THE STATE of ALASKA
GOVERNOR SEAN PARNELL

Department of Health & Social Services
GOVERNOR'S COUNCIL ON DISABILITIES
& SPECIAL EDUCATION
Executive Director's Office

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Medicaid Ad Hoc Committee Agenda

TO CALL IN TO THE MEETING: **Dial 1-866-356-1755, then enter the conference ID: 253 141 0338**

Thursday, October 30, 1-2:30pm

Roll call: Ric Nelson*, Chair, Art Delaune*, Karli Lopez*, Alex Gimarc*, Heidi Haas*, Kathy Fitzgerald, Dave Fleurant*, Emily Ennis. Staff: Patrick Reinhart, Britteny Howell

*voting members (for quorum purposes only)

Call to Order

Roll Call

Introductions, announcements, or good news

Approval of Agenda

Approval of Previous Meeting Minutes (None--Committee has not met in over a year)

Correspondence- Patrick

Reports

Old Business

New Business

- CMS final rule for HCBS waivers
- Medicaid Advisory Reform Group (MRAG) - Britteny & Patrick
- Durable Medical Equipment Re-Use Letter of Support - Patrick
- PCA reductions

- Date and time of next meeting- ??

Adjourn

CHANGES TO 1915(c) WAIVER REGULATIONS

Effective March 17, 2014

- Emphasis on *quality of life* for recipients of waiver services
- Person-Centered Planning
- Definition of "home and community-based settings" in which services may be provided
- "Conflict-free" care coordination
- Added protections for recipients in provider controlled or operated residential settings

PERSON-CENTERED PLANNING

- Clear separation of service planning and service provision
- New requirements for documentation of options offered to the recipient
- Real choice for recipient free from pressure and undue influence

PERSON-CENTERED PLANNING PROCESS

- Led by the recipient and/or with their representative (as defined by recipient)
- Reflect cultural considerations
  - individuals with disabilities
  - limited English proficiency
- Documents the options offered and considered by the individual
- Plan signed by and distributed to all

CONFLICT-FREE CARE COORDINATION

- Complete separation of service planning and service provision
- Prohibition on any agency providing both to same individual
- ***No acceptable degree or percentage of financial or organizational affiliation between agencies that will allow provision of care coordination and service provision***
- **Exception:** only 1 qualified agency in a geographic

HOME AND COMMUNITY-BASED SETTING (HCBS)

Requires the state to verify that all recipients of HCBS receive those services:

- in integrated community settings
- selected by the recipient from among setting options (including non-disability specific settings)
- appropriate to their needs
- settings provide "full access" to the benefits of community living

DEFINITION OF FULL ACCESS

Full access means **to the same degree of access as individuals not receiving home and community-based services** including opportunities to*:*

- *seek employment and work in competitive, integrated settings*
- *engage in community life*
- *control personal resources*
- *receive services in the community*

HOME AND COMMUNITY-BASED SETTING

Qualities of a "home and community-based setting:"

- Physically accessible
- Choice of roommates
- Freedom to furnish and decorate
- Freedom and support to control schedules and activities
- Access to food at any time
- Visitors at any time

HCBS IN PROVIDER-OWNED SETTINGS

In a provider-owned or controlled residential setting the following *additional* conditions must be met:

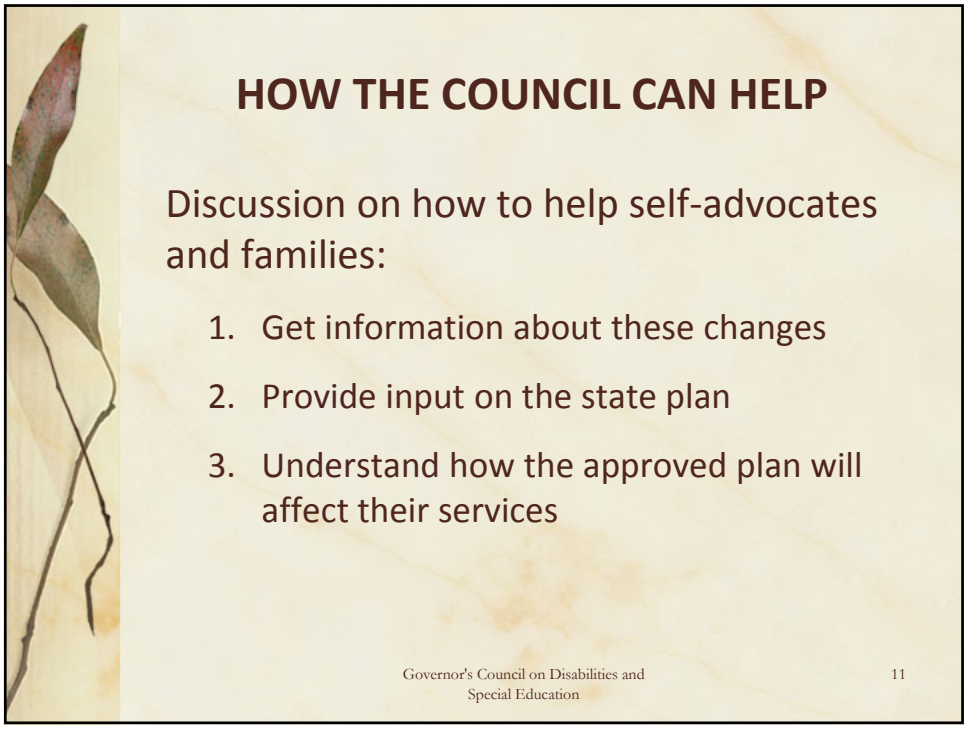
- Must be rented or occupied under a "legally enforceable" agreement
- Same protections from eviction under the landlord/tenant law
- Privacy in sleeping or living unit
- Entrance doors lockable by the individual

