

# STATE OF ALASKA REQUEST FOR INFORMATION



## MEDICAID COORDINATED CARE DEMONSTRATION PROJECT

ISSUED SEPTEMBER 15, 2016

The Alaska Department of Health and Social Services is seeking public input with regard to options for Medicaid coordinated care demonstration projects.

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ISSUED BY:

DEPARTMENT OF HEALTH & SOCIAL SERVICES  
DIVISION OF FINANCE & MANAGEMENT SERVICES

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## SECTION 1: INTRODUCTION AND INSTRUCTIONS

### SEC. 1.01 PURPOSE OF THE REQUEST FOR INFORMATION

Senate Bill 74 (2016) directs the Department of Health and Social Services (the Department, or DHSS) to contract with one or more third parties to implement coordinated care demonstration projects for Medicaid beneficiaries, and requires that the Request for Proposals (RFP) for the first coordinated care demonstration project(s) be released by December 31, 2016. The Department is seeking public input to inform the process for development of the coordinated care demonstration project. The purpose of this Request for Information (RFI) is to solicit information to support preparation of the Request for Proposals (RFP) to be released by the end of the calendar year. Subsequent to release of the initial RFP this year, the Department may elect to issue additional Requests for Proposals for future coordinated care demonstration projects.

### SEC. 1.02 NON-BINDING PROCESS

The sole purpose for this Request for Information is to collect information that may be used for development of the Request for Proposals for coordinated care demonstration projects. No contracts will be issued as a result of the RFI process, and failure to respond to the RFI will not preclude any entity from participation in formal procurements. However, the information and ideas provided in the RFI responses are critical to supporting the DHSS planning process. Those who respond to the RFI will not be bound during the RFP process by what is included in or excluded from their RFI response.

### SEC. 1.03 DEADLINE FOR RECEIPT OF RESPONSES

Please provide responses no later than 4:00 PM prevailing Alaska Time on October 17, 2016. Responses may be sent via mail or email.

### SEC. 1.04 RETURN INSTRUCTIONS

Responses may be submitted in paper or electronic format. Please send one copy of your paper response to the following address:

Department of Health and Social Services  
Division of Finance and Management Services  
Attention: Jon Geselle  
RFI Response: Medicaid Coordinated Care Demonstration Project

If using U.S. mail, please use the following address:

PO BOX 110650  
Juneau, AK 99811-0650

If using a delivery service, please use the following address:

350 Main Street, Suite 125  
Juneau, AK 99801

If a paper response is submitted, please also send an electronic copy via email to [Jon.Geselle@alaska.gov](mailto:Jon.Geselle@alaska.gov). Please submit electronic copies in Microsoft Word or Adobe PDF format.

#### SEC. 1.05 COST OF PREPARING RESPONSES

All costs incurred for response preparation and participation are the sole responsibility of the respondent. The State will not reimburse any respondent for any such costs.

#### SEC. 1.06 RETENTION OF RESPONSES

Documents and information a respondent submits are public records and subject to disclosure. Per SB 74, a competitive bid process will follow this RFI. DHSS may elect to not make RFI responses available to the public until contract award via the subsequent formal proposal request and review process. DHSS also may elect to publicly disclose a summary of RFI responses at any point.

Respondents claiming any portion of their response as proprietary or confidential must specifically identify what documents or portions of documents they consider confidential and submit an additional copy of the response with this information redacted. DHSS shall make the final decision as to whether the documentation or information is confidential.

#### SEC. 1.07 ACCEPTANCE OF RESPONSES

DHSS will accept all responses submitted according to the requirements and deadlines specified in this RFI. DHSS may ask for written clarification of any response.

DHSS welcomes tribal entities to respond to this RFI; however, tribal entities will not be required to apply through the formal RFP process for coordinated care demonstration projects. Due to the government-to-government relationship between tribal entities and the State, these projects would be negotiated through a Tribal Consultation process. DHSS welcomes projects proposing to partner with tribal entities to participate in the formal RFP process and to respond to this RFI.

