

**REVIEW OF BUDGET REDUCTIONS AND INCREASES
PROPOSED AND ANTICIPATED
IN THE GOVERNOR’S PROPOSED BUDGET
FOR THE STATE OF ALASKA
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
FOR FISCAL YEAR 2017**

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Executive Summary

This is a review of the Governor's DHSS FY17 budget with emphasis on savings and reductions.

Although there appear to be many savings in the FY17 budget, much of these savings are through shifting the payment for Medicaid services from the state government to the federal government. These transfers are implemented through "Medicaid reform" initiatives, such as 100% federal payment for travel of Alaska Natives, and increased use of federal funding for home and community waivers. There are other "hard" savings projected through management of super utilizers and prescription drug use reform.

One problem we see with the forecast savings in the FY17 budget is that the projected savings of \$24 million for 1915(i) and (k) plans will not occur until July 1, 2017 which is FY18. Even if these programs are approved by CMS in the latter part of FY17, the total of \$24 million will not be achievable.

We do recommend that the Permanent Fund Hold Harmless provision be done away with. We also recommend that many of the 27 Optional Services in Alaska's Medicaid program be terminated. Alaska Medicaid provides more health services than Medicare, VA care (for non-service connected) and many private health plans. This is a disincentive for those who work and serve their country. And Alaska cannot afford it.

In FY 2014 the cost to the Alaska General Fund for these Optional Services for Medicaid adults was an unsustainable \$222,503,688. This does not include the costs of other optional Medicaid waiver services for adults. Alaska is on the path of unsustainability for Medicaid which may deny the truly needed vital health care services.

Because the price of oil appears not to be rebounding to the former levels in the past few fiscal years, the economy will probably weaken, unemployment will rise, and there will be even more individuals/families enrolling in Medicaid. This will eat up even more of the General Fund and may even rob funds from constitutional requirements such as K12 education and public safety.

Tough choices must be made. It won't be easy, but it will be necessary.

We hope this report provides insight and summary material during this legislative session. Thank you for your service to Alaska.

Introduction

Other than education spending (about \$1.3 billion) the largest annual general fund expenditures by the State of Alaska are for Health and Social Service (HSS) programs (about \$1.1 billion) and the largest of those is Medicaid. (Permanent Fund Dividends are funded from the Alaska Permanent Fund's Undistributed Earnings Account and in FY16 they totaled about \$1.4 billion.) Accordingly, any serious effort to reduce state spending must involve a review of Department of Health and Social Services (DHSS) and its programs. In 2015 the legislature directed DHSS and specifically the Division of Senior and Disability Services (DSDS) (where Medicaid waivers are located in the budget) to cut \$4.4 million from its FY16 budget. Of the departmental budgets for FY17, DHSS is planned to have the largest unrestricted general fund reduction (\$46.7million or 4%) in Gov. Walker's proposed budget.

The DHSS budget is one of, if not the most, complex departmental budget for the State of Alaska. Given the limited time frame to review the recently released budget and prepare this report the author has attempted to cut through complexity to explain the main aspects of the Governor's proposed FY17 DHSS budget as possible. To facilitate this effort, we have focused on the larger reductions/increases and rounded off some totals to the nearest million or half-million dollars.

Proposed Spending Reductions in Governor's FY2017 DHSS Budget

The proposed amount of total general fund FY17 DHSS **net** reductions is \$46.7 million or 4%. Various spending cuts and fund transfers are offset by several major spending increases. The general fund reductions mostly consist of:

\$217,000 reduction from Administration Support from holding positions vacant to meet the reduction to increase the current vacancy factor (that is already above the recommended maximum).

\$735,000 reduction from Pioneer Homes which is explained as:

Reduce eleven positions in the Alaska Pioneer Homes as a cost-saving measure. In order to maintain a safe environment, for residents and staff, the number of residents cared for within the Pioneer Homes will be reduced in proportion to the number of positions deleted. An estimated six beds will be reduced from the Alaska Pioneer Homes' census count in order to maintain the current direct care staff to resident ratios.