NEVER ALLOWABLE AS HCBS SETTINGS

- Nursing home/facility
- Institution for mental disease (16+ beds)
- Intermediate Care Facility/Intellectual and Developmental Disabilities (ICF/IDD)
- Hospital
- Any setting co-located with, on the grounds of, or immediately adjacent to an institution
- Any other location that isolates individuals from the broader community

ALASKA'S NEXT STEPS TO COMPLIANCE

1. *Assess providers on the basis of HCBS settings regulatory criteria*
2. *Determine setting's level of conformity to HCBS setting characteristics*
3. *Develop "Transition Plan"*
4. *Provide opportunity for Public Comment*


HOW THE COUNCIL CAN HELP
Discussion on how to help self-advocates and families:
1. Get information about these changes
2. Provide input on the state plan
3. Understand how the approved plan will affect their services
Governor's Council on Disabilities and Special Education
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ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

Medicaid Reform Advisory Group
September 17, 2014
Next meeting October 29, 2014

Purpose of Meeting: Review 13 items from the Department's Innovations List distributed in July

Commissioner Streur: Be Bold. Be Clear. Give us direction and assistance. There is no way we can reform Medicaid, address the gap population or Medicaid Expansion without involvement of Provider groups.

The purpose of the MRAG is to identify areas to pursue. This does not necessarily mean the department will implement the ideas. The department will write up the motions and key discussion points from the September 17 meeting for further consideration at the October 29 meeting. Final recommendations will be forwarded to the Governor.

ASHNHA provided written and verbal testimony. The advisory group discussed each of the alternatives in the lengthy document and passed motions making recommendations on most of them.

The following is a summary of the motions by alternative number to help provide context. The wording on all of the motions is approximate. It was difficult to follow as motions were amended and modified and not restated before the vote.

The commissioner stated that the motions would be written up and brought back to the group for review at the October meeting and they can revisit them if desired.

Medicaid Innovations List Discussion and Recommendations

 # 4 Comprehensive PCCM payment mechanism with steerage.

Motion 1: Implement care management program for superutilizers.

Motion 2: Implement case management program for all Medicaid users.

Notes: *A new RFP related to superutilizers has gone out to include a minimum of 200 up to 5,000 individuals. 6,000 people have been identified. Certain care management opportunities can be done administratively. Superutilizers pilot is first step, down the road look at metrics. Re steering to primary care management, unless there is a care management program can't direct individuals because of freedom to choose provider provisions.*

#5 Comprehensive payment reform.

Motion 3: The department will work with providers and other groups to make recommendations for payment reform.

Notes: *Committee discussion of bundled payments (most Medicaid is fee for service), specialty*

management (pay for outcomes, pay for performance would need a model), DRG, cost sharing.

#8 Individual cost neutrality for Medicaid home and community-based waivers

Motion 4: Pursue conflict-free care coordination in lieu of cap on Medicaid home and community-based waivers.

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#10 Cost savings through contracted services.

Motion 5: Department may contract out home and community-based waivers assessments an care coordination.

Motion 6: Give the Department the option of using contract pharmacy services for limited number of specialty drugs.