## SECTION 2. BACKGROUND INFORMATION

### SEC. 2.01 BACKGROUND INFORMATION

#### **Introduction**

The mission of the State of Alaska Department of Health and Social Services (DHSS) is to promote and protect the health and well-being of Alaskans. In pursuit of its mission, the department has three service priorities:

1. Health and wellness across the lifespan;
2. Health care access, delivery and value; and
3. Safe and responsible individuals, families and communities.

DHSS is an umbrella agency that administers or provides most of the state's health and social services, including Medicaid, public health, senior and disability services, behavioral health services, public assistance, juvenile justice, and child protection services. DHSS also administers a number of residential facilities, including the Pioneer Homes (state-owned assisted living facilities), the state psychiatric institute, and secure juvenile detention and institutional treatment facilities.

#### **Medicaid Reform**

Senate Bill (SB) 74, passed by the Alaska legislature in April 2016 and signed into law by the Governor in June, directs DHSS to undertake a series of Medicaid reforms intended to improve quality, increase value, and control spending. SB 74 includes initiatives related to fraud and abuse prevention and detection, primary care case management, and reform of the behavioral health system. The law also directs DHSS to implement coordinated care demonstration projects, participate in a hospital emergency department improvement initiative, and implement other payment reform measures. SB 74 includes authorization for the Department to apply to the federal government for Section 1115 Medicaid waivers, and to add new Medicaid state plan services such as Section 1915(i) and (k) home and community based services and Section 1945 health home services.

Responders to this RFI are highly encouraged to review SB 74 closely to understand the scope of the reforms and consider how they might interrelate. A summary of each of the major delivery system reforms and a note about the status of implementation of each follows. A link to SB 74 is included at the end of this Section.

#### **Coordinated Care Demonstration Project**

SB 74 adds AS 47.07.039, which directs DHSS to contract with one or more third parties to implement one or more coordinated care demonstration projects for Medicaid beneficiaries identified by the Department. The purpose of the demonstration(s) will be to assess the efficacy of various health care delivery models with respect to cost, access, and quality of care.

SB 74 requires that proposals for demonstration projects include three or more of the following elements:

1. Comprehensive primary-care-based management for medical assistance services, including behavioral health services and coordination of long-term services and support;
2. Care coordination, including the assignment of a primary care provider located in the local geographic area of the recipient, to the extent practical;
3. Health promotion;
4. Comprehensive transitional care and follow-up care after inpatient treatment;
5. Referral to community and social support services, including career and education training services available through the Department of Labor and Workforce Development under AS 23.15, the University of Alaska, or other sources;
6. Sustainability and the ability to achieve similar results in other regions of the state;
7. Integration and coordination of benefits, services, and utilization management;
8. Local accountability for health and resource allocation; and/or
9. An innovative payment process, including bundled payments or global payments.

Proposals for demonstration projects must also include information demonstrating how the project will implement cost-saving measures, including innovations to reduce the cost of care for Medicaid beneficiaries through expanded use of telehealth for primary care, urgent care, and behavioral health services.

DHSS is permitted by SB 74 to contract with entities situated to improve care coordination for Medicaid recipients and meet the goals of this project, including provider-led entities, Accountable Care Organizations, managed care organizations, primary care case managers, and prepaid ambulatory health plans, to implement a demonstration project. The demonstrations' fee structures may include global payments, bundled payments, capitated payments, shared savings and risk, or other payment structures.

DHSS is required to request proposals for at least one coordinated care demonstration project by December 31, 2016, and is permitted to seek additional project proposals annually thereafter. The statute establishes a Proposal Review Committee (PRC) to review proposals for demonstration projects and defines the membership of the committee. It also requires the Department to work with the state Division of Insurance to streamline the application process for a company to obtain a certificate of authority required under AS 21.09.010 as necessary to participate in a demonstration project.

