

SB

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(FILE 3)

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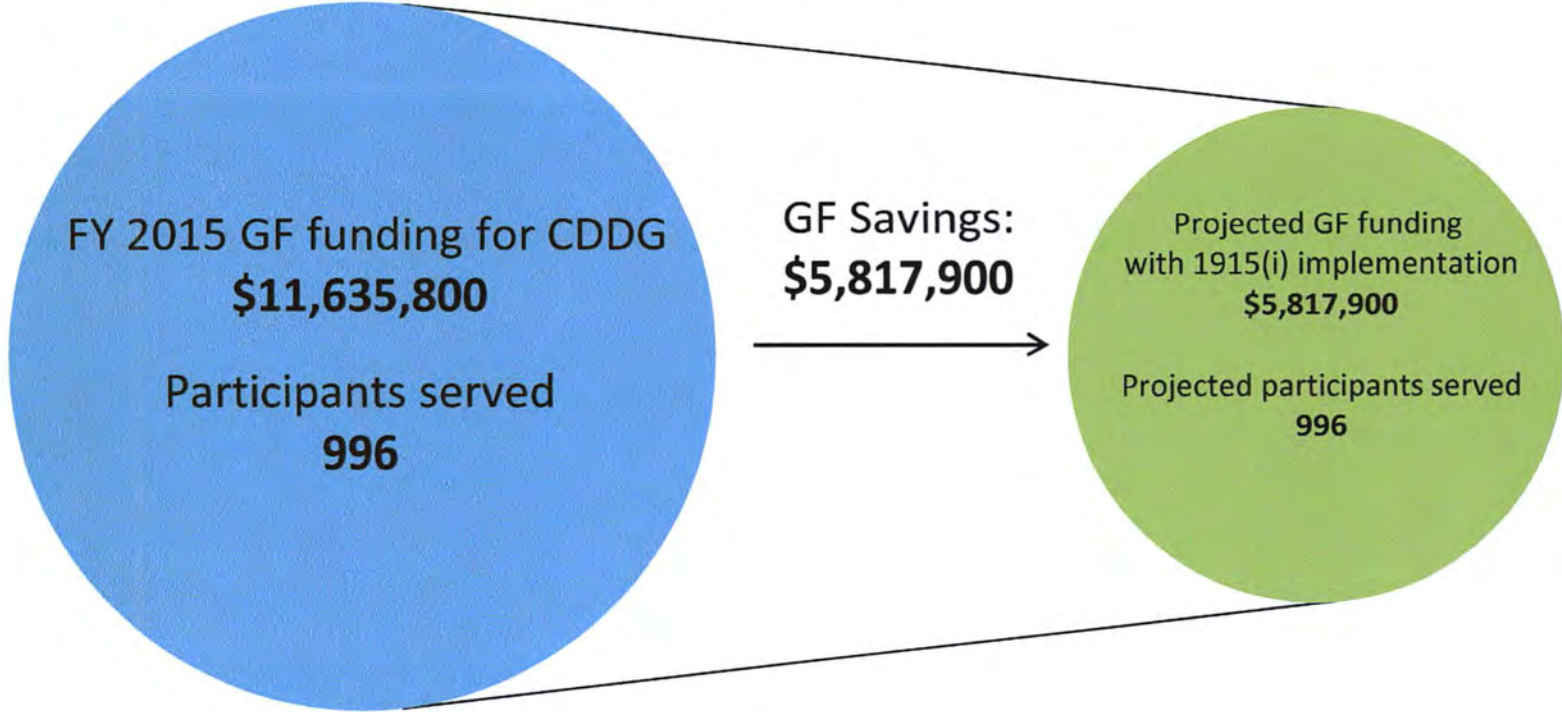
Medicaid Reform in Alaska
Medicaid State Plan Options
1915(i) and 1915(k)

Community Developmental Disabilities Grants 1915(i) Impact



	Current CDDG funding and individuals served	Projected CDDG funding and individuals served with 1915(i) implementation
Individuals served	996	996
GF funding	\$11,635,800	\$5,817,900
Federal funding	\$0	\$5,817,900

All individuals currently receiving CDDG would be eligible for 1915(i) option. As a result, all of the current GF funding (\$11,635,800) can be refinanced under 1915(i) at a 50% federal match.

