Alaska Native Health Board

THE VOICE OF ALASKA TRIBAL HEALTH SINCE 1968

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February 8, 2023

Courtney O'Byrne King and Emily Beaulieu
Medicaid State Plan Coordinators
Alaska Department of Health
3601 C Street, Suite 902
Anchorage, AK 99503

Dear Ms. King and Ms. Beaulieu,

The Alaska Native Health Board (ANHB)[1] writes to provide Tribal Consultation comment on the State of Alaska section 1115 Behavioral Health Demonstration Waiver (1115 Waiver) Extension Application. The Alaska Tribal Health System has been supportive of the primary objectives of the Waiver, and especially its focus on early intervention and community-based services.

1) We support rebalancing the behavioral health system of care to reduce Alaska's over reliance on acute, institutional care and shift to more community-based or regionally-based care.
2) Intervening as early as possible in the lives of Alaskans to address BH symptoms before symptoms cascade into functional impairments.
3) Improving overall BH System accountability by reforming the existing system of care.

We want to acknowledge the challenges we all have faced during the last three years with the pandemic and the cyber-attack while trying to stand up these new services.

During the September 2022, 1115 Waiver Informational Tribal Consultation session, we discussed some of the successes that we have seen under the 1115.

1) It is excellent to have a package of services that providers can get paid for and the service range has been broadened.
2) We are all excited about the Peer Support services certification process and ability to bill for these services while partnering with individuals on their journey towards wellness.
3) Expansion beyond 16 allowable beds for SUD residential programs due to waiving the IMD exclusion.
4) Structure of the Waiver has helped providers be more aware of the levels of care (better language around the continuum of care).
5) Interest in community-based programs.

[1] ANHB was established in 1968 with the purpose of promoting the spiritual, physical, mental, social, and cultural well-being and pride of Alaska Native people. ANHB is the statewide voice on Alaska Native health issues and is the advocacy organization for the Alaska Tribal Health System (ATHS), which is comprised of tribal health programs that serve all of the 229 Tribes and 180,000 Alaska Native and American Indian people throughout the state. As the statewide tribal health advocacy organization, ANHB helps Alaska's Tribes and Tribal programs achieve effective consultation and communication with state and federal agencies on matters of concern.

We are pleased to see the State moving away from the bifurcated Substance Use Disorder (SUD) and Mental Health systems and working towards integrating these services again under the heading of a *Behavioral Health Reform Waiver*. This has been a huge struggle for our organizations and even more challenging for smaller Tribes/Tribal Health Organizations (T/THOs) that operate both SUD and Mental Health care in one program.

A Missed Opportunity

Although we support the renewal of the Waiver, we want the consultation record to reflect that T/THOs do not want to miss an important opportunity that this renewal represents. Due to the timing of the renewal, there has not been an adequate opportunity to discuss expanding services around Social Determinant of Health that are essential to serving SUD individuals; or having a broader discussion on specific areas for amendments to the waiver's current terms and conditions to explore new opportunities to broaden the support the waiver seeks to provide for the continuum of behavioral health care in Alaska. One example of this missed opportunity is recent 1115 waiver options on addressing social determinants of health (SDOH) such as housing supports, transition assistance, nutritional support, and other areas. Many of these SDOH have documented links to behavioral health outcomes.

We wish to make it clear that while we have not requested any amendments for the extension application to support its approval by CMS, we do wish to explore improvements and other opportunities for possible amendments to the waiver. We request a commitment from the State to explore these opportunities with the Alaska Tribal Health System, including the possible additions or amendments to the 1115 Waiver.

Feedback on our Waiver Experience and 1115 Waiver Renewal Application

Our comments and recommendations are intended to help improve the Waiver, so that it can work for all Alaskans, in particular the tribal beneficiaries and community Medicaid recipients that we serve. We have discussed these concerns with the Division of Behavioral Health (DBH) over the course of the Waiver, and these concerns are reported in the renewal application, but we highlight that our concerns have never been fully addressed throughout the lifespan of the existing Waiver. One area which we do not address below, but continues to be a concern is the sustainability of 1115 waiver services and the current rates for services. We submitted comments in the recent regulatory changes addressing rates, but did not want to fail to mention our on-going concern for that issue as well.

Throughout the past several years of waiver operation there has been a lack of data sharing and transparency around what data has been reported and where it was obtained. Data are key to understanding the state of the system and continuum of care and where there are gaps in services in order to target strategies and investments. While we are advocating for more data sharing and transparency, this should not come at the expense of placing more administrative burden and reporting requirements on providers. Coming out of the pandemic and COVID-19 recovery, our system and staff are fragile and cannot take on any new reporting burdens. The current data sets that are reported by providers to the DBH are more than adequate to provide public information about the state of the behavioral health system and the continuum of care, however, it has been difficult for behavioral health organizations and associations to receive any of these requested insights.

