ALASKA NATIVE TRIBAL HEALTH CONSORTIUM

Submitted Via E-mail: courtney.king@alaska.gov

December 29, 2017

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Medicaid State Plan Coordinator
4501 Business Park Boulevard
Building L
Anchorage, AK 99503

RE: Tribal Consultation Comments on DHSS 1115 Behavioral Health Demonstration Waiver

Dear Ms. King:

The Alaska Native Tribal Health Consortium (ANTHC) is a statewide tribal health organization that co-manages the Alaska Native Medical Center (ANMC), a tertiary care hospital and level II trauma center in Anchorage, that serves more than 166,000 Alaska Natives and American Indians (AN/AI) throughout Alaska. ANTHC also provides a wide range of public health, community health, and environmental health programs and services for Alaska Natives and their communities throughout the State. ANTHC's Environmental Health and Engineering programs provide Alaska Native Villages with planning, design, and construction and operations support for clean water and sanitation projects statewide.

On behalf of the ATHS, we are writing to provide the following Tribal Consultation comments and recommendations on the Department of Health and Social Service's (DHSS) 1115 Behavioral Health Demonstration Waiver application that proposes a comprehensive reform of Alaska's Medicaid behavioral health system for children, adolescents, and adults with serious mental illness, severe emotional disturbance, and/or substance use disorders. These comments and recommendations follow our in-person DHSS Tribal Consultation meetings held on December 20th and 21st in Anchorage, Alaska.

Preamble

The ATHS supports the primary objectives of the proposed waiver, and especially its focus on early-intervention and home-based care. However, we are concerned that many of the waiver's design elements do not account for the unique challenges faced by the ATHS and would preclude the patients we serve from benefitting from the services made available through the waiver. Our comments and recommendations are intended to help to improve it, so that the

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reforms proposed in the waiver can work for all Alaskans and the Medicaid recipients that we serve.

The challenges in Alaska's behavioral health system stem largely from the state's vast size, extreme climate and geography, rural nature, and limited road system. Despite the challenges of this environment, and within the limits of available resources, Alaska's tribal health providers have joined together to establish an innovative, cost-effective, and coordinated system of cradle-to-grave medical and behavioral health services. These services are culturally-appropriate and uniquely suited to the service environment, and make extensive use of para-professionals, community health providers, and telemedicine service delivery. In truth, no one understands Alaska's service challenges and workable solutions better than the tribal organizations that comprise Alaska's Tribal Health System. The State's draft 1115 waiver recognizes this and expressly seeks to emulate and build upon the Tribal Health System's successes, by coordinating care for all waiver recipients, covering early-intervention services, and enhancing the availability of home- and community-based services. Therefore, it is key that the demonstration project be structured in a manner that supports and enhances the existing tribal system.

A central feature of the proposed waiver, and one that deeply concerns us, is that DHSS plans to contract with an Administrative Services Organization (ASO) to manage the behavioral health system reforms, including both waiver and non-waiver services. The ASO will be a third-party organization with specialized expertise in integrated behavioral health systems, but it almost certainly will have no direct experience working with a Tribal health system that is comparable in size and scope to the ATHS. Equally concerning is the fact that DHSS proposes to establish either 9 or 14 regional service areas for behavioral health services, whose boundaries do not correspond to the ATHS's established and successful regions. In addition, neither the Request for Information (RFI) for the ASO nor the draft 1115 waiver application explain what additional requirements, if any, might be imposed on ATHS behavioral health providers, and what requirements the State would impose on the ASO to ensure that the ATHS and the patients we serve maintain access to Medicaid behavioral health services. We believe these features, unless specifically adapted for the ATHS and the people we serve, will thwart or supplant our successful system of care and impose additional and unnecessary administrative burdens on it. To truly build on the successes of the ATHS, existing tribal health regions and referral relationships must be preserved, and Tribal providers—not an ASO unfamiliar with Alaska, Alaska Natives, and the ATHS –should continue to coordinate and manage their patients' care.

It is also very important that new waiver services be culturally appropriate and designed to fit the small and remote communities where most AN/AI recipients live, and that they take account of the limited array of services currently available there. This means, among other things, that Community Health Aide/Practitioners (CHA/Ps), Behavioral Health Aide/Practitioners (BHA/Ps), para-professionals, and mid-level providers should be allowed to deliver all services within the limits of their training and licensure. It means that telemedicine

should be recognized as a reimbursable service delivery method to the fullest extent possible. Adult eligibility for waiver services should not be conditioned on three emergency department (ED) or inpatient admissions for individuals who live in communities without access to an ED or hospital. Residential services should be covered in facilities smaller than 10 beds, in communities that have no need or capacity for a larger facility. Lengths of stay limits should reflect the actual availability of step-down services in the community, and not be imposed in communities where step-down services do not exist. Waiver services should be available to persons 65 and over, especially given the special respect and care Alaska Native people and cultures afford to our elders. Otherwise, the proposed requirements will disparately reduce access to waiver services for individuals served by the ATHS in rural areas. Unless changes are made to address these issues, we are concerned that many of the patients we serve will be prevented from accessing needed waiver services.

Recommendations: Executive Summary

1. We request that Alaska Native/American Indian (AN/AI) people eligible for the waiver services be exempt from mandatory enrollment in the ASO, and that they be allowed to receive all waiver and state plan services from any qualified tribal or non-tribal provider. Such an exemption recognizes the significant AN/AI behavioral health disparities that are explained in the waiver application, and recognizes the Alaska Tribal system of care that provides culturally appropriate care through its regional referral networks. Although we do not yet know the full scope of work that will be assigned to the ASO, the waiver application indicates that, at a minimum, all waiver services would be coordinated, authorized, and managed by the ASO.

2. Consequently, the Centers for Medicare & Medicaid Services' (CMS) Medicaid Managed Care Rules and managed care policies come into play. In those rules, and in informational bulletins on the subject, CMS has made clear that States have the option to exempt AN/AIs from mandatory managed care, "in light of the special statutory treatment of Indians in federal statutes concerning Medicaid managed care." Exempting AN/AIs from mandatory enrollment in the ASO, and allowing their care to continue to be coordinated and arranged by the ATHS, is supported by a number of federal laws and long-standing CMS policies that recognize the importance of ensuring that AN/AIs have access to culturally appropriate services furnished by tribal health programs focused on their unique needs. It is also supported by CMS's recognition of Indian health providers as a unique provider and facility type, and facility based reimbursement for the services they provide in approved Tribal uncompensated care waivers in other states. Finally, it is consistent with CMS past practice, which has consistently declined to approve Section 1115 Demonstration Waivers that impose mandatory enrollment in managed care unless they specifically exempt AN/AIs from mandatory enrollment or make enrollment voluntary for AN/AIs.

3. On March 30, 2017, ANHB sent a letter to the Department, in response to the State's RFI on the proposed procurement of an ASO to manage part of Alaska's Medicaid program. -This letter explained that Alaska Tribes were very concerned that transferring many of Alaska's single state agency responsibilities will affect AN/AI access to behavioral health care, as well as impact the ATHS that is responsible for providing behavioral health services to our Tribal and non-tribal population. Our letter included a request to exempt AN/AI and ATHS from the responsibilities of the ASO contract. In a follow-up listening session with the State held on August 31st, ANHB and our tribal partners shared a "Tribal ASO Discussion Matrix" (dated August 29, 2017) that discussed tribal concerns with proposed recommendations on 43 different issues that might be assigned to an ASO. We are concerned that the draft 1115 waiver does not include an explanation on how it will deal with these concerns raised by the ATHS. Therefore, we respectfully request that the issues raised in our March 30th letter and discussed in the "Tribal ASO Discussion Matrix" be included as part of our Public Notice and Tribal consultation comments on the 1115 Waiver. We have included the letter and matrix as an attachment for this purpose, and incorporate them both by this reference.

4. The ATHS respectfully requests that the State continue to consult with Tribes on the development of the waiver in light of the number of technical issues that have been identified through the public notice and Tribal consultation process, as well as changes that public stakeholders and Tribes have requested to be addressed in the final waiver. There are also likely to be additional issues or requirements that will arise in the final negotiations of the waiver between the State and the CMS. The ATHS respectfully requests that the State hold monthly teleconferences to update the ATHS on its negotiations with CMS, and that it convene Tribal consultation meetings as needed on any substantive developments of the waiver that will have a direct effect or place compliance costs on AN/AI beneficiaries or the ATHS. We also request that the State continue to meet with Tribal Behavioral Health Directors and the Tribal Medicaid Task Force to provide updates on the development of the waiver.

5. The remainder of our letter outlines, in matrix format, a number of issues and concerns that Tribal Behavioral Health Directors and other ATHS advocates have identified in the draft waiver application, along with Tribal recommendations on how to address them in the waiver. Our recommendations are intended to address the overarching concerns that are discussed in our Preamble to our comments. Almost all of these issues were discussed during our in-person Tribal Consultation meeting held on December 20th and 21st, although some of the issues we discussed then have been eliminated from the matrix or modified based on the explanation provided by the State during the meeting. Our Tribal Behavioral Health Directors and partners of the ATHS continue to feel that unless these issues are modified as we have recommended, they will have a negative impact on the ability of tribal patients to access needed waiver services and the system of care that provides behavior health services to them.

Tribal Consultation Concerns | Recommendations

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1	15	"Eligibility Group 1: A significant proportion of Alaska's children and adolescents encounter the child welfare system at some point in their upbringing. This waiver would provide an important vehicle for strengthening the support system for these young people in hopes of anticipating and preventing crises and reducing the need for out-of-home placements over time. Individuals in this target population are in the custody of the Alaska Department of Health and Social Services' Office of Children's Services or its Division of Juvenile Justice, or currently or formerly in foster care, or at risk of an out-of-home placement, and include:"	The list of individuals in the target population excludes many Alaska Native children who are in tribal foster care or kinship placements.	Define Eligibility Group 1 as: Individuals in this target population are in the custody of the Alaska Department of Health and Social Services' Office of Children's Services or its Division of Juvenile Justice, or in tribal custody, or currently or formerly in kinship care or foster care, or at risk of an out-of-home placement.
2	15-16	Eligibility Group 1 – "Children, adolescents, and their parents or caretakers with, or at risk of, Mental Health and Substance Use Disorders."	The target population is children, adolescents, and their parents/caregivers but eligibility criteria listed in four bullet points focuses on children and adolescents only. There is no clarity as to how parents and caregivers may become eligible within Group 1 to access the appropriate services detailed on pages 20-23 of the application. Stated intentions are not evident in the written application.	Add the following for clarity: Parents and caretakers are eligible to receive the Group 1 waiver services if they or their children meet the eligibility criteria.
3	16	"Group 1 - eligibility criteria • Individuals up to age 21 who have a child-specific or parental mental health or substance use disorder that has been treated within the past year;	It appears that the intention of these bullets was to place "or" statements between each bullet. We were unable to get clarity on that intent during in-person Tribal consultation.	Place "or" between each of the four criteria.

