

# Overview of Alaska's Behavioral Health System of Care for Children

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**AK | DFCS**  
ALASKA DEPARTMENT OF  
FAMILY AND COMMUNITY  
SERVICES

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# I. Introduction

On December 15, 2022, the United States Department of Justice (DOJ) issued a report finding reasonable cause to believe the state of Alaska is failing to provide services to children “with behavioral health disabilities” in the most integrated setting appropriate to their needs.<sup>1</sup>

Since the release of the DOJ report, the state has received multiple inquiries about what it is doing to improve mental health services for minors in Alaska. This document summarizes the steps the state has taken, and the process it intends follow, to further improve mental health outcomes for minors with behavioral health disabilities.<sup>2</sup>

While DOJ and the state will continue discussing which strategies are appropriate for Alaska, both parties share the overall goal of ensuring Alaskan children and youth receive appropriate behavioral health services in the most integrated setting feasible.

Alaskan children and youth deserve care that is supportive, healing, and engages family, community, and culture. Environmental supports and care received during childhood lay the foundation for children’s health and futures, as well as the foundation for the health and future of Alaskan families, communities, and the state itself. The DOH and the Department of Family and Community Services (DFCS) are committed to reducing reliance on residential treatment programs, including in out-of-state facilities, and ensuring clinically appropriate services are available to more Alaskan children and youth closer to their homes.

Presently, the total number of children placed in out-of-state psychiatric residential treatment facilities is less than 100, compared to approximately 2,995 children receiving behavioral health care in state so far in 2023 (data from the last full calendar year shows approximately 6,511 children received community behavioral health treatment and recovery services in state). This data represents services received by children enrolled in the Alaska Medicaid program, and includes children in the custody of the Office of Children’s Services (OCS).

Those numbers represent significant progress when compared to earlier years, when out-of-state placements reached a high of 965 in 2004. However, the state and its stakeholders still recognize the need for a stronger system of care in Alaska. While DOH and DFCS are actively engaged in a variety of efforts to improve supports that meet the full spectrum of children’s needs, the DOJ report presents an enhanced opportunity for collaboration and problem-solving.

**Presently, the total number of children placed in out of state psychiatric residential treatment facilities is less than 100, compared to approximately 2,995 children receiving behavioral health care in state so far in 2023.**

- 1 The investigation was conducted during the height of the COVID-19 pandemic, which the federal government found as a time period that does not provide useful data. See *Key Substance Use and Mental Health Indicators in the United States: Results from the 2020 National Survey on Drug Use and Health*. <https://www.samhsa.gov/data/sites/default/files/reports/rpt35325/NSDUHFFR1PDFWHTMLFiles2020/2020NSDUHFFR1PDFW102121.pdf>. Moreover, DOJ only conducted site visits in two rural hubs and one village, which is not a representative sample of the unique challenges of service delivery in Alaska, where 80% of communities are off the road system, and rural residents travel an average of 147 miles one way for access to a next level of medical care.
- 2 This document does not fully encompass the state’s defenses to DOJ’s legal claims.



## II. Overview of Alaska's System of Care

In Alaska, non-government entities provide direct care services and are reimbursed through multiple funding mechanisms, including private insurance, grants, and Medicaid. With the exception of the Alaska Psychiatric Institute (API), the state itself does not provide direct health care services to the general public (including children).

Alaska's rural geography and diffuse population centers pose significant challenges to the provision of behavioral health care services, including more limited access to education, public safety, internet access, phone service, electricity, and water. In particular, transportation challenges for those living off the road system make these access problems more acute.

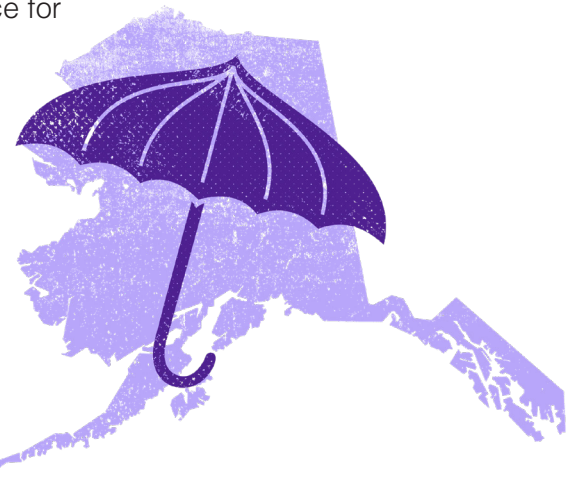
### a. The Medicaid Program.

Medicaid is a joint state/federal program that finances health insurance for low-income families, children, individuals, and those with disabilities. For children, Alaska Medicaid covers all medically necessary behavioral health services. The range of services available to Medicaid beneficiaries depends, like it does in all states, on the extent to which providers exist in Alaska and whether they have agreed to accept Medicaid patients by enrolling with the state as a Medicaid provider.

Alaska is a "fee for service" state. This means there are no managed care entities like those present in most other states in the nation. Alaska's unique relationship with its large tribal health organization (THO) network and tribal beneficiary population is also an important hallmark of the state's Medicaid program. The DOH has tribal consultation requirements and tribal providers are paid on the "encounter" rate, which is set every year by our federal partners.

The Medicaid program is subject to strict rules and regulations determined by the federal government. Unfortunately, the federal Medicaid program reimbursement was not designed for Alaska's frontier geography and demographics. Medicaid payment mechanisms favor more highly resourced and populous urban settings. As a result, Alaska, along with numerous other states, must go through a lengthy and expensive application, negotiation, review, and renewal process to obtain Medicaid waivers that support a stronger behavioral health system of care and better in-community supports for individuals with intellectual and developmental disabilities.<sup>3</sup>

The Alaska DOH has secured six waivers that drastically improve access to services for Alaskans with disabilities, including behavioral health.