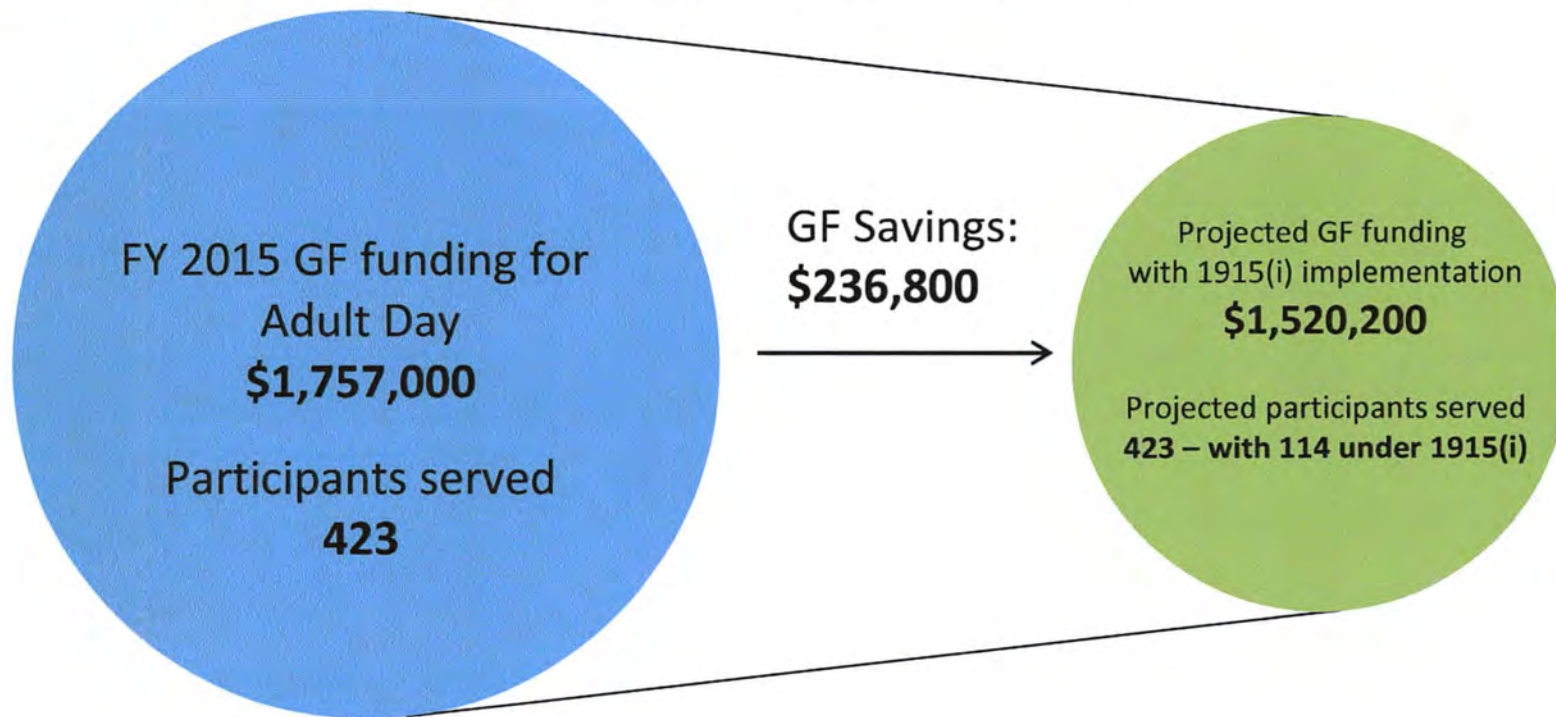


Senior Community Based Grants – Adult Day 1915(i) Impact



	Current Adult Day funding and individuals served	Projected Adult Day funding and individuals served with 1915(i) implementation
Individuals served	423	423 (114 eligible for 1915(i))
GF funding	\$1,757,000	\$1,520,000
Federal funding	\$0	\$236,800

114 individuals currently receiving Senior Community Based Grants – Adult Day services would be eligible for the 1915(i) option. As a result, \$473,500 of the current GF funding can be refinanced at a 50% federal match.

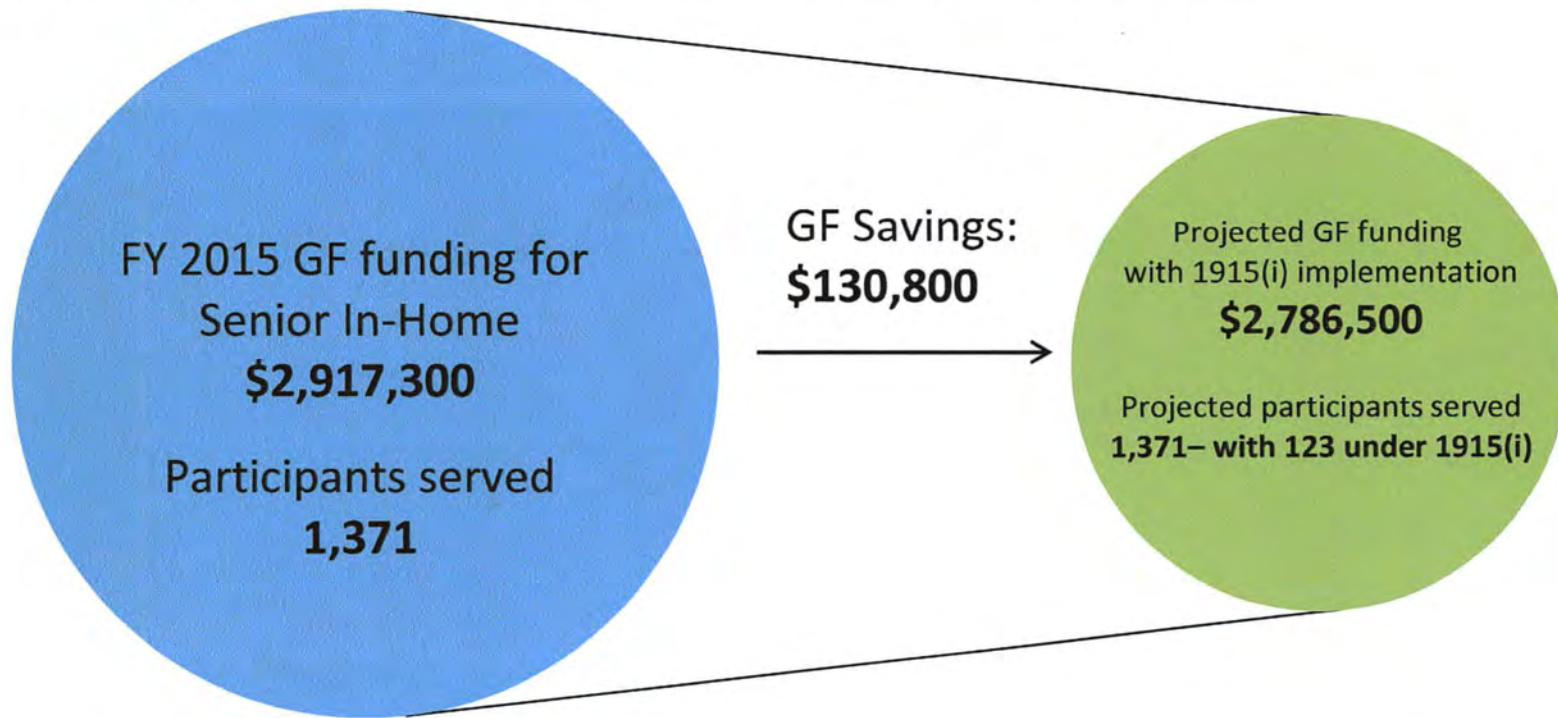


Senior Community Based Grants – Senior In-Home 1915(i) Impact



	Current Senior In-Home funding and individuals served	Projected Senior In-Home funding and individuals served with 1915(i) implementation
Individuals served	1,371	1,371 (123 eligible for 1915(i))
GF funding	\$2,917,300	\$2,786,500
Federal funding	\$0	\$130,800

123 individuals currently receiving Senior Community Based Grants – Senior In-Home services would be eligible for the 1915(i) option. As a result, \$261,700 of the current GF funding can be refinanced at a 50% federal match.

