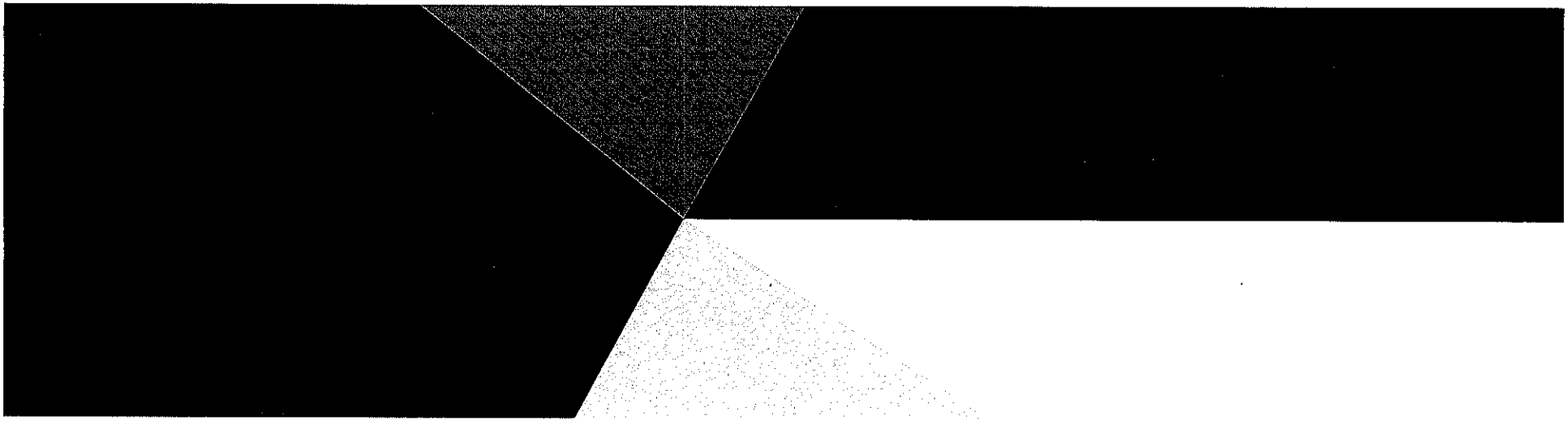

Alaska Mental Health Trust Authority

Medicaid

November 20, 2014

Background

Why focus on Medicaid?

Trust result desired in working on Medicaid policy issues and in implementing several of our focus area strategies:

Making a sustained investment over time will result in permanent systemic changes to improve access to services and other needed supports that ensure quality of life for beneficiaries.

Focused funding and policy work

2005: Trust worked with DHSS- restorative dental services implemented through Medicaid program expansion

- Worked to establish allowable amounts for restoration in lieu of extraction
- Later adaptation: dentures access to two years of funding benefit

2006 Trust establishes focus areas to address gaps in service system for beneficiaries

- Improving service delivery models and evidence based practices
- Addressing financing of programs (Medicaid systems)

Focus areas and Medicaid

Bring the Kids Home – addressed the need for building up community based services to both prevent institutionalization and to prevent it.

- Settings: school based Medicaid programs, increasing capacity to offer lower level services

Disability Justice – state and Medicaid programs assist in treatment and reintegration

- Community based services challenging for successful transition from institution to community
- Single adults not eligible for Medicaid coverage have challenges in community assistance in reintegration

Focus areas and Medicaid

Beneficiary Projects – an initiative to integrate peer support in many settings across service delivery system as a more effective service model:

- Behavioral health – peer support now established as billable Medicaid service
- Developmental Disability services – peer advocacy
- Vocational – vocational peer support
- Housing – peer resident advisors

Peer support as employment for beneficiaries

- many of these services employ beneficiaries and are financed as a component of the service system

Focus areas and Medicaid

Affordable Housing – outreach and engagement services are primary tools for success in housing beneficiaries (not billable services)

- Medicaid is geared for "clinic" use and is a challenge in the community
- Housing costs more for people with higher needs. These costs fall to housing providers if services are not heavily enriched
- Alaska's system of "fee for service" challenges service models that offer extensive outreach, engagement and overlapping services (high needs individuals)
- Mental Health services has rehabilitative levels of services, but most people with a mental illness don't qualify

Focus areas and Medicaid

2007 established Workforce Development – a tool to ensure workforce needs of the state

- Training workforce to respond in service environments – Training cooperative
- Training in procedures to document Medicaid services and work within a "fee for service" environment
- Creating standardized training to assist the state in documenting quality of service for federal requirements (Core Competencies)

MEDICAID

History

Medicaid is a component of the Social Security Act of 1935 enacted under Franklin D Roosevelt's presidency as a component of the *New Deal*.