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		• Children and youth who have utilized an inpatient psychiatric hospital, inpatient general hospital mental health or substance use service; or residential treatment episode within the past year; • Individuals with complicating life circumstances including inadequate housing, negative family circumstances, or other psychosocial complications including unwanted pregnancy, inadequate family and peer support, or history of incarceration; -Children and youth who have been identified through positive responses to evidence- based mental health and SUD screening questions indicating an increased likelihood that a mental health and/or SUD symptom exists and needs further assessment and evaluation."	If "or" statements are placed between each bullet, we believe this is a good list of criteria and no further change is needed. Without "or" statements, each bullet is problematic alone for the following reasons: • Bullet 1: All newly diagnosed children (up to 21) are excluded because the criteria require treatment in the past year. To include a new diagnosis, the criteria needs to remove "that has been treated in the past year" • Bullet 2: This also excludes all newly diagnosed recipients. • Bullet 3: The intent of this section is not clear if it is not intended as a standalone criterion. We do note that these conditions are described by ICD-10 Z codes, which would be a new addition to reimbursable diagnoses. • Bullet 4: This is well written as long as each of the four criteria have an "or" statement.	
4	17	Eligibility Group 2 Bullet 2 –"A co-occurring mental health or substance use disorder; "	The quoted language has raised confusion among providers and does not seem to be necessary.	We recommend deleting the reference to co-occurring mental health or substance use disorders.
5	17	Eligibility Group 2 Bullet 3 – • "Utilized three or more of the following acute intensive services in the past year: • Inpatient psychiatric hospital stay; • Inpatient mental health or substance	The criteria for eligibility adversely and disproportionately exclude those who have the least access to care in much of rural Alaska. This is because services provided to rural patients to stabilize and/or treat in emergency and crisis situations do not meet	Alaska Native people will be adversely impacted by the ER/Hospital eligibility requirement. Most rural communities do not have ERs or inpatient settings. Lack of access to local ERs and Hospitals will prevent Alaska Native

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		abuse general hospital stay; • Inpatient hospital medical/surgical, non-delivery, inpatient maternity delivery, and other inpatient stay; or • Outpatient general hospital emergency room visit."	the four listed criteria. Many Tribal clinics provide hours-long and sometimes overnight stabilization services, yet these emergency services are not tracked as emergency room or hospital visits. In order to meet the stated intent of the waiver, there need to be additional criteria for remote and rural areas that do not have a hospital or operate an emergency room, yet provide services to persons who would need a hospital or emergency room if one were available. Persons in rural areas are maintained by services that are being eliminated rather than using hospitals and emergency room visits. Eliminating these services will do the reverse of the waiver's stated objective of avoiding hospitalization and higher cost care for persons in rural areas. In the Eastern Aleutian region, the cost of a Medevac (to the Emergency Room) is $68,000 per Medevac, if indeed it is possible and reasonable to send someone to an emergency room; in some cases, villages have been locked out for flight or medivac services due to weather for ten days or longer. Additionally, as Alaska has seen with Alaska Psychiatric Institute (API), it is not always possible to access a hospital when it is needed. Due to the access barrier at API, a clinical	people from meeting the criteria for category 2 services. Due to this adverse impact, Alaska Native/American Indian people should be exempt from the three ER/Hospitalization criteria. During in-person consultation the State asked that we propose alternative criteria that would mitigate this adverse impact. Below is a redraft of the criteria. Specifically, referral to the waiver service by a clinician, CHA/P or BHA/P is needed in order to create a way for Alaska Native and American Indian people to access these services. Ultimately, we think the most effective solution is to create an exemption for Alaska Native and American Indian people. Meet one or more of the following criteria: • One Inpatient psychiatric hospital stay • One ex parte for inpatient hospital stay (even if the hospitalization didn't occur) • One inpatient mental health or substance abuse general hospital stay; • One inpatient hospital medical/surgical, non-delivery, inpatient maternity delivery, and

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			decision that API is needed should be considered in lieu of an API admission. The drafted criteria would harm the tribal health system. It is counter to the intended purpose of enhancing the availability of mental health treatment and prevention services. Tribes agree that prevention is the key. Our vulnerable recipients need to have services as close to home as possible; this is the most cost-effective approach and ensures the best outcomes. Tribes are also concerned about Medicaid recipients who do well receiving services under the waiver: if their use of emergency and high intensity services is reduced, will recipients lose their eligibility for these waiver services?	other inpatient stay ○ Three Outpatient general hospital emergency room visits or similar clinic visits in locations that do not have ERs. ○ Three Behavioral Health Crisis Services (S9484 Crisis Intervention or H2011 Crisis Stabilization) provided by a BH Provider (including BHA/Ps) • Referral from primary care or medical home, including ER/Urgent care/specialist (not everyone has a primary care provider) • Positive screening on a behavioral health screening (PMD, GAD-7, etc.) and/or positive screening for suicidal ideation/intent (CSSR or PMD #9, for example) • Referral by Behavioral Health Clinician, Behavioral Health Aide/Practitioner or Community Health Aide/Practitioner • Referral by federal, state, or tribal court. Once initial eligibility for waiver services is met, recipients may continue to receive waiver services as long as is clinically necessary. Recipients will not lose eligibility while receiving a waiver service.

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6	17	Eligibility Group 2 – Diagnoses – • "A Diagnostic and Statistical Manual of Mental Disorders (DSM-5) mental disorder including bipolar disorder, depression, eating disorder, generalized anxiety disorders, obsessive-compulsive disorder, panic disorder, postpartum depression, post-traumatic stress disorder, psychotic disorders, or social anxiety phobia; or "	A partial list of example diagnoses could be construed as a limited set of diagnoses that are eligible. The DSM is updated regularly.	It would be clearer to remove the examples and simply require a DSM diagnosis. Change "DSM-5" to "the most current version of the DSM".
7	17, 19	Eligibility of Adults over age 64. Eligibility Group 2 – "The individuals in this target population are between 18-64 years of age and have:" Eligibility Group 3 – "This waiver proposal seeks to enhance the availability of and provide a more comprehensive continuum of substance use disorder treatment for adults, as well as adolescents and children enrolled in Medicaid in Alaska. The waiver will target individuals between 12 and 64 years of age who:"	Society in general, and especially Native cultures, take care of children and elders, yet elders would be excluded from waiver services. Although persons 65 and older are eligible for Medicare, Medicare will not cover the behavioral health needs of this population adequately: it covers only a limited array of behavioral health therapy services if these are delivered by a licensed clinical social worker or licensed psychologist. Although the new 1915(k) waiver services may be a valuable option for some, not all persons 65 and over will be eligible for these, and the existing state plan services such as comprehensive community support and case management, which do so much to address behavioral health needs of all adults in both rural and urban settings, are identified as state plan services to be deleted on page 53 of the application. Further, Medicare does not recognize rural services (CHA/P and BHA/P).	Remove the upper age limit for adults.

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			For much of the rural Alaska population, LCSW or licensed psychologist services are not available on a regular basis: Medicare simply does not cover the services that are available in rural areas During the in-person Tribal consultation, we heard that one concern related to the population 65 and older is cost. Cost for any age group is a concern in Alaska: however, we would submit that it will be costlier to the state to fund the services that will be required if basic behavioral health services are no longer covered by Medicaid for these individuals.	
8	18-19	Group 3 Eligibility Bullet 2 – "Meet the American Society of Addiction Medicine (ASAM) treatment criteria for addictive, substance-related, and co-occurring conditions definition of medical necessity."	The way this is worded, it looks like having a co-occurring condition is required to receive Group 3 services. As clarified by the State during in-person consultation, a co-occurring condition is not intended to be a requirement.	Delete the second bullet.
9	20-23	"Evidence based clinical assessment" and "comprehensive family assessment"	"Evidence based clinical assessment" and "comprehensive family assessments" do not actually exist. It is unclear how a family assessment and family treatment plan would work. How would it bill? Clarity is needed.	Provide a clear path for parents, caregivers, and other family members to receive services. Because no "evidence-based clinical assessment" or "comprehensive family assessment" exists, we recommend striking this language from 1115 Waiver Application rather than creating workgroups that create these

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				instruments. A simpler path would be: 1. Expand all current Medicaid-reimbursable services to include "Family" modifiers. 2. Allow a treatment plan be written based on the integrated assessment of any member of the family. 3. Allow the services called for in the family treatment plan be provided to any family member and reimbursable under the Medicaid number of the person with the integrated assessment. If this edit is not acceptable, then Tribes will require participation in workgroups for the identification or creation of "evidence-based clinical assessment" and "comprehensive family assessment."
10	20, 21, 23, 24, 53, 55	Screening, Assessment, and SBIRT Services	1. The waiver application provides that screenings, assessments, and SBIRT services would be covered for waiver recipients. It also states that universal screenings utilizing the Alaska Screening Tool will be phased out when the waiver is implemented. Taken together, this seems to mean that screenings, assessments, and SBIRT services will be covered only for the waiver population, and not for all Medicaid recipients under the State Plan. Limiting these services to waiver recipients makes no practical sense, would frustrate the	1. Cover screenings, assessments, and SBIRT services under the State Plan for all recipients, rather than limiting them to those eligible for waiver services. Revise the waiver application to clarify that Medicaid should cover screenings, assessments, and SBIRT services under the State Plan for all Medicaid recipients. 2. Work with Alaska Tribal Behavioral Health Programs to identify or develop culturally-appropriate screening and assessment tools.

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			waiver's purposes, and would be contrary to the public health. First, screenings and assessments are required in order to identify individuals who are eligible to receive waiver services. As a practical matter then, they must be provided before waiver eligibility is determined, and consequently they should be covered under the State Plan. Second, universal screening of all Medicaid recipients, not just those eligible for the waiver, is essential to achieve the waiver's stated goals of intervening early and providing recipients with the right service, at the right time, in the right setting. Finally, when a screening identifies the need for them, brief intervention and treatment services (SBIRT) should be provided immediately and on-the-spot, to protect the recipient. For all these reasons, screenings, assessments, and SBIRT services should all be covered under the State Plan for all Medicaid recipients, and not limited to the wavier populations. 2. It is important that screenings and assessments be culturally appropriate for our Alaska Native and American Indian recipients. 3. It is not always clear in the waiver application whether screenings and assessments will be administered by providers or by the Department or ASO. All screenings and assessments should be	3. Clarify that all screenings and assessments will be administered by providers, not by the Department or the ASO. 4. Permit providers to choose the assessment and screening tools they deem most appropriate for their patients, programs, and accreditation requirements. If a list of approved screenings and assessments is created, create a workgroup comprised of tribal and non-tribal providers to identify or create them. Include on the approved list any screenings and assessments that providers indicate they already use, or grandfather their use by those providers.