There are no state funds available to support planning and development of proposed demonstration projects. The contracts established between DHSS and successful demonstration project organizations will be agreements to make policy, programmatic and system changes, including reimbursement changes, required by both parties to implement the proposed model.

SB 74 requires the Department to contract with a third-party actuary to review demonstration projects established under the bill. The actuary is to review each demonstration project after two years of implementation and make recommendations for the implementation of similar projects. In addition, DHSS is required to prepare a plan for the legislature regarding regional or statewide implementation of a coordinated care project based on the results of the demonstration projects by November 15, 2019.

Implementation Status:

- The State Health & Value Strategies initiative of the Robert Wood Johnson Foundation has contracted with the Pacific Health Policy Group (PHPG) on behalf of the Department to provide consultation on the development of the solicitation for the Coordinated Care Demonstration Projects (CCDP).
- The Department released an RFP on August 26 soliciting the services of a Medicaid payment reform and actuarial consultant to support, in part, evaluation of CCDP proposals. This consultant will also analyze potential costs and savings of other reform initiatives, identify and analyze potential innovative payment models, provide the cost analysis required for the 1115 waiver application for behavioral health reform, and evaluate the selected CCDP projects two years following implementation. The link to this RFP is provided at the end of this Section.
- The release of this Request for Information is an essential step in the Department's development of the CCDP request for proposals.
- Current CCDP Initiative Timeline (*subject to revision*):
  - September 2016: Request for Information issued
  - October 2016: Establish contract with payment reform and actuarial consultant
  - December 2016: Request for CCDP proposals issued
  - February 2017: CCDP proposals due to the department; Proposal Review Committee (PRC) convened
  - March – April 2017: Department and payment reform/actuarial consultant analysis of proposals for PRC
  - May 2017: PRC review of proposals
  - May – June 2017: Selected CCDP offeror negotiations with Department
  - Date(s) of CCDP agreement(s) implementation will be dependent on negotiations; federal approvals; and statutory, regulatory and system changes required for implementation (if necessary)

Other Medicaid Reform Initiatives

Other reform initiatives established by SB 74 may relate to the development of Coordinated Care Demonstration Projects. A summary of each of these initiatives is provided below.

- **1115 Waiver: Behavioral Health Managed System of Care**  
SB 74 adds AS 47.05.270(b) requiring DHSS to develop and manage a comprehensive and integrated behavioral health program that uses evidence-based, data-driven practices to achieve positive outcomes for people with mental health or substance abuse disorders and children with severe emotional disturbances. The program must include a plan for providing a continuum of community-based services to address housing, employment, criminal justice, and other relevant issues. It also must include services from a wide array of providers and disciplines, and efforts to reduce operational barriers that fragment services, minimize administrative burdens, and reduce the effectiveness and efficiency of the program.

SB 74 also adds AS 47.07.036(f) requiring the Department to apply for a section 1115 waiver under 42 U.S.C. 1315(a) to establish one or more demonstration projects focused on improving the state's behavioral health system for Medicaid beneficiaries. The 1115 demonstration project must be consistent with the comprehensive and integrated behavioral health program required under AS 47.05.270(b) and include continuing cooperation with the grant-funded community mental health clinics and drug and alcohol treatment centers that have historically provided care to recipients of behavioral health services.

DHSS anticipates contracting with an Administrative Services Organization (ASO) to implement the behavioral health managed system of care required under the legislation. The ASO would be a third-party organization with special expertise in behavioral health systems management. The department would contract with the ASO through a competitive bidding process to provide certain specified administrative services necessary to manage the behavioral health system of care on the state's behalf.

Implementation Status:

- The Department has convened six public-private workgroups to support the design and development of the 1115 waiver application for Behavioral Health Reform. Those teams are: Policy, Benefit Design, Quality, Cost, Data, and Writing.
  