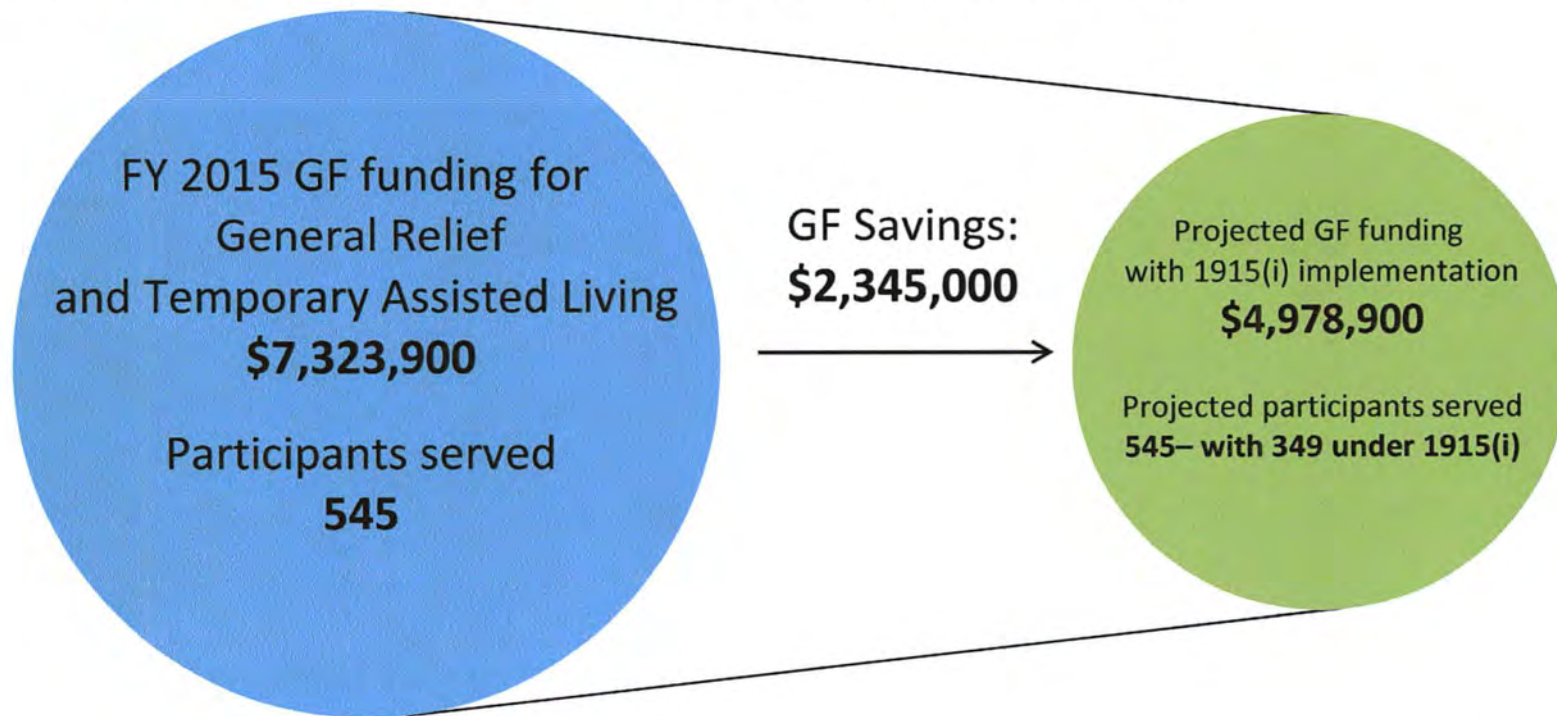


General Relief/Temporary Assisted Living 1915(i) Impact



	Current GR/Temporary Assisted Living funding and individuals served	Projected GR/Temporary Assisted Living funding and individuals served with 1915(i) implementation
Individuals served	545	545 (349 eligible for 1915(i))
GF funding	\$7,323,900	\$4,978,900
Federal funding	\$0	\$2,345,000

349 individuals currently receiving General Relief/Temporary Assisted Living services would be eligible for the 1915(i) option. As a result, \$4,689,900 of the current GF funding can be refinanced at a 50% federal match.