Notes: *Suggestion that the department retain ability to do initial assessments and that contracted services apply to urban areas for reassessments. Current backlog. Estimate of $200 per assessment savings for 2500 assessment. Concern over costs of new drugs, including new Hep C drug and biologics and impact to pharmacies.*

#12 Reduce benefits to essential benefit plan.

Motion 7: Do not reduce essential benefit plan but look at options to encourage recipient accountability.

Notes: *Perception that Medicaid benefits outweigh other policies. Question to department re gap population, what would it cost the state to purchase premiums for these individuals. Commissioner said he can get numbers, but it would be expensive. Rerun discussion of non-emergent transportation and lodging; 60% of the population is off the road system.*

#13 Eliminate loophole allowing responsible relatives refusing to financially support relative so the relative can obtain Medicaid.

Motion 8: Department to review eligibility and financial impact of implementing caps on stays for children in residential treatment. (In lieu of eliminating loophole)

Notes: *MAGI implications—whether parent claims child on their income taxes. Length of stay at Alaska RPTC is one of the highest in U.S. 90% are parent custody kid, problems in the home. "Parents need skin in the game." Some non-disabled kids are a year plus in treatment. Statutory change is possible, such as co-pay for treatment—Minnesota requires a % of income.*

#15 Utilization limits for physical therapy, occupational therapy, speech therapy and speech language pathology.

Motion 9: Authorize the department to contract with OHSU to research caps to benefit levels

based on medical evidence.

Notes: *Oregon Health Sciences University is a leading medical researcher. 12 states contract with OHSU. A leading concern discussed was speech therapy, some individuals using the service five times a week.*

#18 Medicaid fee-for-service- increase co-pays and add new co-pays.

Motion 10: Continue to explore ways to use co-pays and to track administratively and add new co-pays for transportation and accommodation.

Notes: *Generic drug costs doubling/tripling. Reiteration that AN/AI Medicaid at tribal facility results in no copay. As Medicaid individuals transition to the Exchange, they will have co-pay provisions. At this time the department can't track/recommend.*

#19 Allow aged and permanently disabled with fixed incomes to automatically renew based on cost-of-living increases.

Motion 11: Department adopt recommendation 19.

Notes: *Currently, eligibility for these individuals is reviewed once a year. Change of income must be reported in 10 days.*

#20 Expand scope of practice for RNs, LPNs, and home health aides.

Motion 12: Disregard recommendation number 20 not in DHSS control.

#21 Limit total Medicaid spending to no greater than 4% annual growth.

Motion 13: Department to develop a plan to manage Medicaid growth to goal of 4% or less a year.

Motion 13: Department work with medical providers to reduce burden and regulations.

Notes: *Historically, Medicaid growth cycles. We have been in down cycle. Some states have proposed the federal government provide Medicaid as a block grant. Concern, Medicaid is an entitlement program, so what does it do to GF if cycle goes to up cycle. Analysis options will improve when MMIS is fully functioning.*

#22 1915 K capture additional 6% federal match, change 1915 C waiver system to 1915 K include PCA services.

Motion 15: Approve moving forward with 1915 K waiver.

Notes: *A wide range of HCB services could be included under 1915(k). If adopted, the 6% match increase would be $1.7 million for 1215 individuals currently receive PCA under waiver. GF savings of $15 million, based on FY 13 $223 million spending for residential and day habilitation, and more. Many steps to go through.*

State's initial effort to adopt waiver program took 3 years with 5 dedicated staff.

#23 Across-the-board rate freeze for one year.

Motion 16: Actualize a one-year inflationary rate freeze working with providers.

Notes: *Would impact all provider programs. Encounter rates set by feds, tribal health service fee-for-service billing would be impacted. This isn't a one year savings; the $8 million saved the first year would be saved each year forward. Recommendation doesn't take into account rate rebasing.*

Public Comment/Discussion Points

- Reform of health care is a long term process
- Meaningful change happens with provider groups at the table
- Important to have a structured process; payment reform needs to bring business knowledge to the table
- Reform needs to address the gap population; other states are leveraging federal dollars to provide for this group and may provide models that could work. There could be an Alaska Model.
- Pilot opportunities for Alaska:
    - State of Washington has seen 10% reduction in Medicaid use of ER for non-emergencies (?).
    - Care coordination initiative in Ketchikan
- Payment reform – needs engagement with providers
    - Bundled payments needs a lot more work
    - DRG change would require providers to take on risk. Larger hospitals can do but not small critical access hospitals.
    - Limits to annual spending (NY example) – how do you manage if enrollment goes up?
    - Rate freeze for 1 year is stop gap—temp relief but not reform.
- Capping payments shifts risks in a system without capacity to shift.
- Absence of Medicaid Expansion leaves gap population without coverage and lost opportunity to bridge health coverage with minimal cost to the state.