\$400,000 transfer from Health Care Services by shifting Catastrophic and Chronic funding to Federal funds sources.

\$630,000 reduction from Public Health Epidemiology which is explained as:

All vaccines purchased by the state will be purchased through the Vaccine Assessment Fund. General funds can be reduced and current service levels maintained. As vaccine procurement costs increase, the ability to equitably offer vaccines to all Alaskans decreases. The Alaska Vaccine Assessment Program became effective in January, 2015. The Alaska Vaccine Assessment Program facilitates the universal purchase of vaccines in Alaska by collecting payments from health plans, insurers, and other responsible entities and remitting those funds to the Vaccine Assessment Fund. By purchasing all vaccines federally recommended for insured children and for certain adult vaccines, we ensure that Alaskans gain improved access to vaccines; health care providers receive state-supplied vaccines at no charge; and payers benefit from cost savings through the state's bulk vaccine purchase and distribution. However, with the startup of the Alaska Vaccine Assessment Program, there is a three-year period when payers may opt out. The payers do not want to subsidize non-payers. Since 2012 the Division of Public Health has been using \$630.0 in general funds to purchase a small amount of select vaccines for the most vulnerable populations. With the Alaska Vaccine Assessment Program, the general funds have been used to buy vaccine in situations where there was no assessment paid.

There is a shown reduction of \$1 million from the Work Services line item but these funds are transferred to Field Services (\$500,000) and Tribal Grants (\$500,000).

There is a shown reduction of \$4 million from Administrative Support and Information Technology Services but **\$3.8 million** of this is not a real reduction but rather a change of fund source from general fund to general fund interagency fees that have been spread out throughout the DHSS budget components.

There is a shown reduction of \$4.1 million for Facilities Maintenance and Pioneer Home Maintenance from Department Support Services but it is from other funds and not from general funds.

\$5.8 million transfer from state funded behavioral grants to Medicaid behavioral health grants funded 90% federal.

\$9.1 million from **elimination** of State of Alaska portion of energy assistance programs (the federally supported LIHAP Low Income Heating Assistance Program would continue – administered through the state).

\$4.6 million unallocated reduction spread department wide (same amount as budget was increased for 2.5% cost of living salary adjustments in FY16)

\$31.6 million mostly transfer from state funds to federal funds (a general estimate) from Medicaid Reform consisting of:

1. Unspecified cost-saving measures and efficiencies.[estimate \$1.75 million]
2. Prescription drug use reform – managed care of frequent users.
3. Health care management for super utilizers.[estimate \$1.175 million]
4. 100% federal payment for medical travel for Alaska Natives.
5. Reform initiatives – change in source of funds for home and community waivers. [estimate \$13.26 million + \$14.666 million]

The budget indicates four subunits where this \$31.6 million in **cost shifting** will occur but the Office of Management and Budget (OMB) has not fully identified by component where the amount of these Medicaid savings/reductions will come from. OMB reports it is not able to precisely predict how these savings will be spread among these reforms. OMB is also not able to predict **when** these savings will be available because they are dependent on legislative action on specific proposals which they do not yet have. Of concern to the providers of Home and Community Based Services is a statement on page 7 of the DHSS Senior and Disabilities Medicaid Services Component Budget Summary:

Some possible reform initiatives that will help the Department meet this reduction include placing a cap on certain Home and Community Based Services waiver services.

No explanation or detail regarding such “caps” has been provided.