Social Security Act: Attempt to balance the "dangers of the modern American life" –

- old age, poverty, unemployment and the burdens of widows and fatherless children
- Assists through payments to the citizens in these circumstances and grants to states to provide assistance

History

1965: Medicare and Medicaid programs passed into law and became Titles 18 & 19 of the Act respectively.

1971: States given option to cover services in intermediate care facilities (ICFs) for the elderly and individuals with disabilities with lower level of care needs than those in skilled nursing facilities.

History

1972: Alaska's Medicaid program began

1981: states were given the ability to "waive" certain Medicaid rules to offer home and community-based services for people eligible for Medicaid funded institutional care.

1992: the Americans with Disabilities Act passes with requirements for states to provide access to governmental services in the closest location as possible to home/community and protections for the rights of people with a disability

History

1993: States increased use of waivers under SSA section 11 of the Act

- 1115 demonstration waivers used to adapt to growing needs
- Used to expand to cover previously uncovered populations like childless adults
- typically through managed care models

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1993: Alaska applies for the Home and Community Based Waivers through section 1915 of the Act (1915c) for specific populations allowing 'waiver' of typical Medicaid funding limits to provide home and community services

- Alaskans living independently (over 21, nursing facility level of care- LOC)
- Individuals with developmental disabilities (all ages)
- adults with physical and developmental disabilities (nursing LOC)
- children with complex medical conditions.(through age 21, nursing LOC

History

1999: The U. S. Supreme Court rules in the Olmstead v. L.C. that the Americans with Disabilities Act (ADA) can, under certain circumstances, require states to provide community-based services to individuals for whom institutional care is inappropriate

This court decision is not specific to Medicaid, however, it has significant implications for the program as one of the primary funding mechanisms for "home and community based services" (HCBS) settings

Olmstead decision

- States today are adopting an "Olmstead Plan" either through legal requirements or state initiative to demonstrate how services are available and coordinated to ensure access to community services to comply with this ruling
- Comprehensive Integrated Mental Health Plan as Alaska's Olmstead Plan? The Comp Plan would require modification to meet this function

Figure 1

Medicaid's Role in Our Health Care System

Health Insurance Coverage

32 million children & 18 million adults in low-income families; 16 million elderly and persons with disabilities

Assistance to Medicare Beneficiaries

9.6 million elderly and disabled — 20% of Medicare beneficiaries

Long-Term Care Assistance

1.6 million institutional residents; 2.9 million community-based residents

MEDICAID

Support for Health Care System and Safety-Net

16% of national health spending; 40% of long-term care spending

State Capacity for Health Coverage

FY 2014, FMAPs range from 50% – 73.1%

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Medicaid program

Alaska's program and services

Alaska State DHSS administers three distinct programs, commonly referred to as "Medicaid:"

1. Medicaid
2. Denali Kid Care (Alaska's CHIP program – Children's Health Insurance Program)
3. Chronic and Acute Medical Assistance (CAMA) not part of the federal Medicaid program – a state program that uses the same eligibility, provider, and payment infrastructure.

Medicaid program

Three mechanisms for management:

1. Enrollees – who is eligible?
2. Services – required vs optional
3. Rate reimbursements

States are required to have an approved Medicaid State Plan authorized by the Centers for Medicare and Medicaid Services (CMS)

Required Services

Under federal law, states must cover the following "mandatory" services for people who qualify for Medicaid, subject to medical necessity:

- inpatient and outpatient hospital services;
- physician, midwife, and nurse practitioner services;
- early and periodic screening, diagnosis, and treatment (EPSDT) for children up to age 21;
- laboratory and x-ray services;
- family planning services and supplies;
- federally qualified health center (FQHC) and rural health clinic (RHC)
- freestanding birth center services (added by ACA);
- nursing facility (NF) services for individuals age 21+;
- home health services for individuals entitled to NF care;
- tobacco cessation counseling and pharmacotherapy for pregnant women (added by ACA); and
- non-emergency transportation to medical care

