



## THE STEPS TO ESTABLISH BUDGET NEUTRALITY

- The 1115 process requires DHSS to establish *by the end of the five year 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.
- The calculation of cost neutrality is a complex strategy.
- It also means we need to be clear in the waiver application that we are seeking authority to introduce services not otherwise available under existing CMS rules or Alaska's own State Medicaid Plan.

## HERE ARE THE QUESTIONS WE HAVE TO ANSWER TO BEGIN TO ESTABLISH THE PROJECT'S COSTS:

- What populations are we proposing to include in the 1115 Demonstration waiver?
- What target populations will be affected by the new benefits/programs?
- What are the scope of the services to be covered?
- How much will each new service cost?

## HERE'S WHAT GOES INTO DETERMINING HOW MUCH EACH NEW SERVICE WILL COST:

- First, we must determine 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 need to identify – of the target populations we are proposing – which will be able to access the various services.
- We then need to identify the estimated “take up” rate from the target population.
- Next we need to be able to estimate the utilization per day/week/month/year for those who access each of the services.
- And, finally, we then need to propose/set the cost-per-unit (select the rate) that Alaska is estimating for each service?

## WHAT IS THE “TAKE UP” RATE?

- Medicaid Population (i.e., all Alaska's eligible for Medicaid)
- Target Population (of all those eligible for Medicaid, the populations – Medicaid Eligibility Groups – that the 1115 is “targeting” for services under the demonstration waiver)
- The “Benefit Take Up” rate is the rate / 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 what is the expected take up rate of that service: 50%, 75%, etc.

## HERE IS WHAT WE HAVE DONE SO FAR TO MOVE THESE MATTERS FORWARD

- 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** (FMAP 97%)
- **Pregnant Women**
- **Parent/Caretaker Relatives w/Dependent Children Under 19**
- **Age, Blind & Disabled**
- **Dual Eligible** (Medicaid and Medicare)
- **Children In State Custody**
- **Former Foster Care**
- **Waiver(c)/IDD** (only a specific portion: individuals with significant co-occurring IDD and MH behaviors that exceed the capacity of either the HCBS or local BH programs)

## 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 another 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
- Community & Recovery Support Services
  - Community and Recovery Support Services

## CURRENT BH SERVICES PROPOSED TO BE PHASED OUT OVER THE 5 YEARS

- Behavioral Rehab Services
- Recipient Support Services
- Comprehensive Community Support Services
- Therapeutic Behavioral Health Services
- Alaska Screening Tool
- Client Status Review

## GENERAL RATIONALE FOR NEW SERVICES:

- The benefits for all five target populations 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 to maintain recovery, health, and wellness.

## GENERAL RATIONALE FOR NEW SERVICES (continued):

- The major focus of the proposed benefit package for **Children and Adolescents** (primarily Target Populations 1(A), 1(B), & 1(C) is developing community-/regional-based infrastructures to keep children/adolescents in a home environment to the maximum extent possible.
- As the intensity of service need increases from Population 1(A) to 1(C), the level of care required also increases, from totally community-based services for Populations 1(A) and 1(B) to residential services for Population 1(C).
- Community-based services designed to maintain children/adolescents in their communities include Home-based Family Treatment, In-School Behavioral Health services, Mental Health partial hospitalization services, Therapeutic Foster Care services, and Community and Recovery Support Services.

## GENERAL RATIONALE FOR NEW SERVICES (continued):

- Crisis services—designed to intervene as early as possible with non-residential services—include mobile crisis response and 23-hour crisis observation services. If necessary, crisis residential stabilization services are included in the benefit.
- The clinical and support elements of Home-based Family Treatment services are the result of considerable research across several evidence-based, evidence-informed in-home family interventions including:
  - Homebuilders (Washington State)
  - ChildFirst
  - PARTNERS
  - WrapAround Milwaukee
  - Connecticut syllabus of evidence-based practices relating to family engagement and family therapy

## GENERAL RATIONALE FOR NEW SERVICES (continued):

- The major focus of the proposed benefit package for **Adults (Populations 2 & 3)** is also on developing the community-/regionally-based service infrastructure to allow treatment where people live.
- Crisis services include mobile crisis response, 23-hour crisis observation, crisis residential stabilization, & peer-based crisis services. Community-based, sub-acute services—including ACT Teams, ambulatory withdrawal management, intensive case management, intensive outpatient SUD, MH partial hospitalization, and outpatient Medication-Assisted Treatment – these are all designed to allow treatment and recovery based on clinical need.