Medicaid Reform Initiatives

As explained above the largest spending reductions in DHSS proposed in the Governor’s FY17 budget are from “Medicaid reform initiatives.” Although not identified as such in the budget, these “Medicaid reform initiatives” have been previously projected to produce savings of \$24 million. These reform initiatives create savings **not** by reducing the overall costs of the programs but by **shifting some of their costs from state to federal funds**. Before going into the details of that cost shifting, here is some basic background regarding Medicaid from the National Conference of State Legislatures:

Enacted in 1965 as Title XIX of the Social Security Act, Medicaid is a means-tested entitlement program that finances of primary and acute medical services as well as long-term care to more than 55 million people. As an entitlement program, all people who meet Medicaid’s eligibility criteria are eligible to enroll and receive services; enrollment caps and waiting lists for benefits are not allowed. Medicaid covers some federally mandated low-income populations, including pregnant women and young children, children and adults with diverse physical and mental health conditions and disabilities, and poor elderly and disabled Medicare beneficiaries. Eligibility varies widely among states because, although states must meet federal minimum requirements, states may also choose to

cover additional optional populations. Medicaid's expansion under the Affordable Care Act puts the program in the spotlight as states decide whether to cover additional people under the program. States, in partnership with the federal government, have provided low-income children with health insurance coverage for more than a decade through the Children's Health Insurance Program (CHIP). CHIP was created to bridge the safety net gap for low-income children who do not qualify for Medicaid but whose families cannot afford insurance. Nearly 8 million children up to age 19 receive free or low-cost health coverage through the program.

The proposed Medicaid reform initiatives reflected in the Governor's FY17 budget include:

1. \$300,000 in savings from **a shift** to Medicaid 90% federal/10% state funded catastrophic aide grants from current 100% state funding.
2. Shifting the current Medicaid home and community based services waiver program from a limited entry mostly state funded program to 1915(i) and 1915(k) Medicaid options which have a higher ratio of federal funding.

Medicaid Home and Community-Based Services (HCBS)

The Medicaid program provides low-income individuals access to basic medical care such as mandatory physician services and hospitalization, and if a state elects, optional services such as dental care or prescription medication. To participate in the Medicaid program, States develop a *Medicaid State Plan* specifying which service options the State Medicaid program will offer.

One Medicaid service option states may elect is "home and community-based services" (HCBS). HCBS are long-term services and supports such as hands-on personal care, meals on wheels, or help with chores, shopping, or other tasks of daily living. These services, along with supportive case management, assist the elderly and people with disabilities **avoid institutional care**, and remain as independent as possible in their homes and communities. States can offer a variety of services under an HCBS Waiver program. Programs can provide a combination of standard medical services and non-medical services. Standard services include but are not limited to: case management (i.e. supports and service coordination), homemaker, home health aide, personal care, adult day health services, habilitation (both day and residential), and respite care. States can also propose "other" types of services that may assist in diverting and/or transitioning individuals from institutional settings into their homes and community.

Before recent Congressional amendments to the Social Security Act, a state could not elect HCBS through their State Plan, but instead applied to the Centers for Medicare and Medicaid Services (CMS) for a separate "**1915(c) waiver.**" **The waiver requires the state to target HCBS only to those individuals who experience functional limitations so severe, that they would otherwise need to be cared for in a nursing home, hospital, or other institution.** Alaska currently provides HCBS to approximately 4,000

individuals under four 1915(c) Medicaid waiver programs, Children with Complex Medical Conditions (CCMC), Adults with Physical and Developmental Disabilities (APDD), Alaskans Living Independently (ALI), and Individuals with Intellectual and Developmental Disabilities (IDD).

States including Alaska have adopted 1915(c) plans because they allow recipients to receive needed services in non-institutional settings (including state licensed homes which they prefer) and provide those services at a greatly reduced cost compared to institutional providers such as hospitals and nursing homes. The Alaska DHSS reports that its 1915(c) waiver program for (IDD) Medicaid recipients provides **an average annual savings to the State of Alaska of \$79,478 per Alaskan recipient for a total savings of over \$134,897,800 in FY13.** So the HCBS waiver program saves the State lots of money but not all Medicaid eligible Alaskans needing these services are covered by the design of the current state 1915(c) plan. The Affordable Care Act created new waiver plan options for states including the new 1915(i) and (k) plans.