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			administered by the recipient's provider. In our face-to-face consultation, the Department stated this is its intent, but we ask that the waiver application be clear on this point. 4. There are a variety of screening and assessment tools available, and many providers have carefully selected those that best suit their patients and programs. The choice of screening and assessment tools should be left to the provider's professional judgment. If a list of approved tools is required, tribal and other providers should be involved in their selection. Tools currently used should be included and their use should be grandfathered for the providers who use them.	
11	21	Services – Group 1 "**Home-based family treatment services** are unique services proposed for this target population. Services include individual and family therapy, crisis intervention, medication services, parenting education, conflict resolution, anger management, and ongoing monitoring for safety and stability in the home. Two different levels of home-based family treatment would be offered: Level 1 home-based family treatment services are provided for children at moderate risk of out-of-home placement, and Level 2 home-based family treatment services are provided for children at high risk of out-of-home placement. Level 3 services would focus	Home-based family treatment services are a welcome addition and we support their addition to the 1115 waiver proposal. It appears, however, that the levels of home-based family treatment will prevent clinical judgment from determining the specific, individual services that a family might receive. It appears that these services would be required to be "bundled" and delivered to recipients by a single provider agency. Bundling services would preclude Tribal providers from offering specific services that might be called for based on clinical determination, if they do not provide all the services included in the "bundle." This would needlessly separate recipients from the tribal	We recommend eliminating the levels within this new service category, and allowing providers to use clinical judgment to determine which individual services should be included in treatment plans. We also recommend clarifying that home-based family services will not be a bundled payment, allowing multiple providers to provide services.

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		on family therapy. These home-based family treatment services are designed for children at high risk for residential placement – pre-residential treatment or post- residential treatment."	providers who are most familiar with their needs and best able to provide culturally-competent care. It would also be costly to the State, since most services furnished by tribal providers are reimbursed at 100% FMAP. For these reasons, we recommend eliminating the levels within this new service category, and allowing providers to use clinical judgment to determine which individual services should be included in treatment plans. The levels of home-based family treatment services are not clear. The home-based service need should be clinically driven. The three levels do not seem to have clinical rationale.	
12	21, 23	Services – Group 1 – "**Mental health day treatment** services are outpatient services specifically designed for the diagnosis or active treatment of a mental disorder when there is a reasonable expectation for improvement or when it is necessary to maintain a child's functional level and prevent relapse or full hospitalization. Mental health day treatment will be based on the ASAM Patient Place Criteria Level 2.5." Services – Group 2 –"Mental health day treatment for adults will also use the ASAM Patient Place Criteria Level 2.5."	ASAM is not an appropriate criterion for day treatment eligibility. The American Society for Addiction Medicine (ASAM) Criteria are level of care guidelines that recognize six dimensions relevant to the successful treatment of individuals with substance use (or co-occurring substance abuse and mental health) disorders. They are not guidelines for mental health treatment. Reference to ASAM under mental health-only services is inappropriate and should be removed.	Remove ASAM criteria from service description.

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13	21, 23, 24	Waiver service eligibility post successful intervention.	The waiver application proposes to provide specific services to each of three target populations. It is not clear what will happen if a recipient begins receiving a service and the successful intervention results in loosing eligibility. Examples include, but are not limited to, Intensive Case Management, ACT and Community and Recovery Support services. Tribal behavioral health providers have explained that eliminating these services to those individuals who no longer meet the waiver eligibility criteria (e.g. 3 or more acute intensive services in the past year) is not practical and does not make sense if the service helps the recipient avoid relapse and prevents future inpatient hospital admission, and also saves costs. It is counter-intuitive and counter-productive to stop providing waiver services to recipients who respond well to them.	We recommend that the waiver continue to cover these services for recipients who have improved to the point that they no longer meet eligibility criteria, in order to prevent future readmissions to hospitals and save costs. Add to the waiver: Once initial eligibility for waiver services is met, recipients may continue to receive waiver services as long as is clinically necessary. Recipients will not lose eligibility while receiving a waiver service.
14	22	Services – Group 1 – "**Therapeutic foster care** is a new service unique to this target population that will be made available for youth who are in state custody or foster care. These services are clinical interventions that include placement in specifically trained foster parent homes for children ages 0-18 who are in foster care or in the custody of the juvenile justice system and have severe mental, emotional, or behavioral health needs. Therapeutic foster care includes medically necessary	The service description includes additional eligibility criteria – children in state custody and foster care. This service is presently available to children who are not in state custody or already in foster care. This waiver service should also be available to children who are in DJJ custody, OCS custody, tribal custody, foster care, parent or guardian care, or voluntary kinship placements. Clinical delivery of care is not typically what would happen in a foster home. There are not	Require connection to cultures as part of the delivery of foster care. Define eligibility as: Children who are in DJJ custody, OCS custody, tribal custody, foster care, parent or guardian care, or voluntary kinship placements.

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		treatment interventions based on an individualized treatment plan guided by a state-selected level of care assessment tool. Services include individual and family therapy, medication services, crisis services, and care coordination. "	too many therapeutic foster parents who can provide the services listed. "Therapeutic Foster Care" is appears to describe a bundled Behavioral Health services, this time including compensation for room, board, and supervision of the service recipient by a foster family. It is important to acknowledge that the foster family is rarely, if ever, the provider of "individual and family therapy, medication services, crisis services, and care coordination." Therefore, this service is an attempt to include currently separated services into one new service. This approach puts Tribes at a distinct disadvantage because it favors those agencies that already have licensing capabilities for "foster homes". The term "foster care" has historically negative connotations for Tribal people and therefore Tribes do not currently have this capability, nor do they want to. Changing the way this service is named and referenced will be an important first step in getting Tribal involvement in the out-of-home care of children. Until those changes are made, and "foster care" is renamed and re-conceptualized, there will be a gap where this service will only be provided by non-Tribal agencies. These agencies will also provide the currently separate services of "individual and family therapy, medication services, crisis services, and care coordination." As some of	Include respite services for resource families. Include kinship providers. Design an unbundled service such that clinical behavioral health work can be provided by a T.H.O. for tribal recipients. Rename this service omitting the word 'foster'. Perhaps Therapeutic Family Care. We suggest gathering input from THOs and providers on the new name.

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			these services could be provided now by Tribes, it will cost the State more money to bundle them into a service provided by a non-Tribal agency than if the State allowed for separate billing of services. A "bundled" service provided by a non-Tribal agency will also cut off the connection to the natural, culturally-competent treatment provider that the child should return to once "foster care" ends.	
15	22, 23	Services Group 1 and 2 – **"23-hour crisis stabilization services** will also be made available for children and adolescents in crisis. These are services for up to 23 hours and 59 minutes of care in a secure and protected environment. The program is clinically staffed, psychiatrically supervised, and includes continuous nursing services. The primary objective is for prompt evaluation and/or stabilization of individuals presenting with acute symptoms or distress. Services include a comprehensive assessment, treatment plan development, and crisis intervention services necessary to stabilize and restore the individual to a level of functioning that does not require hospitalization."	We support this service to be provided across all three of the waiver's target population groups. This can be accomplished by including telemedicine and Behavioral Health Aides/Practitioners (BHA/P) as a mode of service delivery and reimbursement. Unless this is changed it will be extremely difficult for Alaska Native and American Indian people to access this service in the Alaska Tribal Health System. There are very few psychiatrists in Alaska and fewer still in Alaska Native villages and likely none in very remote locations. Psychiatric services are capably furnished by other providers like BHA/Ps and by telemedicine. Tribal behavioral health providers have also expressed concerns about the continuous nursing services requirements, which would make it impossible to furnish this service in rural and remote locations. We also note that, in certain locations and instances, a jail or detention facility may be the safest and only location to provide this service.	1. In order for eligible Alaska Native and American Indian peoples to have adequate access to waiver services we recommend that the waiver add and specify that telemedicine and distance delivery are acceptable methods of psychiatric supervision. 2. We further recommend that the waiver be amended to include additional professionals who can furnish psychiatric supervision (psychiatric nurse practitioners and physician assistants, behavioral health professional clinicians, and BHPs). 3. In order to address the very rural and remote situations of Alaska Native villages, we recommend that the waiver be amended to allow and include that CHA/P and BHA/P services meet the "continuous nursing" requirement.

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16	22, 23, 25	Services – Groups 1, 2, and 3 – "**Residential treatment services** will be modified based on clinical standards aimed at shortening lengths of stay due to the availability of new step-up and step-down services."	While the waiver aims to create new services levels that will be appropriate step-up and step-down services, this will be a challenge in Alaska's many small and remote communities. Many of the services described in the waiver might be possible in urban locations but will not be possible in the hundreds of village communities across Alaska during the 5-year demonstration. This is a situation unique to Alaska given the small size of villages and the distance between villages and hubs, which most often requires air travel. This creates a unique problem if lengths of stays in residential care are limited and 'step-down' services are not available in small home communities.	Alaska Native people will be adversely impacted by reductions to lengths of stay because it is not possible for appropriate step-up and step-down services to be developed in all local villages during the 5 years of the 1115 demonstration. Due to this adverse impact, exempt Alaska Native people and THOs from length of stay limits. Thank you for clarifying during in-person consultation that the actual length of stay for all individuals receiving residential care will be based on a clinical determination of medical necessity. Lengths of treatment should be clinically determined. We recommend adding the following statement to the 1115 to provide this clarity: "Actual length of stay for all individuals receiving residential care will be based on a clinical determination of medical necessity" Savings realized through reduced residential care should be based on decreasing the number of people needing residential care by creating step-up and step-down services. Calculate savings for cost neutrality based on reducing the number of people in residential care, not the length of residential stays.

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17	22, 23, 24, 25	Services – Groups 1, 2, and 3 – **23-hour stabilization and residential programs** are described as 10-15 bed facilities	There are existing residential programs with fewer than 10 beds. Requiring a minimum of 10 beds does not allow these services to be provided in smaller communities where the population demand and/or existing facilities are less than 10 beds. Allow each community to provide these services and be reimbursed regardless of the number of beds. Allowing each community to provide this service as locally as possible (without a minimum bed requirement) will save Medicaid travel costs for transporting to larger hub communities.	Delete "10-15 beds"
18	23	Services – Group 2 – "**Assertive Community Treatment (ACT)** services are unique to this target population. ACT services are designed to provide treatment, rehabilitation, and support services to individuals who are diagnosed with a severe mental illness and whose needs have not been well met by more traditional mental health services. The ACT team provides services directly to an individual that are tailored to meet his or her specific needs. ACT teams are multi-disciplinary and include members from the fields of psychiatry, nursing, psychology, social work, substance abuse treatment, and vocational rehabilitation. Based on their respective areas of expertise, the team members collaborate to deliver integrated services of the recipients' choice, assist in	The typical ACT model will be challenging to create in rural/smaller population areas. In order to deliver this service successfully, it will need to be modified to include distance delivery, local provider types and flexibility on the hours of the services (24-hour would not be possible in many small communities). The ACT model is designed specifically to help overcome patient deficits in trust, relationship and the overall process of engaging in health services by reaching into the community to make connections. The ACT team caters to a patient population that's often unable to navigate traditional health service systems due to reduced cognitive capacity or an inability to perceive reality accurately. These cognitive challenges affect a patient's ability to provide accurate history often leaving the ACT	Continue to furnish this service to waiver recipients who improve to the extent that they no longer meet waiver criteria. Include in the waiver that modified ACT teams will be supported in rural areas. By nature of the intervention, delivery of an ACT service should not have eligibility criteria.