## GENERAL RATIONALE FOR NEW SERVICES (continued):

- Proposed service definitions/limitations/rates were the result of significant research across State and Federal programs, particularly the following sixteen State Medicaid systems:
  - Arizona
  - Colorado
  - Florida
  - Maryland
  - New Hampshire
  - New York
  - Texas
  - Washington
  - California
  - Delaware
  - Georgia
  - Minnesota
  - New Jersey
  - Oregon
  - Virginia
  - West Virginia

## 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 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).

## 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** between the ages 18-64 years, who meet the following qualifying criteria:
  - Who 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 and Substance Use Disorder; **OR**
    - A co-occurring Mental and Intellectual Developmental Disabilities Disorder not covered by any other Federal waiver; **AND**
  - Who 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:
  - Who 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**
  - Who meet the *American Society of Addiction Medicine Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions'* (ASAM 3<sup>rd</sup> 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, 3<sup>rd</sup> 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
		Sub-Regions			
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
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
		Sub-Regions			
6	Western Region	Kotzebue, Nome, and Bethel	3		43,770
		Northwest Arctic Borough	1		7,774
		Nome Census Area	1		9,952
		Kusilvak (Wade Hampton) Census Area			8,053
		Bethel Census Area	1		17,991
7	Northern Southeast Region	Juneau and Sitka	1	4	54,029
		Haines Borough			2,537
		Hoonah-Angoon Census Area			2,128
		Juneau City & Borough		1	33,026
		Petersburg Borough		1	3,209
		Sitka City and Borough	1	1	9,061
		Skagway Municipality			1,031
		Wrangell City and Borough		1	2,406
		Yakutat City and Borough			631

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

## REVISED TIMELINE FOR MATTERS RELATED TO THE 1115 APPLICATION

### Drafting the 1115 Application

- **July, 2017** First Full Draft of 1115 Application
- **August, 2017** Review Draft with 1115 Teams and Internal Stakeholders (DBH, DHSS Leadership)
- **Sept/Oct, 2017** Time for Public Comment, Tribal Consultation, Trust Review
- **Nov, 2017** Final Draft, Final Team Reviews, Final DHSS Leadership Review
- **Dec, 2017** File Completed 1115 Behavioral Health Demonstration Waiver Application with CMS
- **Jan, 2018** Begin Negotiations with CMS over content of Alaska's 1115 Application

## REVISED TIMELINE FOR MATTERS RELATED TO THE 1115 APPLICATION

### **Coordinating Related Waiver Application Internal Impacts**

- Completing the Budget Neutrality work with Milliman
- Completing the writing of the Application with Harbage Consulting
- Identifying necessary amendments to Alaska's State Medicaid Plan that reflect the proposed reforms to the BH system that do not need to be in the waiver application but do need to be made to the present State Plan, including any new Provider Types, removing waiver- deleted services, etc.
- Identifying necessary new and revised Administrative Regulations that have to be promulgated in conjunction with the content of any the proposed State Plan Amendments, including new Provider Types, deleting removed services, etc.
- Coordination between DBH and HCS in order to identifying the changes that will have to be made to the State's MMIS, timed to the effective date of the 1115 Waiver approval from CMS and anticipated ASO transition / start-up times

## REVISED TIMELINE FOR MATTERS RELATED TO THE 1115 APPLICATION

- **Coordinating Related Waiver Application Internal Impacts (continued)**
- Align care coordination and case management functions across DHSS divisions
- Examine 1115 impacts on DPA eligibility process, ARIES, services codes impacting DPA, HCS, DBH, SDS
- Examine interface with AKAIMS, the HIE, and the "on boarding" process to tie any BH Medicaid provider to the ASO, the HIE, and AKAIMS
- Examine impact of proposed rebased BH Medicaid rates on the State's Medicaid system, the 1115, and the budget neutrality requirement

## REVISED TIMELINE FOR MATTERS RELATED TO THE 1115 APPLICATION

### Contracting for an Administrative Services Organization

- August, 2017     Begin drafting the ASO RFP
- Oct, 2017         Finalize the RFP
- Nov, 2017         Issue the ASO Request for Proposals
- February, 2018   ASO RPF Responses Due
- April, 2018        Award the ASO Contract
- August, 2018     ASO in business and system  
transitioning begins

## QUESTIONS? HAPPY TO TRY AND ANSWER THEM!

- *And* THANKS!
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