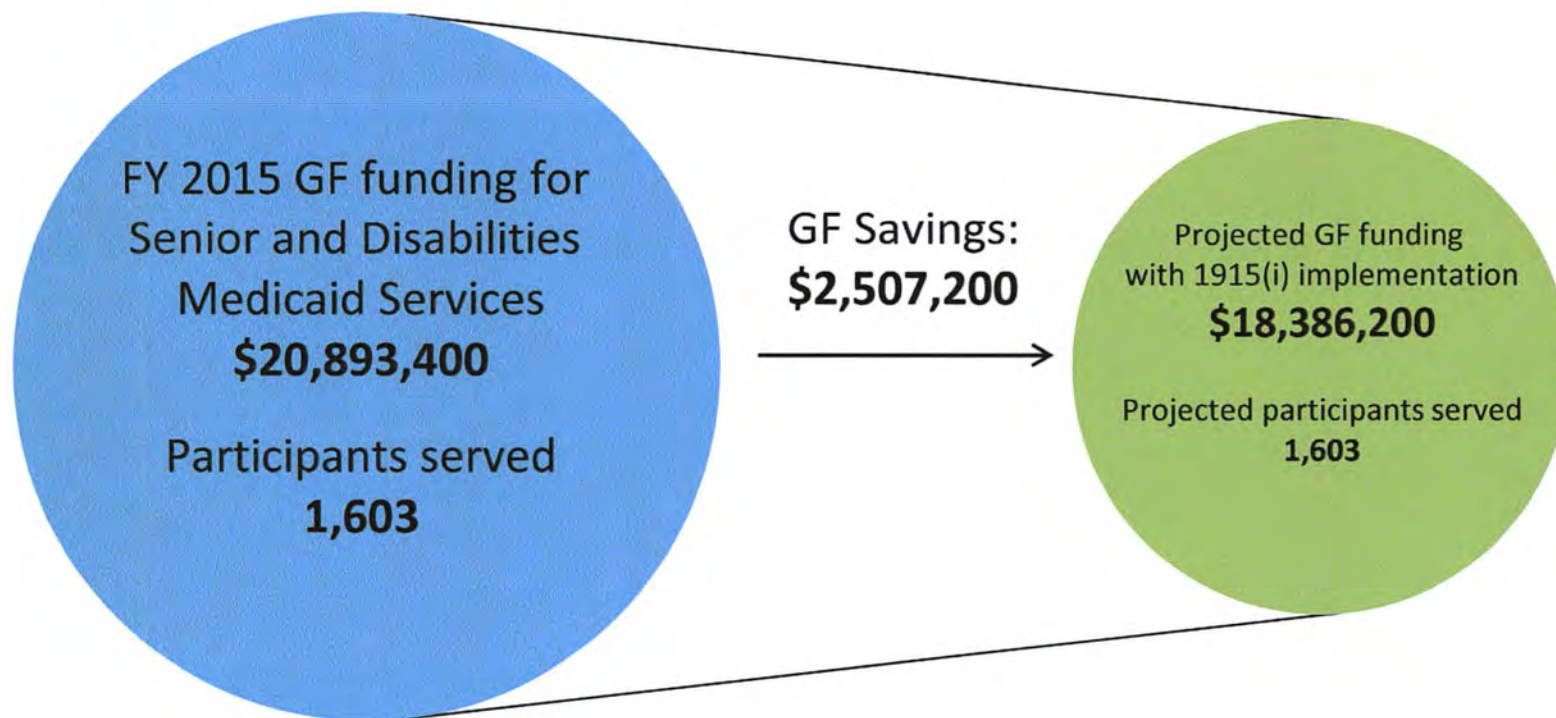


Senior and Disabilities Medicaid Services 1915(k) Impact



	Senior and Disabilities Medicaid Services funding and individuals served	Projected Senior and Disabilities Medicaid Services funding and individuals served with 1915(k) implementation
Individuals served	1,603	1,603
GF funding	\$20,893,400	\$18,386,200
Federal funding	\$0	\$2,507,200

All of the 1,603 individuals currently receiving 1915(c) and Personal Care services would be eligible for the 1915(k) option. This would result in an additional 6% federal match.





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

Dear State Health Official:

The purpose of this letter is to inform state Medicaid agencies and other state health officials about an update in payment policy affecting federal funding for services received by Medicaid-eligible individuals, who are American Indians and Alaska Natives (AI/AN) through facilities of the Indian Health Service (IHS), whether operated by IHS or by Tribes. As described in this letter, IHS/Tribal facilities¹ may enter into care coordination agreements with non-IHS/Tribal providers to furnish certain services for their patients who are AI/AN Medicaid beneficiaries, and the amounts paid by the state for services requested by facility practitioners in accordance with those agreements would be eligible for the enhanced federal matching authorized under section 1905(b) of the Social Security Act at a rate of 100 percent. Upon execution of a written care coordination agreement, this will be effective immediately for states for the expenditures for services furnished by non-IHS/Tribal providers to AI/AN Medicaid beneficiaries who are patients of an IHS/Tribal facility acting under such agreement, as described below. This update in payment policy is intended to help states, the IHS, and Tribes to improve delivery systems for AI/ANs by increasing access to care, strengthening continuity of care, and improving population health.

Background

The IHS, a federal agency within the Department of Health and Human Services, is responsible for furnishing comprehensive, culturally-appropriate health services to almost 2.2 million AI/ANs who are eligible for services from the IHS, per regulations at 42 CFR Part 136. To achieve this goal, IHS operates its own hospitals and clinics and partners with Tribes as authorized by the Indian Self-Determination and Education Assistance Act, P.L. 93-638, as amended. The IHS also provides funding for Urban Indian Health Organizations to operate Urban Indian Health Programs (UIHPs) under title V of the Indian Health Care Improvement Act, P.L. 94-437, as amended. The IHS, Tribes, and UIHPs operate health programs in 36 states.²

¹ For purposes of this document, Tribal facilities are facilities that are operated by Tribes and Tribal organizations under the Indian Self-Determination and Education Assistance Act, P.L. 93-638.

² As of the date of this SHO, the states are: AL, AK, AZ, CA, CO, CT, FL, ID, IL, IN, IA, KS, LA, ME, MD, MA, MI, MN, MS, MT, NE, NV, NM, NY, NC, ND, OK, OR, RI, SC, SD, TX, UT, WA, WI, and WY. This list is subject to change.

AI/ANs who meet the eligibility requirements for the Medicaid program in the state in which they reside are entitled to Medicaid coverage, whether or not they are eligible for services from IHS. IHS-eligible AI/ANs who are also Medicaid beneficiaries may choose to receive covered services from an IHS facility, a Tribal facility, a UIHP, or from any other provider participating in a state's Medicaid program.

Under section 1905(b) of the Social Security Act, the federal government is required to match state expenditures at the Federal Medical Assistance Percentage (FMAP) rate, which is 100 percent for state expenditures on behalf of AI/AN Medicaid beneficiaries for covered services "received through" an Indian Health Service facility whether operated by the Indian Health Service or by a Tribe or Tribal organization (as defined in section 4 of the Indian Health Care Improvement Act).³ If services are not "received through" an IHS/Tribal facility, the federal government will match the state's payment for the services at the state's regular FMAP rate, which in FY 2016 ranges from 50.00 percent to 74.17 percent.

Our long-standing interpretation of this statutory provision as reflected in sub-regulatory guidance,³ Departmental Appeals Board decisions,⁴ and federal court decisions,⁵ has been that 100 percent FMAP is available for amounts expended for services under the following circumstances:

- (1) The service must be furnished to a Medicaid-eligible AI/AN;
- (2) The service must be a "facility service" – i.e., within the scope of services that a facility (e.g., inpatient hospital, outpatient hospital, clinic, Federally Qualified Health Center/Rural Health Clinic, nursing facility) can offer under Medicaid law and regulation;
- (3) The service must be furnished by an IHS/Tribal facility or by its contractual agent as part of the facility's services; and
- (4) The IHS/Tribal facility must maintain responsibility for the provision of the service and must bill the state Medicaid program directly for the service.

