholders consistently commented that improving the

[81] Today, the Office of Administrative Hearings within the Department of Administration is responsible for Alaska's Medicaid recipient case hearings. Similarly, Oregon and Washington conduct hearings through agencies outside of the Authority such as the department of human services or office of administrative hearing.

integration of behavioral and physical health care was necessary to improve health outcomes and reduce health care costs.

Coordination and consultation with the Tribal Health System and supporting current Medicaid claiming could be retained by DHSS or transitioned to the Authority. However, if the Authority is responsible for Medicaid claims processing it would be responsible for ensuring that Tribal Health System claims continue to be processed appropriately and preserve eligibility to receive 100 percent federal funding reimbursement. Also, if the Authority is responsible for the development of statewide health reform initiatives and promotion of wellness, the Authority would need to coordinate and consult with Tribal Health to promote access and quality of care for AI/AN. Other considerations may support continuation of the existing relationship between DHSS and Tribal Health. Further evaluation, including the required consultation with Tribal Health, will be necessary prior to assignment of responsibilities.

Even after the transition, success will be dependent on ongoing coordination and collaboration between the Authority and DHSS. As an example, if DHSS retains responsibility for administration of specialized programs but oversight of the Medicaid Management Information System (MMIS) is transitioned to the Authority to process all Medicaid claims, then DHSS staff would require systems access to support its oversight role.

SECTION 5 – SUMMARY OF KEY DECISION CONSIDERATIONS AND PROVISIONAL MODEL

A. SUMMARY OF DECISION CONSIDERATIONS

Section 4 identified three options for how an Authority could have a role with regard to the administration of Medicaid benefits. These options could be implemented independently or could be implemented as transitional steps.

The policy options represent a significant departure from the current organizational model and how Medicaid benefits are administered. Alaska therefore will need to carefully evaluate the extent to which each option represents a viable solution for advancing its policy objectives. Exhibit 5-1 below presents a summary of the potential opportunities and challenges associated with each option. The summary represents a starting point for evaluation of options and additional opportunities and challenges may be identified as the options are evaluated and refined.

Exhibit 5-1 – Summary of Decision Considerations

Policy Option	Potential Opportunities	Potential Challenges
Coordinated/ Integrated Purchasing	• Strengthens the ability of the State to leverage its purchasing power for both administrative support services and health services • Coordination and/or consolidation of administrative functions could reduce administrative expenses • Development of consolidated analytic capabilities and uniform measures could promote quality and access to care • Streamline provider reporting and monitoring could reduce administrative burden on providers and therefore reduce overall health system costs • Strengthens the ability of the State to leverage its purchasing power to help advance delivery reform models, such as value-based purchasing and community-based models (e.g., provider-led delivery systems)	• Medicaid has specialized program requirements and obligations related to federal compliance; adherence to these requirements across other public programs could be more costly • Federal funding for Medicaid administrative functions potentially could be reduced • Changes to how Medicaid is administered requires federal approval • DHSS currently is engaged in several Medicaid reform initiatives that place a demand on its administrative resources; engagement in coordination with other public programs potentially requires additional resources • Program changes that impact Tribal Health will need to be carefully considered and developed with required Tribal consultation • Any changes to IT-related projects would require federal approval in order to secure federal Medicaid match. The approval process

Policy Option	Potential Opportunities	Potential Challenges
		requires significant resources and time to complete.
Common Benefit Package	• Enhances State's ability to leverage its purchasing power to control program costs and advance health reform • Creates a benefit that defines the State's contribution toward health care • Provides flexibility to establish benefits based on available resources • Centralized administration of common benefit potentially reduces administrative costs • Contributes to provider reimbursement parity	• Inclusion of Medicaid expansion population would require federal approval • Health needs of Medicaid expansion population may increase overall costs • Benefit design may be not fully address health needs of the Medicaid expansion group • Cost sharing obligations for Medicaid expansion population would need to be addressed; other states have experienced challenges with use of HSAs to fund cost sharing and CMS regulations limit cost sharing opportunities.
Integration of Medicaid as Part of the Authority	• Maximizes the State's purchasing power • Reduces costs for health benefit administration • Purchasing power and designation of a single entity supports system-wide health reform • Streamlines contracting, claims processing and utilization management functions • Assigns responsibility to a single entity to ensure a sustainable, high-quality health system	• Medicaid operates under complex regulatory framework that may require certain functions to operate independently • Alaskans' health and social needs may best be met by a department that administers both health and social services • DHSS would need to retain staffing to administer existing social service programs and transitioning health services to a separate entity could increase staff resource needs and impact federal Medicaid funding • If certain Medicaid administrative functions remain with DHSS, overall Medicaid program administration potentially could be less coordinated if divided across two agencies • Administrative changes impacting the Medicaid State Plan and the Cost Allocation Plan will require time to secure federal approval. • A transition period, possibly two years or longer, could be required to allow time to determine staffing, contracts, equipment and physical space • The potential impact on the current Tribal Health System would need to be evaluated and changes would

Policy Option	Potential Opportunities	Potential Challenges
		need to performed in consultation with Tribal entities

Exhibit 5-2 below presents information on suggested tasks to assess the feasibility of: (1) coordinating and/or integrating purchasing efforts across Alaska's public purchasers of health care, (2) implementing a common benefit package across public payer programs and (3) integrating Medicaid within the Authority.

Exhibit 5-2 – Summary of Suggested Assessment Tasks

Evaluation Objective	Key Design Elements	Types of Analyses	Data Requirements
COORDINATING AND/OR INTEGRATING PURCHASING EFFORTS			
Impact on Administrative Costs			
• How does this approach impact State staffing and State staffing costs? • How does this approach impact State contract costs for administrative services?	• Determine whether this approach will be supported by a newly created Authority, with responsibility for identifying and advancing coordination • Determine scope and transition timeline for coordination	• Evaluate and crosswalk all current contracted services to identify opportunities for consolidation or coordination • Evaluate potential efficiencies resulting from coordination/ integration • Determine impact of coordinated functions on existing Departments' staffing and costs • Assess impact pf coordinated functions on total costs as well as the distribution of costs across State, local and Federal funding sources	• Detailed organizational/staffing charts, descriptions of functions and budgets for all governmental units, as well as job descriptions, salary/fringe benefit costs and funding sources for all employees: ○ wholly or partially funded by Medicaid administrative dollars ○ responsible for administration of health care • Historical and projected expenditures for overhead (office space, training, office supplies, IT, phone) • Historical and projected expenditures for contracted services that are health-related, including all contracted services wholly or partially funded by Medicaid administrative dollars • Start-up costs for transition (relocation

Evaluation Objective	Key Design Elements	Types of Analyses	Data Requirements
			of staff and offices, IT needs, job descriptions for new job types and cross-training)
Impact on Health Care Expenditures and Health Care Expenditure Growth			
• How does this approach impact State expenditures for medical services? • Does the approach advance the State's ability to control program cost growth?	• Determine whether health care services potentially could be purchased across State payers • Determine whether coordinated purchasing will be pursued to help advance health delivery reform	• Evaluation of projected expenditures based on alternative payment rates for certain services • Evaluation of opportunities to increase federal funding (e.g., Medicare/Medicaid) via an All-Payer Model • Evaluation of potential fiscal impact of health reform initiatives across all State-funded programs	• Historical utilization (claims) and expenditure data for certain services across payers
Impact on Quality of Care and Access to Care			
• Does this approach impact quality of care? • Does this approach impact access to care?	• Determine whether coordinated purchasing will be pursued to help advance health delivery reform • Determine which model will be deployed to advance best practices/quality monitoring	• Evaluation of opportunities to advance best practices, potentially via health and IT systems investments and/or value-based purchasing	• Assessments of current care delivery gaps • Assessment of additional costs resulting from care delivery gaps • Baseline quality metrics by covered population (e.g., emergency department usage, hospital readmission rates)
COMMON BENEFIT PACKAGE			
Impact on Administrative Costs			
• How does the approach impact State staffing and State staffing costs?	• Determine whether the approach will include any Medicaid populations • Determine whether school district/local government	• If Medicaid populations are included, determine impact of transition on current program administrative costs • If Medicaid populations are	• Historical administrative costs, by funding source, for all populations enrolled under the approach

Evaluation Objective	Key Design Elements	Types of Analyses	Data Requirements
	participation will be mandatory or voluntary	included, assess potential for accessing Federal administrative match to support the approach • Establish Authority's staffing needs and operating budget to support the approach • Identify potential administrative savings across entities • Determine the costs for administering the HSA option, including the additional costs associated with administering HSAs on behalf of individuals enrolled in Medicaid	
Impact on Health Care Expenditures and Health Care Expenditure Growth			
• How does the approach impact State expenditures for medical services? • Does the approach advance the State's ability to control program cost growth?	• Determine populations to be enrolled under the approach • Define benefits to be included under the approach	• Evaluation of projected expenditures under existing programs and under the approach	• Historical utilization (claims) and expenditure data for all populations to be covered under the approach
Impact on Quality of Care and Access to Care			
• Does the approach impact quality of care? • Does the approach impact access to care?	• Determine whether benefit administration will advance best practices/quality monitoring	• Evaluation of opportunities to advance best practices, potentially via value-based purchasing	• Baseline quality metrics by covered population (e.g., emergency department usage, hospital readmission rates)
INTEGRATING MEDICAID WITHIN THE AUTHORITY			
Impact on Administrative Costs			
• How does the approach impact State staffing and State staffing costs?	• Finalize scope of Authority's responsibilities, including the assumption of	• Develop detailed staffing model for Authority • Develop operating budget for Authority	• Detailed organizational/staffing charts, descriptions of functions and budgets for all governmental

Evaluation Objective	Key Design Elements	Types of Analyses	Data Requirements
• How does the approach impact State contract costs for administrative services? • Does the approach create new State functions and costs?	existing State and local functions and new areas of responsibility • Determine extent to which current DHSS/Medicaid functions transition to the Authority (e.g., eligibility and enrollment, behavioral health, home and community based waiver programs, senior services) • Determine extent to which other entities' functions (e.g., school districts) transition to the Authority	• Determine impact of Authority's creation on existing Departments' staffing and costs • Assess impact of the staffing model on total costs as well as the distribution of costs across State, local and Federal funding sources • Evaluate and crosswalk all current contracted services to identify opportunities for consolidation or coordination • Identify additional costs to support new functions	units, as well as job descriptions, salary/fringe benefit costs and funding sources for all employees: ○ wholly or partially funded by Medicaid administrative dollars ○ responsible for administration of health care • Historical and projected expenditures for overhead (office space, training, office supplies, IT, phone) • Historical and projected expenditures for contracted services that are health-related, including all contracted services wholly or partially funded by Medicaid administrative dollars • Start-up costs for transition (relocation of staff and offices, IT needs, job descriptions for new job types and cross-training)
Impact on Health Care Expenditures and Health Care Expenditure Growth			
• How does the approach impact State expenditures for medical services? • Does the approach advance the State's ability to control program cost growth?	• Finalize scope of Authority's responsibilities, including: ○ covered populations ○ its ability to establish payment rates across enrollment groups	• Evaluation of projected expenditures based on alternative payment rates • Evaluation of provider budgets and operating margins • Evaluation of opportunities to increase federal funding (e.g.,	• Historical utilization (claims) and expenditure data for all covered populations • Historical premium payments • Provider costs and revenues, by payer

Evaluation Objective	Key Design Elements	Types of Analyses	Data Requirements
	○ it role related to monitoring and improving Alaska's health care delivery system	Medicare/Medicaid) via an All-Payer Model • Evaluation of potential fiscal impact of health reform initiatives across all State-funded programs	
Impact on Quality of Care and Access to Care			
• Does the approach impact quality of care? • Does the approach impact access to care?	• Finalize scope of Authority's responsibilities, including: ○ covered populations ○ its ability to establish payment rates across enrollment groups ○ it role related to monitoring and improving Alaska's health care delivery system • Define Authority's role and available funding to advance system reform	• Evaluation of payment rate changes on total health care spending • Evaluation of opportunities to advance best practices, potentially via systems investments and/or value-based purchasing	• Assessments of current care delivery gaps • Assessment of additional costs resulting from care delivery gaps • Baseline quality metrics by covered population (e.g., emergency department usage, hospital readmission rates)

B. PROVISIONAL MODEL

The following presents a provisional model for creation of an Authority and the role it would have with respect to the Medicaid program. The provisional model is based the experience in other states and the design elements discussed in prior sections of this report. The model represents one approach among many and is intended to illustrate the potential structure, role and responsibilities of an Authority.

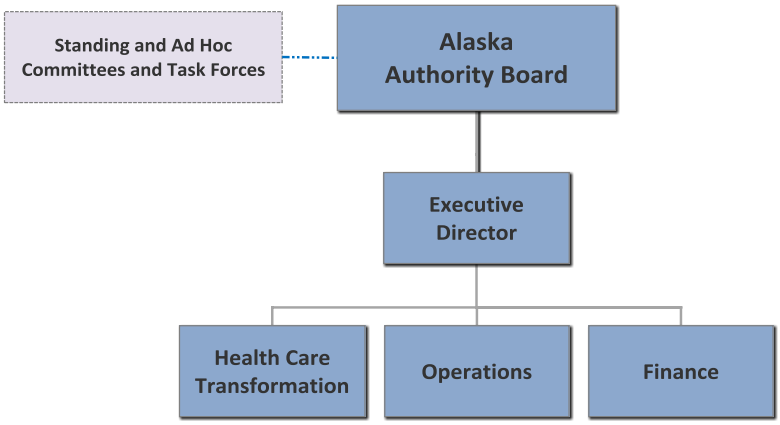
AUTHORITY ORGANIZATIONAL STRUCTURE

Traditionally, Alaska boards and commissions reside within State Agencies (e.g., the Alaska Permanent Fund Corporation is part of the Department of Revenue). Given the scope of the Authority's

responsibilities and the goal for it to have the ability to operate with autonomy, it may be most suitable as an independent entity.

Exhibit 5-3 below provides an approach for how of the Authority's governance, advisory bodies and operations could be organized.

Exhibit 5-3 – Authority Organizational Structure



Governance

The provisional governance structure is modeled off of other states' current board compositions and those utilized by Alaska's quasi-governmental entities. Board memberships typically range from five to twelve, with appointments/confirmations typically by either the Executive or Legislative branches of state government. Section 3 of this report provides an overview of governance structures from other states and Alaska; specifics on each state and entity are provided in *Attachment I – Authority/Governance Models* and *Attachment II – Alaska Governance Models*, respectively.