- Current DHSS 1115 Waiver for Behavioral Health Reform Timeline (*subject to revision*):
  - December 2016: Submission of 1115 Waiver Concept Paper to CMS
  - January 2017: Release of RFLOI for ASO Services
  - April – June 2017: 1115 Waiver application public review process
  - June 2017: Submission of 1115 Waiver application to CMS
  - January 2018: Award of ASO Contract

*Note that proposals for Coordinated Care Demonstration Project (CCDP) models that integrate behavioral health services at the community or regional level are welcome, and the Department will work to align the CCDPs with the behavioral health system reforms. However, due to the schedule of the required behavioral health system reforms noted above, CCDP proposals that would propose a statewide behavioral health system model will not be considered, as such a model would preempt the system reform work currently underway.*

- **Primary Care Case Management**

SB 74 amends AS 47.07.030(d), requiring the Department to establish a primary care case management system (PCCM) or a managed care organization (MCO) contract to increase the use of appropriate primary and preventive care by Medicaid beneficiaries and decrease the unnecessary use of specialty care and hospital emergency department services. DHSS is directed to require Medicaid beneficiaries with multiple hospitalizations to enroll in the program, subject to some exceptions defined in the law. DHSS is required to integrate the PCCM system or MCO contract with the Coordinated Care Demonstration Projects established under AS 47.07.039.

Implementation Status:

- Because SB 74 requires DHSS to integrate the PCCM system with the Coordinated Care Demonstration Projects established under AS 47.07.039, and because of the potential scope

of the behavioral health system reforms, the Department is implementing a temporary program to serve as a bridge to system-wide primary care case management. This approach will allow Coordinated Care Demonstration Projects and the behavioral health system reform initiative to develop and test new models of primary care case management and to be analyzed by the third-party actuary.

- The temporary program involves expanding the current Alaska Medicaid Coordinated Care Initiative (AMCCI) contracts to include as many as 90,000 Medicaid recipients. The Department anticipates transitioning the AMCCI recipients to the new Coordinated Care Demonstration project(s) and behavioral health reform program when those are implemented. For more information on the AMCCI see the link at the end of this section.
- Current DHSS Primary Care Case Management Timeline (*subject to revision*):
  - September – October 2016: Expand AMCCI contracts
  - July 2017 – January 2018: Transition affected Medicaid recipients from AMCCI to new demonstration projects.
  - July 2018 – January 2019: Transition affected Medicaid recipients from AMCCI to Year 2 demonstration projects.
- **Health Homes**

SB 74 adds AS 47.07.036(d), authorizing the Department to implement Health Home state Medicaid plan option services established under Section 1945 of the Social Security Act (SSA)(sometimes referred to as Section 2703 Health Homes for the section of the Affordable Care Act that added Section 1945 to the SSA).

Implementation Status:

- The Department does not intend to begin planning for Health Home services until SFY 2018; however, Coordinated Care Project Demonstration projects may propose to develop and pilot test a Health Home model, and other reform initiatives may choose to implement a Health Home model, earlier than that for specific populations.
- Current DHSS Health Homes Timeline (*subject to revision*):
  - July 2017: Begin planning and development process for Health Homes.
  - July 2019: Implement Health Homes state Medicaid plan amendment(s).
- **Emergency Department (ED) Improvement Project**

SB 74 adds AS 47.07.038, which requires the Department to collaborate with the state hospital association to establish a hospital-based project to reduce the use of emergency department services by Medicaid beneficiaries. The statute stipulates that the hospital association will administer the project, and outlines a series of best practices for emergency departments that this project must address. DHSS is authorized by SB 74 to establish a shared savings mechanism with participating hospitals as part of this project, subject to federal approval.

Implementation Status:

- The Department is currently participating in meetings organized by the Alaska State Hospital & Nursing Home Association and the state chapter of the American College of Emergency Physicians.

- Current DHSS ED Improvement Project Timeline (*subject to revision*):
  - August – December 2016: Collaborate with hospitals and ED physicians on development of required data systems.
  - January – June 2017: Collaborate with participating hospitals on the development of shared savings payment models.
- **Section 1915(i) and 1915(k) Home & Community Based Services**

SB 74 adds AS 47.07.036(d), authorizing the Department to implement home and community-based services authorized under sections 1915(i) and 1915(k) of the Social Security Act. These two service options may provide an opportunity for increasing federal reimbursement for services currently funded with state general fund dollars, and for filling gaps in services for certain populations.