Last year, the Centers for Medicare & Medicaid Services (CMS) announced it was strongly considering re-interpreting the statutory language to expand the services it considers "received through" an IHS/Tribal facility and eligible for the 100 percent FMAP. Specifically, in October 2015, we posted on the CMS Medicaid.gov website a Request for Comment, in which we sought comments on a proposal to re-interpret the statutory language providing 100 percent FMAP for "services received through an IHS facility" by: (1) Modifying the scope of services eligible for enhanced FMAP; (2) Expanding the meaning of contractual agent to be an enrolled Medicaid provider that provides services that are identified in the state's approved Medicaid plan and are arranged for and overseen by the IHS/Tribal facility; and (3) Increasing the flexibility for billing arrangements so that IHS/Tribal facilities or their contractual agents could bill Medicaid directly

³ Memorandum of Agreement (MOA) between IHS and HCFA (July 11, 1996); HCFA Memorandum to Associate Regional Administrators (May, 1997).

⁴ *North Dakota Dept. of Human Services*, DAB No. 1854 (2002); *South Dakota Dept. of Social Services*, DAB No. 1847 (2002); *Arizona Health Care Cost Containment System*, DAB No. 1779 (2001); *Alaska Department of Health and Social Services*, DAB No. 1919 (2004).

⁵ *North Dakota ex. Rel. Olson v. Centers for Medicare & Medicaid Services*, 403 F.3d 537 (8th Cir. 2005); *Alaska Department of Health & Social Services v. Centers for Medicare & Medicaid Services*, 424 F.3d 931 (9th Cir. 2005); *Arizona Health Care Cost Containment System v. McClellan*, 508 F.3d 1243 (9th Cir. 2007).

for services. CMS received 182 comments from 91 commenters including Tribes, Tribal organizations, Urban Indian Health Organizations, states, and other stakeholders. We have reviewed and considered those comments in establishing this new policy interpretation.

Permitting a Wider Scope of Services

In this letter, we are re-interpreting the scope of services considered to be “received through” an IHS/Tribal facility. Under our previous interpretation, in order to be “received through” an IHS/Tribal facility, and therefore, qualify for 100 percent FMAP, the service had to be a “facility service.” By that, we meant that it had to be within the scope of services that a Medicaid facility of the same type (e.g., inpatient hospital, outpatient hospital, clinic, Federally Qualified Health Center/Rural Health Clinic, nursing facility) can provide under Medicaid law and regulation. Under our new interpretation, as described more fully below, the scope of services that can be considered to be “received through” an IHS/Tribal facility for purposes of 100 percent FMAP includes any services that the IHS/Tribal facility is authorized to provide according to IHS rules, that are also covered under the approved Medicaid state plan, including long-term services and supports (LTSS). Medicaid coverable benefit categories include all 1905(a), 1915(i), 1915(j), 1915(k), 1945, and 1915(c) services set forth in the state plan, as well as any other authority established in the future as a state plan benefit.

This scope of service change also applies to transportation that is covered as a service under the state Medicaid plan. Under regulations at 42 CFR 440.170(a), a state can elect to cover transportation and other related travel expenses determined necessary to secure medical examinations and treatment for a beneficiary. Related travel expenses include the cost of meals and lodging en route to and from medical care, and while receiving medical care, as well as the cost for an attendant to accompany the beneficiary, if necessary. Covered transportation services can include both emergency medical transportation and non-emergency medical transportation.

Medicaid Beneficiary and IHS/Tribal Facility Participation is Voluntary

This new interpretation does not provide authority for states to require any AI/AN Medicaid beneficiary to receive services through an IHS/Tribal facility. Nothing in this letter affects the entitlement of AI/AN Medicaid beneficiaries to freedom of choice of provider under section 1902(a)(23) of the Social Security Act. State Medicaid agencies may not, directly or indirectly, require AI/ANs who are eligible for Medicaid to receive covered services from IHS/Tribal facilities for the purpose of qualifying the cost of their services for 100 percent FMAP. Similarly, neither state Medicaid agencies nor IHS/Tribal facilities may require an AI/AN Medicaid beneficiary to receive services from a non-IHS/Tribal provider to whom the facility has referred the beneficiary for care. Nor can a state delay the provision of medical assistance by requiring that beneficiaries initiate or continue a patient relationship with the IHS/Tribal facility. Finally, federal Medicaid law does not require either IHS/Tribal facilities or non-IHS/Tribal providers to enter into the written care coordination agreements described in this SHO.

Request for Services In Accordance With a Written Care Coordination Agreement

In this letter, CMS also revises its interpretation to provide that a service may be considered “received through” an IHS/Tribal facility when an IHS/Tribal facility practitioner requests the service, for his or her patient, from a non-IHS/Tribal provider (outside of the IHS/Tribal facility), who is also a Medicaid provider, in accordance with a care coordination agreement meeting the criteria described below. The purpose of this revised policy interpretation is to enable IHS/Tribal facilities to expand the scope of services they are able to offer to their AI/AN patients while ensuring coordination of care in accordance with best medical practice standards.

A covered service will be considered to be “received through” an IHS/Tribal facility not only when the service is furnished directly by the facility to a Medicaid-eligible AI/AN patient, but also when the service is furnished by a non-IHS/Tribal provider at the request of an IHS/Tribal facility practitioner on behalf of his or her patient and the patient remains in the Tribal facility practitioner’s care in accordance with a written care coordination agreement meeting the requirements described below. Under this policy, both the IHS/Tribal facility and the non-IHS/Tribal provider must be enrolled in the state’s Medicaid program as rendering providers. Second, there must be an established relationship between the patient and a qualified practitioner at an IHS/Tribal facility. Third, care must be provided pursuant to a written care coordination agreement between the IHS/Tribal facility and the non-IHS/Tribal provider, under which the IHS/Tribal facility practitioner remains responsible for overseeing his or her patient’s care and the IHS/Tribal facility retains control of the patient’s medical record.

A non-IHS/Tribal provider from which an IHS/Tribal facility practitioner could request services could include an Urban Indian Health Organization that participates in Medicaid, or any other Medicaid-participating provider. Furthermore, the relationship between the IHS/Tribal facility practitioner and the patient could be based on visits, including the initial visit, through telehealth procedures that meet state and/or IHS standards for such procedures, if the IHS/Tribal facility has that capacity⁶.

A self-request by the beneficiary, or a request from a non-IHS/Tribal provider, does not suffice for purposes of 100 percent FMAP; in such circumstances, the non-IHS/Tribal provider could furnish the service and bill the state Medicaid program, but the state expenditure for the service would not qualify for 100 percent FMAP. Similarly, the non-IHS/Tribal provider may refer the facility patient to another non-IHS/Tribal provider; however, if the patient receives a covered service from that other provider without a request from the IHS/Tribal facility practitioner, or the IHS/Tribal facility practitioner does not remain responsible for the patient’s care, the state expenditure for the service would not qualify for 100 percent FMAP.