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		making progress toward goals, and adjust services over time to meet recipients' changing needs and goals. The staff-to-recipient ratio is low (one clinician for every 10 recipients), and services are provided 24 hours a day, seven days a week, for as long as they are needed."	team with very limited information, particularly at initial engagement. For these reasons, the ACT team eligibility should not be based on number of ED visits (information that will neither be knowable or meaningful at time of enrollment) and instead should be based on functioning, homelessness, or the presence of significant cognitive impairment. The ACT model does not include checking 'eligibility'. Rather an ACT team should have no barriers or obstacles. ACT customers do not 'enroll' in the ACT service. The ACT service should include frequent in person interactions over time to build relationship, trust and motivation in further engagement with the behavioral health system. Given this model, the eligibility criteria are problematic to the ACT model. All Medicaid eligible people in need of the ACT team should be reimbursed without barrier.	
19	23	Services – Group 2 – "the state plans to offer Group 2 **mobile crisis response services**, **23-hour crisis stabilization services,** and **continue residential treatment services** (modified to clarify clinical standards aimed at shortening lengths of stay due to the new step-up and step-down services)."	We learned in tribal consultation that adult mental health residential services are not included in the early stages of the1115 waiver services, but will be built out as there are system savings to reinvest. There is a reference to adult mental health residential services in the waiver application itself. Adding capacity for adult residential mental health services is a crucial need given extremely limited access to API. Even if this service will be phased in, we recommend including adult mental health residential in the waiver service package.	Add adult mental health residential services to the waiver.

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20	23-25, 29	Services – Group 3 Service compendium Table 2 – Proposed Alaska SUD Services by ASAM Level of Care	Many ASAM levels are missing, for example, 1.0 (non-MAT services), 2.5, 3.4, and 3.7). How are SUD ASAM levels not listed in this table reimbursed if they are not included in the waiver service package and the Comprehensive Community Support Services under which these services are currently reimbursed are deleted? The ASAM Criteria is a standardized conceptualization of levels of care based on the evaluation of six dimensions of a person's life. It is intended help the addiction professional determine the least restrictive environment of care that a person requires for successful addiction recovery. It is not a list of services or a specific treatment approach. Within the 1115 Waiver application, the term "ASAM Criteria" seems to be used as a description of services or a specific treatment approach. It appears that the intention of this 1115 Waiver application is to create new service/CPT codes that are "bundles" of currently separate, individual services. We believe this is a mistake. There are currently a number of Tribal providers with the capacity to provide some of the separate, individual services who might not be able to provide the new "bundled" service. While the intention of the Waiver might be to encourage providers to create full "bundled" services, the result will be either a gap in services while Tribal agencies adjust their programs (hiring and	Clarify that all appropriate SUD services are available to Target Group 3 recipients including the appropriate service for all ASAM levels. In order to remain faithful to the ASAM Criteria and its suggestions, references to it throughout the 1115 Waiver application need to be removed, or reviewed and edited. The Tribal Behavioral Health system does not recommend that the State use the ASAM levels of care as "bundles of services". Reference is made within the ASAM Criteria of using the guidelines with managed care organizations. This section should be reviewed by State staff prior to submitting the 1115 Waiver application. Substance abuse treatment providers, Tribal as well as non-Tribal, should be able to use the ASAM Criteria as intended to create treatment plans based on individual service provision, not "bundles".

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			retaining providers is already difficult for Tribes based on remote locations) or non-Tribal providers with more options will step in and take over the services previously provided by the Tribal provider. This will require the State to pay the Medicaid match for Tribal members who access services through non-Tribal agencies, ultimately costing the State more money. Maintaining the current model of billing for services provided allows Tribes to be part of a continuum of care which includes non-Tribal community providers.	
21	24	Services – Group 2 – "**Peer-based crisis intervention** services are services provided in a calming environment by people who have experienced a mental illness or substance use disorder and are designed for individuals in crisis. They are delivered in community settings with medical support and can be used in the event that there is a wait list for services."	Rural Alaska communities are staffed primarily by CHA/Ps who are the only medical responders to local emergencies. CHA/Ps may provide crisis intervention services for days or weeks in the health clinic or jail when the weather is bad and planes cannot make it into the community.	Medical support should include CHA/Ps so that the service can be possible in a smaller or more rural location.
22	24-25	Group 3 Services	There is often a need for 23-hour crisis stabilization services for Group 3. For example, suicidal people who are intoxicated would need this service.	Add 23 hour crisis stabilization to the services available to Target Group 3.
23	25	Services - Group 3- "**Medication-Assisted Treatment (MAT)** (ASAM Level 1.0) service will include injectable Naltrexone or any other medication that is currently approved with consultation with the state Medicaid pharmacist for alcohol and opioid abuse."	The intent of "consultation with the state Medicaid pharmacist" isn't clear. Requiring a consult with the state's pharmacist would create an unneeded bottle neck in the prescribing processes.	Delete the phrase "with consultation with the state Medicaid Pharmacist for alcohol and opioid abuse.

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24	25	Services – Group 3 – "MAT Services would also include **MAT care coordination** services, which is the deliberate organization of patient care activities between two or more participants involved in a patient's care to facilitate the appropriate delivery of integrated SUD and primary health care services. The patient must be in attendance. Care coordination involves a team that provides a wide range of services addressing patients' health needs, including medical, behavioral health, social, and legal services, as well as long-term supports and services, care management, self-management education, and transitional care services."	MAT care coordination is a valuable service and we are glad to see this in the waiver. We have two concerns: 1. There is growing evidence that MAT alone as an intervention is beneficial even without behavioral health treatment. The waiver should allow but not require MAT care coordination. 2. The description requires that "the patient must be in attendance" for MAT care coordination. MAT care coordination is needed and, like other care coordination services, can effectively occur with or without the patient in attendance.	1. In the phrase "MAT Service would include MAT care coordination" replace 'would' with 'could'. 2. Delete the sentence "The patient must be in attendance"
25	31	Waiver goals and objectives – "1. Develop community-based, culturally appropriate behavioral health workforce capacity (i.e., implement additional Medicaid-reimbursed behavioral health provider types) to address existing workforce deficits."	One of the waiver's cross-cutting goals is to develop the capacity for a community-based and culturally-appropriate behavioral health workforce. The most effective strategy to do this in the waiver is to build on the success of CHA/P and BHA/P programs and to also to include traditional healers as eligible service providers and allow their services to be reimbursed. In 1978, with the passage of the American Indian Religious Freedom Act, the Indian Health Service (IHS) policy required their programs and staff to comply with requests by patients seeking the services of traditional healers, to provide a private space to accommodate the services, and to be respectful of a person's religious and native	1. We recommend the Waiver be amended to specify that new services offered under the Waiver may be provided by Community Health Aides/Practitioners and Behavioral Health Aides/Practitioners providers as long as they meet general applicable requirements as determined by their certification by the CHAPCB; 2. Tribal health providers should not be subject to ASO provider certification or credentialing requirements. 3. Workforce medical providers should include the following: • Physician (MD/DO)/Nurse

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			beliefs. In 1994, IHS updated the policy indicating that IHS would facilitate access to traditional medicine practices, recognizing that traditional health care practices contribute to the healing process and help patients maintain their health and wellness. The Indian Health Care Improvement Act (U.S. Code Title 25 Chapter 18) contains several sections noting the acceptance and respect for these practices, with requirements to incorporate them into various preventative service categories, including behavioral health services and treatment. In recognition of this authority, both Arizona and New Mexico have included and authorized traditional healers to provide services and be reimbursed under 1115 waiver authority.[1] [2]	• Practitioner/Physician • Assistant/Community Health Aide/Practitioner (under support of MD/DO) • Masters Level/Psychologist – Licensed Clinical Social Worker, Licensed Professional Counselor, Licensed Psychological Associate, Licensed Marriage and Family Therapist, PhD, PsyD • Paraprofessional – Behavioral Health Case Manager/Behavioral Health Technician - Unlicensed providers working under the supervision of Masters Level Clinician, • Chemical Dependency Counselor • Behavioral Health Aide/Practitioner – under support of Masters Level Therapist We recommend that the waiver include services and support reimbursement for Traditional healing services provided in, at, or through Indian health facilities operated by Tribal organizations under the Indian Self-Determination and Education Assistance Act (P.L. 93-638).

[1] https://www.azahcccs.gov/AmericanIndians/Downloads/Consultations/Meetings/2016/TraditionalHealingWaiverLanguage.pdf
[2] http://www.molinahealthcare.com/members/nm/en-US/hp/medicaid/centennialovw/coverd/services/Pages/traditional.aspx

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				Peer Support – Under the new certification and regulations being drafted for peer support billing.
26	33	Waiver goals and objectives 2.5 "Partnership with Administrative Service Organizations. Health outcomes will be improved through earlier interventions and better coordination of care and the system will, by the end of the demonstration, be managed based on health outcomes supported by real-time data collection and reporting. The ASO will be required to work closely with Tribal Health Organizations, honoring the unique government-to-government relationship of Tribes with the State of Alaska." "2.7 Quality and performance measures."	The waiver describes how DHSS will contract with an Administrative Services Organization (ASO) to manage the service delivery reform efforts described in the waiver. During the Tribal consultation session held on December 20, 2017, DHSS also explained that it will contract with the ASO for all publicly- funded behavioral health services administered by the Department, including both waiver and non-waiver Medicaid services. The Alaska Tribal Health System (ATHS) has previously communicated its concerns about the State's partnership with an ASO (See ANHB RFI Comment Letter dated March 30, 2017; and "Tribal ASO Discussion Matrix" dated August 29, 2017 previously provided to the State at the Pre-Consultation Meeting on August 31, 2017). We attach those materials and specifically incorporate them here by this reference. The ATHS continues to request that DHSS exempt ANs/AIs eligible for the waiver services from mandatory enrollment into the ASO, and that they continue to be allowed to receive all waiver and state plan services from any qualified tribal or non-tribal provider. Such an exemption recognizes the significant AN/AI behavioral health disparities that are	1. We recommend that the State exempt Alaska Native/American Indian (AN/AI) people from auto-assignment to the ASO, and that it continue to allow them to receive all waiver and state plan services from any qualified tribal or non-tribal provider. 2. We recommend that the State exempt tribal health providers as defined under the Indian Health Care Improvement Act from enrollment, licensing, certification, and credentialing requirements managed by the ASO. 3. The ASO's compensation for data collection, care management, and health outcomes managed by the ASO should be tied to its success in reducing the administrative burden to behavioral health providers. 4. The ATHS recommends that the waiver clearly describe that the State will continue its government-to-government responsibility with Tribes in managing the Medicaid program; and it will continue to consult with Tribes on those responsibilities that will be assigned to

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			explained in the waiver and recognizes the importance of the Alaska Tribal Health System that provides culturally appropriate care through its regional referral networks. This is critically important since the full scope of responsibility that will be assigned to the ASO is not known at this time; nor will it likely be known when the waiver is submitted to CMS. Tribal health providers cannot support this process without understanding the full breadth of what this change will mean on Alaska Native/American Indian beneficiaries and the providers that serve them. It is noted that the waiver indicates that, at a minimum, all waiver services would be coordinated, authorized, and managed by the ASO. Consequently, CMS's Medicaid Managed Care Rules and CMS managed care policies come into play. These rules—and in related informational bulletins on the subject—CMS has made clear that States have the option to exempt Alaska Native/American Indian from mandatory managed care, "in light of the special statutory treatment of Indians in federal statutes concerning Medicaid managed care." Exempting AN/AIs from mandatory enrollment in the ASO, and allowing their care to continue to be coordinated and arranged by the ATHS, is supported by a number of federal laws and long-standing CMS policies that recognize the importance of ensuring that AN/AIs have access to culturally appropriate services furnished by tribal health programs	the ASO. Neither of these responsibilities may be delegated to the ASO.