Optional Services

States may also offer "Optional" services, which are often cost-effective alternatives to mandatory services:

- Dental services
- Therapies –PT/OT/Speech/Audiology
- Prosthetic devices, glasses
- Case management
- Clinic services
- Personal care and Self-Directed Personal Care
- Hospice
- Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)
- Psychiatric Residential Treatment Facility for people under 21 (PRTF) (also described as RPTC in Alaska – Residential Psychiatric Treatment Centers)
- Rehabilitative services

Eligibility

- Medicaid is an entitlement program - a governmental mechanism in which public funds are given to people who meet requirements
- Financial limits can be adjusted if using waivers or other programs tied to conditions that would require institutional levels of care
- When qualified for programs that prevent institutionalization, income limits are adjusted

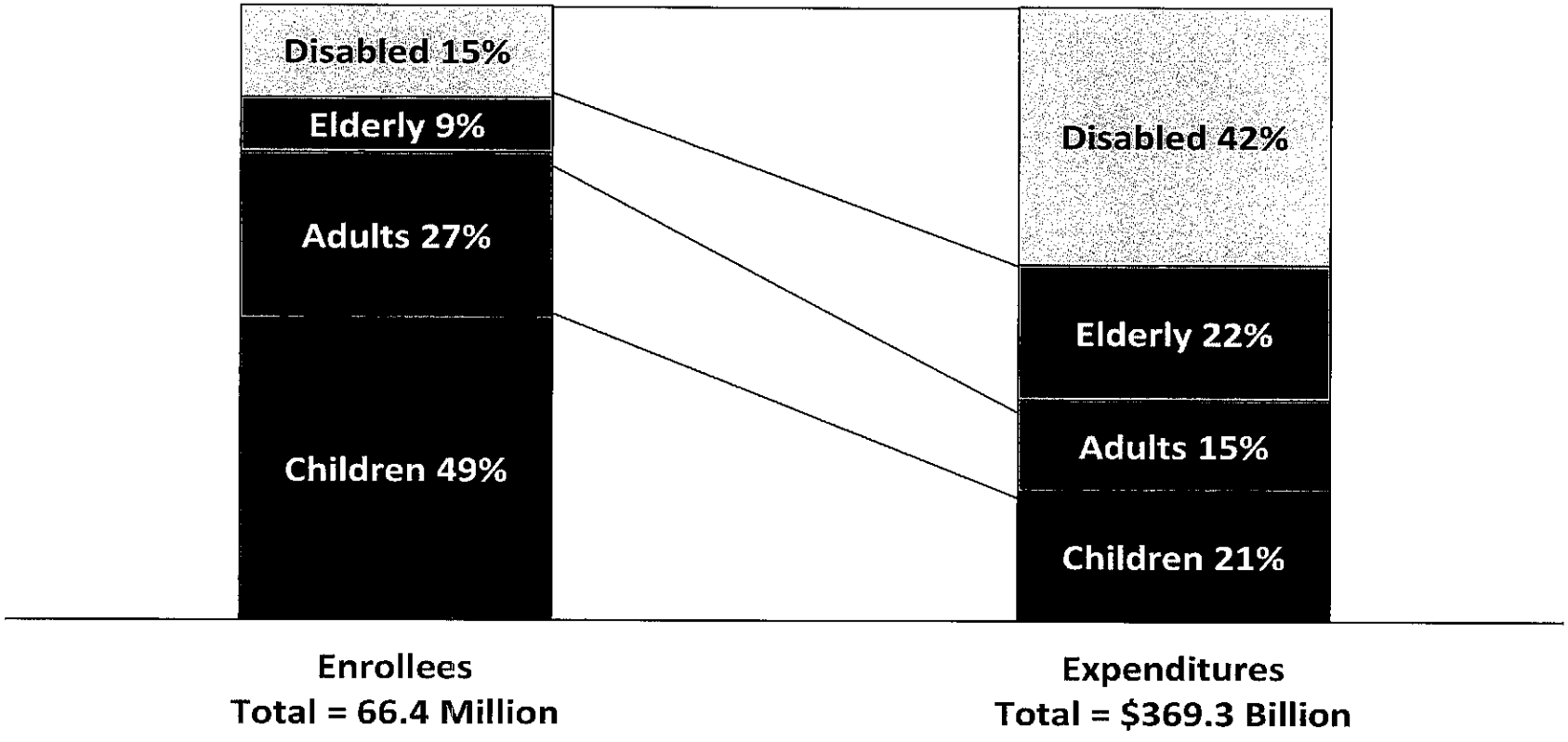
Eligibility

Alaska's levels for many Trust beneficiaries (with federal adjustments):