Implementation Status:

- The Department contracted this past year with Health Management Associates (HMA) to analyze potential opportunities, costs, and savings associated with implementing these two service categories. The final report is scheduled to be released soon.
- Current DHSS 1915(i) & 1915(k) Timeline (*subject to revision*):
  - October 2016: Release HMA 1915(i) & 1915(k) analysis and recommendations
  - November – December 2016: Develop plan for implementing new home and community-based service options.
- **Federal Policy on Tribal Medicaid Reimbursement**

SB 74 adds a new section to the uncodified law of the State of Alaska requiring the department to collaborate with Alaska tribal health organizations and the U.S. Department of Health & Human Services to fully implement changes in federal policy that authorize 100 percent federal funding for services provided to American Indian and Alaska Native individuals eligible for Medicaid. The new federal policy allows the state to claim 100% federal reimbursement for Medicaid services provided to AI/AN Medicaid recipients in non-tribal facilities if the recipients' tribal health organization has a referral agreement established with the non-tribal facility.

Implementation Status:

- The Department is currently negotiating with CMS regarding the process requirements for referral agreements between tribal and non-tribal providers and the associated systems for claiming 100% federal match for Medicaid services provided to tribal beneficiaries enrolled in Medicaid.
- Current DHSS Federal Policy on Tribal Reimbursement Timeline (*subject to revision*):
  - July 2016 – June 2017: Implement tribal claiming systems for air and ground ambulance, transportation management, nursing facility, Residential Psychiatric Treatment Facility, and NICU/PICU services.
  - July 2017 – June 2019: Implement tribal claiming systems for home and community based services; and for in-patient, specialty, and other medical services.
- **Innovative Payment Models**

SB 74 adds AS 47.05.270(a), requiring the Department to implement a program for reforming the state Medicaid program and outlining a series of elements the program must include. One provision directs DHSS to redesign the payment process by implementing fee agreements that

include: 1) premium payments for centers of excellence; 2) penalties for hospital-acquired infections, readmissions, and outcome failures; 3) bundled payments for specific episodes of care; and/or 4) global payments for contracted payers, primary care managers, and case managers for a recipient or for care related to a specific diagnosis.

Implementation Status:

- The Department released an RFP on August 26 soliciting the services of a Medicaid payment reform and actuarial consultant to, in part, identify and analyze potential innovative payment models. A link to this RFP is provided at the end of this Section.
- Current DHSS Innovative Payment Model Timeline (*subject to revision*):
  - October 2016: Establish contract with payment reform and actuarial consultant
  - October 2016 – June 2017: Identify and analyze potential innovative payment models, including those proposed through other reform initiatives.
- **General 1115 Waiver Authority**

SB 74 adds AS 47.07.036(e), requiring the Department to apply for a section 1115 waiver under 42 U.S.C. 1315(a) to establish one or more demonstration projects focused on innovative payment models for one or more groups of Medicaid beneficiaries in one or more specific geographic areas. The demonstration projects may include managed care organizations, community care organizations, patient-centered medical homes, or other innovative payment models that ensure access to health care without reducing the quality of care.

Implementation Status:

- The Department may use this general waiver authority to implement a Coordinated Care Demonstration Project if necessary, but has no current plans to develop additional 1115 Waiver projects beyond the waiver planned for the behavioral health reform initiative.
- **Stakeholder Engagement in Medicaid Redesign Implementation**

The Department, with the support of the Alaska Mental Health Trust Authority, currently has a contract with Agnew::Beck, LLC, to support a number of stakeholder engagement efforts, including:

  - Meetings with a Key Partners group, which includes representatives of major stakeholder groups and associations (will begin meeting in September);
  - Meetings of the six behavioral health 1115 waiver design teams (will begin meeting in September);
  - Meetings of the Telehealth Workgroup (will begin meeting in October);
  - Meetings of the Quality & Cost-Effectiveness Targets Workgroup (will begin meeting in October); and,
  - Public webinars to provide periodic updates on implementation (the first was held September 8 and is available on-line).