<sup>3</sup> Medicaid waivers give states flexibility to redesign and improve Medicaid services and programs by waiving normal Medicaid requirements.

## 1. Section 1115 Demonstration Waiver (“1115 Waiver”).

Of the state’s six waiver programs, the 1115 Waiver is the most significant in expanding access to behavioral health services. The 1115 Waiver created a new structure for providers to receive payment for behavioral health services that previously were not covered by Medicaid and largely did not already exist. In fact, the DOJ report pointed to the community-based behavioral health services authorized under the 1115 waiver as the primary solution to providing services in the least restrictive setting.

The 1115 Waiver improved the state’s mental health program in five key ways:

- (1) It allows the state to support a broader range of substance use disorder and behavioral health services;
- (2) It reduces Alaska’s reliance on late-stage crisis services by emphasizing early-stage outreach, prevention, and intervention;
- (3) It expands Medicaid-covered services to individuals who are at risk of developing a mental health or substance use disorder, which is a profound change from the requirement that service recipients meet the definition of serious mental illness (for adults) or severe emotional disturbance (for children).
- (4) It allows the state to cover services not typically covered by Medicaid; and
- (5) It uses innovative service delivery systems that improve care, increase efficiency, and reduce costs (i.e., intensive case management, therapeutic treatment homes, home-based family treatment).

The state believes that due to the timing of the investigation and the start of the pandemic, DOJ did not develop an accurate picture of how the 1115 Waiver will affect behavioral health services in Alaska. DOJ’s investigation was conducted between December 2020 and December 2022, but the regulations for the behavioral health portion of the waiver did not go into effect until May 2020,<sup>4</sup> just two months after the start of the COVID-19 pandemic and 7 months prior to the DOJ investigation. Utilization of the 1115 behavioral health component could only begin once reimbursement became available in May 2020, and only at that point could individual providers assess whether to offer 1115 Waiver services and begin the onboarding process – after which time recipients could begin to engage in the services.<sup>5</sup>

## 2. Section 1915(c) Waivers.

These waivers allow states to offer home- and community-based services (HCBS) to limited numbers and groups of enrollees as an alternative to institutional care. Section 1915(c) allows the state to waive “comparability” requirements (which normally require the state to provide a Medicaid benefit in the same amount, duration, and scope to all enrollees), and exclude spousal income to keep an individual eligible for Medicaid and the waiver.

**The DOJ report pointed to the community-based behavioral health services authorized under the 1115 waiver as the primary solution to providing services in the least restrictive setting.**

4 The state took the extraordinary step of using use the Emergency Regulation process to expedite 1115 service implementation to ensure 1115 Waiver services were available to all Alaskans.

5 Face-to-face services were also severely limited during that time.

To be eligible for these waivers, an individual must meet the level of care requirement that they would otherwise require institutionalization. The waiver then allows the individual to receive services in the community, preventing institutionalization.

Separate 1915(c) waivers are required for each eligible population. Alaska has five of these waivers.

## **A. Section 1915(c) Individuals with Intellectual and Developmental Disabilities (IDD) Waiver:**

The IDD Waiver allows the state to serve about 2,100 children and adults who meet the criteria for level of care at an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).

## **B. Section 1915(c) Children with Complex Medical Conditions (CMMC) Waiver:**

The CMMC Waiver allows the state to serve about 250 children with severe, chronic physical conditions who would receive long-term care in a facility for more than 30 days per year and who have prolonged dependency on medical care or technology to maintain and well-being and who often need ongoing nursing care.

## **C. Section 1915(c) Alaskans Living Independently (ALI) Waiver:**

The ALI waiver is approved to serve over 3,000 seniors and adults who meet the criteria for nursing facility level of care. The waiver currently serves about 2,000 people, and the state is interested in increasing the number of Alaskans served by the ALI Waiver.

## **D. Section 1915(c) Adults with Physical and Developmental Disabilities (APDD) Waiver:**

The APDD Waiver serves about 125 adults who have both intellectual and physical disabilities who meet the criteria for nursing facility level of care and often need ongoing nursing care.

## **E. Section 1915(c) Individualized Supports Waiver (ISW).**

The ISW Waiver allows the state to offer a limited array of waiver services, not to exceed an individual annual limit of \$22,000. The annual amount assigned as an individual budget limit is indexed to inflation, so rises every year. Services available through the ISW are day habilitation, respite, residential habilitation in home supports and supported living, employment services, intensive active treatment, and transportation, in addition to care coordination.

## b. Grants and General Fund Expenditures.

It is important for the state to have a wide array of providers to serve Alaskans. Accordingly, the state provides additional funding to providers through grants for services and supports not covered by Medicaid. A few of the state's important grant programs impacting minors with behavior health disabilities are described below.

### 1. DOH Division of Behavioral Health (DBH).<sup>6</sup>

In FY22, approximately 14,830 Alaskans were served by organizations that receive grants from DBH. Funding sources include: (1) state of Alaska general funds, (2) federal funding (such as Substance Abuse and Mental Health Services Administration (SAMHSA) block grant funding), and (3) designated funds (such as the Marijuana Education Treatment (MET) funds and Recidivism Reduction Funds).

In the last several years, the state has more than tripled its federal block grant funding through one-time grant opportunities that support behavioral health needs in both youth and adults. For example, the state received a \$7.3 million supplemental Mental Health and Substance Abuse Block Grant; a \$7.9 million SAMHSA Mental Health and Substance Abuse Block Grant; and a \$2 million and a \$2.8 million SAMHSA emergency COVID discretionary grant.