- Adult Public assistance 100% of Federal Poverty Limits
- Children, pregnant women – range 200%-100% based on disability and other program eligibility
- Senior and Disability services waiver programs: 175%
- Differing levels based on program and disability eligibility

Figure 2

Medicaid Enrollees and Expenditures, FY 2010



SOURCE: KCMU/Urban Institute estimates based on data from FY 2010 MSIS and CMS-64. MSIS FY 2009 data were used for CO, ID, MO, NC, and WV, but adjusted to 2009 CMS-64.

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Rates

- Alaska's reimbursement rate is 50% federal funds to state funds.
- This is called the "FMAP" rate or Federal Medical Assistance Percentage.
- There are enhanced FMAP rates for some services:
  - 65% federal for CHIP,
  - 90% federal for family planning,
  - 100% federal for services provided by tribal health providers to IHS eligible Medicaid recipients.

Affordable Care Act

2010: The Affordable Care Act (ACA) was enacted on March 23, 2010 expanded the Medicaid program significantly as part of a broader plan to cover millions of uninsured

- ACA initially proposed automatic expansion of Medicaid eligibility to reach nearly all non-elderly adults with incomes at or below 138% of the federal poverty level (FPL)

2014 – Alaska opts not to expand Medicaid

Affordable Care Act

The law made additional requirements that states:

- simplify and modernize enrollment processes
- create a new coordinated enrollment system for Medicaid programs and the new Insurance Marketplaces.

The ACA also established an array of new authorities and funding opportunities for delivery system & payment reform initiatives in Medicare/Medicaid

- designed better models and cost-effective care,
- particularly for those with high needs and high costs.

Affordable Care Act

Affordable Care Act provided new options and incentives to states to rebalance their Medicaid long-term care programs in favor of community-based services and supports rather than institutional care through Medicaid state plan options and waivers

These new opportunities and mechanisms

- accelerate innovation already taking place in many Medicaid programs
- Give states unique financial and policy leverage to reform the systems of care for the highest needs populations

State Plan Options

Social Security Act Waivers and state plan options

- Many of the new options allow states to group people who are similarly situated (i.e. using a disproportionate amount of higher cost services)
- Allow states to focus on outcomes
- More flexible service delivery mechanisms

State Plan Options

1915 (k) Community First Choice

- In December 2011 SDS contracted with HCBS Solutions to assist in developing a potential Community First Choice program (CFC) to improve and replace our current Personal Care Assistance Program
- This option would generate additional state match for the services and allow for improvement in the programs

State Plan Options

1915(i) Home and Community Based Services Option

- Not tied to institutional levels of care – functional need is defining determinant
- Functional need as a determinant would allow services to people who physically don't require institutionalization but need that level of care (i.e. people with mental illness, Alzheimer's Disease, traumatic brain injury)

State Plan Options

1915(i) components

- Broad range of services
- Single option, with targeted service packages for different subgroups
- No cost neutrality
- Can use broader intuitional financial eligibility criteria only for people who need institutional level of care
- Will need discussion about targeting so program can be effective (target those most in need)

State Plan Options

Other program components are changing at the federal level

- Home and Community Based settings rule
- Conflict Free Case Management requirements
- State submitting request for new service to incorporate "supportive services for permanent supported housing" (Washington State)

Sources

US Centers for Medicare and Medicaid Services (CMS): http://www.cms.gov/

US Government Centers for Medicare and Medicaid Services. Medicaid and Children's Health Program information website: http://www.medicaid.gov/medicaid-chip-program-information/by-topics/by-topic.html

Henry J Kaiser Family Foundation, Medicaid fact sheet: http://kff.org/medicaid/fact-sheet/the-medicaid-program-at-a-glance-update/

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State of Alaska Department of Health and Social Services, Alaska Medicaid Recipient Services Handbook; http://dhss.alaska.gov/dhcs/Documents/PDF/Recipient-Handbook.pdf

Questions and Discussion

- More information to follow in Advisory Board presentation
- Additional information requested?
- Advocacy items?