The Authority would be overseen by the Board. The Board would include seven members:

- One Board Chair appointed by the Governor
- Two additional members appointed by the Governor
- One member appointed by Senate President
- One member appointed by Speaker of the House of Representatives
- Two non-voting members who are active heads of principal Alaska State government departments. These members could be from the Governor's Office or Department executives (e.g., Commissioners, Deputy Commissioners or Division Directors from the Department of Administration, Department of Revenue, Department of Commerce, Community and Economic Development (Division of Insurance) or Department of Health and Social Services)

Appointments to the Board should include a cross-section of stakeholders and could include providers, consumers, state employees and school employees. Members would be "subject matter experts" and possess knowledge and expertise related to health care. Based on the experience of other states, ideally the Board Members would demonstrate the following qualities:

- Knowledge in health care delivery and/or finance
- Leadership skills
- Ability to act independently and free of conflict
- Civic participation and responsibility

In making member appointments, consideration would be given to geographic location, gender and diversity to allow for balanced representation. To foster continuity in the event of an administration change, members would serve staggered four-year terms and have the ability to serve more than one term, subject to the nomination/appointment process.

Advisory Bodies

The Board would be supported by both standing and ad hoc committees and task forces. These committees and task forces would allow for stakeholder outreach and involvement as well as provide research and evidence-based information to make recommendations to and support the Board in its policy-making responsibilities/initiatives. Examples of supporting committees and their roles, along with potential representation, are presented in Exhibit 5-4 beginning below. (Additional committees and task forces could be added as needed.)

Exhibit 5-4 – Supporting Committees

Body	Representation	Role
Member Advisory Group	• State Employees • School Employees • State Retirees • University Employees • Medicaid Recipients	• Provide input regarding Authority policies and initiatives • Provide input regarding delivery system reform
Provider Council	• Authority's Medical Director • Authority Staff • Hospitals • Primary Care Providers • Specialist Physicians • Pharmacists • Tribal Health Providers • Provider Associations	• Provide input regarding value-based purchasing strategies and rate methodologies • Advise Board regarding health care delivery gaps and provide strategies to address • Provide input regarding delivery system reform
Health Information Technology (HIT) Advisory Group	• Authority Staff • Commercial Payers • Providers (Hospitals, Physicians)	• Identify opportunities to coordinate and advance State's HIT goals • Identify opportunities to use data analytics to advance quality oversight and improvement activities • Provide input regarding delivery system reform
Quality and Health Transformation Committee	• Authority's Health Policy Director • Authority's Medical Director	• Provide input regarding quality measures • Identify opportunities to advance uniform quality measurement across payers

Body	Representation	Role
	• Authority Staff • DHSS/Medicaid Staff • Providers • Consumers • Commercial Payers • Tribal Health Providers	• Provide input regarding best practices/clinical guidelines • Provide input regarding population health • Provide input regarding delivery system reform
Medical Care Advisory Committee (MCAC)	• Bylaws for Alaska's MCAC defines the committee structure[82]	• Under the Social Security Act, states are required to establish a Medical Care Advisory Committee to advise the Medicaid agency in order to obtain federal matching funds for the Medicaid program

Operations

Given the potential responsibilities of the Authority, the Authority's Executive Director would be a full-time position. The appointment would be made by the Governor or the Authority Board.

To carry out the Authority's objectives, the Authority could consist of Divisions to cover the following areas:

- ***Health Care Transformation*** – Provides policy development, strategic planning and clinical leadership for public payers and Alaska's health care delivery system. This includes:
    - Evaluation and implementation of health reform initiatives
    - Monitoring of Alaska's health care system, including quality and access
    - Development of delivery system technology tools
    - Investment in infrastructure and initiatives to address gaps in the current delivery system and to advance reform

- ***Operations*** – Administers all facets of operations, such as program integrity/compliance, utilization management, contract oversight, legal services and information technology.

- ***Finance*** – Manages budgets, financial transactions and reporting.

These Divisions could be staffed by Alaska State employees and include key officer positions as follows:

- ***Health Care Transformation*** – Health Policy Director
- ***Operations*** – Chief Operating Officer and a Medical Director
- ***Finance*** – Chief Financial Officer

[82] *See* http://dhss.alaska.gov/dhcs/Documents/MCAC/news_rec_bylaws_mcac/bylawsrev_102905_mcac.pdf.

Funding

The Authority could be funded by appropriations for all designated programs and services (including management of federal Medicaid funding if Medicaid is transitioned into the Authority). The Legislature could commit to fund the Authority at a level that allows for reasonable annual growth and designate the Authority as the entity responsible for managing the public payer health care program to ensure that spending is within this defined limit. Other states have adopted specific cost growth targets.[83] The Authority could have legislative permission to carry reserves.

In order to support the State's health reform objectives, the Authority could financially support health care transformation. The Authority could develop and support innovative approaches to: improve access to care (e.g., infrastructure investment, provider recruitment), develop multi-payer approaches to improve quality and control costs, support care coordination efforts at the community level, and improve population health. Ideally, separate funding would be identified and could have a separate revenue source because of the institutional bias against making long-term investments and system change. In the alternative, the Authority could reinvest any savings within the predetermined annual growth limit to support transformation.

Medicaid Transition Summary

Following its creation, the Authority would be responsible for all state-funded health care, with the exception of Medicaid. Under the provisional model, Medicaid would not transition to the Authority until a later period. The Authority will have an extensive set of implementation tasks to become operational. The transition of Medicaid early in the implementation of the Authority would significantly contribute to the complexity of start-up activities. During this period, the Authority, in cooperation with DHSS, would identify and implement approaches for coordinating administrative functions to better understand the opportunities created by transitioning Medicaid to the Authority and to identify specific Medicaid administrative functions that should be retained by DHSS. The Authority and DHSS would need to account for the complex State and federal regulatory framework that Medicaid operates under and the reform measures underway that continue to support integration of health and social services of

[83] Two examples include Oregon and Maryland. Oregon received federal approval for a Section 1115 Waiver to transform its Medicaid program. As part of its waiver, Oregon committed to reduce the rate of growth of its Medicaid program from 5.4 percent to 3.4 percent per capita. Failure to meet its goal for the 2 percent reduced trend calculated over the life of the waiver or any quality targets (as outlined in the waiver) would result in payment of penalties to the federal government. Oregon's model moved from separate managed care organizations to one managed care entity known as a coordinated care organization (CCO). CCOs accept full financial risk and are accountable for all care for members out of one integrated budget that increases at a fixed rate of growth.

Maryland's All-Payer Model converted hospital payments from fee-for-service to a global system in which hospital total revenue for all payers is set at the beginning of the year; the state committed to limiting growth in the per capita hospital revenues for all payers to the long-term growth rate of 3.58 percent per year.

the Medicaid population. In addition, the Authority, in cooperation with DHSS, would need to determine if certain Medicaid functions should be retained by DHSS (e.g., Medicaid eligibility determinations, enrollment of program-eligible individuals, and administration of specialized programs).

If Alaska transitions the Medicaid program's core administrative functions to the Authority, the Authority would become the Single State Agency for the administration of the Medicaid program. (To allow for this transition, Alaska would need to complete Medicaid State Plan amendment/waiver process and obtain federal approval.) As the Single State Agency, the Authority would be responsible for the Medicaid program's fiscal management, policy development and program oversight. The Authority would continue to collaborate with DHSS to advance coordinated delivery of health and social services for Alaskans.

Exhibit 5-5 below provides a summary of the roles and responsibilities that the Authority and DHSS could have with respect to the Medicaid program's core administrative functions under this provisional model.

Exhibit 5-5 – Summary of Roles and Responsibilities for Medicaid's Core Administrative Functions

	Before Transition		**After Transition**
	Identification and Implementation of Coordinated/Integrated Program Administration and Purchasing	**Development of a Common Benefit Model**	**Transition of Medicaid Core Administrative Functions to the Authority**
Authority Role	*Evaluation and implementation of initiatives*	*Administration of benefits, including member services, claims processing, provider rates and network management*	*Becomes Medicaid Single State Agency, responsible for administration of Medicaid program, including claims processing; provider contracting, capacity development and reimbursement; federal reporting and financial management; and care coordination and chronic care management*
DHSS Role	*Coordination with Authority; retains responsibility for all other Medicaid administrative functions*	*Medicaid reporting/claiming*	*Retains responsibility for Medicaid eligibility and enrollment as well as certain administration functions for specialized programs (e.g., fiscal management, provider oversight, quality, member services, care coordination)*

Implementation Activities

Exhibit 5-6, beginning on the following page, provides a summary of potential implementation activities and estimated timeline that would warrant further evaluation under this provisional model. These potential implementation activities under the proposed model were developed based on program information available at the time of this report and goals identified through SB 74. However, the ability of these activities to achieve the above-mentioned objectives and consideration of countervailing goals of the State will need to be further evaluated and debated. Further evaluation of the draft implementation activities would need to be supported by detailed analyses, including but not limited to:

- Development of operating budgets
- Determination of impact on existing structures and identification of additional costs
- Evaluation of:
    - Potential fiscal impact of health reform initiatives across all State-funded programs
    - Potential efficiencies and impact of coordinated functions on existing staffing and costs
    - Projected expenditures under existing programs and under the proposed approach
    - Potential change in federal funding
    - Payment rate changes on total health care spending, access and quality
    - Opportunities to advance best practices, potentially via systems investments and/or value-based purchasing
- Evaluation and crosswalk of current contracted services to identify opportunities for consolidation or coordination and impact on existing structures

In addition to these analyses, Tribal consultation and stakeholder engagement, including public comment, would be necessary to identify any concerns or gaps for transitioning health care purchasing to a consolidated Authority, including the transition of Medicaid to the Authority.

Exhibit 5-6 – Summary of Implementation Activities

Pre-Transition of Medicaid Administrative Functions		Transition of Medicaid Administrative Functions	
Implementation Activities	**Estimated Timeframe**	**Implementation Activities**	**Estimated Timeframe**
Creation of an Authority			
Legislation to Create Authority	Up to 24 months	Completion of Federal Medicaid State Plan/Waiver Approval Process to Secure Capability to Administer Medicaid (i.e., become Single State Agency)	6 to 12 months
Evaluate Re-Assignment of State Agencies/Staff	3 to 6 months		
Develop Operational Structure	2 to 4 months	Re-Assignment of State Agencies/Staff	18 to 24 months

Pre-Transition of Medicaid Administrative Functions		Transition of Medicaid Administrative Functions	
Implementation Activities	**Estimated Timeframe**	**Implementation Activities**	**Estimated Timeframe**
Develop Integrated Purchasing Initiatives, including revised provider rates, streamlined vendor contracts, care coordination models	9 to 24 months		
Identification and Implementation of Coordinated/Integrated Program Administration and Purchasing			
Identify and Evaluate Opportunities for Administrative Coordination	4 to 6 months	Identify and Evaluate Coordinated Purchasing Strategies for Health Care Services	6 to 12 months
Evaluate Re-Assignment of State Agencies/Staff	3 to 6 months	Develop Contract Requirements and Procurement Materials	2 to 4 months
Implement Coordinated Administrative Functions	4 to 8 months	Contract with Providers	4 to 12 months
		Explore and Develop Future Provider Delivery/Payment Models (e.g., All-Payer Model) and Other Health Reform Initiatives	6 to 24 months
Development of a Common Benefit Model			
Develop Common Benefit Structure	6 to 12 months	Secure Federal Waiver Approval	6 to 12 months
Implement Common Benefit Package	9 to 12 months	Implement Common Benefit Package for Certain Medicaid Populations	9 to 12 months
Expand Common Benefit Package to Other Governmental Entities	12 to 24 months	Identify and Implement Health Reform Initiatives	6 to 18 months

ATTACHMENT I – AUTHORITY/GOVERNANCE MODELS

The following contains additional information on the structure and governance models for other states' Authorities.

Authority/Governance Models	
Hawaii Health Authority	
Overview	
Creation	The Hawaii Health Authority (HHA) was established in 2009.
Purpose	The HHA's dual legislative purpose is the overall health planning and the development of a comprehensive plan of universal health care for all Hawaiians.
Funding	The HHA was initially funded with $100,000 appropriated by the legislature, but it appears it was not released. On January 25, 2017, Hawaii SB 977 was introduced to abolish the HHA "as part of the effort to streamline health planning and policy management" in favor of the state Health Planning and Development Agency and Health Care Innovation Office, which also conduct comprehensive health planning activities. Also on January 25, 2017, Hawaii SB 1269 was introduced to fund the HHA. As of February 17, 2017, both SB 977 and SB 1269 are pending on referral before the Senate Ways and Means Committee; SB 1269 was also considered and passed on by the House.
Board Membership	
Number	The HHA is composed of nine members. One member of the HHA Board is selected as the HHA Executive Director by a majority vote of a quorum of the members of the HHA.
Appointment	Members are appointed by the Governor subject to selection of three members from a list of nominees submitted by the Speaker of the House and three members from a list of nominees submitted by the President of the Senate.
Qualifications	Not stated.
Terms	Each HHA member is appointed for a four-year term and holds office until the member's successor is appointed and qualified.
Structure & Committees	
Structure	The HHA was established as an autonomous public corporate body and instrumentality within Hawaii's Department of Budget and Finance.
Committees	Based on HHA Meeting minutes, the HHA appears to have established a Personnel Committee for the intended purpose of hiring staff. However, appropriated funding did not materialize.
Subsidiaries	N/A
Authorities & Responsibilities (Regulatory Role)	
Authorities	Statutory duties – The HHA's stated statutory authority includes: • Overall health planning for the State • Determining future capacity needs for health providers, facilities, equipment, and support services providers As part of this charge, the HHA was to develop a comprehensive health plan of universal coverage for all Hawaiians that includes: • Establishing eligibility for inclusion for all individuals in a health plan • Determining all reimbursable services to be paid by the Authority • Determining all approved providers of health plan services • Evaluating health care and cost effectiveness under such plan • Establishing a health plan budget

Authority/Governance Models	
Hawaii Health Authority	
	• Determine the necessary and available waivers under federal law, rule, or regulation implement and maintain such plan
Responsibilities (Regulatory Role)	Reporting – As required by establishing legislation, the HHA's defined legislative responsibilities included comprehensive health planning, and reporting on these activities, findings and recommendations to the legislature: • *Health Futures Task Force* (1999) • *Update to Health Futures Task Force Report* (December 2011) • *The Hawaii Health Authority Proposal: Using The Affordable Care Act as a Stepping Stone Toward Universal Health Care* (January 2013)
Staffing	
Staffing	Presently, none. SB 1269 amends HHA enacting legislation by providing for the hire of an executive director and other staff necessary to assist in the performance of the HHA's duties and responsibilities. SB 1269, as passed and considered by the House, is pending before the Senate Ways and Means Committee.
Other	N/A
Medicaid Considerations	
Federal regulatory requirements	N/A
Other Considerations	
State and Federal Regulatory or Statutory Changes	Legislation clearly defining authority and reorganization.
Opportunities and Challenges	Consideration of adequate timelines.
Technical/Implementation Issues	Preparing an adequate plan and timetable for implementation and conforming to the enabling legislation to avoid legal challenges on scope.