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			focused on their unique needs. It is also supported by CMS's recognition of Indian health providers as a unique provider and facility type, and reimbursement for the services they provide in approved uncompensated care waivers in AZ, CA, and OR. Any Section 1115 Demonstration Waiver must be "likely to assist in promoting the objectives" of the Medicaid statute. We are concerned that unless exemptions are made for the ATHS, the waiver will not advance the objectives of the Medicaid statute with regard to Indian health. It is noted that Congress authorized IHS and tribal health care facilities to access the Medicaid program through Section 1911 of the Social Security Act in order "to enable Medicaid funds to flow into IHS institutions" (H.R. Rep. 94-1026 at p. 20). It was intended "as a much needed supplement to a health care program which for too long has been insufficient to provide quality health care to the American Indian" (H.R. Rep. 94-1026 at p. 21). We are concerned that eligibility criteria such as requiring three inpatient stays will limit access to waiver services for the patients we serve who do not have the same access to hospital services as others in the State. We are equally concerned that an ASO with no background in the ATHS will seek to impose care coordination and prior authorization	

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			requirements that are inconsistent with the ATHS' proven methods of coordinating care through our integrated health care delivery system. Unless exceptions are made, these and other requirements in the waiver will reduce access to Medicaid resources by the ATHS compared to other providers in the State.	
27	34	"2.6 As part of the implementation process, Alaska DHSS will require that all providers of behavioral health and SUD services meet specified criteria, including ASAM requirements, prior to participating in the Medicaid waiver program."	"ASAM requirements" isn't clear. ASAM is a clinical assessment tool, not a provider requirement. Furthermore, ASAM is not applicable to mental health services for target groups 1 and 2.	Delete the phrase "including ASAM requirements".
28	41	**8. "If fee-for-service payment will be made for any services, specify any deviation from State plan provider payment rates. If the services are not otherwise covered under the State plan, please specify the rate methodology."** 9. "Payment methodologies under this waiver will be consistent with those approved in the State plan. If any changes are made to State plan payment methodologies, waiver payment methodologies will also be updated"	The waiver would allow or require many services to be provided in a recipient's home or other community settings. We agree this will improve both access to care and outcomes for many patients. But under a recent clarification by CMS, the Medicaid clinic benefit excludes services provided outside a clinic's "four walls," which means that tribal clinics cannot be reimbursed for them at the applicable encounter rate after January 2021. To address this place of service limitation, Alaska Tribal Health Providers are evaluating the possibility of reenrolling as FQHCS under a State Plan Amendment that would adopt the encounter rate for tribal FQHC services. However, regardless whether such a SPA is adopted, tribal providers should be reimbursed at the encounter rate for their services, whether they are furnished within the facility's four walls, or offsite at the	Include FQHCS as authorized providers of waiver services. Seek waiver authority to allow payment at the encounter rate for offsite services, whether furnished by a tribal clinic, tribal FQHC, or other specified tribal provider type.

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			patient's home, school, or other appropriate location.	
29	42	"Impact of Demonstration on Delivery System **10. If quality-based supplemental payments are being made to any providers or class of providers, please describe the methodologies, including the quality markers that will be measured and the data that will be collected.** The state is considering use of a fixed price incentive contract for the ASO procurement, which would allow the state to quantify ASO performance in terms of costs and services and/or deliverables. If this happens, the ASO will pass those performance incentives on to providers over the course of the waiver, once provider infrastructures are developed."	Any reimbursement structure needs to include full payment in the initial payment amount. Providers cannot sustain delayed reimbursement.	Any incentive payments should supplement Medicaid encounter rate payments and not delay the full encounter rate payment.
30	43	"The Department is considering a three-year phase in plan to implement services included in this demonstration proposal. DHSS will seek further stakeholder input and request CMS guidance on the implementation plan."	New waiver services need to be available to all regions. No region should have services that are not available to others. At this point, it is highly unlikely that service providers have the capacity to furnish these services. There is concern that providers will be penalized for not furnishing services.	We encourage implementation of services equally across the regions to the extent this is possible. The tribal health system will gladly participate in the development process.

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31	43, Reference C	Regions	Given the geographical size and remote nature of Alaska, the Waiver proposes to divide the State into 9 or 14 regions whose hub communities will serve as geographical centers for the provision of services. The regions will be organized by population size, so that each region has a population of at least 20,000 and considers Tribal hubs/hospitals; and transport and referral patterns across the state for all providers and hospitals. The ATHS is an established affiliation of Tribal health organizations that provide health care to over 153,000 Alaska Native/American Indian people throughout Alaska. The ATHS is a diverse and multifaceted health care delivery system that has evolved over the last 30 years. The ATHS has its own service delivery regions that include 180 small community primary care centers in village clinics, 25 sub-regional mid-level care centers, 7 multi-physician health centers, 6 regional hospitals, and tertiary care provided by the Alaska Native Medical Center. This system is interconnected via an established and sophisticated referral system through each of the Tribal regions. Tribal health organizations are concerned that the waiver's proposed regions will not align with the established Tribal service delivery regions and system of referrals and will disrupt care provided to patients. It is very important that the Waiver's proposed regions	The ATHS recommends that the waiver's proposed regional system correspond to tribal health system regions or Treat the ATHS as one state-wide region in recognition of the ATHS' uniqueness as a tribal health provider that contracts to carry out health programs from the federal government under the Indian Self-Determination and Education Assistance Act.

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			be aligned with the Alaska Tribal Health System to avoid any disruption in patient care.	
32	43	"The Department is considering a three-year phase in plan to implement services included in this demonstration proposal. DHSS will seek further stakeholder input and request CMS guidance on the implementation plan."	New waiver services need to be available to all regions. No region should have services that are not available to others. At this point, it is highly unlikely that service providers have the capacity to furnish these services. There is concern that providers will be penalized for not furnishing services.	We encourage implementation of services equally across the regions to the extent this is possible. The tribal health system will gladly participate in the development process.
33	47-48	"Residential SUD treatment services: Alaska also seeks expenditure authority under Section 1115(a)(2) of the Social Security Act to claim expenditures made by the state for services not otherwise covered or included as expenditures under Section 1903 of the Act, such as services provided to individuals residing in facilities that meet the definition of an Institution for Mental Disease (IMD), and to have those expenditures regarded as expenditures under the State's Title XIX plan. Alaska Psychiatric Institute services: • Alaska also seeks expenditure authority	We would welcome the elimination of the IMD restriction for services under both the Medicaid state plan and the 1115 waiver.	Specify that services for individuals covered by both the state plan and the 1115 waiver can be regarded as expenditures under the State's Title XIX plan.

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		under Section 1115(a)(2) of the Social Security Act to claim expenditures made by the state for services not otherwise covered or included as expenditures under Section 1903 of the Act, such as services provided to individuals residing in facilities that meet the definition of an Institution for Mental Disease (IMD), and to have those expenditures regarded as expenditures under the State's Title XIX plan."		
34	53	"The following services will be deleted from the state plan array of behavioral health services: Behavioral rehab services H0018 Case Management services T1016 Recipient support services H2017 Comprehensive Community Support Services H2015 & HQ Therapeutic behavioral services H2019, HR, HQ, HS Alaska screening tool T1023 Client Status review H0046 "	Many existing Behavioral Health Services will be deleted from the state plan per page 53 of the waiver application and these are not adequately replaced by waiver services. Examples of services that will be terminated and not replaced by waiver services include: Children: We do not have clarity on the eligibility criteria for group 1. It is unclear if the four bullets on page 16 are each 'or' statements or if multiple bullets must be met in order for a child to be eligible for group 1 services. If the criteria are NOT 'or' statements, we are concerned that the following services will be terminated per page 53: Children and Adolescents: • All skill building, case management, clinical associate led groups and other clinical associate interventions provided	Add the following sentence to page 53 of the Waiver: Services listed will not be eliminated until appropriate new services for the non-waiver population are added to the state plan.

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			under a treatment plan. This includes programs like Southcentral Foundation's TRAILS youth program and services offered to support children in school. • Residential treatment for both children and adolescents who do not meet the waiver criteria and for those who receive residential services in a facility that has fewer than 10 or more than 15 beds. Adults: The reactionary nature of the Group 2 criteria (interventions post 3 acute intensive services) raises concern about adult services listed on page 53 such as: • SCF's Quyana Clubhouse – adult services including therapy, groups and clinical associate led skill building, along with. Group and non-clinician individual Comprehensive Community Support Services, are listed on page 53 as going away. • Outpatient therapy – Group Comprehensive Community Support Services are often part of a treatment plan in outpatient therapy and are commonly led by clinical associates. Adolescents and Adults with SUD (Group 3): Some, but not all ASAM levels are included in the waiver. Unless all ASAM levels are added	

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			the following services, all Comprehensive Community Support Services, would go away per page 53: • All services delivered by chemical dependency counselors • All services delivered by clinical associates • All groups led by CDCs and CAs.	
35		Communication	What is the public process for notifying recipients of the new waiver services and eligibility?	Partner with the ATHS on a communication plan for Alaska Native/American Indian recipients.

Conclusion

ANTHC feels strongly that any Section 1115 Demonstration Waiver must be "likely to assist in promoting the objectives" of the Medicaid statute. We are concerned that unless exemptions are made for the ATHS, the waiver will not advance the objectives of the Medicaid statute with regard to Indian health. Congress authorized IHS and tribal health care facilities to access the Medicaid program through Section 1911 of the Social Security Act in order "to enable Medicaid funds to flow into IHS institutions." (H.R. Rep. 94-1026 at 20.) Medicaid funds were intended "as a much needed supplement to a health care program which for too long has been insufficient to provide quality health care to the American Indian." (H.R. Rep. 94-1026 at 21.) We are concerned that eligibility criteria such as requiring three inpatient stays will limit access to waiver services for the patients we serve who do not have the same access to hospital services as others in the State. We are equally concerned that an ASO with no background in the ATHS will seek to impose care coordination and prior authorization requirements that are inconsistent with the ATHS' proven methods of coordinating care through our integrated health care delivery system. Unless exceptions are made as we have recommended, these and other requirements in the waiver will reduce access to Medicaid resources by the ATHS compared to other providers in the State.