These new options provide new ways the state can administer the home and community based waiver services, which the state Medicaid program already provides. In order to use the (i) and (k) options the state will need to apply for the change through the federal Center of Medicaid Services. The 1915(i) option will allow the state to collect federal Medicaid dollars for people who do not meet the physical needs definition of 'nursing home level of care' currently required by the waiver but who require care due to other criteria, such as Alzheimer's or dementia. Currently people (mostly elders) who need a high level of care due Alzheimer's or dementia do not qualify for Medicaid waivers. However, the state still pays for care for these patients through General Relief, which is paid 100% from the state general fund. By updating the waiver criteria using option (i) the State can begin collect 50% federal reimbursement for services which are currently being paid 100% from the state general fund.

Option (k) also relates to the home and community based waiver system. For certain waiver services which the state is already providing, the (k) option will increase the federal reimbursement from 50% to 56%. The Health and Social Service department has estimated \$24 million in saving for implementing these two options.

The State has provided these additional explanations of the 1915(i) and (k) options:

1915 (i) is a State Plan Option that does not allow for a waitlist for services. These are NOT waiver services. The eligible individual must be Medicaid eligible and have a functional need, but does not meet LOC for institutionalization. The target groups for these services are Traumatic Brain Injury, Intellectual Developmental Disabilities, Severely Mentally Ill and Seniors with Dementia.(includes Alzheimer's)

1915 (k) is a Community First Choice plan. It also does not allow for a waitlist. These services are for individuals who meet institutional LOC like the 1915 (c) plan; however, SDS does not believe these services will

do away with the 1915 (c) waiver services (Alaska’s current waiver plan). Caps are allowed on these services. The FFP (federal financial portion) for these services is 56%, an increase from the 50% match with 1915 (c) services.

Additionally, the State of Alaska has provided the below explanation:

1915(i) State Plan HCBS Benefit – 1915(k) Community First Choice Option

Beginning with the Deficit Reduction Act of 2005 and continuing with the Affordable Care Act, Congress amended the Medicaid program to encourage states to take advantage of the benefits of HCBS. **Section 1915(i) allows states to make HCBS available to people not eligible for institutional care, but still in need of service and supports to remain independent. Section 1915(k) creates a financial incentive for states to provide HCBS to people who would otherwise need institutional care, by offering a 6% increase, from 50% to 56%, in the “federal financial participation rate” (FFP).** These options also offer administrative simplicity, as states may elect to provide HCBS under sections 1915(i) and 1915(k) not through a waiver, but through a Medicaid State Plan amendment.

State Plan HCBS benefits have several significant advantages over the 1915(c) HCBS waiver. The 1915(i) allows the state to offer less intensive services and supports earlier and at lower costs, often keeping individuals from progressing to institutional care. In addition, individuals with significant disabilities that do not rise to the need for institutional care, such as Alzheimer’s disease or related dementias (ADRD), fetal alcohol spectrum disorder (FASD), or traumatic brain injury (TBI), may qualify for low-level, stabilizing HCBS.

Unlike the current 1915(c) waivers, individuals who experience behavioral health disabilities are eligible for 1915(i) State Plan benefits. Provided currently with 100% state general funds via mental health grants, 1915(i) HCBS benefits provide needed access to services, while allowing the state to refinance them with 50% FFP.

1915(i) HCBS can also target adults leaving the corrections system and youth transitioning from the juvenile justice system. Access to health and behavioral health care has been shown to reduce recidivism in these populations, improving personal outcomes and saving the state money.

In addition to the 56% FMAP, 1915(k) HCBS allow the recipient to purchase goods and services in lieu of personal care, such as a microwave oven, personal safety alert device or other assistive technology.