At a minimum, care coordination will involve:

- (1) The IHS/Tribal facility practitioner providing a request for specific services (by electronic or other verifiable means) and relevant information about his or her patient to the non-IHS/Tribal provider;

⁶ Or as specified in a demonstration project authorized under section 1637 of the Indian Health Care Improvement Act.

- (2) The non-IHS/Tribal provider sending information about the care it provides to the patient, including the results of any screening, diagnostic or treatment procedures, to the IHS/Tribal facility practitioner;
- (3) The IHS/Tribal facility practitioner continuing to assume responsibility for the patient's care by assessing the information and taking appropriate action, including, when necessary, furnishing or requesting additional services; and
- (4) The IHS/Tribal facility incorporating the patient's information in the medical record through the Health Information Exchange or other agreed-upon means.

Written care coordination agreements under this policy could take various forms, including but not limited to a formal contract, a provider agreement, or a memorandum of understanding and, to the extent it is consistent with IHS authority, would not be governed by federal procurement rules. The IHS/Tribal facility may decide the form of the written agreement that is executed with the non-IHS/Tribal provider.

Medicaid Billing and Payments to Non-IHS/Tribal Providers

For services provided to Medicaid-eligible AI/AN beneficiaries that are rendered by a non-IHS/Tribal provider in accordance with a written care coordination arrangement, there are several options regarding how those services may be billed to Medicaid.

The first option is for the non-IHS/Tribal provider to bill the Medicaid agency directly. If the non-IHS/Tribal provider bills the state Medicaid program directly, the provider would be reimbursed at the rate authorized under the Medicaid state plan applicable to the provider type and service rendered. To support the application of the 100 percent FMAP, the state should ensure that claims include fields that document that the item or service was "received through" an IHS/Tribal facility. When a non-IHS provider bills a state directly, the state's payment rate for a covered service furnished by a non-IHS/Tribal provider to an AI/AN Medicaid beneficiary under a written care coordination agreement must be the same as the rate for that service furnished by that provider to a non-AI/AN beneficiary or to an AI/AN beneficiary who self-refers to the provider. Similarly, a state agency cannot establish one rate for services furnished by the facility to AI/AN beneficiaries and another for the same services provided by that facility to non-AI/AN Medicaid beneficiaries.

A second option is for the IHS or Tribal facility to handle all billing. In that case, the IHS/Tribal facility would have to separately identify services provided by non-IHS/Tribal providers under agreement that can be claimed as services of the IHS/Tribal facility ("IHS/Tribal facility services") from those that cannot. Inpatient services that are furnished by non-IHS providers outside of IHS/Tribal facilities could never be claimed as IHS/Tribal facility services. For IHS, other services provided by non-IHS providers outside of an IHS facility generally cannot be claimed as IHS facility services. Tribal facilities generally may have more flexibility than IHS and should consult with their state to determine the circumstances in which other services provided by non-Tribal providers can be claimed as Tribal facility services. The circumstances under which Tribal facilities may claim services as their own are the same as those that apply for other similar facilities in the state (e.g., inpatient or outpatient hospitals, nursing facilities, Federally Qualified Health Centers, etc.). Services that can properly be claimed as IHS/Tribal facility services may be billed directly by the IHS/Tribal facility and are paid at the applicable Medicaid state plan IHS/Tribal facility rate. For all other services provided by non-IHS/Tribal

providers, IHS or the Tribe could bill for these services as an assigned claim by that provider and the payment rate would be the state plan rate applicable to the furnishing provider and the service, not the applicable Medicaid state plan IHS/Tribal facility rate. These services are still eligible for the 100 percent FMAP, provided other requirements have been met.

The billing arrangement should be reflected in the written agreement between the IHS/Tribal facility and the non-IHS/Tribal provider. Payment methodologies for facility services furnished by both the IHS/Tribal facility and rate methodologies paid to non-IHS/Tribal providers must be set forth in an approved state Medicaid plan. Payment rates can reflect the unique access concerns in particular geographic areas, or with respect to certain types of providers. However, rates may not vary based on the applicable FMAP. States should review existing state plans to ensure compliance with the policy articulated in this letter.

Managed Care

The discussion above assumes that the Medicaid-eligible AI/AN has “received [services] through” the IHS/Tribal facility on a fee-for-service basis. In some cases, however, Medicaid-eligible AI/ANs may be enrolled in a risk-based Medicaid managed care organization (MCO), prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP), in which case the state Medicaid agency is making monthly capitation payments on behalf of the AI/AN enrollee to the MCO, PIHP, or PAHP. The state may claim 100 percent FMAP for the portion of the capitation payment attributable to the cost of services “received through” an IHS/Tribal facility if the following conditions are met:

- (1) The service is furnished to an AI/AN Medicaid beneficiary who is enrolled in the managed care plan;
- (2) The service meets the same requirements to be considered “received through” an IHS/Tribal facility as would apply in a fee-for-service delivery system and the managed care plan maintains auditable documentation to demonstrate that those requirements are met;
- (3) The non-IHS/Tribal provider is a network provider of the enrollee’s managed care plan;
- (4) The non-IHS/Tribal provider is paid by the managed care plan consistent with the network provider’s contractual agreement with the managed care plan; and
- (5) The state has complied with section 1932(h)(2)(C)(ii) of the Act consistent with CMS guidance.

States would be permitted to claim the 100 percent FMAP for a portion of the capitation payment for AI/ANs who are enrolled in managed care, even though the state itself has made no direct payment for services “received through” an IHS/Tribal facility. The portion of the managed care payment eligible to be claimed at 100 percent FMAP must be based on the cost of services attributable to IHS/Tribal services or encounters received through an IHS/Tribal provider meeting the requirements outlined in this section.