Below are summaries of four of DBH's main grant programs:

- **Comprehensive Behavioral Health Treatment and Recovery (CBHTR).** CBHTR is DBH's largest grant program. It supports programs including children's residential care; substance use disorder residential and outpatient programs; psychiatric emergency services; peer supports; and onboarding support for 1115 Crisis Services.
- **Pediatric Telehealth Psychiatry through the Alaska Partnership Access Line (PAL PAK).** PAL PAK is a 5-year project that funds pediatric psychiatric consultation for prescribers in Alaska with the Seattle Children's Hospital, which is nationally recognized for its excellence in child psychiatry. PAL Pak offers immediate support to pediatric care providers (doctors, nurse practitioners, and physician assistants) in Alaska who have questions about child and adolescent mental healthcare, such as diagnostic clarification, medication adjustment, or treatment planning. In addition, there is an option for pediatric care providers to be connected with a program that locates resources for patients and their families. This five-year program is supported by approximately \$500,000 annually. In September 2022, DBH was awarded an additional \$300,000 by the Health Resources and Services Administration ("HRSA") for efforts to support rural school counselors through consultation provided by University of Washington School Psychologists. The HRSA funds are supporting school professionals

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<sup>6</sup> Additional information about grantees and categories can be found in the [FY22 DHSS grant book](#).

(counselors, nurses, etc.) by providing training for school districts across the state on behavioral health topics and BRISC (Brief Intervention for School Clinicians) a research-based strategy for mental health practitioners working in schools.

- **Treatment and Recovery.** The overall goal of treatment and recovery is to ensure that Alaskans have access to a statewide continuum of behavioral health (mental health and substance use disorder) services across their lifespan. Service categories include psychiatric emergency services, withdrawal management (detox) services, residential treatment services, outpatient treatment services, housing services, and peer supports.
- **Prevention and Early Intervention.** This program provides funding to support coalition-lead, community-based activities in Alaska intended to reduce individual and community risk factors and harmful consequences of substance misuse and mental health issues. This focuses on the promotion of protective factors and activities and empowers communities to create population-level change.

Additional grants, agreements, and contracts funded in the FY24 budget include the following:

- **Individualized Services Agreement (ISA) Funding.** The ISA program provides material support to families and youth in need. Clients receiving services in behavioral health programs can access funds for emergency assistance with essential items, if clinically recommended and linked to a client's treatment plan. These funds also support vulnerable youth and parents who need additional supports to maintain positive treatment outcomes.
- **Trauma Informed Care (TIC).** Under the 1115 waiver, TIC training is mandatory for all therapeutic foster parents. TIC funds a training grant facilitating travel to training sites for DBH grantees.
- **Trauma Training Contract (TTC).** TTC provides training on the causes and effects of trauma and continues to explore ways to increase the scope of, and access to, the training.



## 2. Department of Family and Community Services Office of Children's Services (OCS).

DFCS and OCS also maintain several important grant programs that improve outcomes for minors with behavioral health disabilities.

- Individual Service Agreement (ISA) Fund. ISA utilizes general fund dollars to prevent children from requiring a more restrictive level of placement.



- In FY 23, OCS has approved \$16,452.35 for a wide array of items/ services including weighted blankets, fidget toys, additional foster care stipends, and extracurricular activities. OCS anticipates spending will match previous years by the end of FY 23.
  - In FY22, OCS approved nearly \$33,400 to fund an array of items/services including: additional foster care stipends, iPads, therapeutic objects, gym memberships, and other extracurricular activities.
  - In FY21, OCS approved approximately \$33,400 to fund an array of items/services including: additional foster care stipends, respite, one-to-one supervision for children, personal care aid, iPads, therapeutic objects, gym memberships, and other extracurricular activities.
- **Family Support Services Program (FSSP)**. FSSP is a child maltreatment prevention grant program which provides parent education, service coordination, and facilitated access to resources to families identified as at risk. The program does not directly provide children's behavioral health services, but representatives work with families to connect them to appropriate services in their community.
- **Circles of Support Program (CSP)**. CSP provides service or case plan implementation, coordination and monitoring, assessment of family progress, parent education and support, and transportation services for families involved with OCS. Like FSSP, CSP does not directly provide children's behavioral health services, but representatives work with families to connect them to appropriate services in their community.
- **Other Supports**. OCS leveraged ongoing funding sources, including Child Abuse Prevention and Treatment Act (CAPTA), to support DFCS' current efforts to address complex issues that often contribute to families becoming, or staying, involved in the child welfare system. This includes:
  - (1) Funding for the Alaska Impact Alliance and Bothe Consulting, both of which are coordinating with multiple stakeholders to implement primary prevention programs to meet the needs of Alaskan families prior to involvement with OCS.
  - (2) A smart phone program, which provides smart phones and/or data plans so children and parents can participate in telehealth and engage in family and caseworker visits.
 

This service has assisted many families, especially in rural areas, to obtain smart phones, or increase data plans, and participate directly in case plan related services, meet with their OCS caseworker, and FaceTime family contacts with children.
  - (3) Chafee supplemental funding, which provides Direct to Youth Grants supporting access to services, transportation, debt reduction,

education, and other needs. These Direct to Youth grants put money directly in the hands of youth. One youth was able to pay off her medical debt, purchase a vehicle, and gain insurance. This allowed the youth to overcome transportation and debt barriers and improve her access to services.

### 3. DFCS Division of Juvenile Justice (DJJ).

In 2018, DJJ secured a time limited “Second Chance Mental Health Grant,” which provides funding to implement specialized treatment units and improved programming for: females, violent offenders, substance users, and youth with neurobehavioral issues. In addition, providers under this grant are now offering neurofeedback to youth identified as having regulation issues and are reporting successful results. This grant expires at the end of September 2023.

## III. The state’s Efforts to Improve Mental Health Outcomes for Minors.

The state of Alaska is committed to improving access to behavioral health services. Successful improvement will depend on a meaningful understanding of the unique communities and geography of Alaska, full engagement with stakeholder groups, and careful analysis of the underlying reasons for poor outcomes and how to address them.