Authority/Governance Models	
Maryland All Payer Model - Health Services Cost Review Commission	
Overview	
Creation	The Maryland Health Services Cost Review Commission (HSCRC) was established in 1971.
Purpose	The HSCRC is charged with regulating hospital rates for all Maryland payers, as measured by the following goals of: • Constraining hospital cost growth • Ensuring hospitals have the financial ability to provide efficient, high quality services to all Marylanders • Increasing equity and fairness of hospital financing
Board Membership	
Number	The HSCRC is governed by seven-member Commission.
Appointment	Commissioner members appointed by the Governor.
Qualifications	Commissioners are volunteers appointed to serve the "public interest" representing consumers, payers, providers and hospital administrators from a variety of healthcare backgrounds.
Terms	Each Commission member serves a 4-year term.
Structure & Committees	
Structure	The HSCRC is an independent State agency.
Committees	Advisory Council – All Payer Hospital System Modernization Advisory Council. There are 25 members currently serving on the 2016 Advisory Council, which provides DHMH and HSCRC with: • Senior-level stakeholder input on Maryland's long-term vision for healthcare and transformation efforts • Discussion and debate among stakeholders to generate solutions and, a forum to do when consensus is not possible • Identify issues for staff information and Commissioners' consideration for action
Subsidiaries	N/A
Authorities & Responsibilities (Regulatory Role)	
Authorities	Public disclosure of hospital data and operating performance. The HSCRC operates as the all-payer rate-setting system under a Section 1814(b) Waiver that exempts it from the Inpatient Prospective Payment System (IPPS) and Outpatient Prospective Payment System (OPPS) and allows it to set rates for these services.

Responsibilities (Regulatory Role)	HSCRC responsibilities include:
	• Setting rates for all payers, including Medicare and Medicaid
	• Development and implementation of payment-related initiatives designed to promote the overall quality of care in Maryland hospitals.
	• Data Collection and Public Disclosure including:
	• Financial Data:
	  ○ Annual Revenue, Expenses and Volume data
	  ○ Audited Financial Statements
	  ○ Unaudited Monthly Financial Statements
	  ○ Monthly Revenue and Volume Reports
	  ○ Wage and Salary Survey
	• Patient Level Case Mix Data:
	  ○ Inpatient Discharge Abstract
	  ○ Outpatient Abstract

Authority/Governance Models	
Maryland All Payer Model - Health Services Cost Review Commission	

	• Major Reports/Disclosures:
	  ○ Annual Governor's Report
	  ○ Annual Disclosure on Hospital Operations (Statistical/Financial)
	  ○ Financial Conditions Report
	  ○ Hospital Performance Guide
	  ○ Uncompensated Care Policy Report
	  ○ Special Audit Report
	  ○ Reasonableness of Charges Report
	  ○ Monitoring Maryland Performance Report

Staffing	

Staffing	• HSCRC Staff:
	  ○ Executive Director
	  ○ Legal Department: Assistant Attorneys General (2)
	• Center for Revenue and Compliance
	  ○ Director
	  ○ Chief, Hospital Rate Regulation
	  ○ Health Services Rate Analysts (3)
	  ○ Associate Director, Audit and Compliance
	  ○ Chief, Audit and Compliance
	  ○ Assistant Chiefs, Audit and Compliance (2)
	• Center for Population Based Methodologies
	  ○ Director (presently vacant)
	  ○ Associate Director, Research and Methodology
	  ○ Chief, Special Projects
	  ○ Health Policy Analyst (presently vacant)
	  ○ Associate Director, Quality Initiative
	  ○ Chief, Quality Analysis (presently vacant)
	  ○ Associate Director, Performance Measurement
	  ○ Programmer Analyst
	• Center for Clinical and Financial Information
	  ○ Director
	  ○ Associate Director, Policy Analysis
	  ○ Chief, Information Management and Program Administration
	  ○ Advanced Programmer Specialist
	  ○ Program Manager
	  ○ Programmer Analyst
	  ○ Data Analyst
	• Center for Engagement and Alignment
	  ○ Director
	  ○ Project Manager
	  ○ Chief, Budget and Personnel
	  ○ Administrative Officer III
	  ○ Associate Director, Information Technology
	  ○ IT Supervisor
	  ○ Computer Network Specialist

Other	N/A

Authority/Governance Models	
Maryland All Payer Model - Health Services Cost Review Commission	
Medicaid Considerations	
Federal regulatory requirements	N/A
Other Considerations	
State and Federal Regulatory or Statutory Changes	Legislation clearly defining authority and reorganization.
Opportunities and Challenges	Consideration of adequate timelines.
Technical/Implementation Issues	Preparing an adequate plan and timetable for implementation and conforming to the enabling legislation to avoid legal challenges on scope.

Authority/Governance Models	
Mississippi Health Finance Authority	
Overview	
Creation	Although created in 1994, the Health Finance Authority does not appear to have conducted any activity. Both the Authority and Board are set for abolishment effective July 1, 2017 under Mississippi SB 2572, as signed by the Governor on April 5, 2017.
Purpose	Created under the Mississippi Health Policy Act of 1994 and organized under the MS Department of Health, the Health Finance Authority was charged to analyze health care expenditures and patterns of utilization; identify potential savings through preventive, primary care and managed care reductions and cost-sharing;; identify measures to encourage employer participation, promote competition and contain costs; and increase health benefits to Mississippians.
Funding	N/A
Board Membership	
Number	The HFA Board consists of seven members.
Appointment	Members are appointed by the Governor with the advice and consent of the Senate.
Qualifications	One member each of Mississippi's five congressional districts and two from the state at large
Terms	Initial staggered 4-year terms.
Structure & Committees	
Structure	N/A
Committees	N/A
Subsidiaries	N/A
Authorities & Responsibilities (Regulatory Role)	
Authorities	N/A
Responsibilities (Regulatory Role)	N/A
Staffing	
Staffing	N/A
Other	N/A
Medicaid Considerations	
Federal regulatory requirements	N/A
Other Considerations	
State and Federal Regulatory or Statutory Changes	N/A
Opportunities and Challenges	N/A
Technical/Implementation Issues	N/A

Authority/Governance Models	
New Mexico Retiree Health Care Authority	
Overview	
Creation	1990
Purpose	The New Mexico Retiree Health Care Authority (NMRHCA) administers health care benefits for retirees of state agencies and eligible participating public entities and their families, providing life insurance and medical, dental and vision plans for non-Medicare and Medicare-eligible retirees and their dependents.
Funding	NMRHCA's current fund balance is $416.8M with primary funding from: • Employer and Employee Contributions • Proceeds from the Taxation and Revenue Suspense Fund • Member Plan Premiums • Investment Income
Board Membership	
Number	The NMRHCA Board of Directors may not exceed 12 members.

Appointment	Representation consists of stakeholder entities, retirees, active employees and one member appointed by the Governor as follows:
	• One member appointed by the governor to serve at the governor's; may not be employed by, act on behalf of, or contracting with an employer participating in or eligible to participate in the Retiree Health Care Act
	• Educational Retirement Director or the Educational Retirement Director's designee
	• One member selected by the Public School Superintendents' Association of New Mexico
	• One member who is a teacher certified and teaching in elementary or secondary education - selected by three-member committee from one designee each from the New Mexico Association of Classroom Teachers, the National Education Association of New Mexico and New Mexico Federation of Teachers
	• One member who is an eligible retiree of a public school and elected by the New Mexico Association of Retired Educators
	• The Executive Secretary of the Public Employees Retirement Association or the Executive Secretary's designee
	• One member who is an eligible retiree receiving benefits from the Public Employees Retirement Association and selected by the retired public employees of New Mexico
	• One member who is an elected official or employee of a municipality participating in the Retiree Health Care Act and selected by the New Mexico municipal league
	• The state treasurer or the state treasurer's designee
	• One member who is a classified state employee selected by the personnel board
	• Provided they qualify, one member each who is an:
	  ○ Eligible retiree of an institution of higher education participating in the Retiree Health Care Act selected by the NM Association of Retired Educators, and
	  ○ Elected official or employee of a county participating in the Retiree Health Care Act selected by the New Mexico Association of Counties

Qualifications	Implied by appointment.

Authority/Governance Models	
New Mexico Retiree Health Care Authority	
Terms	No stated term of service; each member serves at the pleasure of the selecting party and continues to serve unless that member's board position is eliminated.
Structure & Committees	
Structure	The NMRHCA is an independent governmental agency, governed by a Board of Directors.
Committees	The Board has the following standing committees: • Executive Committee – consisting of the officers of the Board • Audit Committee – consisting of four Board Members, including the Chairperson • Finance and Investment Committee – consisting of five Board Members, including the Chairperson • Legislative Committee – consisting of five Board Members, including the Chairperson • Wellness Committee – consisting of five Board Members
Subsidiaries	N/A
Authorities & Responsibilities (Regulatory Role)	
Authorities	The NMRHCA Board has the authority to take all reasonably necessary actions to implement and achieve the Retiree Health Care Act's purpose, including to: • Employ or contract for services of the state fiscal agent or select its own fiscal agent under the Procurement Code • Employ or contract for persons to assist it in carrying out the Retiree Health Care Act and determine duties and compensation • Collect and disburse funds • Collect current and historical claims and financial information for procurement of lines of insurance coverage • Promulgate and adopt necessary rules, regulations and procedures for implementation of the Retiree Health Care Act • Negotiate policies for coverage of benefits as determined appropriate by the board (but not abridge required federal/state law coverage) • If practical, to wholly or partially self-insure the retiree health care coverages • Procure group health care and other coverages authorized by the Retiree Health Care Act in accordance with the Procurement Code and the Health Care Purchasing Act • Establish procedures for contributions and deductions • Determine methods and procedures for claims administration • Administer the fund • Contract for and make available to all eligible retirees and eligible dependents basic and optional group health insurance plans • Provide different plans for eligible retirees and eligible dependents covered by Medicare than the plans provided for non-Medicare eligible retirees and eligible dependents • Promulgate and adopt rules and regulations governing eligibility, participation, enrollment, length of service and any other conditions or requirements for providing substantially equal treatment to participating employers

Authority/Governance Models	
New Mexico Retiree Health Care Authority	

Responsibilities (Regulatory Role)	NMRHCA administers:
	• An operating budget as approved by the state budget division of the Department of Finance and Administration
	• Health care benefits for retirees of state agencies and eligible participating public entities and their families
	• Senior prescription drug program in through the consolidated purchasing process pursuant to the Health Care Purchasing Act
	• Audit Reports – Filed annually (by June 30) and includes:
	  ○ NMRHCA Financial Statements and Report
	  ○ Actuarial Valuation and Review

Staffing	
Staffing	By statute, the NMRHCA Board may employ staff as needed to assist it in carrying out the Retiree Health Care Act.
Other	N/A
Medicaid Considerations	
Federal regulatory requirements	N/A
Other Considerations	
State and Federal Regulatory or Statutory Changes	N/A
Opportunities and Challenges	Significant Challenges: • Short/medium term financing and administrative challenges • Extended Solvency - NMRHCA extended its solvency period through 2033 (from 2014 as of 2009) by aggressively adjusting subsidy levels, premiums and plan designs and a legislative increase in employer/ employee contributions • Investment Funds - NMRHCA investment funds suffered because of the economic downturn. The current fund balance of $416.8M has appreciably increased (from $123M in 2009) due to increased returns and $145M in contributions
Technical/Implementation Issues	N/A

Authority/Governance Models	
Oklahoma Health Care Authority	
Overview	
Creation	1993
Purpose	The Oklahoma Health Care Authority (OHCA) is the primary state agency charged with legislative responsibility for controlling costs of state-purchased health care, whose stated mission is to: • Responsibly purchase state and federally-funded health care in the most efficient and comprehensive manner possible • Analyze and recommend strategies for optimizing the accessibility and quality of health care • Cultivate relationships to improve the health outcomes of Oklahomans
Funding	Funding of the OHCA's budget (annually, over $5 billion) is from the legislature, federal grants and funding match, with the following: • Oklahoma Health Care Authority Revolving Fund • Oklahoma Health Care Authority Federal Disallowance Fund • Oklahoma Health Care Authority Medicaid Program Fund
Board Membership	
Number	Seven-member Board of Directors.
Appointment	Board members are appointed under a mixed process as follows: • Three members are appointed by the Governor of Oklahoma • Two members are appointed by the President pro tempore of the Oklahoma Senate • Two members are appointed by the Speaker of the Oklahoma House of Representatives
Qualifications	Consumer members of the Board must not have any financial or professional interest in medical care, health care services, health care delivery, health finance, health insurance or managed care. With exception for consumer members, members must include persons having experience in medical care, health care services, health care delivery, health care finance, health insurance and managed health care. In making appointments, consideration must be given to urban, rural, gender and minority representation.
Terms	Board members serve a four-year term without compensation
Structure & Committees	
Structure	Primary State Agency divided into four service branches as follows: • SoonerCare Operations • Financial Services • Information Services • Legal Services
Committees	OHCA Board Committees are: • Behavioral Health Advisory Council – The Council provides input to the OHCA and designated agents regarding behavioral health care within Oklahoma's Medicaid programs • Drug Utilization Review (DUR) Board – DUR advises OHCA about the appropriate and optimal use of pharmaceuticals for Oklahoma Medicaid recipients • Living Choice Advisory Committee (LCAC) – The LCAC advises and assists the OHCA and its partner agencies in the design, development and implementation of the Living Choice program

Authority/Governance Models	
Oklahoma Health Care Authority	
	• Medical Advisory Committee (MAC) – The MAC assists the OHCA in policy issues and quality standards of the Medicaid program • OHCA State Plan Amendment Rate Committee (SPARC) – The Advisory Committee on Rates and Standards make recommendations for changes to rates that necessitate a State Plan Amendment • Tribal Consultation Meetings
Authorities & Responsibilities (Regulatory Role)	
Authorities	The OHCA's primary regulatory authority includes: • Purchasing health care benefits for Medicaid recipients and others who are dependent on the state for necessary medical care • Entering into contracts for the delivery of state-purchased health care and establishing standards and criteria which must be met by entities to contract with the Authority for the delivery of state-purchased health care • Administering programs and enforcing laws placed under the Authority's jurisdiction pursuant to the Oklahoma Health Care Authority Act, and such other duties prescribed by law • Collaborating with and assisting the Insurance Commissioner in the development of a Uniform Claim Processing System for use by third-party payers and health care providers • Collaborating with and assisting the State Department of Health with the development of licensure standards and criteria for pre-paid health plans • Exercising all incidental powers which are necessary and proper to carry out the purposes of the Oklahoma Health Care Authority Act
Responsibilities (Regulatory Role)	The OHCA's primary regulatory responsibilities include: • Developing a proposed standard basic health care benefits package or packages to be offered by health services providers, for Medicaid recipients • Studying all matters connected with the provision of state-purchased and state-subsidized health care coverage • Developing and submitting plans, reports and proposals; providing information and analyzing areas of public and private health care interaction under the Oklahoma Health Care Authority Act • Serving as a resource for information on state-purchased and state-subsidized health care access, cost containment and related health issues
Staffing	

Staffing	OHCA key staff positions include the following:
	• Office of the Administrator – led by the Administrator of the Authority, immediate staff of the Administrator and provides policy direction for Authority and support to Board of Directors
	  ○ Administrative Services – led by Administrator's Chief of Staff
	  ○ Civil Rights/Freedom of Information Act Office
	  ○ Policy, Planning and Integrity Office – led by Deputy Chief Executive Officer
	  ○ Communications, Outreach and Reporting Office – led by Deputy Chief Executive Officer
	• SoonerCare Operations – led by State Medicaid Director
	  ○ Medical Professional Support

Authority/Governance Models	
Oklahoma Health Care Authority	
	○ Program Operations and Benefits ○ Quality Assurance/Quality Improvement ○ Opportunities for Living Life ○ Insure Oklahoma • Financial Services – led by Chief Financial Officer • Information Services – led by Chief Information Officer • Legal Services – led by General Counsel
Other	N/A
Medicaid Considerations	
Federal regulatory requirements	N/A
Other Considerations	
State and Federal Regulatory or Statutory Changes	Legislation clearly defining authority and reorganization.
Opportunities and Challenges	Consideration of adequate timelines.
Technical/Implementation Issues	Preparing an adequate plan and timetable for implementation and conforming to the enabling legislation to avoid legal challenges on scope.