1. ***Data***

The TBHD have been requesting data on the 1115 Waiver for some time. The renewal application and associated interim evaluation report are the first time we are seeing the data that providers and organizations have been submitting to the state for years. The data and results were surprising to many of us. It will take time to really understand the data and results. We request time with the State to better understand the data and methodology in this report.

The data contained in the 1115 Waiver Renewal Application used to validate hypotheses:

1) We have not had enough time prior to this consultation to examine the data to evaluate the hypothesis;
2) Data does not support or validate the Waiver hypotheses,
    a. For example, paid claims data are used to measure access, quality and cost neutrality. This is not appropriate because:
        i. Access to service means that a service is available. For a service to be included in paid claims data, a service would need to be available to an individual, furnished to a Medicaid recipient and paid by Medicaid in a way that conforms with the measure definition. There can be a substantial gap between availability and Medicaid payment at any time.
        ii. The Administrative Services Organization (ASO) is struggling to pay claims timely and correctly. We are therefore concerned that even the reduced subset of access that a paid Medicaid claim would represent is not accurate and complete for the purposes of the evaluation.
3) We want to be involved in data collection and examination;
4) Until the state can get decent data shared out, there are not measures that support the assertion that the Waiver made progress in improving access, quality, and cost neutrality;
5) Data is important to help us determine where to focus attention and effort in the Tribal Health System and that our organizations can review to look at best practices and clinical outcomes.

2. ***Workforce***

In order to meet the goals outlined in the 1115 Waiver we need the workforce to not only meet current needs but also to expand to other 1115 Waiver services. Workforce was a challenge before the pandemic. The pandemic has only exacerbated our workforce challenges. The ability to realistically grow and expand services with all of these workforce shortages is extremely challenging. The expansion of the 1115 Waiver services has created more, not less workforce barriers and challenges. This is why our regulatory comments on 1115 Waiver services rates is so critical to expanding 1115 Waiver services across the state.

While not directly tied to aspects of the 1115 Waiver renewal, initiatives to support workforce efforts are critical for us to be able to continue to staff our programs. Partnerships with UAA, APU, and other training programs are critical. Second, we request licensing reciprocity for individuals moving to Alaska. This reciprocity may need legislation, or an emergency regulatory fix—please push for these within the state administration and before the Legislature. Finally, current licensed providers need a reliable and prompt process for licensure renewal. This is a big issue for providers given the time it takes to receive approval. The Division of Corporations, Business, and Professional Licensing needs to receive a subsidy in order to quickly staff up all of its licensing sections.

3. *Certification Requirements*

We are concerned about the QAP certification requirement since this came up and the disproportionate impact this requirement has on rural and remote communities in Alaska. During the past 3 years, we have experienced significant turnover and costs to meet these requirements in our provider pool. We appreciate the one-year extension to meet the QAP requirement, but this is still not enough for us to continue to have the workforce to deliver these services.

The State did a nice job in the original SUD Waiver application acknowledging the gap between supply and demand with a plan to decrease that gap. In the Waiver Demonstration renewal application, the state continues to highlight the incredible gap between urban and rural providers. Again, we see in the 1115 Waiver Evaluation Report, which is part of the renewal application, that **no** SUD providers are billing for services in regions 3, 6, 7, 8, and 9—the rural and remote regions of the state.

In addition, the Alaska Commission on Behavioral Health Certification (ACBHC) updated the CDC Counselor II (CDC II) and CDC-Supervisor (CDC-S) requirements effective 1/1/26. A CDC II will require a bachelor's degree and a CDC-S will require a master's degree. Requiring a master's degree for a CDC-S sets a higher standard than their peers who can bill 1115 Behavioral health waiver services under the BH Clinical Associate standards. Without a change to the CDC II QAP requirements these changes will impact all providers, however, these changes will disproportionately impact T/THOs and stop and limit any progress that has been made with the SUD treatment workforce in rural Alaska. There is no data that these new certification requirements lead to better clinical outcomes of care for Alaskans.

The following are recommendations that ANHB has shared with ACBHC and would like the State to help make sure that the following can occur: 1) A pathway remain for those without higher education degrees to become a CDC provider. 2) We recommend removing the requirement for CDC-Supervisors to have a master's degree. This seems like an unnecessarily high standard which is not in alignment with NAADAC requirements for equivalent certification. This would limit the number of hours a master's level therapist could spend in direct care at a time when we are experiencing significant workforce shortages. 3) Additionally, there should be financial support for organizations to support certification costs, plus supervision, or time away from direct care, overtime (alleviating administrative burden).

