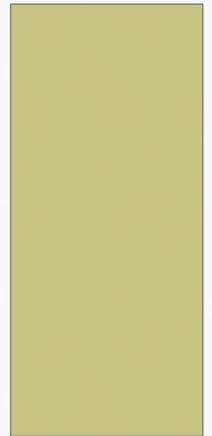


THE 1115 BEHAVIORAL HEALTH DEMONSTRATION WAIVER

UPDATED FOR THE GCDSE – 10/3/2017



ACHIEVEMENTS TO DATE

- The Populations that we are targeting under the State's application to CMS for an 1115 Behavioral Health Demonstration Waiver are defined and continuously being refined as we move forward.
- The work with the State's Medicaid claims data and applying/working with the data in the **Drive Tool** that Milliman created for Alaska has taken more time that anticipated, as we are having to understand how we need to present our requests to Milliman, the actuarial firm working with DHSS on this complex project.

THE STEPS TO ESTABLISH BUDGET NEUTRALITY

- A successful 1115 Demonstration waiver requires DHSS to establish – *by the end of the five year period of the demonstration project* – the cost neutrality of all of the program and service changes being recommended to the State’s present behavioral health system of care.
- It also means we need to be clear in our waiver application to CMS that we are seeking authority to introduce Medicaid services and options – and impose participation or exclude participation – that is not otherwise available under existing CMS rules or Alaska’s own State Medicaid Plan.

HERE ARE THE QUESTIONS WE ARE ANSWERING TO ESTABLISH THE PROJECT'S COSTS:

- What Medicaid populations are we proposing to include in the 1115 Behavioral Health Demonstration waiver?
- What target populations will be affected by the new benefits/programs being proposed?
- What are the scope of the services to be covered?
- How much will each new waived service cost?
- Remember: the 1115 waiver will create a pool of persons with behavioral health needs that we have specifically targeted because of what our claims data has shown us; if a child or adult or family meets the Medicaid eligibility criteria set by this proposed 1115 waiver, then the range of benefits created and identified for this new 1115 insurance program will be available to these BH clients on enrollment.

HERE'S WHAT HAS GONE INTO DETERMINING HOW MUCH EACH NEW SERVICE WILL COST:

- First, we have determined whether any of these services are presently provided in the State, but outside the Alaska's Medicaid program (and whether we can move to include them in the waiver).
- Then we have identified – of the target populations we are proposing to include – which populations will be able to access what new services.
- Then we need to identify the estimated “take up” rate from the target population (I will explain “take up” shortly).
- Next we need to be able to estimate the utilization per day/week/month/year of those who access each of the services identified in the waiver.
- And, finally, we need to propose/set the cost-per-unit (select the rate) that Alaska is estimating for each service.

WHAT IS THE “TAKE UP” RATE?

- This is a very interesting and important but somewhat difficult rate to calculate/estimate. Indeed we are still struggling with this issue and it was, in fact, the subject of a significant part of our meeting with the Milliman consultants last month.
- Think of this a declension or a reverse pyramid:
 - Total Medicaid Population (i.e., all Alaskan’s eligible for Medicaid)
 - Target Population (of all those eligible for Medicaid, what are the specific populations – the Medicaid Eligibility Groups (MEGs) – that the 1115 is “targeting” for services under the BH demonstration waiver)
 - The “Benefit Take Up” rate is the rate or estimated number of Medicaid-eligible persons within EACH Target Population that are actually expected to access each of the services being proposed by the waiver for the population, i.e., the number of those that are expected to “take up” or utilize each individual service identified for that particular MEG.
 - So, out of possible 100% utilization of a particular service by a particular population, what is the expected take up rate by those eligible for that service: 30%, 50%?, 75%?, etc.