Authority/Governance Models	
Oregon Health Authority	
Overview	
Creation	2009
Purpose	The OHA has oversight over most of Oregon's health-related programs including: • Behavioral health • Public health • The Oregon State Hospital (residential psychiatric care) • Oregon Health Plan (Medicaid)
Funding	State and Federal.
Board Membership	
Number	Nine-member citizen Oregon Health Policy Board.
Appointment	Appointment – Board members are nominated by the Governor and must be confirmed by the Senate, subject as follows: • Represent various geographic, ethnic, gender, racial and economic diversity of the State to the greatest extent practicable • Collectively offer expertise, knowledge and experience in consumer advocacy, management of a company that offers health insurance to its employees, public health, finance, organized labor, health care and the operation of a small business • Board Chairs – The Governor selects the chairperson and vice chairperson from the Board membership
Qualifications	Board Members qualify subject to following: • Are U.S. citizens and Oregon residents • Have demonstrated leadership skills in their professional and civic lives • No more than four members of the board may be individuals: o Whose household incomes come from health care or from a health related field, during their tenure on the board or during the 12-month period prior to appointment o Who receive health care benefits from a publicly funded state health benefit plan • At least one actively licensed Oregon health care provider member appointed to serve in addition to other the other members offering collective knowledge, expertise and experience
Terms	Staggered four-year term of office.
Structure & Committees	
Structure	The OHA is structured as a state government agency under passage of HB 2009 and is organized under the following divisions: • Health Systems Division o Addictions and Mental Health programs o Children's Wraparound Initiative o Oregon Health Plan • Health Policy o Health Analytics o Health and Policy Research o Health Information Technology • Office of the Director o Office of Communications o Office of Equity and Inclusion o Office of Oregon Health Policy and Research

Authority/Governance Models	
Oregon Health Authority	

	• Oregon Educators Benefit Board
	• Oregon Health Policy Board
	  ○ Health System Transformation
	• Pharmacy Services
	  ○ Oregon Prescription Drug Program
	  ○ Oregon Prescription Drug Monitoring Program
	  ○ CAREAssist Ryan White ADAP Program
	• Public Employees' Benefit Board
	• Public Health Division
	  ○ Office of the State Public Health Director
	  ○ Center for Health Protection
	  ○ Center for Prevention and Health Promotion
	  ○ Center for Public Health Practice

Committees	The OHA has the following (30+) Advisory Boards and Committees:
	• Oregon Health Policy Board (OHPB)
	  ○ Early Learning Council-Oregon Health Policy Board Joint Subcommittee
	  ○ Coordinated Care Model Alignment Work Group (2014-2016)
	  ○ Health Care Workforce Committee
	  ○ Health Information Technology Oversight Council (HITOC)
	  ○ Health IT and Health Information Exchange Community Advisory Council (HCOP)
	• Health Systems
	  ○ CCO Rates Advisory Panel
	  ○ Children's System Advisory Committee (CSAC)
	  ○ Oregon Consumer Advisory Council
	  ○ Health Policy and Analytics Advisory Groups and Committees:
	  ▪ Addictions and Mental Health Planning and Advisory Committee (AMHPAC)
	  ▪ All-payer All-claims Technical Advisory Group
	  ▪ Behavioral Health Information Sharing Advisory Group
	  ▪ Certified Community Behavioral Health Clinics (CCBHC) Advisory Group
	  ▪ Common Credentialing Advisory Group
	  ▪ Coordinated Health Partnership (CHP) Advisory Council
	  ▪ Health Evidence Review Commission (HERC)
	  ▪ Hospital Performance Metrics Advisory Committee
	  ▪ Medicaid Advisory Committee (MAC)
	  ▪ Metrics and Scoring Committee
	  ▪ Pain Management Commission (PMC)
	  ▪ Palliative Care and Quality of Life Interdisciplinary Advisory Council
	  ▪ Pharmacy & Therapeutics Committee
	  ▪ Provider Directory Advisory Group
	  ▪ Quality & Health Outcomes Committee (QHOC)
	  ▪ SBIRT (Screening, Brief Intervention, Referral to Treatment) Workgroup
	  ▪ Substance Use Disorder (SUD) Stakeholder Advisory Committee
	• Office of Equity and Inclusion

Authority/Governance Models	
Oregon Health Authority	
	○ Community Advisory Council ○ Cultural Competence Continuing Education Approval Committee ○ Health Equity Policy Review Committee • Public Health ○ Drinking Water Advisory Committee (DWA) ○ Immunization Policy Advisory Team (IPAT) ○ Retail Marijuana Scientific Advisory Committee (RMSAC) ○ Public Health Advisory Board (PHAB)
Authorities & Responsibilities (Regulatory Role)	
Authorities	The duties, functions and powers that the Oregon legislature transferred to the OHA includes: • Administration of the state's Medicaid Program (Oregon Health Plan) • Department of Human Services (DHS) respecting health and health care • Department of Administrative Services (DAS) with respect to public employees and retirees (PEBB), and school employees and retirees (OEBB) • Department of Consumer and Business Services (DCBS) – operation of the Oregon Medical Insurance Pool and the Oregon Medical Insurance Pool Board
Responsibilities (Regulatory Role)	The OHA Board serves as the policy-making and oversight body for the OHA and is responsible for implementing the health care reform provisions of HB 2009. Under HB 2009, OHA's regulatory responsibilities includes budgeting, administration, policymaking and quality oversight and improvement for: • Medicaid and Public Health (including health facilities regulation) • Addictions and Mental Health programs • High-risk insurance pool • Public Employees' Benefit Board (PEBB) and Oregon Educators Benefit Board (OEBB)
Staffing	
Staffing	OHA key staff leadership includes the following positions: • Director – OHA • Director – Office of Equity and Inclusion • Director – External Relations Division • Chief Financial Officer/Chief Operating Officer (single individual holds both positions) – Fiscal and Operations Division • Director – Health Policy and Analytics Division • Chief Health Systems Officer – Health Systems Division • Director – Public Health Division • Superintendent – Oregon State Hospital
Other	N/A
Medicaid Considerations	
Federal regulatory requirements	N/A
Other Considerations	
State and Federal Regulatory or Statutory Changes	Legislation clearly defining authority and reorganization.

Authority/Governance Models	
Oregon Health Authority	
Opportunities and Challenges	Consideration of adequate timelines.
Technical/Implementation Issues	Preparing an adequate plan and timetable for implementation and conforming to the enabling legislation to avoid legal challenges on scope.

Authority/Governance Models	
Vermont Green Mountain Care Board	
Overview	
Creation	2011
Purpose	The Green Mountain Care Board (GMCB) was created by the Vermont legislature for the stated purpose of: • Improving Vermont's population health • Reducing Vermont's per-capita rate of growth in health services expenditures across all payers without compromising access and quality of care • Enhancing the patient and provider experience of care • Recruiting and retaining high-quality health care professionals, and • Achieving administrative simplification in health care financing and delivery.
Funding	State and Federal
Board Membership	
Number	The GMCB consists of a chair and four members.
Appointment	The GMCB chair and members are appointed by the governor under nomination by the GMCB Nominating Committee and confirmed by the Vermont Senate. The Board Chair is responsible for the overall operations of the Board, the position is a full time equivalent.
Qualifications	Board Qualifications – Chair and members must be Vermont state employees and may not have been denied Senate confirmation within six years of their nomination. Nominating Committee candidates are considered on their: • Commitment to Vermont's expressed health care reform principles • Knowledge or expertise in health care policy, delivery or financing and openness to alternative health care approaches • Personal integrity and characteristics, administrative and communication skills, social consciousness, public service and regard for the public good • Attributes complementing those of the remaining board members • Impartiality and freedom from undue influence
Terms	The Chair/members serve staggered six-year terms and may serve more than one term, subject to the nomination and appointment process and may be removed only for cause.
Structure & Committees	
Structure	The GMCB is structured as a state agency, independent of any other Vermont agency, department or office.

Committees	The GMCB has the following Advisory Boards and Committees:
	• Advisory Committee of the Green Mountain Care Board – Established in 2011 under the GMCB enacting legislation to provide input and recommendations to the GMCB. Broadly inclusive of stakeholders, the Advisory Committee includes consumers, patients, business and health care professionals, with 56 current members.
	• The Primary Care Advisory Group (PCAG) – Established by the legislature in 2016, the PCAG provides input to the GMCB relating to the administrative burdens faced by primary care providers including:
	  ○ Meaningful measure reporting and alignment
	  ○ Reducing prior authorization requirements for radiology, medication and specialty services
	  ○ Development of a uniform hospital discharge summary

Authority/Governance Models	
Vermont Green Mountain Care Board	
	○ PCAG consists of 21 active members, three GMCB staff and one GMCB board member • Office of Health Care Ombudsman – Although the GMCB is an independent agency, by statute it must seek input from the Office of the State Health Care Ombudsman on Vermont patient and consumer interests. The ombudsmen may suggest policies, procedures, or rules to the GMCB to protect patient and consumer interests.
Subsidiaries	N/A
Authorities & Responsibilities (Regulatory Role)	
Authorities	The GMCB regulatory authority includes: • Payment Reform – GMCB's payment reform responsibilities includes setting overall policy goals and testing systems on a pilot basis with willing providers and payers, including the ACO Shared Savings (Community Health Accountable Care (CHAC), OneCare Vermont (OCV) and Vermont Collaborative Physicians/ Healthfirst (VCP)) and All-Payer Models • Health Information Technology (HIT) – GMCB's existing authority was refined by the Vermont legislature in 2015 to address exchange connectivity and conduct budget/core activities oversight of Vermont Information Technology Leaders (VITL). The GMCB has initiated a transparent regulatory process for its VITL oversight responsibilities revised Vermont's HIT Plan. • Vermont Health Care Innovation Project (VHCIP) – Awarded under a State Innovation Models (SIM) grant in 2013. VHCIP coordinates policy and resources for health care reform statewide, funds proposals to improve health care delivery, to build health information technology and databases, and to test new models for paying providers. VHCIP efforts promote collaboration among the GMCB, the Vermont Agency of Human Services, Medicaid and Vermont private health insurers and health care providers.
Responsibilities (Regulatory Role)	The GMCB's regulatory responsibility includes: • Hospital Budget Review – GMCB has established Vermont state hospital rates and regulated the average change in rate since Hospital fiscal year 2013. GMCB's review is guided by Hospital Budget Rule 3.000 and established Board policies on net patient revenue, community needs assessments, physician transfers, and enforcement, which are issued to Vermont hospitals under GMCB's Hospital Budget Reporting Requirements. • Certificate of Need (CON) – The GMCB administers the CON process, which guides establishment for all new health care projects in Vermont. The GMCB and CON process prevents unnecessary duplication of health care facilities and services, promotes cost containment and ensures the provision and equitable allocation of high quality health care services and resources. • Rate Review – GMCB holds primary responsibility for reviewing rate requests for comprehensive major medical health insurance plans through a filing, public comment, opinion and final decision process. As part of the process, the GMCB has full administrative examination

Authority/Governance Models	
Vermont Green Mountain Care Board	
	authority to determine insurer asset sufficiency and solvency to ensure payment of claims on behalf of Vermont policyholders. • Registered Entities – The GMCB administers the annual registration process for comprehensive major medical health benefit plans (insured or self-insured, Medicare Supplement and Medicare Parts C and D) plans, pharmacy benefit managers (PBMs) and third-party administrators (TPAs). The GMCB facilitates data collection and prepares the Annual Paid Claims and Enrollment Report (APCER), for payment of the Vermont Health Care Claims Tax by insurers, PBMs, and TPAs. RFP, grant and contract administration.
Staffing	
Staffing	GMCB key staff positions include the following: • Executive Director • Chief of Health Policy • Financial Director • Associate General Counsel • Administrative Services Coordinator • Program Management Specialist • Director of Health System Finances • Grants and Stakeholder Coordinator • General Counsel • Health Policy Director • Senior Health Policy Analyst • Health Care Project Director • Executive Assistant / Legislative Affairs Coordinator • Health Policy Advisor • Health Policy Analyst • Health Policy Project Director • Financial Administrator • Payment Reform Evaluator • Senior Financial Policy Analyst • Board Legal Technician • Financial Administrator • Director of Data and Analytics
Other	N/A
Medicaid Considerations	
Federal regulatory requirements	N/A
Other Considerations	
State and Federal Regulatory or Statutory Changes	Legislation clearly defining authority and reorganization.
Opportunities and Challenges	Consideration of adequate timelines.
Technical/Implementation Issues	Preparing an adequate plan and timetable for implementation and conforming to the enabling legislation to avoid legal challenges on scope.