4. *Administrative Burden*

One of the goals of the Senate Bill 74, the legislation authorizing the 1115 Waiver in Alaska, was to reduce administrative burden. Although this is a very broad statement and not specific to the 1115 Waiver, the ASO has added significantly more administrative burden on providers. Tribal Behavioral Health Directors have consistently shared this feedback during their quarterly meeting with state officials. Some examples of this additional administrative burden include:

1) Service Authorizations,
2) Separate 1115 Waiver Enrollment and Claims Process,
3) Level of Care documentation,
4) Difficulty in finding the most recent and accurate regulations, guidelines, etc. needed to start-up these programs.

Service authorizations have been burdensome for years, and the topic has been brought up many, many times to state officials. The 1115 Waiver adds more required service authorizations

and prior authorizations for providers. We understand that CMS does require medical necessity to be shown for services, but CMS guidance does not state specifically that this has to be done through service authorizations. We offer recommendations to address administrative burden below:

1) We request medical necessity for behavioral health and SUD services be determined based on the appropriate clinical documentation. The service authorization form is duplicative of what is already present in clinical documentation. Additionally, the disparity in bureaucratic requirements between medical health care and behavioral health care is startling. The number of pages needed to satisfy authorization requirements for managed mental illnesses like bipolar disorder is an order of magnitude greater than for treating managed diabetes or high blood pressure.
2) Reduce barriers to care and overall complexity, such as service authorizations, multiple enrollments, and multiple data entry requirements.
3) Clinical Documentation burden should mirror that of conventional health care documentation requirements.
4) Transportation – Travel parity for behavioral health emergencies. Far too often individuals in rural and remote Alaska are forced to wait days for authorization for transport due to an acute behavioral health crisis. This does not happen for an individual with a physical injury or cardiac emergency.

5. *Administrative Services Organization*

One of the central goals of the waiver was to contract with the ASO to manage the behavioral health system reforms for both waiver and non-waiver services. This experience for the Alaska Tribal Health System has been difficult, costly, and challenging for providers. We can see the outcome of our experience in that **no** SUD providers are billing for Medicaid Services in waiver Regions 3, 6, 7, 8, and 9. These regions represent all of the rural and remote areas of Alaska and should greatly alarm state officials. More needs to be done to ensure that Tribal beneficiaries and community members in the most rural and remote parts of Alaska have access to these services in their communities and regions.

We want to make sure that the challenges that have impacted the ability for Tribal providers to either transition or stand up these services are heard by state officials:

1) Enrollment and the start-up process are very cumbersome and confusing. Responses to requests for guidance and clarification have been inconsistent among T/THOs.
2) Claims processing and timely payments have been a huge administrative burden for organizations and have jeopardized the financial viability of many providing organizations across the state.
3) In addition, because so many measures are based on claims data, we are concerned that the failure to process claims in an accurate and timely manner may impact the accuracy of the measures reported in the waiver renewal application.
4) Most of us are part of a larger THO system that has a separate process for enrollment and billing. The difficulties associated with the ASO have led to our organizations having to hire additional staff to enroll and bill for 1115 Waiver services.
5) We have significant concerns about the re-start of service and prior authorizations. The behavioral health system in Alaska has not been burdened by service and prior authorizations for years now, nor have the staff at the ASO. However, once the federal PHE expires these requirements will come crashing back down on providers,

organizations and the ASO. It is unclear if there are still staff remaining with the ASO who have experience with these authorizations.

6) In addition, we have concerns about the ASO's ability to carry out their contractual obligations including reducing administrative burden and reporting measures outlined in the ASO contract.
7) As the ASO hires more staff, we request that those employees are familiar with Alaska and the Tribal health system in our state. THO staff that interact with Optum often report having to educate these national employees about Alaska and the Tribal health system.

6. *Health Homes and CCBHCs*

The 1115 Waiver renewal application references exploring innovative delivery system initiatives, such as a state plan option to implement health homes or the federal Certified Community Behavioral Health Clinic (CCBHC) demonstration which may complement the behavioral health reform waiver. The application present these as opportunities to bring additional resources to Alaska and build integrated capacity to support this objective.

We have questions about what the state is proposing with medical homes and CCBHC. We expect to be at the table prior to submitting any demonstration applications and prior to implementation of any new regulations.