Thank you again for the opportunity to comment on this important 1115 waiver proposal. Please know that, despite the concerns we have expressed here, we recognize and appreciate the Department's sincere and significant efforts to develop the 1115 waiver application to respond to Alaska's behavioral health needs. Please do not hesitate to contact me if you should have any questions at (907) 729-1908 or by email gmoses@anthc.org.

Sincerely,

Gerald Moses
Senior Director of Intergovernmental Affairs

cc: Valerie Davidson, DHSS Commissioner
Jon Sherwood, DHSS Deputy Commissioner
Karen Forrest, DHSS Deputy Commissioner
Randell Burns, Director Behavioral Health, DHSS
Gennifer Moreau-Johnson, Division of Behavioral Health, DHSS
Renee Gayhart, Tribal Health Program Manager

Attachments:
March 30, 2017 ANHB ASO/RFI Comment Letter
August 29, 2017 Tribal ASO Discussion Matrix

Alaska Native Health Board

THE VOICE OF ALASKA TRIBAL HEALTH SINCE 1968

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March 30, 2017

SENT VIA: Jon.Geselle@alaska.gov

Dear Mr. Geselle:

Established in 1968, Alaska Native Health Board (ANHB) serves as the statewide voice on Alaska Native health issues. ANHB is a 28-member representing tribes and tribal organizations carrying out health services on behalf of the 229 federally recognized Tribes in Alaska, and works on behalf of over 158,000 Alaska Native People. ANHB's purpose is to promote the spiritual, physical, mental, social and cultural well-being and pride of Alaska Native people. As the statewide tribal health advocacy organization, ANHB assists tribal partners, state and federal agencies with achieving effective communication and consultation with tribes and their tribal health programs.

On behalf of ANHB, we are writing to provide recommendations on the Department of Health and Social Services (DHSS) request for information to create an Administrative Services Organization as part of Alaska's Medicaid program. SB 74 requires the Department to develop and implement a comprehensive redesign and reform of the State's behavioral health system.[1] An integral part of this transformation is the development of an 1115 Demonstration Waiver and a contract with an Administrative Services Organization (ASO) to manage a comprehensive behavioral health system.

Background

In response to the above requirements, the State submitted to the Centers for Medicare & Medicaid Services (CMS) the "1115 Behavioral Health Waiver Demonstration Project Concept Paper" that explains DHSS' intent to contract with an ASO to manage a number of requirements that fall under the Department's responsibility. The Concept Paper explains that the ASO may oversee access to behavioral health screening and interventions, treatment and recovery supports, support integration efforts through coordination of care, and network development—while also ensuring continued access to appropriate specialty behavioral health care. In addition, the paper also explains that the ASO may be responsible for utilization management, claims processing, network management and provider recruitment, quality and data management, and cost management or containment.

[1] AS 47.07.036(f)

Managed Care/Potential ASO Challenges

On February 1, 2017, ANHB sent a letter to the Department, explaining that Tribes were very concerned about transferring this broad authority to an ASO. Tribes are concerned that transferring many of Alaska's single state agency responsibilities will affect Alaska Native and American Indian (AN/AI) access to behavioral health care as well as impact the Alaska Tribal Health System (ATHS) that is responsible for providing behavioral health care to our Tribal population. An "ASO" is not a defined term in the Medicaid program, and not all ASOs are necessarily subject to federal rules for Medicaid managed care entities. However, it appears that DHSS intends the ASO to administer what is essentially a behavioral managed care system, albeit one where the ASO would not be paid on a capitated basis and would not incur direct financial risk for the Medicaid services it administers. [See generally, 42 CFR 438] We believe strongly that managed care of any type–especially by an entity that is likely to be unfamiliar with Alaska, Alaska Natives and American Indians (AN/AIs), and the Alaska Tribal Health System (ATHS)—threatens Indian health programs' access to Medicaid resources and is very likely to pose barriers to AN/AI participation in the Medicaid program.

Medicaid managed care has not succeeded in Indian country and is not likely to work in Alaska unless the role of the ASO is clearly defined and DHSS consults with Tribes over these matters. Medicaid managed care—including ASOs—have little to no familiarity with the Indian health system and routinely disregard the rights of AN/AIs and Indian health providers under the Medicaid statute, the Indian Health Care Improvement Act (IHCIA), and other federal law. This lack of familiarity has been the experience of Tribes in the lower 48 states and the ATHS does not expect it to be different in Alaska. The experience in the lower 48 has found that AN/AIs find it difficult to access Indian health care providers in managed care settings, managed care entities impose administrative requirements that impact timely access to care, and Indian health care providers (IHCPs) routinely have difficulties being reimbursed by managed care entities and the Medicaid program. We underscore the importance of conducting Tribal consultation prior to the responsibilities of the ASO being finalized into a procurement for services.

Exempt ATHS from ASO Responsibilities

In light of the experience that AN/AI beneficiaries and IHCPs have had with managed care organizations, we recommend that DHSS exempt AN/AIs and IHCPs from the responsibilities of an ASO in Alaska's behavioral health system. We respectfully request that the State continue the current behavioral health system for AN/AIs and fee for service arrangements for IHCPs that are in place today. We feel strongly the strategies that an ASO will utilize to control costs and improve quality can best be carried out by working directly with ATHS and not a third- party entity that does not understand or know our patient population or the ATHS.

We also recommend that if the ASO will be paid for any care coordination activities associated with patients that it will manage, that similar payment arrangements be extended to the ATHS. The RFI discusses a number of different initiatives that are required

under SB74 and gives an impression that the ASO would be contracted on a narrow basis at first (behavioral health), and over time its responsibilities could be expanded and aligned with the Coordinated Care Demonstration Project (CCDP), Primary Care Case Management (PCCM) program, or other SB74 care initiatives. We recommend that similar opportunities within these programs be extended to the ATHS and not be contracted solely through an ASO.

Tribes believe that there is good justification and precedent for our request to exempt AI/AN beneficiaries and IHCPs from the ASO process. In order for a State to mandatorily enroll Indians into any form of managed care (in this case an ASO) it must obtain approval from CMS either through a State Plan Amendment or through Waiver Authority. The State of Alaska has the option to exempt AN/AIs from being enrolled into managed care, or in this case the responsibilities of the ASO, and should do so. The State should take into consideration such factors as how the ATHS is currently organized and delivers care, contracting and payment difficulties with managed care or an ASO, timely access to care standards, and continued access to culturally appropriate providers before a decision is made to mandatorily require AN/AIs and IHCPs be subject to an ASO. Again, because the ATHS does not know precisely what the ASO responsibilities will be, or their experience at working with Tribes and the ATHS, we recommend AN/AIs and IHCPs be exempt from this process.

To CMS' credit, it has consistently refused to mandate AN/AIs into managed care through Section 1115 waivers. Since the ASO is coupled with the 1115 behavioral health concept paper, it is appropriate to provide comment on this concern as it relates to the RFI for an ASO. CMS refused to do so in waivers it approved in New Mexico and Kansas, and has continued to do so in waivers related to Medicaid expansion. For example, although a new Michigan waiver expanding Medicaid has a managed care component, participation in managed care remains optional for AI/ANs in that State. The same is true for the HIP 2.0 waiver approved in the State of Indiana. In addition, CMS has refused to mandate AN/AI participation in premium assistance models like those approved in Arkansas and Iowa.

This de facto policy against mandating AN/AI participation in managed care has been critical in ensuring continued access to the Medicaid program for AI/ANs as states seek to use the 1115 waiver process to radically alter their Medicaid programs through mandatory managed care and premium assistance Medicaid expansion models—or in the case of Alaska, through an ASO. We would hope that Alaska would take the opportunity it has now to formalize and codify this policy in developing the requirements for the ASO in the behavioral health redesign. Doing so is critical to maintaining meaningful access to the Medicaid program and the resources it brings to the ATHS for years to come and in successive DHSS Administrations.

ASO Requirements and Managed Care Rules

We believe that, given the range of activities DHSS contemplates transferring to the ASO, it would effectively operate as a managed care entity, albeit one that would not necessarily be paid on a capitated basis or bear any financial risk for the services it

manages. Consequently, and especially if AN/AIs and the Alaska Tribal Health System are not carved-out of the ASO's responsibilities, we believe the ASO should be required to comply with the same rules that apply under the federal Medicaid Managed Care regulations to "non-risk" managed care entities, including the special provisions regarding AN/AIs and Indian Health Care Providers at 42 CFR 438.14. The managed care regulations articulate and implement a range of statutory Indian managed care protections, including those in section 1932(h) of the Social Security Act that were added by section 5006 of the American Recovery and Reinvestment Act (ARRA). These provisions allow AN/AIs enrolled in Medicaid and the Children's Health Insurance Program (CHIP) to receive services from an Indian Health Care Provider (IHCP) and requires that IHCPs are reimbursed appropriately for services provided.

If the DHSS is not willing to exempt AN/AIs from the ASO process it must require the ASO to comply with all the requirements pertaining to AN/AIs and IHCPs in the Medicaid managed care rule. The ASO should be required to implement the following items that are covered under the managed care rule just as a managed care organization would have to do:

- Meet network sufficiency standards and provider choice at 42 C.F.R. §§438.14(b), 438.56(c), 457.1209, 457.1212;

- Require ASO to process claims in accordance with 42 C.F.R. §§438.14(c)(2), 438.14(c)(3), and 457.1209 to allow IHCPs to receive the applicable encounter rate published in the Federal Register by the Indian Health Service, or if no published rate, the amount provided under the state plan FFS payment method;

- If the ASO adjudicates and pays claims, the State should allow either the ASO or the State to pay the full amount that the IHCP is eligible to receive under the applicable encounter rate or FFS, and not require the IHCPs to process settle-up payments for a lesser amount received;

- If the ASO will oversee utilization management and require prior authorization of services it must permit IHCPs to refer an AN/AI to one of their network providers whether the IHCP has a contract or is an out of network provider as required at §§438.14(b)(6) and 457.1209;

- If the DHSS makes auto assignment of AN/AIs to any providers that the ASO will manage, then the ASO should be required to offer contracts to IHCP and have patients within that region assigned to the IHCP. If the ASO network does not include IHCPs then the patient should be allowed to dis-enroll and seek service through IHCPs or out of state if necessary as required at §§438.14(b)(5) and 457.1209;

- IHCPs are entitled to special protections and managed care contract terms under federal law. When the ASO contracts with IHCPs it should be required to use a "Medicaid and CHIP Indian Managed Care Addendum" to be mutually developed by IHCPs, the ASO, and DHSS.

ARRA establishes—and the Medicaid managed care rules[2] define—an Indian Managed Care Entity (IMCE) as a Managed Care Organization, Pre-paid Inpatient Health Plan, Pre-paid Ambulatory Health Plan, Primary Care Case Management, or a Primary Care Case Management entity that is controlled by IHS, a Tribe or Tribal organization, or urban Indian Organization, or consortium. To the extent that the State may require the services of an ASO, it should utilize the new IMCE authority to contract directly with IHCPs to carry out the functions and responsibilities of the ASO. The ATHS would be happy to discuss these options with DHSS before it finalizes the ASO procurement and the final 1115 behavioral health waiver.