Authority/Governance Models	
Washington State Health Care Authority	
Overview	
Creation	1988
Purpose	The Washington State Health Care Authority (HCA) was created by the Washington legislature to develop a comprehensive health benefit plan and health plan option for state employees, retirees and their dependents, as managed by the Public Employees' Benefits Board (PEBB) within the HCA. In 2011, the Legislature directed administrative responsibilities for the state's Medicaid program (Apple Health) to the HCA.
Funding	State and Federal.
Board Membership	
Number	The Public Employees' Benefits Board consists of nine members.
Appointment	The PEBB members are appointed by the governor appointed by the governor and composed as follows: • Board Administrator – Chair of the PEBB; • State Employee Representatives – Two members; one representing a certified union of classified state employees and the other, a retired state employee receiving public employee benefits, to represent organized public employee retirees; • School District Employees – Two members; one representing an association of school district employees and the other, a retired school district employee, to represent organized school employee retirees; and • Public Members – Four members experienced in health benefit management and cost containment.
Qualifications	As appointed above.
Terms	Members serve staggered two-year terms.
Structure & Committees	
Structure	The Washington State Health Care Authority (HCA) is a lead independent state agency created by the Washington legislature within the executive branch under direct oversight of the Office of the Governor. The HCA maintains oversight responsibility for PEBB and Apple Health and both are directly tiered under the HCA.

Committees	The HCA has the following (11) Advisory Boards and Committees:
	• Pharmacy and Therapeutics (P&T) Committee
	• Health Technology Clinical Committee
	• Medicaid Title XIX Advisory Committee
	• Health Technology Assessment Committee
	• Health Innovation Leadership Network
	• Healthier Washington Accelerator Committees:
	  ○ Communities and Equity Accelerator Committee
	  ○ Healthier Washington Clinical Engagement Accelerator Committee
	  ○ Healthier Washington Rural Health Innovation Accelerator Committee
	  ○ Healthier Washington Collective Responsibility Accelerator Committee
	• Performance Measures Coordinating Committee
	• PEBB Appeals Committee

Authority/Governance Models	
Washington State Health Care Authority	
Authorities & Responsibilities (Regulatory Role)	
Authorities	The HCA's regulatory authority includes: • Administering state employee and school employee insurance benefits (including retirees and disabled employees) • Administering the basic health plan • Administering the children's health program

Responsibilities (Regulatory Role)	The HCA's regulatory responsibility includes:
	• Implementing state initiatives, joint purchasing strategies, and techniques for efficient administration with potential for application to other state purchased health services
	• Administering grants that further the mission and goals of the authority
	• Analyzing state purchased health care programs in order to maximize cost containment while ensuring access to quality health care
	• Analysis of state purchased health care programs and to explore options for cost containment and delivery alternatives including:
	  ○ Economic incentives that encourage appropriate utilization of services
	  ○ Developing flexible benefit plans to offset increases in individual financial responsibility
	  ○ Provider arrangements that encourage cost containment
	  ○ Coordinating state agency drug purchasing efforts
	  ○ Developing a volume discount medical equipment and supporting services purchasing program
	  ○ Developing data systems to obtain utilization data from state purchased health care programs
	  ○ Using evidence-based, common performance measures
	  ○ Implementing contractual financial incentives with insurers, health care facilities, and providers that reward improvements in health outcomes
	  ○ Increasing use of health information technology through provider incentives
	• Promoting and increasing the adoption of health information technology systems, including electronic medical record through state health purchasing, reimbursement, or pilot strategies

Staffing	

Staffing	The HCA has approximately 1,100 employees, including the following key staff and officers:
	• Health Care Authority - Director
	  ○ Executive Secretary
	• Chief Medical Officer
	  ○ Deputy Chief Medical Officer
	  ○ Deputy for Clinical Strategy and Operations
	• Chief Financial Officer
	  ○ Deputy Chief Financial Officer
	  ○ Executive Special Assistant
	• Chief Operations Officer
	  ○ Assistant Director, Enterprise Technology Services
	  ○ Assistant Director, Employee Resources Division

Authority/Governance Models	
Washington State Health Care Authority	
	○ Assistant Director, ProviderOne Operations and Services • Assistant Director, Division of Legal Services ○ Deputy Assistant Director, Division of Legal Services • HCA PEBB Director ○ Deputy Assistant Director • Chief Policy Officer, Policy Planning and Performance ○ Deputy Assistant Director, Policy Planning and Performance • Chief Communications Officer ○ Audit and Accountability Management • Medicaid Director ○ Assistant Director, Medicaid Eligibility and Community Support ○ Assistant Director, Medicaid Program Operations and Integrity ○ Deputy Assistant Director, Medicaid Program Operations and Integrity
Other	N/A
Medicaid Considerations	
Federal regulatory requirements	N/A
Other Considerations	
State and Federal Regulatory or Statutory Changes	Legislation clearly defining authority and reorganization.
Opportunities and Challenges	Consideration of adequate timelines.
Technical/Implementation Issues	Preparing an adequate plan and timetable for implementation and conforming to the enabling legislation to avoid legal challenges on scope.

Authority/Governance Models	
West Virginia Health Care Authority	
Overview	
Creation	1983
Purpose	The West Virginia Legislature created the Health Care Cost Review Authority (HCCRA) in 1983, with the principal responsibility for conducting hospital rate reviews. The HCCRA was later renamed as the West Virginia Health Care Authority (WVHCA) in 1997.
Funding	State and federal funding.
Board Membership	
Number	The WVHCA is governed by a three-member board.
Appointment	Appointment – Board members are appointed by the governor on advice and consent of the Senate and no more than two of the board members may be members of the same political party.
Qualifications	Qualifications – Members must be West Virginia citizens and residents: • One board member must have a background in health care finance or economics • One board member must have previous employment experience in human services, business administration or substantially related fields • One board member must be a consumer of health services with a demonstrated interest in health care issues
Terms	Members are appointed for six year terms, except that an appointment to fill a vacancy is only for the unexpired term.
Structure & Committees	
Structure	The WVHCA is an autonomous agency of the Department of Health and Human Resources, divided into five divisions (Financial Analysis, Clinical Analysis, Legal, and Information Technology).
Committees	The State Health Plan Advisory Group (SHAG) was created to advise the Board on the Board's health reform efforts and regulatory activities. SHAG membership includes consumer, business, and provider/payer and state agency stakeholder representatives. SHAG sub-groups include the Cardiovascular Panel, Low Back Injury Panel, Diabetes Panel, End of Life Panel, Long Term Care and Quality Advisory Group.
Authorities & Responsibilities (Regulatory Role)	
Authorities	The WVHCA Board has regulatory authority to set hospital rates, including individual and groups providing inpatient or outpatient services under a contractual agreement with hospitals); to approve hospital budgets; and, jurisdiction over West Virginia's health care Certificate of Need program.
Responsibilities (Regulatory Role)	The Board's regulatory responsibilities are carried out by the WVHCA divisions as follows: • Financial Analysis Division – Facility Financial Disclosures collection, research and analysis in support of the Certificate of Need program. • Clinical Analysis Division – Collection and analysis of clinical health care data in in support of the Certification of Need program and statewide health planning efforts. • Legal Division – Counsel and advisor to the WVHCA Board for all agency contracts and other legal matters. • Information Technology Division – Responsible for data collection security and WVHCA IT support.

Authority/Governance Models	
West Virginia Health Care Authority	
	• Privacy Division/State Privacy Office – Acts as lead for the West Virginia Executive Branch Privacy Management Team (PMT), which facilitates best practices and legal requirements for protecting personally identifiable information; and advances data security compliance and oversight, policy and procedure, and education and training programs.
Staffing	

Staffing	WVHCA key staff and officer positions are:
	• Board Members
	  ○ Chair Of The Board
	  ○ Board Members (2) (1 vacant)
	• Board Staff
	  ○ Executive Director
	  ○ Executive Secretary (vacant)
	• Legal
	  ○ General Counsel
	  ○ Assistant General Counsel (vacant)
	• Administrative
	  ○ Chief Financial Officer
	  ○ Human Resources, Payroll
	  ○ Fiscal And Purchasing
	  ○ Purchasing
	  ○ Accounts Payable
	• Certificate Of Need
	  ○ Director, Certificate Of Need
	  ○ Program Manager
	  ○ Interim Director, Clinical Analysis
	  ○ Health Care Financial Analyst (3)
	  ○ H&R Associate

Other	N/A
Medicaid Considerations	
Federal regulatory requirements	N/A
Other Considerations	
State and Federal Regulatory or Statutory Changes	Legislation clearly defining authority and reorganization.
Opportunities and Challenges	Consideration of adequate timelines.
Technical/Implementation Issues	Preparing an adequate plan and timetable for implementation and conforming to the enabling legislation to avoid legal challenges on scope.

ATTACHMENT II – ALASKA GOVERNANCE MODELS

The following contains additional information on governance models utilized in Alaska.

Alaska Governance Models	
Alaska Permanent Fund Corporation	
Overview	
Creation	The Alaska Permanent Fund (APF) was established by Alaska State constitutional amendment in 1976.
Purpose	The APF is a governmental endowment, which is funded annually through a 25% deposit of Alaska's oil revenues. The APF's stated legislative purpose is "to benefit all generations of Alaskans" as an offset to loss of non-renewable natural resources through the State's oil production and sale. Initially funded with a deposit $734,000 in 1977, the APF's current valuation is approximately $55.4 billion. In 1980, the Alaska legislature created the Alaska Permanent Fund Corporation (APFC) as a semi-independent, state-owned corporation to manage APF assets. Previously, APF assets were managed by the Treasury division of Alaska's Department of Revenue.
Fund Structure	Section 15 of Alaska's Constitution apportions the APF between Principal and Earnings Reserves: • Principal – the Principal Fund portion is non-spendable and can only be used for income-producing investments • Earnings Reserves – Established by statute, Earnings Reserves may only be spent through legislatively approved appropriations
Board Membership	
Number	APFC oversight is provided by a six-member Board of Trustees
Appointment	Members are appointed by the governor subject to the following: • State Department Cabinet Members – Two active heads of principal Alaska State governmental departments; one seat is statutorily assigned to the Commissioner of Revenue and the governor selects one additional cabinet member to sit on the Board • Public members – Four public members open to the Governor's selection
Qualifications	Public members – By statute, public members must: • Have recognized competence and experience in finance, investments, or other business management-related fields, and • Not hold any other elective/appointive state or federal office, position or employment during board service
Term	Public Members serve staggered, four-year terms.

Alaska Governance Models	
Alaska Permanent Fund Corporation	
Structure & Committees	
Organizational Structure	Semi-independent, state-owned corporation

Committees	The APFC has the following (3) committees:
	• Audit Committee – Three-trustee committee which provides financial oversight to the APFC Board through:
	  ○ Financial, accounting and legal compliance
	  ○ Monitoring performance and independence of external auditors
	  ○ Reporting and communication channels among external auditors, APFC Officers and management and the APFC Board
	• Governance Committee – Assists in APFC Board governance. By Charter, the Vice Chair of the APFC Board serves as the Governance Committee Chair with Governance Committee Members appointed by the APFC Board Chair. Committee duties include:
	  ○ Extensive review of APFC Board and Committee policies and charters
	  ○ Monitoring and compliance under APFC policies and charters
	  ○ Periodic performance reviews and self-evaluations
	• Investment Advisory Board – Required by Board Charter in 2001, the Advisory Board consists of three members, who each serve a staggered three-year term such that only one seat expires annually. Members are appointed and serve at the pleasure of the Board and must have considerable knowledge and experience in the management and investment of large endowment or trust funds.

Authorities & Responsibilities (Regulatory Role)	

Authorities	• APF Management and Budget – APFC Board authority extends to managing and reasonably diversifying APF investments under the "prudent-investor" standard, which includes:
	  ○ Adopting policies and regulations under APFC bylaws to carry out the corporate mission
	  ○ Employing an Executive Director and staff as necessary for corporate operations and functions
	  ○ Designating allowable types of income-producing APF investments to meet prudent investor standards (e.g., balanced asset distributions in liquid/illiquid stocks, public equities, fixed income bonds, real estate, private equity/growth and infrastructure/income opportunities, hedge funds and cash)
	  ○ Recommendations by the Executive Director to adopt and implement annual budgets
	  ○ Enter and enforce contracts as necessary for managing APF assets and APFC operations
	  ○ Submitting APFC investments reports to the Legislative Budget and Audit Committee (quarterly) and the Governor and public (annually) which includes:
	  ▪ Independently audited financial statements
	  ▪ APF investment valuation
	  ▪ Market value appraisal
	  ▪ Investment activity during the reporting period

Alaska Governance Models	
Alaska Permanent Fund Corporation	
	• Earnings Reserve and Dividend Payments – Permanent Fund earnings on principal (earnings reserve) have been historically used to pay annual dividends to all Alaskans (see below), to inflation proof the Fund, and for Fund operational costs and expenses. NOTE: Though Earnings Reserves have not been accessed for general government operations, the Alaska House recently approved Senate Bill 26, which applies a portion of earnings reserves to Alaska's $2.8 billion annual deficit. The Senate voted on a similar bill earlier and reconciliation between the House and Senate bills is anticipated. As a result, the Permanent Fund Dividend would decrease to $1,250 for 2017-2018. • Permanent Fund Dividend (PFD) – The PFD, which has been paid to qualifying Alaska residents annually since 1982, is calculated upon the Fund's five-year average performance in consideration of Fund program obligations, expenses and costs. • MHTF Management – By statute, the APFC holds and invests cash and security assets of the Alaska Mental Health Trust Fund (MHTF). (The MHTF is discussed separately below.)
Staffing	
Staffing	• Executive Director – As permitted by statute, the Board appoints an Executive Director who, under APFC Bylaws, serves as the CEO of the APFC at the pleasure of the Board. By charter, the Executive Director provides broad leadership to the APFC to attain its mission, goals and objectives as managed in accordance with guidelines and parameters established by the Board and law. • Staffing – The APFC uses an internal staff of about 35 individuals and external money managers and consultants to manage Fund assets.
Medicaid Considerations	
Federal regulatory requirements	Designation of a Single State Agency to administer the Medicaid program and retain authority over policy making.
Other Considerations	
State and Federal Regulatory or Statutory Changes	• Legislation clearly defining authority and reorganization • Designation of a Single State Agency to administer the Medicaid program and retain authority over policy making
Opportunities and Challenges	Consideration of adequate timelines.
Technical/Implementation Issues	Preparing an adequate plan and timetable for implementation and conforming to the enabling legislation to avoid legal challenges on scope.