The public may also submit comments and questions to [Medicaid.Redesign@alaska.gov](mailto:Medicaid.Redesign@alaska.gov).

## SEC. 2.02 LINKS TO ADDITIONAL INFORMATION

Additional background information may be accessed via the following links.

- SB 74:  
<http://www.legis.state.ak.us/PDF/29/Bills/SB0074Z.PDF>
- RFP for Medicaid Payment Reform and Actuarial Consulting Services:
  - Public Notice:  
<https://aws.state.ak.us/OnlinePublicNotices/Notices/View.aspx?id=182646>
  - To access the solicitation without an IRIS vendor account, click the “Public Access” button on this page and scroll down to the Medicaid Payment Reform solicitation:  
<https://iris-adv.alaska.gov/webapp/PRDVSS1X1/AltSelfService>
- Alaska Medicaid Program Annual Report:  
<http://dhss.alaska.gov/dhcs/Documents/PDF/Alaska-Medicaid-Annual-Report-SFY2015.pdf>
- Alaska Medicaid Coordinated Care Initiative (AMCCI): *(Note – This initiative is not directly associated with the SB 74 Coordinated Care Demonstration Project. It predates SB 74, and was initially established as the “Super-Utilizer” project intended to reduce overuse of hospital emergency department services)*  
<http://dhss.alaska.gov/dhcs/Pages/amcci/default.aspx>

## SEC. 2.03 DEFINITIONS

**Health information infrastructure:** Health care specific information technologies, data, and analytic capabilities that support health care delivery, payment, and evaluation.

**Telehealth:** The practice of health care delivery, evaluation, diagnosis, consultation, or treatment, using the transfer of health care data through audio, visual, or data communications, performed over two or more locations between providers who are physically separated from the recipient or from each other or between a provider and a recipient who are physically separated from each other. (AS 47.05.270(e))

**Value-based payment:** A payment model intended to promote quality and value of health care services by shifting from pure volume-based payment models such as fee-for-service, to payment based on quality metrics and outcomes.

## SECTION 3. RESPONSE FORMAT AND CONTENT

### SEC. 3.01 RESPONSE FORMAT AND CONTENT

Respondents are encouraged to answer all of the questions listed below if possible to help inform the development of the request for proposals, but are not required to answer every question. It is not necessary to repeat the question in the response, but please clearly indicate the question number for which a response is provided.

Throughout the response, please highlight the information considered to be critical to the proposed model. Respondents who are not prepared to answer these questions are invited to share concepts for improved delivery system models they would like the Department to consider.

A suggested page limit is provided for each question, but respondents are not bound by the page limits if additional space is required. However, the total response should not exceed 25 pages.

### SEC. 3.02 QUESTIONS

#### 1. Overview (3 pages)

- a. Please identify the entity (or entities if a collaborative effort) submitting the Coordinated Care Demonstration Project (CCDP) RFI response. If a collaborative effort, please identify the lead entity. Please identify the key contact person for this effort.
- b. What is (or would be) the organizational structure for the proposed coordinated care model?
- c. Please provide a high-level description of the model.
- d. Please identify the elements from SB 74 (listed below) the model addresses and how the model addresses each identified element. (Note that SB 74 requires CCDP projects to include a minimum of three of the following nine elements)
  1. Comprehensive primary-care-based management for medical assistance services, including behavioral health services and coordination of long-term services and support;
  2. Care coordination, including the assignment of a primary care provider located in the local geographic area of the recipient, to the extent practical;
  3. Health promotion;
  4. Comprehensive transitional care and follow-up care after inpatient treatment;
  5. Referral to community and social support services, including career and education training services;
  6. Sustainability and the ability to achieve similar results in other regions of the state;
  7. Integration and coordination of benefits, services, and utilization management;
  8. Local accountability for health and resource allocation; and/or
  9. An innovative payment process, including bundled payments or global payments.
- e. Please describe how the model will utilize telehealth.