“TAKE UP” RATE EXAMPLE

- A good example: the 1115 will require the use of a brief, universal evidenced-based screening of all persons, regardless of setting (Primary Care Clinic, BH Clinic, Health Fairs, etc.) in order to identify any potential behavioral health symptoms in order to assist in intervention with the child, the family, or the individual adult with potential BH needs. Since this is a requirement, the take up rate is 100% and it will be budgeted at that percentage.
- If the screening indicates there would be value in further assessment, the referral for the assessment will not have a 100% take up rate, although the ASO would work very hard to help that family or child or single adult get a follow-up appointment for that assessment. We are estimating an 60% take up rate for the assessment service.

HERE ARE THE DECISIONS WE HAVE MADE SO FAR AROUND “MEGS”

- We have defined the **Medicaid Eligibility Groups** (MEGs) that we are targeting in our 1115 Demonstration Waiver:
- **Medicaid Child/Denali KidCare** (eligible infants and children under 19, all qualified under **CHIP** (FMAP 88%) to age 21, Pregnant Women), to include **TEFRA** children (under 19 with severe disabilities)
- **Medicaid Adult**
- **Medicaid Expansion Adult** (FMAP 97%, dropping to 90%)
- **Pregnant Women**
- **Parent/Caretaker Relatives w/Dependent Children Under 19**
- **Aged, Blind & Disabled**
- **Dual Eligible** (Medicaid and Medicare 64 and under)
- **Children In State Custody**
- **Former Foster Care Children** (up to age 26)
- **Waiver(c)/IDD** (only a specific portion of the HCBS waiver: individuals with significant co-occurring IDD and MH behaviors that exceed the capacity of either the HCBS or local BH programs)

GENERAL RATIONALE FOR NEW SERVICES:

- The new service benefits are designed to decrease use of inpatient hospital, hospital emergency room, and residential services by conducting universal screenings; intervening early (when symptoms are first identified); utilizing sub-acute, community-based step-up/step-down clinical services as alternatives to residential and inpatient services; and developing community-based supports (at the region or regional-hub level) to maintain recovery, health, and wellness.

NEW SERVICES BEING *PROPOSED*

- **Prevention / Engagement Services:**
 - SUD and MH Evidence-based Screenings – required screening instruments to identify children and adults w/BH symptoms that may require assessment and service/treatment referrals
- **Outpatient Intervention Services:**
 - MAT Treatment Care Coordination
 - MAT Treatment (Injectable Naltrexone for alcohol and opioid abuse)
- **Intensive, Community-Based Intervention Services**
 - Assertive Community Treatment (ACT)
 - Home-based Family Treatment (Levels 1 – 3) (wrap around individual and family services in the home for children ages 0 – 20 who are either at risk for out of home placement or at risk of DJJ detention)
 - Intensive Case Management (ICM)
 - Mental Health Partial Hospitalization (outpatient service)
 - SUD Intensive Outpatient Services (IOP)

NEW SERVICES (continued)

- **Acute Residential Services**
 - Crisis Residential / Stabilization; two types:
one for ages 5 – 17 and the other for 18+
 - Therapeutic Foster Care (TFC) for ages 0 – 18
- **Acute Intensive Community-Based Services**
 - 23 Hour Crisis Stabilization
 - Mobile Crisis Response Services (MCRS)
 - Peer-Based Crisis Services (calming environments with supports for individuals in crisis; medical supports, no more than two days)
- **Community & Recovery Support Services**

CHILDREN & ADOLESCENT SERVICES

- PROPOSED TARGET POPULATION 1(A):
 - Medicaid Eligibility Groups:
 - Children under 19, Children Under 21 (+ TEFRA), Pregnant Women, Newborns, and Parent/Caretakers who meet the following qualifying criteria:
 - Who have a child-specific or parental mental health or substance use disorder which has been *diagnosed or treated within the past year,*
- OR**
- Who have been identified through *positive responses to evidence-based mental health and substance use disorder screening questions* indicating an increased likelihood that a mental health and/or SUD symptom exists and needs further assessment and evaluation.