We thank you for the opportunity to provide our comments on the Request for Information as the State works to procure an Administrative Services Organization. We look forward to continuing to work with DHSS to improve the behavioral health system in Alaska. If you should have any questions concerning our recommendations, please contact, Verné Boerner at vboerner@anhb.org or (907) 562-6006.

Sincerely,

Lincoln Bean Sr

Lincoln Bean, Sr., Chairman
Alaska Native Health Board

[2] 1932(h); §§438.14(d) and 457.1209.

Tribal ASO Discussion Matrix
August 29, 2017

Glossary of Terms:

MCO – Managed Care Organization
PIHP – Prepaid Inpatient Health Plan
PAHP – Prepaid Ambulatory Health Plan
PCCM – Primary Care Case Management
IHCP – Indian Health Care Program
IMCE – Indian Managed Care Entity

Item No.	Potential Administrative Service Organization (ASO) Function	Concern/State Requirement	Summary Solution/Tribal Recommendation
1.	Tribal Consultation	Section 1902(a)(73) of the Social Security Act (SSA) requires States to consult and seek advice with the Tribal Health Organizations (THOs) on a regular and ongoing basis regarding Medicaid and CHIP matters that will have a direct effect on AN/AI access and THO participation in Medicaid and CHIP. Presidential Executive Order 13175, Section 1115 Transparency Regulations 42 CFR 43 l .408(b), and CMS Tribal Consultation and HHS Tribal Consultation Policies also require States to consult with Federally-recognized Tribes and Tribal organizations on matters that will have a direct effect. THOs are concerned about what consultative process, if any, will be followed on issues or concerns that should arise in the relationship between the ASO and THOs?	a. The State should not be allowed to delegate the requirement for Tribal Consultation to the ASO in any form. b. The State and THOs should develop and agree on conflict resolution language that will be included in the ASO contract.
2.	Eligibility determination	Tribes would like to hear what the State proposes.	The State cannot outsource overall Medicaid program eligibility determination per CMS rules.
3.	Service authorizations (prior authorizations, re-authorizations)	• Will the ASO require prior authorization when a THO can provide a BH service? • Will the ASO require prior authorization when a THO determines it is not able to provide a BH service and makes a referral to another THO? • Will the ASO require prior authorization/or an additional in-network referral, when a THO is not able to provide a BH service and makes a referral to non-tribal provider? THOs are concerned this will create delay and administrative burden.	Each THO can determine what care it can provide to its patients (including non-Native) without any service/prior authorization requirements. Each THO functions as part of the well-orchestrated Alaska Tribal Health System (ATHS), and has established referral processes and levels of care between THOs and with non-tribal partner organizations. The Medicaid Managed Care rule at §§438.14(b)(6) and 457.1209 add a requirement

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			to specify that MCOs, PIHPs, PAHPs, and PCCM entities (if applicable)s must permit an out-of-network IHCP to refer an Indian to a network provider for covered services, and such IHCP referrals to a network provider shall be deemed to satisfy any coordination of care or referral requirement. This should also apply to the ASO. This is intended to avoid duplicate visits to a network provider to obtain a referral and any delay in treatment when referrals are made under these circumstances.
4.	Service/Prior Authorizations	Service authorizations require at least an hour of provider time in addition to finance and support staff time.	
5.	Care management for acute care	Many ASOs in other States are responsible for creating care management or care coordination services. This makes sense in an environment of 'island' providers who are not operating as a system. The ATHS, however, already has effective layers of care coordination. And, if more coordination is needed, it would be valuable within the ATHS not by an external ASO that will have little to no familiarity with the ATHS. Please note that the ATHS already coordinates management of care across geographic regions and moving from village to sub regional hub, to regional hub, to ANMC based on acuity. We request clarification of what is being considered "acute care “with concrete examples of what "acute care" is included in this proposal.	Any investment made by the State of Alaska (SOA) in care management or care coordination should (a) ensure that equal funding is given to the tribal system as compared to the non-tribal providers; and (b) allow that funding to be given directly to the ATHS so that care coordination can be built within the tribal system rather than above the tribal system in the ASO.

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6.		ASO success is often measured in terms of cost savings. Because of 100% FMAP is one of the most effective means of demonstrating cost savings is to keep AI/AN Medicaid beneficiaries within the ATHS. It is important that ASOs do not consider transferring AI/AN Medicaid beneficiaries out of the ATHS which is reimbursed at the CMS and OMB approved encounter rates into the private sector which is reimbursed at fee for service to be cost savings. For example simply directing an AI/AN Medicaid beneficiary to a private sector provider whose average CBHC reimbursement may be $200 per encounter as compared to the ATHS average reimbursement of $616 per encounter does not save the state general fund $416 per encounter.	
7.	Care coordination including integrated care with BH	The tribal system as it currently exists integrates primary and behavioral health care (to various extents in the various THOs), using a "no wrong door" point of entry. Adding the ASO to this process would actually impede coordination within the tribal system.	The tribal health organizations already have both areas of care within their service provision and are already coordinating care. Any portion of the ASO's funding dedicated to such care coordination should be contracted directly with THOs to coordinate care within the tribal system rather than above the system by the ASO.
8.	Real time management (no later than one week from receipt of raw data)	Request clarification	

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9.	Concurrent/retrospective reviews, Provider performance monitoring	There is concern that the ASO will create a new layer of audit and review and the end result will be more, not less, administrative burden for the behavioral health system. The ASO may, over time, create value based payment systems that require providers to provide measurement and/or that will be monitored by audit functions. Because THOs will continue with the Federal OMB established cost based encounter rate, all such work that is tied to payment will not add value but rather will simply create unneeded administrative burden for THOs and the ASO.	The tribal health system should be exempted from any circumstance where the ASO/State might create additional data requirements tied to payment because the tribal health system payment is set in federal policy and cannot be superseded. The Medicaid Managed Care rules stipulate that regardless of whether the IHCP participates in the network of an MCO, PIHP, PAHP and PCCM entity, §438.14(c)(2) and §457.1209 requires that the IHCP receive the applicable encounter rate published annually in the Federal Register by IHS, or in the absence of a published encounter rate, the amount it would receive if the services were provided under the state plan's FFS payment methodology. THOs expect that CMS will require an ASO to comply with this requirement. The state should task the ASO as a specific measure of its work with reducing the administrative responsibilities of behavioral health providers by 50%. The best way to improve care delivered is to spend more time delivering said care and less time with administrative functions. The reduction can be incremental with a goal of reducing administrative burden by 50% by the end of year 3, with the contractor's payment tied to this reduction.
10.	Onsite operational annual audits	As mentioned above, there is concern that the ASO will create additional administrative burden for providers. THOs request the State to clarify if it will require the ASO to conduct any type of audits.	State-mandated accreditation should be considered as a substitute for any ASO audit requirements since they are already in place. If financial audits will be required to meet ASO financial requirements, that the audits that are required under the ISDEAA should suffice to meet such requirements.

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11.	Wait list elimination, trend projections to improve service utilization, provider recruitment ASO Network Sufficiency Standards and Provider Choice	If increased service is needed in Alaska's BH continuum of care and the ASO is contracting with agencies to build that service, how will the ASO choose between tribal and non-tribal providers? The ATHS has demonstrated that the best care happens when it is owned and managed at the most local level (self-determination). If the ASO determines a need to increase access to a service we would argue that the provider that should be recruited to build that access should be the existing, locally managed provider. The ATHS is best suited to build services to communities in Alaska.	Should the ASO determine that additional services are required in Alaska, those services and related funding should be contracted to the tribal health system as a priority. The Managed Care final rule at §§438.14(b)(1) and 457.1209 requires every MCO, PIHP, PAHP, or PCCM entity, to the extent the PCCM entity has a provider network, to demonstrate that there are sufficient IHCPs participating in the network to ensure timely access to services available under the contract from IHCPs for Indian enrollees who are eligible to receive services. THOs recommend that this requirement apply to the ASO equally. In the event that timely access to IHCPs in network cannot be guaranteed due to few or no network participating IHCPs, §§438.14(b)(5) and 457.1209 provides that the sufficiency standard in §§438.14(b)(1) and 457.1209 is satisfied if (1) Indian enrollees are permitted by the MCO, PIHP, PAHP, or PCCM entity (if applicable) to access out-of-state IHCPs or (2) this circumstance is deemed a good cause reason under the managed care plan contract for Indian enrollees to dis-enroll from the state's managed care program into fee-for-service in accordance with §§438.56(c) and 457.1212. This requirement should also apply equally to the ASO. The final rule at §§438.14(b)(3) and 457.1209 permits any Indian who is enrolled in a non-Indian managed care plan and eligible to receive services from a network IHCP to choose that IHCP as his or her primary care provider, as long as that provider has the capacity to provide the services. THOs recommend that this requirement also apply to the ASO.

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12.	Provider contract management	The ATHS has a government-to government relationship with the State that sets it apart from non-tribal Medicaid providers. As the State's designated "single state agency" for Medicaid, the Department is required to engage directly with the ATHS on a government-to-government basis, seeking its advice and input on proposals that "are likely to have a direct effect on" the ATHS or its beneficiaries, or that may impose "substantial direct compliance costs" on tribal providers. These responsibilities must remain with the Department itself and may not be delegated to the State's contracted ASO.	All discussion, planning and consultation on policies that may have a direct effect on the ATHS or beneficiaries, or that may impose substantial direct compliance costs on tribal providers, should continue through the current government to government consultation process. Consistent with the CMS Tribal Consultation Policy, and the requirements of section 1902(a)(73) of the SSA, added by ARRA §5006(e), states are required to engage in a meaningful consultation process with federally recognized Tribes and/or IHCPs located in their state prior to the submission of a SPA, waiver, demonstration, and policies that will have a direct effect on Tribal programs.
13.	Access management ASO Offers to Contract	In other states with ASOs we have heard that the interface between tribal and non-tribal systems is an access sticking point. Non-tribal providers refuse to accept tribal provider assessments during the referral process, resulting in duplicate assessments and delayed access. A second concern is that the ASO may be tasked with auto-enrolling Alaskans into specific provider networks or to specific providers.	Tribal systems have referral processes in place and should be exempt from additional and duplicative ASO requirements. The Medicaid Managed Care rule at §§438.14(b)(6) and 457.1209 add requirement to specify that MCOs, PIHPs, PAHPs, and PCCM entities (if applicable)s must permit an out-of-network IHCP to refer an Indian to a network provider for covered services, and such IHCP referrals to a network provider shall be deemed to satisfy any coordination of care or referral requirement of the ASO._This is intended to avoid duplicate visits to a network provider to obtain a referral and any delay in treatment when referrals are made under these circumstances. In the event that timely access to IHCPs in an ASO network cannot be guaranteed due to few or no network participating IHCPs, §§438.14(b)(5) and 457.1209 provides that the sufficiency standard in §§438.14(b)(1) and 457.1209 is satisfied if (1) Indian enrollees are permitted by the MCO, PIHP, PAHP, or PCCM entity (if applicable) to access out-of-state IHCPs or (2) this circumstance is deemed a good cause reason under the managed care plan contract for Indian enrollees to disenroll from the