Alaska Governance Models	
Alaska Mental Health Trust Authority	
Overview	
Creation	The Alaska Mental Health Trust Fund (AMHTF) was created under the federal Alaska Mental Health Enabling Act of 1956, which transferred federal responsibility for providing mental health services to the territory, and eventual State of Alaska. Funded initially with a one million acre land grant to generate income for a comprehensive integrated Mental Health Program. By 1982, only about 35 percent of the MHTF land remained in state ownership. The Alaska Mental Health Trust Authority (AMHTA) is a public corporation established within the Department of Revenue as a result of a final class action settlement (*Weiss v State of Alaska)* brought over the dissipation of the original MHTF land. The *Weiss* settlement compelled reconstruction of the MHTF land holdings with 500,000 acres of original MHTF land, 500,000 acres of replacement land and $200 million in cash. The AMHTA oversees management of MHTF cash and non-cash, land assets. MHTF cash assets are managed by the Alaska Permanent Fund and MHTF land assets are managed by the Alaska Trust Land Office within the Department of Natural Resources.
Purpose	The purpose of the AMHTA is to: • Act as Trustee for the Alaska Mental Health Trust Fund • Ensure an integrated comprehensive mental health program for Alaskans • Administer the office of the long term care ombudsman established by statute
Board Membership	
Number	The MHTF is overseen by a seven-member board of trustees.
Appointment	Trustee Appointment – Trustees are appointed by the governor on recommendation by stakeholder panel (below) and confirmed by the Legislature. List of Appointment Candidates – A six- person panel consisting of beneficiaries, their guardians, family members or representatives, prepares a list of considered appointment candidates for the Governor. Each Panel member selection is made upon stakeholder recommendation from the: • Alaska Mental Health Board • Governor's Council on Disabilities and Special Education • Advisory Board on Alcoholism and Drug Abuse • Alaska Commission on Aging • Alaska Native Health Board • Mental Health Trust Authority
Qualifications	Trustees are selected upon their financial, investment or land management or in-service abilities to MHTF beneficiaries. Trustee Restrictions – Trustees may not be a State officer or employee within the preceding two years or, during the member's term of office, have an interest in, served on the governing board of, or been employed by an organization that has received money from MHTF settlement income under a grant or contract for services during that same period.
Term	Board Term – Appointed for five-year terms; on expiration, continues service until re-appointed/reconfirmed or until a new candidate is appointed and confirmed.

Alaska Governance Models	
Alaska Mental Health Trust Authority	
Structure & Committees	
Structure	Structure – By statute, the MHTF is apportioned between cash principal and net income: • Cash Principal – Retained perpetually for investment by the Alaska Permanent Fund Corporation • Net income – Transferred by the corporation to the mental health trust settlement income account at the end of each fiscal year
Committees	All Trustees are members of the following four AMHTA committees: • Finance Committee • Planning Committee • Resource Management Committee • Executive Committee
Authorities & Responsibilities (Regulatory Role)	
Authorities	AMHTA's statutory obligations are to: • Enhance and protect the trust • Provide leadership in advocacy, planning, implementing, and funding of a Comprehensive Integrated Mental Health Program • Propose a budget for Alaska's Comprehensive Integrated Mental Health Program • Coordinate with state agencies on programs and services that affect beneficiaries • Report to the Legislature, the governor and the public about The Trust's activities

Responsibilities (Regulatory Role)	AMHTA's statutory responsibilities include:
	• Trust Settlement Income – MHTF settlement income account monies can only be used for:
	  ○ Awarding grants/contracts to fulfill the AMHTA's purpose to ensure an integrated comprehensive state mental health program
	  ○ Obtaining private/federal grants and soliciting gifts, bequests, and contributions to further the ensure the mission of an integrated comprehensive state mental health program
	  ○ Reimbursing the APFC and Department of Natural Resources for their respective costs of managing mental health trust assets and land
	  ○ Offsetting the effect of inflation on the value of the MHTF principal
	  ○ Meeting necessary administrative to properly discharge responsibilities
	• Surplus Settlement Income – If necessary expenses are met, surplus from the MHTF settlement income account is transferred to the unrestricted general fund for other public purpose expenditures
	• Provide leadership in advocacy, planning, implementing, and funding of a Comprehensive Integrated Mental Health Program
	• Propose a budget for Alaska's Comprehensive Integrated Mental Health Program
	• Coordinate with state agencies on programs and services that affect beneficiaries
	• Report to the Legislature, governor and the public about the Trust's activities

Alaska Governance Models	
Alaska Mental Health Trust Authority	
Staffing	
Staffing	Current AMHTA staff includes: • Senior Program Officer • Evaluation and Planning Officer • Administrative Assistant and Travel Planner • Legislative Liaison • Interim Chief Executive Officer • Administrative Manager • Chief Communications Officer • Grants Administrator • Program Officer • Grants Accountability Manager • Budget Coordinator • Program Special Assistant • Data Analysis and Policy Planning Officer • Chief Operating Officer
Medicaid Considerations	
Federal regulatory requirements	N/A
Other Considerations	
State and Federal Regulatory or Statutory Changes	Legislation clearly defining authority and reorganization.
Opportunities and Challenges	Consideration of adequate timelines.
Technical/Implementation Issues	Preparing an adequate plan and timetable for implementation and conforming to the enabling legislation to avoid legal challenges on scope.

Alaska Governance Models	
Alaska Housing Finance Corporation	
Overview	
Creation	The Alaska Housing Finance Corporation (AHFC) is a public corporation created in 1971. The AHFC is a government instrumentality housed within the Department of Revenue, yet maintains a separate legal existence independent of the State.
Purpose	The AHFC's stated mission is providing Alaskans access to safe, quality, affordable housing through low-cost mortgage financing. In 1992, the Alaska State Housing Authority (ASHA) merged into AHFC – resulting in AHFC's assumed management of Alaska's public housing and rural loan and energy programs. AHFC now provides complete State housing services to Alaskans through five primary functions: • Offering public rental housing and private rental market housing vouchers for low-income Alaskans • Issuing bonds to raise capital in the financial markets • Offering home mortgages and renovation loans • Promoting residential energy efficiency • Offering grants and administering federal tax credits for affordable and special needs housing
Funding	AHFC funds operations through its mortgage activity, federal housing/VA loan assistance dollars and investment earnings. AHFC surplus earnings are paid annually as a dividend into Alaska's General Fund.
Board Membership	
Number	By statute, the AHFC is governed by a seven-member board of directors.
Appointment	AHFC Board of Directors – By statute, the AHFC is governed by a seven-member board of directors, seated by law and appointment, as follows: • Commissioner of Revenue (statutory) • Commissioner of Commerce, Community & Economic Development (statutory) • Commissioner of Health & Social Services (statutory) ○ Public Service Commissioners can designate a deputy to attend and act on their behalf as a full member when unable to attend board meetings • Four public members – members appointed by the Governor
Qualifications	Governor appointed public members should collectively lend reasonable geographic balance among regions of the State and have recognized competence and wide experience in housing, finance, or other business management-related fields. Individual members must: • Have expertise or experience in finance or real estate • Be a rural resident or have expertise or experience with a regional housing authority • Have expertise or experience in residential energy-efficient home building or weatherization • Have expertise/experience providing senior or low-income housing
Terms	Public members each serve two-year terms
Structure & Committees	
Structure	The AHFC is a public corporation and government instrumentality housed within the Department of Revenue but maintaining a separate legal existence independent of the State.

Alaska Governance Models	
Alaska Housing Finance Corporation	
Committees	The AHFC Board established the following (4) committees: • Audit • Budget/Housing Policy Committee • Investment Advisory Committee • Personnel Committee
Subsidiaries	AHFC's structure includes the following subsidiary corporations: • Alaska Corporation For Affordable Housing (ACAH) – Created as a 501(c)(3) organization in 2011 under HB119 for developing affordable housing throughout Alaska. ACAH shares AHFC's seven-member board and officers (President, Vice President and Secretary/ Treasurer). • Alaska Housing Capital Corporation (AHCC) – Created April 18, 2006 under SB 232 by appropriation of $300,000,000 from Alaska's general fund for funding capital projects, including financing expenses. • Northern Tobacco Securitization Corporation (NTSC) – Created August 30, 2000 to issue bonds on behalf of the State of Alaska as a benefit under the Master Settlement Agreement (MSA) ending litigation by Alaska and other states against several U.S. cigarette manufacturers. A portion of Alaska's MSA revenues secure NTSC bonds.
Authorities & Responsibilities (Regulatory Role)	
Authorities	The AHFC's legislative authorities and responsibilities include: • Alaska Housing Finance Revolving Fund Administration – obligations under the revolving fund consist of appropriations made to the revolving fund by the legislature, money or other assets transferred to the revolving fund by the corporation, and unrestricted repayments of principal on loans made or purchased by the corporation • Insuring Veteran's Loans – purchasing and insuring state veterans' loans as material aid in the continuance of residential housing to veterans • Purchasing other mortgage loans – serves a public purpose in benefiting the people of the State
Responsibilities (Regulatory Role)	The AHFC's primary regulatory role is to facilitate and implement the acquisition and development of land and the construction, rehabilitation, financing, management, maintenance, sale, and rental of dwelling units for persons of lower and moderate income or persons in remote, underdeveloped, or blighted areas of the State.
Staffing	
Staffing	AHFC staffing currently includes the following key positions: • CEO/Executive Director • Deputy Executive Director • Director – Administrative Services • Director – Audit • Director – Budget • Chief Financial Officer/Finance Director • Controller • Director – Governmental Relations and Public Affairs • Director – Housing Operations • Director – Human Resources • Director – Information Systems • Director – Mortgage Operations

Alaska Governance Models	
Alaska Housing Finance Corporation	
	• Director – Planning & Program Development • Director – Public Housing • Director – Research & Rural Development • Counsel – the Alaska Attorney General serves as AHFC's chief counsel, advisor and representative in litigation
Other	Alaska Council on the Homeless – Created by Gov. Murkowski on April 30, 2004 and reauthorized by Governor Palin in 2007 under the umbrella of the AHFC. Council on the Homeless membership includes: • AHFC • Alaska Mental Health Trust Authority (AMHTA) • Alaska State Departments of Education, Public Safety and Corrections • Health and Social Services, and • Six public members from the homeless provider community The Council released its initial report "*Keeping Alaskans Out of the Cold*" in October 2005 and more recently, its 2016 Progress Report on Alaska's long-term plan to end homelessness (plan published/adopted October 2015).
Medicaid Considerations	
Federal regulatory requirements	N/A
Other Considerations	
State and Federal Regulatory or Statutory Changes	Legislation clearly defining authority and reorganization.
Opportunities and Challenges	Consideration of adequate timelines.
Technical/Implementation Issues	Preparing an adequate plan and timetable for implementation and conforming to the enabling legislation to avoid legal challenges on scope.

Alaska Governance Models	
Alaska Gasline Development Corporation	
Overview	
Creation	2010
Purpose	Formed under HB 369 with the purpose of determining the feasibility of developing the in-state North Slope Alaska Stand-alone pipeline (ASAP) and in-state liquefied natural gas (LNG) projects on the State's behalf.
Funding	AGDC received multi-year funding in 2013 to advance the Alaska Stand Alone Pipeline (ASAP) under HB 4. In 2014 under SB 13, the legislature provided the AGDC $69.8M to fund the State's equity participation and expanded AGDC's mission and responsibility to develop the LNG project.
Board Membership	
Number	AGDC is governed by a seven-member Board.
Appointment	Five public and two heads from Alaska principal state departments are appointed by the Governor subject to legislative confirmation.
Qualifications	• Public Members – Members are required to be a registered voter or resident of Alaska but the Governor's written statement to the legislature must explain the reasons for appointment • Department Members – May be appointed as any head of an Alaska principal department, excepting the Commissioner of Natural Resources and Commissioner of Revenue
Terms	Public members serve staggered five-year terms at the pleasure of the governor.
Structure & Committees	
Structure	The AGDC is structured as an independent, public corporation and government instrumentality of the State administered within the Department of Commerce, Community, and Economic Development. AGDC's existence may not be terminated unless no obligations of the corporation or subsidiary exist or it is no longer engaged in an in-state natural gas pipeline or an Alaska liquefied natural gas project.
Committees	AGDC Committees include: • Governance Committee • Technical Committee • Communication Committee • Community Advisory Council
Authorities & Responsibilities (Regulatory Role)	
Authorities	AGDC's responsibilities broadly include the development, construction and marketing of the Alaska Stand Alone Pipeline (ASAP) and liquefied natural gas (LNG) projects. AGDC's plenary authority respecting its powers include: • Determining forms of ownership, entering joint ownership/operation agreements and structure of an in-state natural gas pipeline • Creating subsidiaries or the purpose of developing, constructing, operating, and financing the ASAP and LNG projects • Creating operating budgets of the AGDC and any subsidiary • Planning, financing, constructing, developing, acquiring, maintaining, and operating such pipeline and all related systems • Executing contracts, leases and acquire facilities, structures, and properties • Exercising powers of eminent domain, file declarations of taking

Alaska Governance Models	
Alaska Gasline Development Corporation	
	• Adopting bylaws, regulations and policies in connection with the performance of its functions and duties • Employing consultants, engineers, and other employees and staff • Borrowing money and sue in its own name • Managing investments, funds, and swaps related to hedge, cap or other commodity contracts under the ASAP and LNG projects
Responsibilities (Regulatory Role)	The AGDC's primary regulatory role is the development and operational activity of the ASAP and LNG projects.
Staffing	
Staffing	Current Executive Management consists of: • President – Executive Director • Senior Vice-President – Program Management • Vice-President – LNG/Administrative Services • Vice-President – Project Management • Vice-President – Commercial and Economics • Vice-President – Communications Executive Advisor
Other	N/A
Medicaid Considerations	
Federal regulatory requirements	N/A
Other Considerations	
State and Federal Regulatory or Statutory Changes	Legislation clearly defining authority and reorganization; funding.
Opportunities and Challenges	Consideration of adequate timelines.
Technical/Implementation Issues	Preparing an adequate plan and timetable for implementation and conforming to the enabling legislation to avoid legal challenges on scope.

Alaska Governance Models	
Alaska Energy Authority	
Overview	
Creation	The Alaska Energy Authority (AEA) was created in 1976.
Purpose	The AEA's primary legislative purpose was to develop Alaska's state energy resources. Following legislation in 1993 and 1999, the AEA's primary role was realigned to include ownership over Alaska's existing hydroelectric projects and associated transmission lines (the Alaska Intertie), in addition to management and oversight responsibilities for state-owned energy assets.
Board Membership	
Number	The AEA is governed by a seven-member Board of Directors. The AEA directors are also the members of the Alaska Industrial Development and Export Authority (AIDEA) board (discussed below).
Appointment	Directors are appointed by the governor subject to the following: • State Department Cabinet Members – Statutorily includes the Commissioner of Revenue and the Commissioner of Commerce, Community, and Economic Development • Public members – Five public members open to the Governor's selection
Qualifications	By statute, public members must possess demonstrated leadership skills and private sector business or industry experience.
Term	Public Members serve two-year terms at the pleasure of the Governor.
Structure & Committees	
Structure	The AEA is structured as an independent State corporation.
Committees	The primary AEA committees are: • Emerging Energy Technology Fund (EETF) Advisory Committee • Intertie Management Committee (IMC) • Bradley Lake Project Management Committee
Subsidiaries	AEA ownership includes the Bradley Lake Hydroelectric Project and the Alaska Intertie transmission line.
Authorities & Responsibilities (Regulatory Role)	
Authorities	The AEA's principal authority includes management of AEA owned assets (Bradley Lake Hydroelectric Project and the Alaska Intertie transmission line) and core energy program funds (the Renewable Energy Fund and the Emerging Energy Technology Fund).
Responsibilities (Regulatory Role)	The AEA's regulatory responsibilities include: • Lead energy portfolio planning and policy development • Alaska Affordable Energy Strategy Development – Provides policy, financing regulatory and other administrative recommendations in support of Alaska's interior energy needs not serviced by the in-state natural gas pipeline project • Energy infrastructure investment and rural energy technical & community assistance
Staffing	
Staffing	The AEA key executive management positions include: • Executive Director • Assistant Executive Director/Energy Policy Director • Chief Operating Officer • Human Resources and Administration Director • Government Relations and Outreach Efficiency Manager

Alaska Governance Models	
Alaska Energy Authority	
Other	N/A
Medicaid Considerations	
Federal regulatory requirements	N/A
Other Considerations	
State and Federal Regulatory or Statutory Changes	Legislation clearly defining authority and reorganization.
Opportunities and Challenges	Consideration of adequate timelines.
Technical/Implementation Issues	Preparing an adequate plan and timetable for implementation and conforming to the enabling legislation to avoid legal challenges on scope.