Committee question: who is gap population?

40,000 in ANTHC reports; 17,000 estimated in other reports. Understanding varies—up to 135% FPL and up to 100% RPL.

Committee question related to disparity in payments, specifically private provider and ANMC reimbursement amounts: Why different? Who figures it out?

Tribal outpatient receives an encounter rate. It is not capitation, not fully bundled, it is an all-inclusive rate based on cost report. Streur suggested it is like a "flat rate"

Committee question: concerned that Medicaid inhibits individuals who might otherwise get a job and be in an upward mobility mode, has there been consideration to opportunities such as health savings accounts, state match, a gap insurance program – something other than "pushing them on Medicaid"

Committee question related to gap population: How many are eligible for IHS

Explanation – IHS is not insurance, but based on trust relationship, underfunded by at least health.

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October 29, 2014

Re: Medicaid Innovation Recommendations to Governor Parnell on November 15, 2014

The Governor's Council on Disabilities and Special Education (GCDSE) fills a variety of federal and state roles, including serving as the State Council on Developmental Disabilities (SCDD) under the Developmental Disabilities Assistance and Bill of Rights Act. As the state DD Council, GCDSE works with Senior and Disabilities Services and other state agencies to ensure that people with intellectual and developmental disabilities and their families receive the services and supports that they need, as well as participate in the planning and design of those services. One of the duties of the state DD Council is providing comments on proposed recommendations that may have an impact of individuals with intellectual and/or developmental disabilities and their families.

The GCDSE wishes to express both our commendations and concerns regarding the Medicaid Advisory Group's recommended innovations to the Governor next month. First, we are pleased that the group will not be recommending capping waiver recipients to nursing home levels of care. If this cap were initiated, more people with significant disabilities may need to be sent out of state for institutional care. Not only is institutionalization against the mission of GCDSE and disability provider agencies in Alaska, but significant costs have already been incurred by the state in an effort to bring home individuals who had been institutionalized (e.g. Bring the Kids Home initiative). Additionally, CMS has released a final rule requiring HCBS settings to be integrated into broader communities and involving conflict-free, person-centered planning; significant steps toward eliminating institutionalization.

We are also excited to see renewed interest in adopting the 1915(k) Community First Choice Option to replace many of our current 1915(c) waiver services. By recommending the 1915(k) amendment to the state plan in addition to the PCA services plan, the state will receive an additional 6% federal match. Although implementation could take two years, this change could save the state $15 million in general funds and result in an additional $13 million from the federal match[i]. As suggested in your last meeting on September 17, the Governor's Council on Disabilities and Special Education is ready to serve as the required Development and Implementation Council for the transition plan.

The GCDSE supports a review of how Medicaid HCBS waiver and personal care services assessments are conducted, with the possibility of contracting this service out to conflict-free third parties. Currently, all assessments and reassessments are being performed by state

assessors, who have fallen significantly behind, particularly in PCA assessments. Additionally, the state assesses individuals for waiver eligibility ***after*** they have been drawn off the waitlist. This process results in people waiting on the waitlist for years, and when they are finally drawn for services, their assessments may reveal that they are not actually eligible for services after all (i.e. that they do not meet institutional level of care). For many Alaskan families on the waitlist, this scenario is devastating. If contracting out assessments will reduce costs and allow more assessments to be completed, with quality control and oversight by the state assessors, the GCDSE urges the state to also consider changing their waitlist processes to conduct these waiver-eligibility assessments ***before*** people are placed on a lengthy waitlist.

The Council is concerned about the recommendation for an across-the-board rate freeze for one year, given that current reimbursement rates are being reviewed and analyzed for appropriateness across many different HCBS services. We believe that this process should be carried forward and a cost-based rate structure be adopted which reimburses providers at a fair rate for services. We also believe more can be done by the State to encourage and reward organizations for efficiencies obtained, while maintaining quality home and community-based services to clients and families.