Below are key areas of focus for the state.

#### a. Improved Medicaid Reimbursement Structure and Medicaid Participation.

Medicaid pays for services, but providers must be available and willing to provide services to Medicaid recipients in order for the state to support a wider array of services.

Rates of reimbursement are often cited as a barrier for providers to offer services to Medicaid beneficiaries. To ensure reimbursement rates do not discourage providers from serving Medicaid beneficiaries, DOH is pursuing a multi-pronged approach:

- **Increased Rates for 1115 Services:** In 2023, DBH promulgated regulations increasing rates for 1115 services by 4.5%. These are effective March 26, 2023.
- **Increased Rates for Senior and Disabilities (SDS) Services:** In response to the FY23 operating budget increment of \$32 million made by the legislature, DOH increased rates to home and community based services provider agencies by 10%. This took effect July 1, 2022.

- **Rebased Rates for Community Behavioral Health Providers:** DOH is currently undergoing a process of rebasing rates for community behavioral health providers.
- **Rebased Rates for SDS Services:** Medicaid rates for Home and Community Based Services (HCBS) were recently rebased with an effective date of 5/1/2023. The new rates went through a robust public comment period and revision before finalization.

**b. Expanding Methods of Service Delivery and Facility Types.**

In addition to incentivizing providers to serve Medicaid beneficiaries, the departments have taken numerous steps to make services more accessible to Alaskans. Much of this work was done after recommendations from and collaboration with stakeholders, providers, advocates, tribal health partners, and policy makers.

- **Improved Continuum of Care.** In July 2022, Governor Dunleavy signed into law a bill to improve Alaska’s behavioral health continuum of care. House Bill 172<sup>7</sup> created license types for “subacute” crisis centers, where individuals can receive immediate stabilization and support while they are connected to appropriate resources. This will reduce the number of individuals being escalated to acute or institutional levels of care by filling a long-standing gap in Alaska’s continuum of care.
- **Telehealth Delivery Bill and Related Regulations.** In 2022, the legislature passed a telehealth delivery bill that increased the ability of in- and out-of-state health care providers to provide care through telehealth. DOH expedited the regulation process and currently has enabling regulations out for public comment from February 28 – April 6, 2023.
- **Additional Non-Medicaid Efforts.**
- **Psychiatric Emergency Services (PES) Program.** PES is a grant-funded statewide network of PES providers. Services may include crisis intervention, brief therapeutic interventions for stabilization, and family consumer and community wrap-around support. PES providers are a combination of non-profit community behavioral health providers and tribal health organizations.
- **Broadband Task Force.** In May 2021, Governor Dunleavy issued an Administrative Order creating a broadband task force. The task force<sup>8</sup> was charged with conducting a needs and gaps assessment and providing recommendations regarding broadband goals and policies, guidelines for state involvement in broadband infrastructure development, and equitable use of state funds to assist in the buildout of networks. The task force issued its final report in November 2021<sup>9</sup>. This work is incredibly important to carrying out the missions of both DFCS and DOH. Expanded and reliable broadband access to more remote areas of Alaska is critical to providing telehealth services.

7 <https://www.akleg.gov/PDF/32/Bills/HB0172Z.PDF>

8 <https://gov.alaska.gov/admin-orders/administrative-order-no-322/>

9 <https://indd.adobe.com/view/42ddcfe3-5ea9-4bcb-bd09-a71bcb63869a>

- In addition to existing programs and services, the state is actively engaging with stakeholders to discuss Alaska-specific solutions for individuals who need a higher, residential level of care. One option the state is considering is an intermediate care facility, which could allow Alaska to serve more youth in state who experience complex behavioral health needs, including individuals dually diagnosed with a developmental disability. This would keep young Alaskans closer to family and culturally relevant care.

**c. Crisis Stabilization Services.**

For several years, the state and Alaska Mental Health Trust Authority have collaborated extensively to create a structure for behavioral health crisis service care delivery. These efforts are modeled after “Crisis Now,” a model of behavioral health/psychiatric care designed to provide an intermediary, diversionary level of care in the least restrictive setting and at the earliest moment possible to support individuals in crisis. This provides support to individuals in crisis before their needs escalate and require higher levels of care.

“Crisis Now” is a specific model comprised of three components:

1. A regional or statewide crisis call center that coordinates in real time with the other components to connect patients, providers, and families to services;
2. Centrally deployed, 24/7 mobile crisis teams (often, a clinician and a peer) to respond in-person to individuals in crisis; and
3. 23-hour and short-term stabilization, which may be operated separately or jointly, offering a safe, supportive, and appropriate behavioral health crisis placement for those who cannot be stabilized by call center clinicians or mobile crisis team response.

DOH is successfully partnering with community stakeholders on implementation of all three components. Additionally, DBH is leading a coalition focused on organizing a statewide crisis call center which would direct calls to Alaska’s existing Careline suicide prevention call line and to “988.” The 988 line will connect to emergency mental health services, including suicide prevention, mobile crisis response teams working in Anchorage and Fairbanks, and local support like nearby counselors, in the same way 911 connects to emergency services.

**d. Out of state Placements.**

Medicaid reimbursement is available for a wide array of services, in community and residential, as well as in and out of state. Out of state placements are an option of last resort, whether for children in OCS custody, or for Medicaid recipients. Before a child is placed out of state, his or her case undergoes an intensive review process.





## 1. The OCS Process.

Under OCS' policies and procedures, there are multiple layers of approval before a child can be placed out of state.

When a child presents with needs for services that do not exist within the community, a Team Decision Meeting (TDM) or Regional Placement Committee (RPC) is held. During these meetings it must be determined that the child requires a residential treatment level of care, less restrictive resources have been exhausted, and parties come to consensus that out of state placement is appropriate. In instances when it is in the child's best interest to be placed in residential treatment out of state, he or she is then referred to the Statewide Out of State Placement Committee (OSPC).