Alaska Governance Models	
Alaska Industrial Development and Export Authority	
Overview	
Creation	The Alaska Industrial Development and Export Authority (AIDEA) was created in 1967.
Purpose	The AIDEA's primary legislative purpose is promoting Alaska's economic growth and development of state natural resources through manufacturing, industrial and business expansion financing.
Board Membership	
Number	The AIDEA and the AEA share the same Board and membership requirements. See the AEA Board discussion above.
Appointment	See AEA Board membership discussion above.
Qualifications	See AEA Board membership discussion above.
Term	See AEA Board membership discussion above.
Structure & Committees	
Structure	The AIDEA is structured as an independent State corporation.
Committees	The primary AIDEA committees are: • Audit and Budget Subcommittee • Project Evaluation Committee • Project Review Committee • RFP Review Committee
Subsidiaries	AIDEA projects include: • Camp Denali Readiness Center • Alaska Mining support projects • Federal Express Aircraft Maintenance Facility • Ketchikan Shipyard • Lik Deposit Transportation System • Mustang Road development and gravel production pad • Seward Marine Industrial Center Skagway Ore Terminal • BlueCrest Energy, Inc.
Authorities & Responsibilities (Regulatory Role)	
Authorities	The AIDEA has various management authority arrangements over its projects listed above as well as authority over its infrastructure, energy development and financing programs, which include: • Loan Participation Program • Project Development Program • Infrastructure Development Program • Energy Development Finance Program • Conduit Revenue Bond Program • New Markets Tax Credit (NMTC) Assistance Guarantee and Loan Program • Rural Development Initiative and Small Business Economic Development Loan programs • Business and Export Assistance programs
Responsibilities (Regulatory Role)	AIDEA's regulatory role is to serve as the state's development financing authority for Alaska's infrastructure, manufacturing, industrial and business development through its own funding and partnership resources with other financial institutions, economic development groups and guarantee agencies.

Alaska Governance Models	
Alaska Industrial Development and Export Authority	
Staffing	
Staffing	The key AIDEA executive management positions include: • CEO/Executive Director • Commercial Finance Director • Chief Infrastructure Development Officer • Project Development and Asset Management Director • Chief Financial Officer • Business Development and Communications Director • External Affairs Officer • Human Resources Director
Other	N/A
Medicaid Considerations	
Federal regulatory requirements	N/A
Other Considerations	
State and Federal Regulatory or Statutory Changes	Legislation clearly defining authority and reorganization.
Opportunities and Challenges	Consideration of adequate timelines.
Technical/Implementation Issues	Preparing an adequate plan and timetable for implementation and conforming to the enabling legislation to avoid legal challenges on scope.

Alaska Governance Models	
Regulatory Commission of Alaska	
Overview	
Creation	The Regulatory Commission of Alaska (RCA) was created in 1999.
Purpose	The RCA regulates the safe and adequate provision of public utilities and pipeline services at just and reasonable rates, terms, and conditions.
Board Membership	
Number	The RCA is governed by a five-member Board of Commissioners.
Appointment	Commissioners are appointed by the governor and confirmed by the legislature in joint session.
Qualifications	To qualify for appointment as a commissioner, a person must either be a member of the Alaska Bar in good standing or have a degree major in engineering, finance, economics, accounting, business administration, or public administration from an accredited college or university. In lieu of Bar membership or degree requirements, the active practice of law for at least five years or equal experience in the field of engineering, finance, economics, accounting, business administration, or public administration serves as a degree equivalent.
Term	Each member serves a six-year term and continues to hold office at the end of term until a successor is appointed and qualified. Any vacancy in office is filled by the governor's appointment as confirmed by the legislature in joint session. The vacancy appointee holds office for the balance of the term on which the predecessor was appointed.
Structure & Committees	
Structure	The RCA is structured as an independent state agency housed within the Department of Commerce, Community, and Economic Development.
Committees	NA
Subsidiaries	The RCA Communications Carriers Section develops, recommends and administers policies and programs regarding regulation of rates, services, accounting, and facilities for wire, cable, radio, and space satellite communications common carriers within the State.
Authorities & Responsibilities (Regulatory Role)	
Authorities	The RCA is authorized to regulate public utilities by certifying qualified providers of public utility and pipeline services, which includes telecommunications and electric and natural gas monopolies.
Responsibilities (Regulatory Role)	The RCA serves as a regulatory decision making body to utilities and pipeline carriers throughout Alaska, including the safe delivery of services, and service rates, terms, and conditions, monitoring active certificates and regulating water and wastewater systems. Any tariff (rate) change is subject to an evidentiary review process. The RCA fulfills this role through regulatory notice and comment periods, quasi-judicial administrative hearings and administrative appeal processes.
Staffing	
Staffing	The Commission staff includes the following key positions: • Administrative Law Judges • Engineers • Financial analysts • Telecommunications specialists • Tariff analysts • Consumer protection officers

Alaska Governance Models	
Regulatory Commission of Alaska	
	• Paralegals • Administrative and support staff
Other	N/A
Medicaid Considerations	
Federal regulatory requirements	N/A
Other Considerations	
State and Federal Regulatory or Statutory Changes	Legislation clearly defining authority and reorganization.
Opportunities and Challenges	Consideration of adequate timelines.
Technical/Implementation Issues	Preparing an adequate plan and timetable for implementation and conforming to the enabling legislation to avoid legal challenges on scope.

Alaska Governance Models	
North Pacific Fisheries Management Council	
Overview	
Creation	1976
Purpose	The North Pacific Fishery Management Council (NPFMC) is one of eight US regional councils established by the Magnuson-Stevens Fishery Conservation and Management Act to manage U.S. fisheries. The NPFMC acts primarily through development of Fishery Management Plans that correspond to the variety of fisheries within Alaska's 200-mile Exclusive Economic Zone (EEZ), which encompasses the Gulf of Alaska, Bering Sea, and Aleutian Islands.
Funding	NPFMC activities are funded through federal appropriations, private contributions and fees/fines levied for regulatory violations.
Board Membership	
Number	The NPFMC is composed of 15 members (11 voting/4 non-voting).
Appointment	The 11 voting members include: • Director of the Alaska Department of Fish and Game or designee • Director of the Washington Department of Fish and Wildlife, or a designee • Director of the Oregon Department of Fish and Wildlife, or a designee • The Regional Administrator of the National Marine Fisheries Alaska Regional Office or a designee • Seven private citizens (Alaska - 5 members; Washington - 2 members) Private citizen voting members are appointed by the Secretary of Commerce upon recommendation by the governors of Alaska and Washington who each proffer a list of three nominees (effectively a pool of six candidates for each Council vacancy). The four non-voting members include representatives from: • The Pacific States Marine Fisheries Commission • The U.S. Fish and Wildlife Service • The U.S. Department of State • The U.S. Coast Guard
Qualifications	Private citizen voting members are qualified by their familiarity with the fishing industry, marine conservation or both. The four non-voting members substantively assist the Council in the following area: • Data and research – Pacific States Marine Fisheries Commission • Seabirds, Ecosystems, Otters and Walrus – U.S. Fish and Wildlife Service • Issues of International Impact – U.S. Department of State • Enforcement and Safety Issues – U.S. Coast Guard
Term	Voting members each serve a term of three years; vacancy appointments to fill any unexpired term serve only for the remainder of that term.
Structure & Committees	
Structure	The Council is a structured as a federal nonprofit governmental organization.
Committees	The NPFMC utilizes its committees to facilitate and execute NPFMC regulatory and enforcement responsibilities and promote broad stakeholder participation. Stakeholder interests, including commercial and recreational fishing interests, industry processors, public interests, and non-governmental organizations and

trade coalition, are primarily expressed through NPFMC committees and activities as follows:

- Advisory Panel (AP) – Serves to assist and advise the NPFMC in carrying out NPFMC regulatory and policy functions.
- Scientific and Statistical Committee (SSC) – Represents statistical, biological, economic, social, and other scientific information/economic input for NPFMC Agenda issues. The SSC is significantly relevant to the NPFMC fishery management plan development; the SSC meets in advance of the NPFMC to afford public/stakeholder comment and input on SSC recommendations to the Council. SSC membership includes public interest, fishing industry and conservation stakeholder interests.
- Joint Protocol Committee – Serves to coordinate, complement and inform fisheries management issues in State and Federal waters under the NPFMC's and the Alaska Board of Fisheries cross-jurisdictional authority. Includes three members from each organization and meetings are held at least annually and open to the public for comment.
- Legislative Committee – Established to review all impacting and issue related legislation affecting NPFMC authority and interests.
- Ecosystem Committee – Provides advice on national ecosystem specific analyses and North Pacific fisheries management. The Committee has nine members, six of whom represent different stakeholder constituencies and three that represent public agency interests. Stakeholder outreach is targeted to engage stakeholders not traditionally involved in committee and council processes. Members of the public and industry stakeholders have encouraged to participate in policy input through public testimony, comment and statement review periods; public testimony during Committee deliberations and public request for scoping papers on proposed Ecosystem Based Fishery Management (EBFM) development process and actions.
- Enforcement Committee – Established to review proposed Fisheries Management Plan (FMP) amendments, regulatory changes, and other management actions in reference to enforcement, monitoring and safety actions particular to the North Pacific fisheries. Meetings are held in conjunction with regularly scheduled NPFMC meetings and are open to public comment.
- The Individual Fishing Quota (IFQ) Committee – Provides recommendations to the Council on IFQ program issues. The IFQ Committee consists of broad stakeholder membership, including directed fishery representatives (halibut/sablefish) and fishery processors. Additionally, the enabling legislation requires that the IFQ process is subject to formal and detailed review, affording both public comment and review of regulatory impacts by proposed IFQ Committee actions, and addressing formal Tribal consultation requests.
- Rural Outreach Committee – Documents rural community/Alaska Native participation in the development of fishery management actions and conducts ongoing communication and outreach specific to particular projects affecting rural stakeholders and Alaska Native communities. Provides instrumental outreach and communication to Alaska's rural communities/Alaska Native entities to advise on opportunities for better

Alaska Governance Models	
North Pacific Fisheries Management Council	

	understanding and participation; feedback on community impacts; and recommendations on proposed Council actions requiring specific outreach plans and prioritized actions as necessary.
	• Directed Fishery Committees – Aligns directed fishery interests including:
	  ○ Halibut Management Committee – Aligns internal US halibut fishery interests with the International Pacific Halibut Commission within the NPFMC process through strategic planning, communication and coordination of mutual management/research activities.
	  ○ Charter Halibut Management Committee – Develops recommended management alternatives for Alaska's regional charter halibut fisheries.
	  ○ Pacific Northwest Crab Industry Advisory Committee (PNCIAC) – Provides Alaska Board of Fisheries management advice on Bering Sea and Aleutian Islands (BSAI) King and Tanner crab fisheries; allows channel for non-resident input to the Alaska Board of Fisheries; serves in consultative role to Alaska Fish and Game Advisory Committees.

Authorities & Responsibilities (Regulatory Role)	
Authorities	The NPFMC has broad policy-making, regulatory and enforcement authority regarding fishery management and allocation decisions within its jurisdiction over the Gulf of Alaska, Bering Sea, and Aleutian Islands fisheries.
Responsibilities (Regulatory Role)	The NPFMC's primary regulatory responsibilities include • Fishery Management Plans (FMPs) – Develops and recommends fishery management plans and regulations fisheries occurring in federal waters (3-200 nm from shore), coordinates management programs in federal and state waters (0-3 nm from shore) and addresses habitat, catch limits, allocation and other management concerns. • Fishery allocation decisions – Made in concert with the International Pacific Halibut Commission (resource management in U.S. - Canada waters) and the Alaska Board of Fisheries (State of Alaska jointly managed resources).
Staffing	
Staffing	NPFMC staff are not federal government employees. Key executive and management staff support the NPFMC by providing management input and information on Council decisions, information to the public on NPFMC activities, and facilitation and coordination of public participation in the FMP process. Technical staff prepare regulatory impact and decisional analyses for the FMP process, which includes economic, social science, biology, ecosystem, and habitat considerations. Council staff positions include: • Executive Director • Deputy Director • Finance Officer • Communications/IT Specialist • Economist (2) • Fisheries Analyst • Protected Species Coordinator • Data Manager • Plan Coordinator (2)

Alaska Governance Models	
North Pacific Fisheries Management Council	
	• Administrative Assistant (2)
Medicaid Considerations	
Federal regulatory requirements	The NPFMC is structured as a federal non-governmental organization under the Magnuson-Stevens Fishery Conservation and Management Act. To the extent that the NPFMC exercises federal authority under established Fishery Management Plan development, it must adhere to federal notice rule making procedures.
Other Considerations	
State and Federal Regulatory or Statutory Changes	None identified.
Opportunities and Challenges	None identified.
Technical/Implementation Issues	None identified.

ATTACHMENT III – COORDINATION/INTEGRATION MODELS AND ALASKA MEDICAID CONSIDERATIONS

The following identifies coordination/integration models explored by states that may be of interest to Alaska. In addition, this attachment provides a preliminary framework for the areas that Alaska could evaluate in consideration of its Medicaid program.