Compliance and Documentation

To ensure accountability for program expenditures, in states where IHS/Tribal facilities elect to implement the policy described in this letter, the Medicaid agency will need to establish a process for documenting claims for expenditures for items or services “received through” an

IHS/Tribal facility. The documentation must be sufficient to establish that (1) the item or service was furnished to an AI/AN patient of an IHS/Tribal facility practitioner pursuant to a request for services from the practitioner; (2) the requested service was within the scope of a written care coordination agreement under which the IHS/Tribal facility practitioner maintains responsibility for the patient's care; (3) the rate of payment is authorized under the state plan and is consistent with the requirements set forth in this letter; and (4) there is no duplicate billing by both the facility and the provider for the same service to the same beneficiary.

Applicability to Section 1115 Demonstrations

State expenditures for services covered under section 1115 demonstration authority are eligible for 100 percent FMAP as long as all of the elements of being "received through" an IHS or Tribal facility that are described in this SHO are present.

Relationship Between 100 Percent FMAP for Tribal Services and Other Federal Matching Rates

The 100 percent FMAP for services "received through" an IHS/Tribal facility is available for services provided to AI/ANs as described in this SHO instead of the regular FMAP rate described in section 1905(b) of the Act, the newly eligible FMAP rate described in section 1905(y) of the Act, the enhanced FMAP rate for breast and cervical cancer, or the enhanced rate for Community First Choice services.

We intend to issue additional guidance materials after the release of this SHO. CMS is available to work closely with each state to implement the policy established in this state health official letter regarding receiving 100 percent FMAP for services "received through" an IHS/Tribal facility. If you have any questions regarding this information, please contact TribalAffairs@cms.hhs.gov or Kirsten Jensen, Director, Division of Benefits and Coverage, 410-786-8146.

Sincerely,

/s/

Vikki Wachino

Director

cc:

National Association of Medicaid Directors

National Academy for State Health Policy

American Public Human Services Association

National Governors Association

Council of State Governments

Association of State and Territorial Health Officials

Federal Medicaid Authorities for Restructuring Medicaid Health Care Delivery or Payment 3-25-16

Demonstration Waiver

AUTHORITY	DESCRIPTION	KEY FLEXIBILITIES AND/OR LIMITATIONS	CSSB74(FIN)am
<p>Section 1115 Demonstration Program Waivers</p>	<p>Broad waiver authority at the discretion of the Secretary to approve projects that test policy innovations likely to further the objectives of the Medicaid program.</p> <p>Permits states to provide the demonstration population(s) with different health benefits, or have different service limitations than are specified in the state plan.</p> <p>Granted for up to 5 years, and then must be renewed.</p>	<ul style="list-style-type: none"> • Must further the objectives of the Medicaid program. • Requires some eligibility or benefit expansion, quality improvement, or delivery system restructuring to improve program. • Must have a demonstration hypothesis that will be evaluated with data resulting from the demonstration. • Provides most flexibility of all Medicaid authorities to waive Medicaid requirements. • Comparability of services, freedom of choice, and statewideness are not required. • Must be budget neutral for the federal government. • Managed care enrollment may be voluntary or mandatory. 	<p>Section 30 Pg. 29-30 AS 47.07.036(e) & (f)</p>

Health Homes Option

AUTHORITY	DESCRIPTION	KEY FLEXIBILITIES AND/OR LIMITATIONS	CSSB74(FIN)am
<p>Section 1945 Health Home State Plan Option</p>	<p>Provides states with the 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.</p> <p>To be eligible, individuals must have: (1) at least two chronic conditions; (2) one chronic condition and be at risk of another; or (3) a serious and persistent mental health condition.</p> <p>Health home services must include:</p>	<ul style="list-style-type: none"> • State can select the chronic conditions to be addressed. • Comparability requirements apply; must be available to any categorically eligible individual with the selected conditions. • Must be voluntary and allow choice of provider. • Medicare-Medicaid enrollees must be included. • Comparability of services and statewideness are not required. • Permits a tiered-payment methodology based on the severity of an individual's condition or the capabilities of the designated provider. 	<p>Section 30 Pg. 29- AS 47.07.036(d)(3)</p>

	<ol style="list-style-type: none"> (1) Comprehensive care management; (2) Care coordination and health promotion; (3) Comprehensive transitional care; (4) Individual and family support; (5) Referral to community and social support services; and (6) Use of health information technology. 	<ul style="list-style-type: none"> • Allows alternative payment models. • Requires public notice in line with standard state plan amendment requirements. • Provides a 90% FMAP for the first eight fiscal quarters the state plan amendment is in effect. • Support for planning activities is available. • Health home providers must submit quality measures to the state. • States implementing health homes must take part in an impact assessment (survey and independent evaluation). 	
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Home & Community-Based Services Waivers & Options

AUTHORITY	DESCRIPTION	KEY FLEXIBILITIES AND/OR LIMITATIONS	CSSB74(FIN)AM
<p>Section 1915(c) “Home and Community-Based Services (HCBS)” Waivers</p>	<p>Renewable waiver authority that allows states to provide long-term care services delivered in community settings as an alternative to institutional settings. The state must select the specific target population and/or sub-population the waiver will serve.</p> <p>1915(c) waivers are renewable for 5 years after the initial, 3-year approval (or, if applicable, initial 5-year approval).</p>	<ul style="list-style-type: none"> • Freedom of choice is required absent a concurrent Medicaid authority that permits the state to waive this requirement. • Can implement in limited geographic areas. • Comparability of services with non-waiver enrollees is not required; however, services must be comparable within the waiver population. • Must demonstrate cost neutrality. • Must specify the maximum number of participants for each waiver year, and criteria for selection of entrants. • May include individuals with income up to 300% of the Federal SSI benefit rate. 	<p><i>Current Medicaid program. Not in CSSB74(FIN)AM.</i></p> <p><i>Current AK 1915(c) Waivers:</i></p> <ul style="list-style-type: none"> • <i>Alaskans Living Independently</i> • <i>Adults w/Physical and Developmental Disabilities</i> • <i>Children w/Complex Medical Conditions</i> • <i>People w/Intellectual and Developmental Disabilities</i>
<p>Section 1915(i) “Home and Community-Based Services”</p>	<p>States can amend their state plans to offer HCBS as a state plan optional benefit statewide. If states choose the option to target the benefit to specific populations, CMS approval would be for a 5-year period and such</p>	<ul style="list-style-type: none"> • Participants do not have to meet an institutional level of care. • Income eligibility at or below 150% of FPL, but states can opt to also provide HCBS to individuals with incomes up to 300% of the Federal SSI benefit rate if 	<p>Section 30 Pg. 29- AS 47.07.036(d)(1)</p>