But adopting these new waiver plans will take time. Federal approval requires involvement of stakeholders in the design and implementation of 1915(i) State Plan HCBS Benefits, and 1915(k) Community First Choice Option. Federal regulations require creation of a consumer “Development and Implementation Council” to guide creation and implementation, with the majority of members seniors, people experiencing disabilities, and their representatives. The report of a state contractor projects the following ten steps to implement these new waiver options:

- 1-Stakeholder Input Process
 - Development and Implementation Council
 - Provider and Community Forums
 - In person in Anchorage, Barrow, Bethel, Fairbanks, Mat-Su Valley, Juneau, Kenai, Ketchikan, Nome
 - Statewide webinar
- 2- Review of Federal and State Regulations
- 3- Review of Current Operations
- 4- Identify Eligibility, Resource Allocation Criteria and Target Populations
- 5- Evaluate Functional Assessment Tools
- 6- Determine Service Package
- 7- Establish Quality Assurance and Improvement Plan
- 8- Develop a Provider Manual/Conditions of Participation
- 9- Conduct a Cost Impact Analysis
- 10-Develop the Implementation Plan

The target date to have an implementation plan is 7/31/2016. The plan would be submitted to the federal government in January 2017 with approval hoped for by 6/30/17. **This schedule places the start of the new waivers and their resulting savings as 7/1/17, the beginning of FY18.**

So why does the Governor’s FY17 proposed budget include millions of dollars in reductions from shifting to the new 1915(i) and (k) waiver plans if they will not be in place until July 2017?

In January 2016 the DHSS website provided the following answers to frequently asked questions regarding the planned transition to 1915(i) and (k) waivers.

Frequently Asked Questions About the Department of Health and Social Services’ Project to Explore Two Options in the Social Security Act Known as Medicaid 1915(i) Home and Community-Based Services and 1915(k) Community First Choice.

1. What is a state plan option?

To receive federal funding for Medicaid services, states must comply with the federal Medicaid law. This law defines what states: (1) must do; (2) can choose to do; and (3) cannot do. Those benefits that a state can choose

to include in their Medicaid State Plan is referred to as a “state plan option” or “optional benefit.”

2. Why is the State of Alaska pursuing the 1915(i) and the 1915(k) state plan options?

Seniors and people with disabilities in Alaska, by and large, want to stay in their homes and communities. Home and community-based services (HCBS) support these individuals in doing so. Given the State of Alaska’s financial concerns, the State needs to leverage as much federal funding as possible to help pay for home and community-based services. When services are administered under the Medicaid State Plan, state dollars are matched by federal dollars. The federal government will pay 50% of the cost of the Medicaid services under 1915(i), and 56% of the cost of the Medicaid services under the 1915(k) option. Some services currently funded by State General Fund dollars only could be administered under the Medicaid State Plan which would bring more federal dollars into the State.

3. Will some seniors and people with disabilities lose their benefits?

The state plan options will extend Medicaid benefits to additional populations for specific services, not exclude individuals currently receiving benefits. While we cannot expand home and community-based services due to the State budget deficit, the state plan options will allow Alaska to draw down more federal dollars to help pay for these services.

4. How is the 1915(i) state plan optional benefit similar to Alaska’s 1915(c) waiver?

- The allowed services under the 1915(i) state plan option may be identical to those offered under the waiver. In addition, the 1915(i) state plan option may include personal care services.
- Both 1915(i) state plan option and the 1915(c) waiver include specific targeting criteria for eligibility. For 1915(i), the state may define and limit the target group(s) served. For 1915(c) waiver, the following groups are targeted: aged/disabled, persons with intellectual disabilities/developmental disabilities, persons with severe mental illness.
- Neither the 1915(i) state plan option nor the 1915(c) waiver can cover room and board (except for allowable transition costs from an institutional setting to a home and community-based setting), special education and related services provided under the Individuals with Disabilities Education Act that are education-related only and vocational services provided under the Rehabilitation Act of 1973.