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			state's managed care program into fee-for-service in accordance with §§438.56(c) and 457.1212.
14.		The ATHS is concerned that If the ASO is responsible for developing a network of behavioral health providers, setting requirements, and standards that this may result in THOs not being included.	THOs recommend that the State must require the ASO to demonstrate network sufficiency and timely access to care from and IHCP by offering network provider agreements using an Indian Managed Care Addendum to all IHCPs in their service area who request one. ASOs and BHOs in other States often use nonnegotiable network provider agreements that require IHCPs to waive their federal rights under the Indian Health Care Improvement Act and other laws and apply licensing and provider certification requirements on IHCPs that are also inconsistent with the Indian Health Care Improvement Act. The use of a Managed Care Addendum would facilitate the successful execution of agreements with the ASO. In order for the ASO to meet network adequacy requirements set forth at § 438.14(b)(1) that there be ''sufficient'' THOs must be included. The standards in § 438.14(b)(1) for network sufficiency require that THOs be included in order to meet anticipated Indian enrollment. States have the flexibility to specify

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			in the ASO contract that it must offer a provider agreement to all THOs in the service area or establish other measures of network adequacy similar to § 438.68 or other appropriate measures.
15.	Provider satisfaction surveys	How will these be used? Are these the same surveys we are already required to use, or something additional that will add to administrative burden to both clients and providers.	
16.	CQI culture within network, including use of NiaTx PDSA framework	Tribal (and likely non-tribal) providers already have CQI systems in place. Any CQI elements from the ASO must add value and not increase an already heavy administrative burden.	No additional CQI requirements should be mandated since state-mandated accreditation bodies already include requirements for improvement; different requirements from the ASO could cause unnecessary conflict.
17.	Access & service standards development, implementation & review	Request clarification	See discussion at Item No. 13.
18.	Chart reviews/audits	Each tribal provider already has a process for chart reviews and audits in place. Further, outside reviews also include chart reviews and audits. This is simply duplicative and an additional burden to providers.	Since accreditation requirements already include expectations for chart reviews, there should be no additional mandates; different requirements from the ASO could cause unnecessary conflict.

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19.	Incident/complaint investigation	Each tribal provider already has a process for incidents and complaints, and in some instances, the incidents/complaints are reportable to state or other agencies, which in turn have their own processes. This sounds like another level, and it's hard to understand what purpose it would serve. It's also hard to understand how an agency unfamiliar with tribal health, locations, or culture could be successful with such investigations.	All THOs must follow internal, regulation, accreditation, and federal mandates to respond to incidents and complaints on behalf of the customer owners. We do not need an additional layer on top of the THOs.
20.	Population-wide studies	The tribal health system already works to create population level analysis. Concern that an ASO population wide study might be duplicative or might not be built on the existing population wide ATHS.	Require that any studies undertaken by the ASO are developed in partnership with the tribal health system.
21.	Systematic review of provider and service recipient satisfaction surveys	Tribal health organizations are by definition owned and managed by the customers they serve. Therefore, customer satisfaction input and direction is a key part of how THOs operate. There is concern that an ASO might create recipient satisfaction surveys that are duplicative of the THOs' existing processes, which would create burden both for THOs and for Alaska Native people.	An ASO recipient satisfaction survey may be useful to some THOs and should be available to THOs on a voluntary basis. PCCM covers contracts with the State to furnish case management services (which include the location, coordination and monitoring of primary health care services) to Medicaid beneficiaries. Since the Medicaid Managed Care rules include a definition that IHCP meet the definition of a PCCM entity, then the activities that the THOs undertake to implement quality improvement including administering satisfaction surveys or collecting data necessary for performance measurement of providers should meet requirements of the ASO.
22.	Quality of care trends across network		Inasmuch as quality is tied to reimbursement, the tribal system should be exempt.
23.	Collect/report required data, including but not limited to NOMS and selected HEDIS measures	Any reporting requirement runs the risk of imposing additional administrative burden without any benefit to service recipients or providers. Who defines required data?	THOs already submit quality data in several settings. The ASO should make use of data already transmitted in other settings. Further, THOs should be exempted from any measurement tied to payment since it is set in federal policy. See discussion at Item No. 21.

Item No.	Potential Administrative Service Organization (ASO) Function	Concern/State Requirement	Summary Solution/Tribal Recommendation
24.	Real time capacity	Request clarification	
25.	Generate systematic reports (enrollment data; utilization by provider, service recipient, population & network-wide; outcomes by service, service recipient, and network-wide; cost by service, service recipient, population, & network-wide; utilization/cost/outcomes patterns across network providers; service rates; & predictive modeling)	All comments and concerns about dual reporting and dual Medicaid systems apply here. Tribal (and non-tribal) providers should not be faced with an increased administrative reporting burden to accomplish this objective.	The ASO should report based on existing sources and provide such data to THOs for health system planning.
26.	Report provider administrative costs real time	This could be tricky for the tribal providers because of how their payment structures differ from other providers.	Is the state considering this as an ASO function, and if so, what does this mean?
27.	Exchange electronic data files	There are multiple formats already in place. Concern that requiring one format will be unduly burdensome to providers.	The ASO should be able to accommodate multiple file formats via multiple transmission modes from a variety of EHR/CM/practice management systems and have structures and protocols in place to "normalize" the data based on a set of standards and defined criteria.
28.	E.H.R.	We are assuming that this does not mean that the ASO would implement a standard E.H.R. That would be problematic.	An ASO would/should not supplant any provider's existing EHR, but rather be able to interface with it.
29.	Process claims and adjustments from original receipt through determination of disposition	In other states we have heard that the ASO has paid claims to THOs at the non-tribal rates with a true-up process. This will create administrative burden for the state, ASOs and THOs. The current claims processing for medical and behavioral health claims is through a single contractor, Conduent. The tribal health system consists of providers who bill both behavioral health and medical services. Separating behavioral health and medical claims with two processes and two contractors will create undue burden for tribal	If the State will require the ASO to adjudicate payment of claims, then the State should allow the ASO to pay the full OMB encounter rate or rate set forth in the State Plan (CHAP/BHA rates). Creating two contractors for billing, one for medical and one for behavioral, will create undue burden for the ATHS because THOs are both medical and behavioral providers. The tribal recommendation is to be exempt from the ASO.

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		providers: it continues the false assumption that mind and body are two separate things and should be handled separately and runs in direct conflict with the state's goal of supporting behavioral health/medical service integration.	
30.	Receive, verify, and log claims and adjustments received, Perform internal claims edits, Performing claim validation edits, Complete claims development and adjudications, Maintain pricing and user files, Generate reports-routine and ad hoc reporting, denial management, claims resolution tracking, error analysis, medical review of claims, reporting of claims payments to payers	Realizing that the Enterprise MMIS system implementation created many challenges for not only providers but for DHSS as well, why at a time where the new Enterprise MMIS is finally working at an acceptable level would DHSS want to go through another system massive system implementation? An ASO MMIS should not be viewed as a solution to overcome the shortcomings of the Enterprise MMIS.	Conceivably the state could have the ASO work with the fiscal agent (Conduit; aka Xerox) to provide support for claims management; however, THOs should be exempt as cited above. If the State will require the ASO to adjudicate payment of claims, than the State should allow the ASO to pay the full OMB encounter rate or rate set forth in the State Plan (CHAP/BHA rates).
31.	Member outreach education, and issue resolution	Two Medicaid systems will be incredibly confusing for members in and of itself. Any misalignment between the two systems will further increase member confusion and inaccuracy. Many states have separate managed care entities handling medical services vs behavioral health services, and have seen challenges in person-centered care.	The tribal health system should be exempt from the ASO and the ASO or the State should contract directly for this service from THOs
32.	Create/distribute benefit summary and member enrollment materials.	Benefit summary forms that include THO delivered care and Medicaid cost for that care are problematic because (a) Alaska Native people do not have out of pocket costs for THO delivered care and (b) the costs in the reports will be misleading in that they are average cost based rates across all types of encounters. The encounter rate is not a reflection of the payment for one service, but rather the average payment for all services.	Do not show any cost/price/financial data for services delivered by THOs on the benefit summary forms Any material distributed to AI/AN people should be created in conjunction with the ATHS.

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33.	Create/distribute member handbooks	Enrollment into an ASO network whether via auto enrollment or self-enrollment is a huge concern for the ATHS. AI/AN Medicaid beneficiaries must have unfettered access to the ATHS. Description in member handbooks should be carefully written with this in mind.	AN/AI people should be exempt from auto enrollment or any enrollment requirements and have unfettered access to the tribal health system and/or any provider of their choice. Any material distributed to AI/AN people should be created in conjunction with the ATHS. Likewise, any provider network lists showing IHCPs should be limited to just eligible beneficiaries of the Indian health system. This is due to stringent statutory and regulatory eligibility policies that govern the Indian health system. The state should require the ASO to work with the ATHS in the development of any handbooks or materials distributed to Alaskans.
34.	Train the trainer		
35.	Onsite enrollment benefit education	Given all the complexity related to AI/AN people and THOs, this could be confusing and should be carefully written.	ASO to partner with the tribal health system in developing benefit education materials and processes. See discussion at Item No. 33.
36.	Electronic enrollment interfaces	Two enrollment interfaces (medical and behavioral health) will create undue burden. All comments and concerns about dual Medicaid systems apply here.	The tribal health system would like to partner with the state to ensure a streamlined process for organizations that offer both behavioral health and medical care.
37.	Regionalization of BH delivery system	Administer the State's Medicaid plan through regions as described in the 1115 waiver that would be inconsistent with the service delivery areas of THOs. The ATHS already has a regional structure and we build the continuum of care through our existing regions. The State's proposed regions are similar but not exactly the same as the ATHS's regions. We would like clarity on the State's vision of regions and what the impact will be on the ATHS.	Planning together with the state and the tribal workgroup on the impact of regionalization of the Medicaid plan. If the ASO assigns AN/AIs to regional providers, the auto-assignment algorithm must ensure that an appropriate logic is used to accomplish the most appropriate assignment and must include THOs. Such criteria could include an enrollee's historical relationship with a IHCPs. Additionally, the ASO should ensure that information on the process for changing providers is easily accessible and, at a minimum, described in the enrollee handbook and on the ASO website as required in §§438.10(f)(2)(x), §438.10(f)(3), and

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Other Discussion Items:

38. Culturally and linguistically appropriate services
39. Complaints and grievances
40. Experience with tribal organizations, including Alaska Native/ American Indian health systems and providers
41. Rural and remote area service delivery
42. Digital technology (telehealth, digital and mobile technology, patient portals in the websites) and
43. Coordination and integration of care across multiple systems (judicial system, OCS, welfare system, etc.)