If the TDM or RPC refers a child to the OSPC, they must provide a recommendation for out of state treatment, a psychiatric evaluation or doctor's note finding medical necessity for RPTC within the last 60 days, the denial letters from all the in-state facilities, the court order assigning custody to the department, and a placement history report. If an out of state facility has accepted the child, the forms for the Interstate Placement of Children Compact (ICPC) must also be provided. The OSPC committee, which is comprised of representatives from DBH, DJJ, and OCS, then reviews the out of state placement referral. A meeting is held with the above listed parties and a case presentation is provided by primary staff working directly with the youth. Because all of the in-state options have already been exhausted, the OPSC typically approves the out of state placement, but will also require: 1) a discharge plan for youth, and 2) that someone in the child's life participate in their therapy services during the out of state treatment.

After the OSPC approval, the referral packet is submitted to the Superior Court. Per AS 47.10.087 placement in a secure residential treatment facility requires Superior Court approval regardless of location. Alaska statute does allow for placement in an out-of-state facility when a clinical diagnosis determines residential treatment is necessary and the services are not available within the state.<sup>10</sup>

## 2. The Medicaid Process.

DBH only authorizes paying Medicaid funds for minors receiving care out of state as a last resort. For example, the DBH resource team ensures youth are not placed out of state for residential psychiatric treatment centers (RPTC) or also known as Psychiatric Residential Treatment Facilities (PRTF) unless those services are needed and unavailable in Alaska.

It is important to note that a child cannot receive treatment in any level of residential setting, including out of state placement, without the consent of the custodial parent(s) or legal guardian. **DBH has no authority to make any final placement decisions.** Its role is confined to determining if a placement meets medical necessity, and if a provider is enrolled with the Alaska Medicaid program and authorized for payment. DBH contracts with Comagine Health

<sup>10</sup> See AS 47.10.087 and AS 47.14.100. See also OCS Policy 6.5.1 Regional Placement Committee and OCS Policy 6.5.2 Residential Psychiatric Level of Care, <https://aws.state.ak.us/OnlinePublicNotices/Notices/Attachment.aspx?id=135698>

(Comagine) which performs independent review of referral requests to ensure that appropriate services at the appropriate level of care are provided to Alaska Medicaid Recipients.

Before Medicaid can be used to pay for a youth out of state residential placement, the following must occur:

1. A provider submits a referral form to DBH.
2. The DBH resource team committee meets (membership is cross-departmental and multi-divisional, and includes members from SDS, OCS, DJJ, and DBH).
3. A case presentation is considered by resource team. The case presentation covers the reason for referral to an out of state facility, confirmation of a minimum of three in-state denials, the youth's behavior health profile, past psychiatric behaviors, social history, and a general review of how the placement meets the needs of the child.

After team consideration:

1. If out of state placement is deemed not appropriate by the team, DBH notifies the referring provider and sends a letter to Comagine, which then begins a case management process to assist with finding in-state services.
2. If the team determines that the out of state treatment is appropriate and that all in-state options have been exhausted, DBH notifies Comagine.
  - a. The receiving facility then submits an approval request to Comagine, which conducts an independent review to determine if medical necessity criteria are met and that Medicaid funds can be used for this purpose.

Finally, a dedicated staff member at DBH continues to monitor placements and facility compliance after placement, including recurring cross-divisional meetings to coordinate care for specific youth.

#### **e. Coordination and Collaboration with Stakeholders and Families.**

DFCS and DOH cannot solve Alaska's behavioral health issues alone, and both Departments are working with stakeholders to improve the state's ability to support all individuals with complex or intensive needs. In that regard, DOH and DFCS have taken numerous steps to involve stakeholders and families in the process of improving behavioral health services in Alaska.

##### **1. Recently Added Positions.**

- **DES/DET Coordinator:**<sup>11</sup> This position was established in 2020 and is based in DFCS. This position streamlines the coordination and review process for all ex parte involuntary commitment orders. The Coordinator tracks all youth cases from the time they receive an involuntary commitment order through receiving the notice of dismissal, and collaborates with facilities to ensure individuals receive treatment

<sup>11</sup> *DES/DET* refers to the facilities that have been designated by the department for the evaluation and/or treatment of individuals with acute mental illness under involuntary commitment laws.

in a timely manner. Furthermore, this position participates in statewide meetings and committees including the Alaska Hospital and Healthcare Association (AHHA) clinical meetings, daily hospital huddles, and behavioral health collaboration meetings.

Duties include:

- o Tracking and documenting each patient who has an ex parte involuntary commitment order;
- o Monitoring bed count at DET facilities;
- o Facilitating a patient's return to their home community;
- o Holding complex case reviews as needed and appropriate; and
- o Requesting status hearings to review cases that clinical staff feel are not appropriate for API or other settings.

- **Complex Care Systems Coordinator:** DFCS recently hired this position, which will be responsible for interdivisional and departmental coordination for Alaskans who need support for complex needs including behavioral health and intellectual and developmental disabilities.

Duties include:

- o Analyzing current systems within Alaska that work with individuals with complex care needs and identifying current gaps;
- o Developing a monitoring system for all individuals who are identified as having complex needs to reduce gaps in support;
- o Gathering data;
- o Developing improvements to the current system to address identified gaps;
- o Improving communication and coordinating efforts among the divisions within DFCS to ensure divisions are working together to identify service and placement needs for individuals with complex needs;
- o Improving communication between DOH and DFCS to ensure continued collaboration regarding these cases; and
- o Participating in the case response team.

- **Family Coordinator:** This position at DFCS works with families to ensure they receive appropriate care coordination, and advocates for the most appropriate placement settings. In addition, the Family Coordinator works to increase partnerships with treatment facilities and create more community based placement options.