5. How is the 1915(i) state plan optional benefit different from the 1915(c) waiver?

- While the waiver limits home and community-based services benefits to those who meet a Nursing Facility or Intermediate Care Facilities for

Individuals with Intellectual Disabilities level of care, the 1915(i) state plan option provides home and community-based services to individuals who would not otherwise meet the Nursing Facility or Intermediate Care Facilities for Individuals with Intellectual Disabilities level of care eligibility requirement.

- While the availability of waiver services can be limited to certain parts of the state, the 1915(i) state plan optional benefit must be provided to everyone who meets eligibility criteria statewide.
- The 1915(c) waiver allows caps on the number of people that can be served and establishes a waiting list (or registry) for those who are eligible but exceed the service cap. The 1915(i) state plan optional benefit is not allowed to set caps on the number served under the benefit and therefore, anyone who meets the eligibility criteria for the benefit is entitled to the service.

6. How is the 1915(k) Community First Choice state plan optional benefit similar to the Personal Care Services state plan benefit?

Both the 1915(k) and Personal Care Services cover personal care attendant services that support individuals with their Activities of Daily Living (e.g., bathing, dressing, eating, etc.) and Instrumental Activities of Daily Living (e.g., meal preparation, housekeeping, etc.).

7. How is the 1915(k) Community First Choice state plan optional benefit different from the Personal Care Services state plan benefit?

- Unlike the Personal Care Services benefit, to be eligible for the 1915(k) state plan optional benefit, an individual must meet the Nursing Facility or Intermediate Care Facilities for Individuals with Intellectual Disabilities level of care.
- While the Personal Care Services benefit receives the traditional federal match to state dollars allocated to fund the program, 1915(k) state plan optional benefits are eligible for an enhanced federal match. In Alaska, the traditional federal match is 50% (for every 50 cents the state puts in, the federal government puts in 50 cents). Under 1915(k), the federal match is 56%.
- In addition to the personal care attendant benefits that both 1915(k) and Personal Care Services cover, 1915(k) also includes additional required and optional benefits spelled out in the response to Question 12.

Eligibility

8. What are the eligibility criteria for 1915(i) and 1915(k)?

- For 1915(i), individuals must be eligible for Medicaid under the State plan up to 150% of Federal Poverty Level, and may include special income group of individuals with income up to 300% Social Security Income.
- For 1915(k), individuals must meet institutional level of care. Individuals must also be eligible for Medicaid under the State plan up to 150% of Federal Poverty Level. Individuals with income greater than 150% of the

Federal Poverty Level may use the institutional deeming rules which means that parents' or spouse's income and resources are not taken into account.

9. Can you receive services through the 1915(c) waiver and also be eligible for services under a state plan option?

Yes.

10. What populations will be targeted in 1915(i)?

While this is currently being determined, preliminary target groups include persons with Alzheimer's Disease and Related Dementias, Severe Mental Illness, Intellectual and Developmental Disabilities, and Traumatic Brain Injury. Individuals with Fetal Alcohol Spectrum Disorders may be included as well.

Services

11. What services are covered under 1915(i)?

1915(i) services include those services currently covered under 1915(c) waiver:

- Case Management
- Homemaker Services
- Home Health Aide
- Personal Care
- Adult Day Health
- Habilitation
- Respite Care
- For Chronic Mental Illness: Day treatment or Partial Hospitalization, Psychosocial Rehab, Clinic Services

The Affordable Care Act revised 1915(i) to include "additional services requested by the state as the Secretary may approve." For example: Behavioral Supports, Cognitive Rehabilitative Therapy, Crisis Intervention, Exercise and Health Promotion, Health Monitoring, Housing Counseling, Assistive Technology, Live-In Caregiver Payment, and Family Training.

12. What services are covered under 1915(k)?

Services that must be covered include:

- Assistance with Activities of Daily Living such as eating, toileting, grooming, dressing, bathing, and transferring; Instrumental Activities of Daily Living such as meal planning and preparation, managing finances, shopping for food, clothing, and other essential items, performing essential household chores, communicating by phone or other media, and traveling around and participating in the community; and health-related tasks, e.g., assistance with medication administration, catheter, oxygen.
- Skills training to help people to accomplish Activities of Daily Living / Instrumental Activities of Daily Living, and health-related tasks.