2. Service Area (1 page)

- a. Please identify the proposed service area for the model. If the service area could potentially change over time, please explain.

3. Covered Populations (2 pages)

- a. Please identify the Medicaid-eligible populations to be served by the model (e.g., families, Denali KidCare, Medicaid Expansion, long-term care participants, individuals dually eligible for Medicare and Medicaid, etc.)
- b. Please identify populations the model will specifically serve, if applicable (e.g., individuals diagnosed with specific conditions or chronic diseases, such as SMI, SUD, diabetes, or asthma; homeless; individuals reentering society from the correctional system; etc.).
- c. Does the model require a minimum or maximum membership threshold? If so, please specify and explain the rationale.
- d. Would voluntary or mandatory participation (subject to regulatory restrictions that prohibit mandatory participation) best support the model?
- e. If the covered population potentially could change over time, please explain.

4. Covered Services (2 pages)

- a. Please describe the services covered within the model.
- b. Please explain the rationale for excluding certain services from the model, if applicable.
- c. Please describe how the model will support coordination across the full array of health services.
- d. If certain services would be excluded at the outset, does the model allow for expansion of covered services over time?

5. Payment Methodology (2 pages)

- a. Please provide a general overview of the payment methodology (e.g., risk-based, shared savings, administrative fee, etc.).
- b. Please describe how the proposed payment methodology promotes value-based payment (i.e., payments to providers based on performance (including positive and/or negative adjustments based on quality and/or efficiency) rather than solely based on volume of provided services).
- c. Please describe how the payment methodology promotes the project's objectives.
- d. Please note if the payment methodology addresses local accountability for health and resource allocation, and if so, how.

6. Model Opportunities (8 pages)

- a. What do you see as the greatest challenges to delivering accessible, high quality and cost effective care to Alaskans statewide (or in your proposed service area) and how does your model address these challenges?
- b. Please describe any innovative approaches within the model for meeting the needs of program participants and promoting health.
- c. Please describe how the service delivery model promotes the project's objectives, including local accountability for health and resource allocation.

- d. How does the model promote person-centered and person-directed care?
- e. How does the model promote appropriate access to quality care?
- f. Please describe how the model promotes high quality care and improved outcomes. Please describe the methodology that you would propose for evaluating the effectiveness of the model.
- g. Please describe how the model generates program savings and constrains the rate of expenditure growth for the State Medicaid program. Please describe how the model advances transformation of the delivery system to control overall costs.

7. Alignment with other State Initiatives (2 pages)

To the extent that you are able based on your knowledge and understanding, please:

- a. Describe how the model might align or integrate with other health reform initiatives described in SB 74 and in implementation by DHSS (as described in the Background Section), including the behavioral health demonstration and advancement of telehealth?
- b. Describe how the model might align with the tribal health delivery system and support the state's ability to fully implement the new federal tribal FMAP policy?
- c. Describe how the model might support and utilize Alaska's health information infrastructure?
- d. Describe how the state's Health Information Exchange, administered by the Alaska eHealth Network, would be used to support the model?

8. Implementation Considerations (5 pages)

To the extent of your ability based on the current status of model development and your understanding of State and federal operations and requirements, please describe:

- a. The major implementation tasks, and provide a high-level timeline for implementation activities.
- b. How development and implementation activities will be funded, recognizing that no state funds are available to support project planning, development and implementation.
- c. Model components (e.g., services, populations, payment approaches) that could be refined post-implementation and the timeline for these changes.
- d. State activities that would be required to implement the model.
- e. Federal requirements with which the model would have to comply
- f. Statutory or regulatory changes that would be necessary to permit the model to operate.