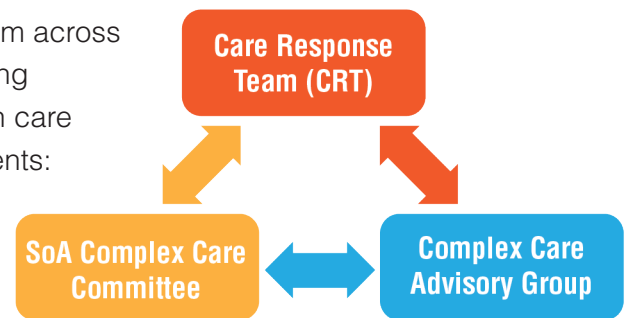
Duties include:

- o Identifying facilities that offer services needed by children with complex medical and behavioral health needs;
  - o Enlisting facilities to provide services under the complex placement provider agreement which offers funds to utilize innovative ideas to create placements;
  - o Collaborating with facilities regarding discharge planning; and
  - o Assisting in expanding the number of Alaska Medicaid enrolled facilities able to provide services.
- **DOH Care Coordinator Liaison.** SDS received funding from the Trust in 2023 for a Care Coordinator (CC) Liaison position to support the many care coordinators who work with waiver recipients. The CC liaison hosts office hours to be available for questions or technical assistance. They facilitate a monthly “info share” meeting which is well attended by care coordinators and streamline the dissemination of information to care coordinators.

**f. Collaborative Relationships and Inter-Departmental Coordination.**

- **The Complex Behavior Collaborative.**<sup>12</sup> The Complex Behavior Collaborative is a long-standing resource within the Division of Behavioral Health which helps providers meet the needs of Medicaid clients with complex needs who are often aggressive, assaultive and difficult to support. The CBC program offers consultation and training to providers and clients’ natural supports, including family members, to support individuals with co-occurring behavioral health and co-morbidities (IDD, complex medical, etc.). The CBC offers consultation and training to providers and the individual’s natural supports to help keep the person in community while ensuring wrap-around treatment supports are available.

- **Multisector and Multilevel Complex Care Coordination.** DFCS and DOH are currently implementing a coordinated system across departments that ensures person-centered care by utilizing multidisciplinary teams to deliver equitable, whole-person care across settings and sectors. This involves three components: (1) at the individual level, a case response team (CRT) will immediately communicate and coordinate care, as well as align payment for emergent cases, and rely on existing resources like the Complex Behavior collective; (2) at the agency level, a Complex Care Committee (CCC) will address systemic gaps in access to care for patients with complex needs; (3) at the community level, a Complex Care Advisory Group (CCAG) will integrate all stakeholder perspectives and provide the opportunity for advocacy groups and provider groups to give feedback and recommendations on how to implement community-based care solutions.



<sup>12</sup> <https://health.alaska.gov/dbh/Documents/TreatmentRecovery/CBC-FAQ-12.11.20.pdf>



## g. Tribal-state Collaboration.

Alaska is home to 229 of the 574 federally recognized tribes, and one-fifth of the state's population is Alaska Native. Alaska's tribal health system is robust, with 8 tribal hospitals, 27 health centers, and 166 village clinics. Tribal health organizations have developed and implemented innovative ways to expand behavioral health services to rural communities. Examples include the "Counselor in Every Village" program (founded in 2003) and the Behavioral Health Aide program (founded in 2009). These programs offer crucial support for rural communities and provide insight into opportunities to expand these, or similar, models.

Collaboration with tribal health partners is critical to the state's efforts to maintain and improve Alaska's behavioral health system. This partnership has successfully increased access to care. In fact, SAMHSA's 2023 **National Guidelines for Child and Youth Behavioral Crisis Care** report<sup>13</sup> specifically recognizes Alaska's efforts to supplement its behavioral health workforce in rural Alaska.<sup>14</sup>

Below are several examples of initiatives the state has undertaken with its Tribal partners.

- **Medicaid Tribal Task Force, Tribal Behavioral Health Directors, and Medicaid Tribal Consultation.** The Medicaid Task Force (MTF) created the Medicaid Tribal Behavioral Health Directors subgroup to focus specifically on behavioral health services and partnering with the state to assess gaps in service delivery areas and work toward creating a sustainable revenue stream to maintain a continuum of care across tribal regions. The subgroup meets regularly and reports to the MTF, which reports to the Alaska Native Health Board Mega Meeting. The purpose of this group is to fill services gaps so Alaska Native beneficiaries can receive services as close to their home community as possible and maintain their cultural identity. The subgroup works closely with DOH to prioritize funding and program development leading to implementation of services. This group also discusses capital needs for infrastructure and telehealth delivery of services so the furthest removed communities have access to essential behavioral health services.
- **The Division of Behavioral Health and the Administrative Services Organization (ASO).** Both DBH and its ASO vendor have an embedded tribal liaison who engages in various ad hoc meetings with tribal partners. In addition, tribal stakeholder engagement has included a variety of forums that allow for meaningful engagement with tribal leaders in multiple roles (clinical/administrative/executive). One specific example is the Continuum of Care/1115 Task Force. A task force comprised of providers, associations, and Tribes was formed to advise the state on behavioral health continuum of care issues and 1115 waiver goals, planning, and implementation.