- Back-up systems (e.g., emergency response button) and mechanisms to ensure continuity of services and supports.
- Voluntary training on how to select, manage, and dismiss attendants.
Other services that may be covered include:
- Transition costs required for an individual to transition from a nursing facility or other institution to a community-based home setting (e.g., items necessary to establish household to transition from a nursing facility or other institution.)
- Goods and services that increase an individual's independence or substitutes for human assistance, to the extent that expenditures would otherwise be made for human assistance, e.g., ramp that allows person to enter home independently.

Settings

13. In what settings can the 1915(i) and 1915(k) state plan optional benefits be offered?

A federal rule sets forth requirements of the settings that are eligible for reimbursement for the Medicaid home and community-based services provided under sections 1915(c), 1915(i) and 1915(k) of the Medicaid statute. The rule requires that all home and community-based settings meet certain qualifications. These include:

- The setting is integrated in and supports full access to the greater community;
- Is selected by the individual from among setting options;
- Ensures individual rights of privacy, dignity and respect, and freedom from coercion and restraint;
- Optimizes autonomy and independence in making life choices; and
- Facilitates choice regarding services and who provides them.

Excluded settings include nursing facilities, institutions for mental disease, intermediate care facilities for individuals with intellectual disabilities, and hospitals. Other Medicaid funding authorities support services provided in these institutional settings.[\[1\]](#)

Functional Assessment and Person-Centered Care Plans

14. I understand the State may develop or adopt a new functional assessment tool to assess an individual's needs for 1915(i) and 1915(k). Why is the State looking at new assessment tools?

The federal government is requiring functional assessment tools to be consistent with "person-centered planning." This type of planning includes processes whereby the needs and preferences of the individual receiving services are described by that person, along with family, friends and other care team members. This helps to ensure that the individual's care plan includes, and the individual receives, the covered services they need in a way that they prefer. These requirements apply across the 1915(c) and 1915(i) programs and are consistent with the final person-centered planning requirements for 1915(k).[\[2\]](#)

15. Will there be any changes to selection and training of individuals to administer the tools?

To the extent that the functional assessment tool changes, staff will be trained on new features of the tool.

16. How does the State propose to meet the conflict-free case management requirement of 1915(k) in remote areas of Alaska where there are no or limited independent case managers?

Conflict-free case management is the provision of case management services by an independent entity, one that does not have a conflict of interest in either the assessment or care plan. For example, case managers cannot be employed by providers of State plan home and community-based services for an individual. However, exceptions may be made if the provider is the only willing and qualified entity in the area. In this case, the State must develop additional safeguards including an alternative dispute resolution process. The State of Alaska is currently in dialogue with the Centers for Medicaid and Medicare Services about this exception in rural Alaska; the State will communicate the result of its discussions at the appropriate time.

Efficiencies

17. How will the State avoid duplication between waiver programs and the state plan option services?

The State’s contractor is currently conducting an operational assessment – including meetings with service providers and participants – to identify opportunities to streamline common processes such as the application process, assessment process, information systems, etc.

[1]CMS Fact Sheet: Summary of Key Provisions of the Home and Community-based Services Settings Final Rule. January 10, 2014. <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/downloads/hcbs-setting-fact-sheet.pdf>

[2]Medicaid.gov. Home and Community Based Services, Q and A. May 7, 2012. <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/downloads/final-q-and-a.pdf>

Proposed Spending Increases in Governor’s FY2017 DHSS Budget

The proposed reductions in the Governor’s FY2017 DHSS Budget are offset by about **\$9.5 million** in increased general fund spending. The result is a budget showing a \$46.7 million reduction. The major increases are:

The Child Services unit includes **increases for Subsidized Adoption of \$4.8M and Management of \$1.8M**. Despite this **actual increase of about \$6.4M** this Unit shows a \$2.6M reduction because of a transfer of Early Childhood program funds totaling \$9.25M to the Senior and Disabilities Services (SDS) Unit which shows a \$8.9M increase. Senior and Disability Services (SDS) shows an increase of \$8.9M but it is due to the \$9.25M Early Childhood program **transfer** to SDS.