State Plan Option	<p>states will be able to request CMS renewal for an additional 5-year period if federal and state requirements are met.</p>	<p>eligible for HCBS under 1915(c) or 1115 demonstration.</p> <ul style="list-style-type: none"> • Must specify needs-based eligibility criteria. • Comparability of services is not required. • No cost neutrality requirement. • No waiting lists or limits on the number of participants. • Cannot waive statewideness. 	
Section 1915(k) Community First Choice	<p>Allows states to provide home-and community-based attendant services and supports for beneficiaries on a statewide basis.</p> <p>States must cover assistance and maintenance with activities of daily living, instrumental 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. Services can be provided through an agency or a self-directed model.</p> <p>This does not create a new eligibility group; eligible individuals are those who are eligible for Medicaid under the state plan, have incomes up to 150% FPL or over 150% FPL and meet institutional level of care standards.</p>	<ul style="list-style-type: none"> • States provided a 6 percentage point increase in Federal matching payments for service expenditures under this option. • States have the option to cover transition costs, expenditures related to participant’s independence and services, or supports linked to an assessed need or goal. • Financial management services must be available when provided through a self-directed model. • Cannot waive statewideness. 	<p>Section 30 Pg. 29- AS 47.07.036(d)(2)</p>

Managed Care Authority, Waivers & Options *not addressed in CSSB 74 (FIN) am*

AUTHORITY	DESCRIPTION	KEY FLEXIBILITIES AND/OR LIMITATIONS
Section 1915(a) Exception to State Plan Requirements for Voluntary Managed Care	<p>Used to authorize voluntary managed care programs on a statewide basis or in limited geographic areas implemented through CMS Regional Office approval of the managed care contract. The state has the ability to use passive enrollment with an opt-out within this authority.</p>	<ul style="list-style-type: none"> • No waiver or state plan amendment required. • No mandatory enrollment or selective contracting allowed.

<p>Section 1932(a) State Plan Amendment Authority</p>	<p>State plan authority for mandatory and voluntary managed care programs on a statewide basis or in limited geographic areas.</p> <p>States may choose to include dual eligibles as part of a broader managed care program authorized under Section 1932(a).</p>	<ul style="list-style-type: none"> • Permanent state plan authority. • No cost-effectiveness or budget-neutrality requirement. • Allows selective contracting. • No mandatory enrollment of dual eligibles for Medicaid services; however, dual eligibles may voluntarily enroll. • Comparability of services, freedom of choice and statewideness are not required.
<p>Section 1915(b) Waivers</p>	<p>Two-year (or five-year, if serving dual eligibles) renewable waiver authority for mandatory enrollment in managed care on a statewide basis or in limited geographic areas.</p> <p>1915(b) waivers must not substantially impair beneficiary access to medically-necessary services of adequate quality.</p>	<ul style="list-style-type: none"> • Allows for mandatory managed care or PCCM enrollment for dual eligibles for Medicaid services through 1915(b)(1) authority. • Locality may act as a central enrollment broker through 1915(b)(2) authority. • May provide additional, health-related services through 1915(b)(3). • Allows for selective contracting under 1915(b)(4) authority. • Can identify excluded populations. • Comparability of services, freedom of choice and statewideness are not required. • Must be determined to be cost-effective and efficient. Waiver requirements are more administratively burdensome than 1915(a) or 1932(a).
<p>Concurrent 1915(a)/(c) Authority</p>	<p>Used to implement a voluntary managed care program that includes HCBS in the managed care contract. The state may use passive enrollment with an opt-out within this authority.</p>	<ul style="list-style-type: none"> • No mandatory enrollment allowed. • Cannot selectively contract with managed care providers.
<p>Concurrent 1915(b)/(c) Waivers</p>	<p>Used to implement a mandatory or voluntary managed care program that includes waiver HCBS in the managed care contract. The 1915(c) waiver allows a state to target eligibility and provide HCBS services. The 1915(b) then allows a state to mandate enrollment in managed care plans that provide these HCBS services, and to exercise other 1915(b) options, such as selective contracting with providers.</p> <p>States must apply for each waiver authority concurrently and comply with the individual requirements of each.</p>	<ul style="list-style-type: none"> • Allows for selective contracting with providers. • Requires administration of two separate concurrent waivers with separate reporting requirements.

3/28/16

HEALTH MANAGEMENT ASSOCIATES

**1915(i) and 1915(k) Options for the State
of Alaska
House Finance Committee
Medicaid Reform**

March 28, 2016

State Plan Options Overview

1915(k) Background (Community First Choice)

1915(k) State Plan Option Key Features

- In 2012, 1915(k) became a new option to provide consumer-directed, home and community-based attendant services and supports
- Eligibility
 - Must meet functional eligibility equal to an institutional level of care
 - Medicaid eligible
- As long as eligibility criteria are met, benefits are available to all Alaskans statewide regardless of age or diagnosis
- Federal government contributes more money (56% instead of typical 50% Medicaid match to state dollars in Alaska)
- Agency model and consumer-directed model at state's discretion

PCA State Plan

- PCA total spend is \$85,200,043.36
 - 49% (\$41,786,777.39) of expenditures by individuals currently on a waiver
 - 1,603 individuals currently on a waiver receiving PCA services
 - 3,308 individuals receiving PCA services not on a waiver

State Plan Options Overview

1915(i) Background

1915(i) State Plan HCBS Key Features

- State plan option to provide consumer-directed, home- and community-based attendant services and supports
- Individuals do NOT need to be eligible for an institutional level of care currently required under 1915(c) HCBS waivers or 1915(k) (Community First Choice)
 - Medicaid eligible
 - Targeted populations
- Federal government contributes (50% match to state dollars in Alaska)

1915 (i) SDS General Fund Refinancing

- GR Program: Estimated 349 of 545 recipients eligible for 1915i program.
- Adult Day Grants: Estimated 114 of 423 recipients eligible for 1915i program.
- Senior In-home Grants: Estimated 123 of 1,371 recipients eligible for 1915i program.
- Community Developmental Disability Grants: Estimated all recipients eligible for 1915i program.
- Estimated savings of shift to 1915i is \$8,530,000.

Target Dates

- Implementation Plan Due- 7/31/2016
- Submit to CMS
- CMS Approval
- Begin Implementation