13 *National Guidelines for Child and Youth Behavioral Health Crisis Care.* [https://store.samhsa.gov/sites/default/files/SAMHSA\\_Digital\\_Download/pep-22-01-02-001.pdf](https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/pep-22-01-02-001.pdf)

**SAMHSA's 2023 National Guidelines for Child and Youth Behavioral Crisis Care report specifically recognizes Alaska's efforts to supplement its behavioral health workforce in rural Alaska.**

- **Juvenile Justice Tribal Diversion Programs.** The state currently has 36 memoranda of understanding with tribal governments and a partnership with the Alaska Native Justice Center to provide services at McLaughlin Youth Center.
- **OCS Tribal Compacting.** Beginning in 2017, the state of Alaska and Tribes partnered to reimagine Tribal Child Welfare through the Alaska Tribal Child Welfare Compact, a government-to-government agreement. Under the Compact, Tribes exercise their inherent sovereign right to provide support services to their Tribal children and families involved in or at risk of involvement with OCS. The Compact provides funds to Compact Tribes to develop or enhance their primary and secondary prevention services.
- **OCS Tribal Title IV-E Prevention Grant.** Title IV-E Tribal grantees participated in training through the Child Welfare Academy. The grantees are partnering with OCS staff to identify appropriate prevention cases. Tribes are providing culturally appropriate services to high-risk families, including behavioral health services.
- **Tribal/State Collaboration Group.** A partnership of representatives from tribes, Alaska Native community partners, and OCS meet to collaborate on how to meet the needs of Alaska Native and American Indian Youth including access to culturally appropriate behavioral health services.
- **Tribal/State Advisory Team (TSAT).** The TSAT meets quarterly to discuss and partner on issues, solutions, and alternative ideas for the child welfare system. Workgroups are formed to problem solve larger gaps including access to culturally appropriate behavioral health services.
- **Regional Tribal/State Groups.** Each region within OCS has a tribal/state group that meets regularly to discuss regional successes and challenges for child protection services within the region. These meetings provide a time to share information, plan gatherings, and schedule joint trainings.

## V. What's Next?

The state of Alaska is committed to improving access, options, and outcomes for Alaskan youth with behavioral health needs. The challenges facing Alaska are unique and require a variety of approaches coordinated across state and federal agencies and partner organizations. Substantial efforts to address these challenges have occurred in the past through focused campaigns such as Bring the Kids Home,<sup>14</sup> as well as ongoing work including the initiatives described in the prior sections.

<sup>14</sup> <https://health.alaska.gov/Commissioner/Pages/btkh/default.aspx>

## a. Near Term Efforts

In the near-term, multiple efforts are underway, including those described below.

- **Workforce.** Support agency-wide workforce development and paraprofessional trainings for behavioral health providers across the state.
  - Continue the Family Services Training Center partnership with UAA to provide free training to clinicians and paraprofessionals.
  - Continue developing the concept of psychiatric specialty training/certification for professionals and paraprofessionals. Develop standardized modules/online training programs.
  - FY24 budget asks for position to coordinate healthcare workforce development.
- **Provider support.** Engage directly with providers and facilitate provider-to-provider connections across the state.
  - DOH, AHHA, and the Trust supported an Alaska delegation of over 20 providers traveling to Arizona for the November 2022 National Update on Behavioral Emergencies (NUBE) conference.
  - DOH and AHHA have now partnered to establish an ongoing educational webinar series addressing topics of interest to Alaska providers, which began March 29, 2023.
- **Increase Behavioral Health Infrastructure.**
  - DOH is providing ongoing technical assistance and has standing workgroups with multiple providers in different hubs, who are in the process of developing behavioral health crisis centers.
  - Regulations are in process to define two new license types for crisis stabilization and crisis residential centers.
  - Telehealth related regulations are currently posted for public comment.
- **Increase Utilization of Waivers.**
  - On March 1, 2023, Alaska submitted a request to CMS to extend its 1115 waiver, now entitled “Alaska Substance Use Disorder and Behavioral Health Program.” Federal public comment ends April 9, 2023.
  - A regulations package to continue tailoring the waiver to Alaska’s needs is currently in the public comment period.<sup>15</sup>
  - In December 2022, SDS submitted to the legislature a “Plan for Eradicating the Intellectual and Developmental Disabilities (IDD) Waitlist.”

<sup>15</sup> <https://aws.state.ak.us/OnlinePublicNotices/Notices/View.aspx?id=210673>

- ***Develop Infrastructure for Complex Care Coordination.*** DFCS and DOH have partnered to implement a cross-departmental Complex Care Coordination infrastructure. The vision is to create a coordinated system across DOH and DFCS that ensures person-centered care by utilizing multidisciplinary teams to deliver equitable, whole-person care across settings and sectors.
  - The DES/DET Coordinator, Complex Care Systems Coordinator, and Family Coordinator will all belong to this unit.
  - In addition to those three positions, DFCS has requested the legislature appropriate funds for FY 24 to create three new positions:
    - A Deputy Director with a clinical background to oversee the operations of the unit and assist in finding appropriate treatment, services, and placement for children and adults.
    - A second Complex Care Systems Coordinator with job duties that mirror the current Complex Care Systems Coordinator, but with two coordinators one may focus on children while the other can focus on adults.
    - A Social Services Associate to assist the unit in everyday administrative tasks.
- Three new groups will be formed to fill current gaps and augment existing complex care coordination efforts across departments following the split. The three groups approach complex care from three different lenses: individual level, state agency level, and community-wide systems level.
  - ***The Case Response Team*** will support individual cases and meet regularly to communicate, coordinate care, and align payment for emergent individual cases not served by existing complex care groups.
  - ***The State of Alaska Complex Care Committee*** will identify solutions to address systemic gaps in access to care for patients with complex needs, provide forward-looking guidance and implement solutions as identified.
  - ***The Complex Care Advisory Group*** will incorporate non-government stakeholders into a committee that identifies community-level gaps in delivering quality care to patients with complex needs by reviewing de-identified data and reports from other complex care groups. This committee also provides the opportunity for advocacy groups and provider groups outside of state government to provide feedback and recommendations and to have a seat at the table in identifying potential community-level solutions.



## b. Long Term Planning

Critical work remains to identify and build out the services necessary to complete a robust continuum of care for Alaskan youth. All of this work must be part of a larger, comprehensive plan, developed with a regional focus that includes specific services, funding needs, targeted dates, and community input. The state plans to undertake a phased approach focused on coordination, planning, and implementation of a behavioral health roadmap.