The Public Assistance component shows reductions including a \$9.1M elimination of the state funded energy assistance program and \$1M from the Work Services line item. But **increases of \$1.9M in the Public Assistance Field Services line item and \$0.5M for Tribal Assistance Programs** reduced the reduction to \$7.65 million.

The Public Health unit is **increased by \$350K**.

The Juvenile Justice unit is **increased by \$1.275M**

Information Technology is reduced by \$3.8M in Departmental Support Services but this is **not a real reduction but rather a fund source transfer** from general fund to interagency receipts.

Administrative Support Services has a transfer of \$975K from general fund to interagency receipts. This is **not a real reduction but rather a fund source transfer**.

Work Services in Public Assistance is **reduced by \$1M**. While this is a real reduction, the funds were “transferred” to **Field Services and Tribal Assistance Program grants as described above which show increases**. The budget offers the following explanation of this transfer:

General funds from this component have often been used to offset Maintenance of Effort requirements in other components. Grants issued from the Tribal Assistance Programs component are funded with a combination of General Funds and Permanent Fund Dividend program funding. These grant expenditures are used by the division to satisfy a Maintenance of Effort mandate for the receipt of the Temporary Assistance for Needy Families block grant. Permanent Fund Hold Harmless funds are insufficient to fully fund the Tribal Assistance Grants and excess general fund authority exists in the Work Services component. This transfer will allow for the division to fully fund the grant program at levels consistent with prior years. This transfer will also be used to fund position costs in the Field Services component

Note that Permanent Fund Hold Harmless funds are funds that would otherwise be distributed to all permanent fund dividend recipients but are deducted to pay for additional funds to “hold harmless” Alaskans who become ineligible for public assistance payments due to their receipt of a permanent fund dividend.

Note that “maintenance of effort requirements” are mandates regarding receipt of federal funds prohibiting states from reducing expenditures without a total loss of federal funds for a particular federal program. This prevents states from pro rata reductions in federal programs – states are faced with all or nothing funding decisions for most partially federally funded programs.

Questions

The target date to implement the new 1915(i) and (k) plans is 7/1/2017. This schedule places the start of the new waivers and their resulting savings as 7/1/17 the beginning of the FY2018. But the FY17 Governor’s budget indicates millions of dollars in savings from this funding shift during FY17. There was some indication that the estimated savings from a full year of this fund shifting is about \$24 million. As previously discussed, no specific amount is identified as coming from this fund shifting in the FY17 budget but the total savings from this and other reforms is projected to be \$31.6M and the other reforms identified only account for a lot less than \$10M even if successful.

So why does the Governor’s FY17 proposed budget include millions of dollars in reductions from shifting to the new 1915(i) and (k) waiver plans if they will not be in place until July 2017? **It appears at this time that the FY17 DHSS budget is actually missing a possible \$24 million of the claimed \$46.7 million reduction. And that is IF the other proposed reforms such as cutting waste and fraud are successful.**

Conclusion

Without the transfers from state to federal funding, the significant reductions in actual spending proposed are the elimination of the state funded energy assistance program (\$9.1 million), Work Services reduction (\$1 million), and the Pioneer Homes reduction (\$735,000) for a total of about \$11M. The general fund increases total about \$9.5M; so the actual reduction in total spending on DHSS services related to these general fund reductions and transfers not counting transfers to federal funds is about \$1 million or less than one-half percent. But the fund source transfers related to Medicaid are actual potential general fund reductions that will reduce the current state budget deficit.