Coordination/Integration Models & Alaska Medicaid Considerations	
Model Option: Care Coordination	
Model Description	Organization of health and related support activities between providers involved in the recipient's care to facilitate delivery of needed services (such as behavioral health and LTSS), with preference for providers located in geographic area of recipient, to extent possible
Model Alignment with Alaska Reform Objectives	• SB 74 directs DHSS to contract with one or more third parties to implement one or more coordinated care demonstration projects for Medicaid beneficiaries • Proposed models include: managed care organization, prepaid inpatient health plan, prepaid ambulatory health plan; care management entity; and provider-based reform
Model Target Population	• Individuals with chronic conditions and co-morbidities, including mental and behavioral health and substance abuse • Individuals identified as super-utilizers (e.g., frequent use of hospital emergency room) • Individuals receiving long term services and supports • Individuals dually eligible for Medicaid and Medicare
Model Target Services	• All services for target populations
Evaluation Area	**Medicaid Considerations**
Current Alaska Administrative Functions and Resources	• DHSS issued a request for proposals in 2016 with return of April 2017 • Division of Health Care Services: Temporary care coordination program involves expanding current Alaska Medicaid Coordinated Care Initiative (AMCCI) and transitioning recipients to the new coordinated care demonstration project(s) and behavioral health reform program when implemented
Alaska Medicaid Populations and Expenditures	• Approximately 16 percent of SFY 2016 Medicaid enrollees accounted for 44 percent of expenditures
Alaska Demographic Considerations	• Primary and specialty care availability due to limited provider access
Fiscal	• Federal match funds for services may be impacted (Cost Allocation Plan)
Regulatory (State and Federal)	• Need authority to pay for care coordination
Operations	• Oversight of program activities, data collection and analysis and contractual oversight
Access to Care	• Provider network limitations
Quality of Care	• Model holds providers accountable to collect information on quality of care
Utilization	• Potential for less savings because of provider network limitations

Coordination/Integration Models & Alaska Medicaid Considerations	
Model Option: Care Coordination	
Provider Network	• Local primary and specialty care providers' willingness to participate
Implementation/Start-Up Considerations	• Regulatory approval, enrollment

Coordination/Integration & Alaska Medicaid Considerations	
Model Option: Quality Management	
Model Description	Framework to help providers assure and continuously improve the effectiveness of service delivery, communicate/report and monitor efforts
Model Alignment with Alaska Reform Objectives	• SB 74 tasked as a part of primary care case management/managed care organization contracting, creation of a performance and quality reporting system
Model Target Population	• All enrollees of public payer health care programs
Model Target Services	• Enrollee population-specific
Evaluation Area	**Medicaid Considerations**
Current Alaska Administrative Functions and Resources	• Qualis Health currently is contracted to provide utilization management, case management services, quality of care reviews and provider education
Alaska Medicaid Populations and Expenditures	• Targeting evidence-based strategies for proper use of emergency rooms • Develop patient decision aids to empower decision-making
Alaska Demographic Considerations	• Targeting
Fiscal	• Opportunity to utilize measurements applied to commercial health plans
Regulatory (State and Federal)	• N/A
Operations	• Role of Chief Medical Officer
Access to Care	• N/A
Quality of Care	• Integrating opportunities with care coordination, value-based purchasing and provider payment initiatives
Utilization	• N/A
Provider Network	• N/A
Implementation/Start-Up Considerations	• Develop functional description of quality and identify quality data measures as standards • Identify and recommend evidence-based strategies • Method for tracking and reporting quality measure data (infrastructure and data systems) • Provider education • Validation by independent quality entity

Coordination/Integration Models & Alaska Medicaid Considerations	
Model Option: Value-Based Purchasing	
Model Description	Payment model intended to promote quality and value of health care services by shifting from pure volume-based models, such as fee-for-service, to payment based on quality metrics and outcomes
Model Alignment with Alaska Reform Objectives	• SB 74 directs DHSS to implement payment reform measures to shift current model away from traditional fee-for-service payment mechanism to model intended to increase efficiency and quality of care and improve care outcomes
Model Target Population	• All enrollees of public payer health care programs
Model Target Services	• All services
Evaluation Area	**Medicaid Considerations**
Current Alaska Administrative Functions and Resources	• Relies solely on fee-for-service delivery system for Medicaid population
Alaska Medicaid Populations and Expenditures	• Fee-for-service delivery system currently utilized with different rate methodologies for providers
Alaska Demographic Considerations	• Accustomed providers; transition how providers are paid from volume-based fee-for-service to reimbursement based on quality
Fiscal	• SFY 2016 expenditures for Medicaid exceeded $1.65 billion for population of approximately 152,000 enrollees
Regulatory (State and Federal)	• Define services to be paid on fee-for-service versus alternative payment model • Obtain appropriate federal approval to change provider reimbursement methodology (e.g., changes to Medicaid State Plan)
Operations	• Oversight of program activities, data collection and analysis • Contractual oversight
Access to Care	• Measure ability of recipients to get needed services in a timely manner
Quality of Care	• Measure ability of recipients' access to delivery of services to improve health outcomes
Utilization	• Improve delivery efficiency by reducing duplication of services
Provider Network	• Providers take on risk
Implementation/Start-Up Considerations	• Obtain state and federal approval to modify payment structure • Identify quality measures and promote their use • Develop population health management strategies to reduce cost and utilization • Develop payment structure/methodology for quality reporting and quality performance • Develop tools for providers to measure and report • Implement transparency and public reporting features to enhance accountability • Implementation and adoption of electronic health records and health information technology

Coordination/Integration Models & Alaska Medicaid Considerations	
Model Option: Value-Based Purchasing	
Model Description	All public health plans move to a single unified method for how payments are made to providers (i.e., same payment structure for provider type)
Model Alignment with Alaska Reform Objectives	• SB 74 directs DHSS to contract with provider-led entities, ACOs, managed care organizations, PCCMs and PAHPs to implement a demonstration project with fee structures that may include global payments, bundled payments, capitated payments, shared savings and risk, or other payment structures • Moves away from current fee-for-service structure
Model Target Population	• All enrollees of public payer health care programs
Model Target Services	• All services
Evaluation Area	**Medicaid Considerations**
Current Alaska Administrative Functions and Resources	• Alaska Medicaid utilizes fee-for-service reimbursement with different reimbursement rate methodologies for each provider type and within most methodologies there are multiple rates • DHSS' Office of Rate Review (ORR) establishes Medicaid payment rates for hospitals, nursing facilities, home health agencies, ambulatory surgical centers and FQHC/RHC, and works with Tribal providers and other DHSS agencies
Alaska Medicaid Populations and Expenditures	• N/A
Alaska Demographic Considerations	• N/A
Fiscal	• Based on 2011 Milliman study, Alaska's physician reimbursement is approximately 59% higher than average of comparison states and exceeds for each type of payer and each provider of specialty, though the differential varies • Alaska has the highest Medicaid physician fee index of fee-for-service Medicaid in the nation and has reimbursement rates higher than Medicare
Regulatory (State and Federal)	• As with other delivery system and payment reforms, obtain appropriate federal approval to change provider reimbursement methodology (e.g., changes to Medicaid State Plan)
Operations	• Oversight of program activities, data collection and analysis • Contractual oversight
Access to Care	• Provider network limitations
Quality of Care	• Model holds providers accountable
Utilization	• Model holds providers accountable
Provider Network	• Provider network limitations
Implementation/Start-Up Considerations	• Regulatory approval, enrollment

Coordination/Integration Models & Alaska Medicaid Considerations	
Model Option: Value-Based Purchasing	
	• Need for transparency to payers and providers • Establish initial payment rates and process for payment rate updates that take into account program sustainability • Adjust for risk based on incident of illness within a given population if global/bundled payment approach not utilized • Develop supports and tools to encourage providers (e.g., investment in health information technologies, reward coordination of care)

Coordination/Integration Models & Alaska Medicaid Considerations	
Model Option: Information Technology/Systems and Health Analytics	
Model Description	Framework and approaches to use information technology and systems to advance health care delivery
Model Alignment with Alaska Reform Objectives	• Streamline health care operations • Utilize data to support pricing and quality initiatives
Model Target Population	• All enrollees of public payer health care programs
Model Target Services	• All services
Evaluation Area	**Medicaid Considerations**
Current Alaska Administrative Functions and Resources	• Alaska has a health information exchange (Alaska eHealth Network) • Two year study completed by the Alaska Health Care Commission that recommended in its 2013 Annual Report to the governor and legislature that the state establish an APCD to support health care price and quality transparency, payment reform and strengthen the health information infrastructure • Proposal to locate the program in DHSS • SB 74 calls for collaborative, hospital-based project to reduce use of emergency department services which includes a system for real-time electronic exchange of patient information, including recent emergency department visits, hospital care plans for frequent emergency department users, and data from the controlled substance prescription database • SB 74 also directs DHSS to develop a health information infrastructure plan to strengthen health information infrastructure, including health data analytics capability • Allows for data utilization for care coordination and quality improvement
Alaska Medicaid Populations and Expenditures	• N/A
Alaska Demographic Considerations	• N/A
Fiscal	• Alaska Health Care Commission report indicated potential and ongoing start-up operating expenses[84] • Potential for funding through federal Medicaid administrative match funds and other federal grant sources
Regulatory (State and Federal)	• State legislature to specify legislative intent, provide data collection authority, require data privacy and security standards, establish governance structure, ensure stakeholder

[84] See http://dhss.alaska.gov/ahcc/Documents/2014ReportAPPENDIX%20B.pdf for additional information.

Coordination/Integration Models & Alaska Medicaid Considerations	
Model Option: Information Technology/Systems and Health Analytics	
	participation, provide regulatory authority and appropriate for start-up and ongoing operations
Operations	• Functionality would need to support gathering and storing data as well as report generation
Access to Care	• N/A
Quality of Care	• N/A
Utilization	• N/A
Provider Network	• N/A
Implementation/Start-Up Considerations	• Establish authority to collect and store data (DHSS statutory framework) • Establish organizational home for APCD program with collaboration of other entities • Create governance structure and stakeholder advisory committee • Provide for data privacy and security concerns • Develop data governance rules • Develop phased-in approach to data collection

Coordination/Integration Models & Alaska Medicaid Considerations	
Model Option: Provider Management	
Model Description	Centralized provider management that establishes common provider management policy
Model Alignment with Alaska Reform Objectives	• N/A
Model Target Population	• N/A
Model Target Services	• N/A
Evaluation Area	**Medicaid Considerations**
Current Alaska Administrative Functions and Resources	• Alaska contracted with Conduent (formerly Xerox) to develop and manage its Medicaid Management Information System (MMIS). Conduent serves as the state's fiscal agent and is responsible for provider enrollment, communication and education • Development and implementation of the MMIS required four years, including the resolution of significant systems/processing issues • Alaska is in the process of securing federal certification
Alaska Medicaid Populations and Expenditures	• N/A
Alaska Demographic Considerations	• N/A
Fiscal	• Enhanced federal funding is available for the MMIS development and operations • A cost allocation methodology would need to be developed and approved by the Federal government
Regulatory (State and Federal)	• N/A
Operations	• N/A
Access to Care	• N/A
Quality of Care	• N/A
Utilization	• N/A
Provider Network	• Modifications for existing provider systems may require additional funds
Implementation/Start-Up Considerations	• Modifications for existing Departmental systems and interfaces may require additional funds

Coordination/Integration Models & Alaska Medicaid Considerations	
Model Option: Medical Management	
Model Description	Centralized medical management division/department that establishes common medical management policy
Model Alignment with Alaska Reform Objectives	• SB 74 incorporates recommendations from the Controlled Substances Advisory Committee and use of the prescription drug monitoring program • SB 74 directs DHSS to coordinate with the Alaska Mental Health Trust Authority to efficiently manage a comprehensive and integrated behavioral health system with evidence based, data driven practices and measurable outcomes • SB 74 directs DHSS to partner with third-party entities on projects that would direct individuals to the right care in the right place at the right time, including collaboration with statewide hospital organization to design and implement project to reduce non-urgent use of emergency departments
Model Target Population	• All populations
Model Target Services	• High expenditure services such as emergency room, opioid abuse, substance abuse disorder treatment
Evaluation Area	**Medicaid Considerations**
Current Alaska Administrative Functions and Resources	• The pharmacy and therapeutics committee advises the Division of Health Care Services • Alaska's contract with Conduent includes pharmacy benefits management system services and surveillance and utilization review • Alaska's contract with Qualis Health includes utilization management services • Alaska contracts with Magellan Medicaid Administration to provide: pharmacy benefit administration; Magellan processes electronic point of sale pharmacy claims and provides recipient eligibility verification and allowable amounts and prospective drug utilization review
Alaska Medicaid Populations and Expenditures	• N/A
Alaska Demographic Considerations	• N/A
Fiscal	• A cost allocation methodology would need to be developed and approved by the Federal government
Regulatory (State and Federal)	• N/A
Operations	• N/A
Access to Care	• N/A
Quality of Care	• N/A
Utilization	• N/A
Provider Network	• N/A
Implementation/Start-Up Considerations	• Single chief medical officer or director to implement policy across all programs

Coordination/Integration Models & Alaska Medicaid Considerations	
Model Option: Contracted Services: Benefits	
Model Description	Contracting with single entity to administer benefits across public payer programs
Model Alignment with Alaska Reform Objectives	• Administrative simplification
Model Target Population	• All enrollees of public payer health care programs
Model Target Services	• Care coordination, vision, pharmacy, dental
Evaluation Area	**Medicaid Considerations**
Current Alaska Administrative Functions and Resources	• Alaska contracts with Magellan Medicaid Administration to provide: pharmacy benefit administration; Magellan processes electronic point of sale pharmacy claims and provides recipient eligibility verification and allowable amounts and prospective drug utilization review • Alaska contracts with Rochester Optical for lenses, glasses, frames and contact lenses; all vision service providers are required to order from this contractor
Alaska Medicaid Populations and Expenditures	• N/A
Alaska Demographic Considerations	• N/A
Fiscal	• N/A
Regulatory (State and Federal)	• N/A
Operations	• Medicaid has unique tracking and reporting requirements to support Medicaid drug rebates and 340(b) pricing
Access to Care	• N/A
Quality of Care	• N/A
Utilization	• N/A
Provider Network	• N/A
Implementation/Start-Up Considerations	• Coordination for certain contracted services such as vision, PBM and dental

Coordination/Integration Models & Alaska Medicaid Considerations	
Model Option: Contracted Services: Administration	
Model Description	Contracting with single entity to provide administrative services across public payer programs
Model Alignment with Alaska Reform Objectives	• Administration simplification
Model Target Population	• N/A
Model Target Services	• Administrative services
Evaluation Area	**Medicaid Considerations**
Current Alaska Administrative Functions and Resources	• The Office of Rate Review (ORR) establishes Medicaid payment rates for facilities
Alaska Medicaid Populations and Expenditures	• N/A
Alaska Demographic Considerations	• N/A
Fiscal	• N/A
Regulatory (State and Federal)	• N/A
Operations	• Consider single Medicaid director and common practice guidelines across programs
Access to Care	• N/A
Quality of Care	• N/A
Utilization	• N/A
Provider Network	• N/A
Implementation/Start-Up Considerations	• N/A