CHILDREN & ADOLESCENT SERVICES

- **PROPOSED TARGET POPULATION 1(B):**
 - Medicaid Eligibility Groups:
 - Children under 19, Children under 21 (+ TEFRA), Pregnant Women, Newborns, & Parent/Caretakers **who *are in the custody of either the Alaska Department of Health and Social Services' Office of Child Services or its Division of Juvenile Justice, or who are in foster care*** and who meet the following qualifying criteria:
 - Who have a child-specific or parental mental health or substance use disorder which has *been diagnosed or treated within the past year,*
- OR**
- Who have been *identified through positive responses to evidence-based mental health and substance use disorder screening questions* indicating an increased likelihood that a mental health and/or SUD symptom exists and needs further assessment and evaluation.

CHILDREN & ADOLESCENT SERVICES

- PROPOSED TARGET POPULATION 1(C):
- Medicaid Eligibility Groups:
- Children under 19 (ages 5 - 18), Under 21 (+ TEFRA, ages 5-18), and Former Foster Care Children (ages 5 - 18), who meet the following qualifying criteria:
 - **Who are in residential treatment or have used residential treatment services during the past year** (includes all levels of children's residential services and Residential Psychiatric Treatment Center services).
- The Department's work with tribal social services agencies to develop a template for compacts with individual tribes around child welfare issues (replacing much of the child protection and family intervention work presently within OCS' purview) will have to be reviewed after those compact negotiations are completed.

ADULTS (AGES 18 – 64)

- **PROPOSED TARGET POPULATION 2:**

- Medicaid Eligibility Groups:

- Children under 21, the Aged/Blind/Disabled, Medicaid Expansion, and Former Foster Care Children **IF** persons in these MEGs are between the ages 18-64 years and meet the following qualifying criteria:

- Have one or more of the following diagnoses from the Diagnostic and Statistical Manual of Mental Disorders (DSM-5):
 - A Mental Disorder including anxiety disorder, attention deficit hyperactivity disorder (ADHD/ADD), bipolar disorder, depression, eating disorder, generalized anxiety disorder, obsessive-compulsive disorder, panic disorder, postpartum depression, posttraumatic stress disorder, schizophrenia, seasonal affective disorder, and social anxiety phobia; **OR**
 - A co-occurring Mental Health and Substance Use Disorder; **OR**
 - A co-occurring Mental Health and Intellectual Developmental Disabilities Disorder not covered by any other Federal waiver; **AND**
- Have used more than one (1) of the following acute intensive services in the past year:
 - Inpatient Psychiatric Hospital—API and All Other
 - Inpatient General Hospital for MH/SA
 - Inpatient Hospital Medical/Surgical/Non-Delivery, Inpatient Maternity Delivery, and Other Inpatient
 - Outpatient General Hospital Emergency Room

SEVERE SUD ADULTS (AGES 18 -64)

- **PROPOSED TARGET POPULATION 3:**

- Medicaid Eligibility Groups:

- Children under 21, Aged/Blind/Disabled, Expansion, and Former Foster Care, ages 18 - 64 years, who meet the following qualifying criteria:

- Have one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) for Substance-Related and Addictive Disorders (with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders), **AND**
- Meet the *American Society of Addiction Medicine Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions'* (ASAM 3rd Edition) definition of medical necessity for services:

"Medical necessity pertains to necessary care for biopsychosocial severity and is defined by the extent and severity of problems in all six multidimensional assessment areas of the patient. It should not be restricted to acute care and narrow medical concerns (such as severity of withdrawal risk as in Dimension 1); acuity of physical health needs (as in Dimension 2); or Dimension 3 psychiatric issues (such as imminent suicidality). Rather, medical necessity encompasses all six assessment dimensions so that a more holistic concept would be clinical necessity." *The ASAM Criteria, 3rd Edition. 2013, page 422.*