7. *Evidence-Based System for Clinical Guidelines*

The 1115 Waiver renewal application references creating an evidence-based system for clinical guidelines. Treatment should be customized for individuals and providers should have flexibility to choose the tools based on what is clinically appropriate for the individual and populations that we serve. We are concerned about requiring any clinical assessment that is not culturally sensitive. We request that the Alaska Tribal Health System is included in any process related to establishing evidenced-based system for clinical guidelines, in order to ensure that any additional screenings or assessment tools are culturally sensitive.

8. *Screenings*

Reference to exploring opportunities to compensate providers for SUD and mental health screenings outside of a behavioral health setting. We applaud the State's effort to move toward reimbursement for screenings and brief intervention being delivered in primary care settings. We request to be part of the conversation as this continues to move forward.

We agree with the Waiver goal to focus on prevention and early intervention services. For screening and intervention services to be sustainable in a non-behavioral health setting, providers need to be able to bill and receive payment for those services.

9. *DOJ Report and Continuum of Care*

We acknowledge that the issues resulting in the Department of Justice (DOJ) report[2] pre-dated the original 1115 Waiver. However, strategic implementation of changes to the behavioral health system, especially in rural Alaska, through the 1115 Waiver can remediate the underlying issues that resulted in the DOJ report. We agree with the goal of rebalancing the current system of care to reduce Alaskans over-reliance on acute, institutional care and shift to more community-based

[2] U.S. Department of Justice Report, *Investigation of the State of Alaska's Behavioral Health System for Children*, December 15, 2022. (https://www.justice.gov/opa/press-release/file/1558151/download)

or regionally-based care. The waiver mechanisms should also focus attention on community care for priority populations like children at risk of hospitalization or institutional placement.

The ATHS is extremely concerned about the content of the DOJ report and the most recent death of an Alaska Native youth in out-of-state placement. This is truly heartbreaking and an emotional time for many Alaska Native people who experienced similar situations with boarding schools.

We need to come together quickly to make sure that our Alaska Native children are able to receive the needed behavioral health and substance use disorder treatment services in their communities, regions or within the State. In order to do this, we need to partner with DOH on the following:

1) Infrastructure funding,
2) Technical assistance for starting up new programs,
3) Programmatic start-up funding for the first 3 years and possibly ongoing,
4) Workforce,
5) Housing for providers,
6) Data to drive system improvements and investments.

Many of the 1115 Waiver services seem to be focused on urban areas. We encourage the State to engage with TBHD to evaluate and plan for 1115 Waiver services and discuss modifications to the service descriptions so that these services can be offered in regions.

Additionally, while the DOJ report focuses on the tragedy of children being sent out of state for institutional treatment, it is important to note that a similar story plays out with far too many adults being sent out of state for behavioral health treatment—stories that would not need to be repeated if the State played a stronger role in starting up services across the nine waiver regions.

10. *Tribal Engagement and Collaboration Process*

We request an agreed upon process for the DOH and ATHS to formally determine how we will collaborate to ensure 1115 Waiver services are available in regions across Alaska and work to remove any barriers for implementing these services. We were discouraged to see a comment in the report about lack of CMS guidance on how the State will work with Tribes. We respectfully disagree and believe we have a good working relationship and can come up with a way to work together to achieve these goals.

The application references that the State is fully committed to supporting providers and reducing administrative burdens within the program throughout the extension period. The TBHD created a workgroup to explore ways to reduce administrative burden with our State partners. However, state officials' participation in this group ended after 2 meetings. We need the State to commit to working with providers to reduce barriers and challenges that are faced by all providers but impact T/THOs significantly due to workforce shortages and limited resources in rural and remote parts of Alaska.

The State of Alaska and Division of Behavioral Health will need Tribal Behavioral Health providers' clinical expertise in order to meet the improved health and wellness outcomes described in the 1115 Waiver application. Tribal providers need data, collected by the Division, in order to lead our efforts and respond to the needs of Alaskans. Up to now, the State of Alaska and DBH has attempted to impose clinical expertise on Tribal (and non-Tribal) providers while withholding data from them. We request a paradigm shift in this area. The State of Alaska and the Division of Behavioral Health should not impose regulations without supplying data that back up the changes.

The changes suggested by providers are our best efforts at improving the system; if our suggestions are invalid then we would like to know, empirically, why. We would like to hear the State's recommendation on how we can partner together on the 1115 Waiver Tribal-specific recommendations.

Conclusion

We thank the State for engaging in Tribal Consultation on the 1115 Waiver renewal application. While there are many areas of concern, we still wish to work collaboratively to make the waiver successful. If you have any questions regarding our recommendations, you may contact ANHB at anhb@anhb.org or via telephone at (907) 729-7510.

Sincerely,

Chief William F. Smith, Chairman
Alaska Native Health Board
Tribally-Elected Leader of the Valdez Native Tribe