We are also concerned about the suggestion to impose utilization limits for physical therapy, occupational therapy, and speech therapy. These are beneficial therapies that have been proven effective for most people with disabilities, especially for our children. Research has clearly demonstrated that appropriate early intervention therapies provide sizable benefits later on in academic achievement, behavior, health, delinquency, crime reduction, and labor market successes. Capping these effective services at 6 hours of visits and requiring additional authorization for subsequent visits would increase administrative and participant burden resulting in therapy delays and increased administrative costs, since many waiver recipients require more than 6 hours of therapy. This recommendation also affects the education of children with disabilities, from birth to graduation. The state's Infant Learning Program and many of its public schools rely on Medicaid funding for the appropriate provision of necessary therapies. The Infant Learning Program is required by Federal Law to access Medicaid whenever applicable for early intervention services and families. Public schools can also access Medicaid for related services that must be provided in a school setting. The burden of paperwork is already overwhelming for families and administrators in these programs. Many interventions necessary to remediate cognitive, physical, and developmental disabilities in the youngest Alaskans will likely be discontinued if families and programs must have these necessary services continually reauthorized. At the very least, it will cause delays in therapy that can have a lifelong impact on children who require early and uninterrupted services for the best outcomes.

The GCDSE recommends the advisory group also consider recommending changes to the state regulations that currently prohibit the use of telepractice for HCBS waivers. Due to the remote nature of much of our state and high health care costs, telepractice would benefit all Alaskans as well as reduce state Medicaid costs significantly. One of the state waiver programs is currently piloting a project to conduct eligibility re-assessments remotely and we request to see these efforts expanded greatly. Since CMS does not prohibit telepractice of HCBS services and

most professional licensing organizations encourage telepractice, we strongly urge the state to amend Medicaid regulations to allow HCBS waiver services to be practiced remotely, when possible. Not only will this result in more frequent and more cost-effective services provided to our underserved rural residents, but telepractice will result in significant savings even in our urban locations.

Lastly, per our letter to Commissioner Streur on September 24, we encourage the state to adopt regulations that allow for the re-use and recycling of durable medical equipment purchased via Medicaid. Currently, the regulations do not allow for this, and in some cases, particularly with expensive power wheelchairs, hospital beds, and other assistive technology, there exist real opportunities for re-use and potential savings to the state of Alaska.

The Governor's Council on Disabilities and Special Education is in support of the overall intent of many of the proposed Medicaid innovations and we appreciate the opportunity to offer our comments.

Sincerely,

Ric Nelson
Council Chair
Medicaid Ad Hoc Committee Chair

Art Delaune
Developmental Disabilities Committee Chair

[i] *According to the Medicaid innovations document provided on the MRAG website at: http://dhss.alaska.gov/Commissioner/Pages/mrag/Sept-17-meeting.aspx*

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September 24, 2014

Bill Streur, Commissioner
Department of Health and Social Services
3601 C Street, # 902
Anchorage, AK 99503

Dear Commissioner Streur:

The Governor's Council on Disabilities and Special Education strongly encourages regulations for the re-use and recycling of durable medical equipment and assistive technology purchased by the State of Alaska through Medicaid and/or other state-supported programs. The initiative we envision would allow for equipment purchased by healthcare providers, school districts, and vocational rehabilitation programs to be shared by a statewide re-use and recycling program. In addition, such an initiative would include shipping support for rural communities.

Recently, the Division of Health Care Services issued draft regulations that would amend Medicaid regulations to allow for a "Medicare-capped rental model which will create an inventory of used durable medical equipment." The Council supports this model and recommends changes that would allow for the identification of equipment which has potential for re-use. Eligible equipment would be returned to non-profit organizations or even for-profit durable medical providers qualified to handle the equipment. These entities would accept used equipment in reasonable shape on behalf of the state, catalog items, refurbish equipment, part them out, or dispose of items. We believe such a program would reduce the number of instances whereby the state purchases expensive durable medical equipment or assistive technology for an eligible consumer, who passes away, moves away, or grows out of the equipment (i.e. devices for children or young adults). One can find much of this state-purchased equipment on Craig's list, where someone other than the consumer is profiting from the sale.

The Council is aware of several states that have adopted similar policies that have resulted in savings to the state-run Medicaid program and to individual buyers of used equipment. The Council has done quite a bit of research in this area and we are prepared to help move this concept forward. Fortunately in Alaska, we have formal and informal community programs that currently recycle used equipment. For instance, Access Alaska and Center for Independent Living have programs that recycle equipment in Anchorage, Mat-Su, and Fairbanks. However, standards for the handling, repair, and sanitization of used equipment and assistive technology

have to be put in place to be effective. In addition, regulations will need to spell out under what circumstances the state will authorize the purchase of used equipment and to assure that appropriate used equipment is matched up with consumers.

We hope the State of Alaska Department of Health and Social Services moves forward in support of this concept. The Council stands ready to assist in this effort while further regulations are developed to support it.

Sincerely,

Ric Nelson
Council Chair

Art Delaune
Developmental Disabilities Committee Chair