1115 WAIVER - 9 REGIONS PROPOSED

Division of Behavioral Health's 9 Regions					
No.	Regions	Regional Hubs	No. of Tribal Hospitals	No. of Non-Tribal Hospitals	Population
		<i>Sub-Regions</i>			
1	Anchorage Municipality	Anchorage	1	5	300,549
2	Fairbanks North Star Borough	Fairbanks		1	97,972
3	Northern and Interior Region	Fairbanks and Utqiagvik (Barrow)	1		23,936
		North Slope Borough	1		9,711
		Denali Borough			1,785
		Yukon-Koyukuk Census Area			5,477
		Southeast Fairbanks Census Area			6,963
		3			
4	Kenai Peninsula Borough	Soldotna and Homer		3	57,212
5	MatSu Borough	Wasilla		1	98,063

Division of Behavioral Health's 9 Regions

No.	Regions	Regional Hubs	No. of Tribal Hospitals	No. of Non-Tribal Hospitals	Population
		<i>Sub-Regions</i>			
6	Western Region	Kotzebue, Nome, and Bethel	3		43,770
		Northwest Arctic Borough	1		7,774
		Nome Census Area	1		9,952
		<i>Kusilvak (Wade Hampton) Census Area</i>			8,053
		Bethel Census Area	1		17,991
		1			
7	Northern Southeast Region	Juneau and Sitka	1	4	54,029
		<i>Haines Borough</i>			2,537
		<i>Hoonah-Angoon Census Area</i>			2,128
		Juneau City & Borough		1	33,026
		<i>Petersburg Borough</i>		1	3,209
		Sitka City and Borough	1	1	9,061
		<i>Skagway Municipality</i>			1,031
		<i>Wrangell City and Borough</i>		1	2,406
		<i>Yakutat City and Borough</i>			631
		6			

Division of Behavioral Health's 9 Regions					
No.	Regions	Regional Hubs	No. of Tribal Hospitals	No. of Non-Tribal Hospitals	Population
		<i>Sub-Regions</i>			
8	Southern Southeast Region	Ketchikan		1	20,251
		Ketchikan Gateway Borough		1	13,825
		<i>Prince of Wales-Hyder Census Area and Prince of Wales-Outer Ketchikan Borough</i>			6,426
		2			
9	Gulf Coast/Aleutian Region	Anchorage, Kodiak, and Dillingham	1	3	39,819
		<i>Aleutians East Borough</i>			3,070
		<i>Aleutians West Census Area</i>			5,727
		Kodiak Island Borough		1	13,797
		<i>Valdez-Cordova Census Area</i>		2	9,567
		<i>Bristol Bay Borough</i>			942
Dillingham Borough/Census Area	1		5,044		
<i>Lake and Peninsula Borough</i>			1,672		
		6			
Total	9	14 Regional Hubs	7	18	735,601
	Regions	17 Sub-Regions	Tribal Regional Hospitals	Community Hospitals	

UPDATED TIMELINE FOR MATTERS RELATED TO THE 1115 APPLICATION

Drafting the 1115 Application

- **November 2017** Complete Draft of 1115 Application and Review Draft with 1115 Teams and Internal Stakeholders (DBH, DHSS Leadership)
- **December 2017** Time for Public Comment, Tribal Consultation, Trust Review
- **January 2018** Final Draft, Final Team Reviews, Final DHSS Leadership Review
- **January, 2018** File Completed 1115 BH Demonstration Waiver Application with CMS
- **February, 2018** Begin Negotiations with CMS over content of Alaska's 1115 Application

DRAFT TIMELINE FOR MATTERS RELATED TO THE 1115 APPLICATION**

Contracting for an Administrative Services Organization

- September 2017 Began drafting the ASO RFP
- December 2017 Finalize the RFP
- January, 2018 Issue the ASO Request for Proposals
- April, 2018 ASO RFP Responses Due
- June, 2018 Award the ASO Contract
- January, 2019 ASO fully operational (most ASOs have indicated a preference for a six-month start up process, including provider engagement / enrollment, etc.)

** These time frames may be adjusted further back as the 1115 process unfolds.

QUESTIONS? HAPPY TO TRY AND ANSWER THEM!

- *And* THANKS!
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