Building a robust network of care in an environment as economically and geographically challenging as Alaska requires time, substantial financial commitment, and focus. This roadmap will form the basis of a statewide plan that can be implemented over multiple years to achieve the expansion of provider services necessary to complete the continuum of care. This is intended to build upon existing studies, models, and work already underway.

The state intends to undertake the following beginning in May, 2023:

- Initiate a steering committee to determine goals, recommended approach, and timeline, and outline necessary resources to develop statewide and regional plans. The steering committee will include key stakeholders, including representatives from state agencies, behavioral health stakeholder groups, tribal health organizations, provider representatives, and the Alaska Mental Health Trust Authority.
- The roadmap will focus on statewide and regional services. The steering committee will identify regions and establish regional workgroups comprised of local providers, governmental authorities, policymakers, and residents to inform a regional plan. The plan will identify key needs, gaps in the services available, barriers to offering these services, and options for how to address the barriers as well as a timeline and resource plan for the buildout and implementation of services.
- The draft plan will be shared publicly. Listening sessions and robust public comment will be conducted statewide and in the specific regions.
- When complete, the plan will provide a framework with specific, phased approaches to statewide and regional service building, including an implementation timeline and measurable results. The plan will be shared with the legislature and other governmental agencies.

**DOH and DFCS remain committed to improving the continuum of care and serving more Alaska youth in community settings.**

The intent is that this roadmap will provide a focused path to: 1) create a shared vision for behavioral health services in Alaska; 2) align funding opportunities and requests with service delivery needs; 3) identify barriers including regulatory, fiscal, technology, or other issues not fully addressed; and 4) ensure unique regional and cultural needs are cared for and local solutions leveraged as much as possible.

## VII. CONCLUSION

DOJ's investigation took place during the two most severe years of the COVID-19 pandemic. The pandemic has resulted in catastrophic health care workforce shortages, universal experiences of isolation, limited transportation, and increased unemployment, which exacerbated the challenges rural areas were already facing. This interruption to health care services and access fundamentally altered the information available for analysis and the methods by which that information was collected as in-person data collection methods were drastically reduced.<sup>16</sup> Accordingly, the citations provided in the DOJ Report do not provide information that is representative of that time period.

For instance, the DOJ relies on a 2019 report focused on psychiatric boarding in emergency departments, which itself noted the unavailability of Alaskan data to review and thus relied on Arizona's data as a model.<sup>17</sup> At the time of publication, API was at less than half capacity; there were only three DETs in the state; and the 1115 Waiver had not yet been approved. Since then, API has returned to full bed capacity with Chilkat also open, Mat Su Regional Medical Center has become a DET, and the behavioral health portion of the 1115 waiver was approved in May 2020.

More importantly, the state has made significant efforts, which we are still seeing unfold. The state believes DOJ failed to account for those efforts, and their future impacts, in its report. Nevertheless, DOH and DFCS remain committed to improving the continuum of care and serving more Alaska youth in community settings.

The state is committed to the work plan outlined herein and to bringing forward robust action steps that its stakeholders and providers are supportive of implementing.

<sup>16</sup> "NSDUH underwent some major methodological changes for 2020... Therefore, care must be taken when attempting to disentangle the effects on estimates due to real changes in the population (e.g., the COVID-19 pandemic, other events) from these methodological changes. Researchers have raised concerns that the COVID-19 pandemic could have negative effects on substance use and mental health outcomes. However, the methodological changes for the 2020 NSDUH also can affect the 2020 estimates. Therefore, direct comparison of NSDUH estimates in 2020 with those from prior years can be misleading." *Key Substance Use and Mental Health Indicators in the United States: Results from the 2020 National Survey on Drug Use and Health*, pages 8-9. <https://www.samhsa.gov/data/sites/default/files/reports/rpt35325/NSDUHHFRPDFHTMLFiles2020/2020NSDUHFR1PDFW102121.pdf>

"Real changes in substance use or mental health outcomes in the population during the COVID-19 pandemic may have been hidden, lessened, or exaggerated by the methodological changes. Because it was not possible to know the size of the effects caused by the introduction of data collection via the web, the Substance Abuse and Mental Health Services Administration (SAMHSA) advised against comparing 2020 estimates with those from 2019 or earlier years." *2021 National Survey on Drug Use and Health (NSDUH): Methodological Summary and Definitions*, page 168-169. <https://www.samhsa.gov/data/sites/default/files/reports/rpt39442/2021NSDUHMethodSummDefs100422.pdf>

"In addition to impacting the mental health of people in the United States, COVID-19 has also disrupted access to mental health services. Comparing the period from March to October 2020 with the same period in 2019, there were approximately one-third fewer Medicaid or Children's Health Insurance Program claims for mental health services for children and one-fifth fewer mental health claims for adults. Given that mental health needs increased during the pandemic, this means that many people did not receive needed care. In 2019, 11% of children 12 years and older who accessed mental health services did so through schools. School closures potentially disrupted these supports in both rural and non-rural areas, which may have further reduced access to care for young people. The COVID-19 pandemic has presented additional challenges to providers trying to deliver mental health services in rural areas." *Mental Health System Development in Rural and Remote Areas during COVID-19*, pages 5-6. [https://www.nasmhpd.org/sites/default/files/7\\_Rural-RemoteTribal\\_508.pdf](https://www.nasmhpd.org/sites/default/files/7_Rural-RemoteTribal_508.pdf)

<sup>17</sup> [https://www.alaskahha.org/\\_files/ugd/ab2522\\_26376a6bb0b54a85bcf0381aff984a75.pdf](https://www.alaskahha.org/_files/ugd/ab2522_26376a6bb0b54a85bcf0381aff984a75.pdf) page 9