December 29, 2017

PUBLIC & TRIBAL CONSULTATION COMMENTS ARE DUE 12/29/2017 @ 5:00PM ALASKA TIME	
FOR PUBLIC COMMENTS SEND TO:	**FOR TRIBAL CONSULTATION COMMENTS:**
1115_Public_Comments@alaska.gov 1115 Public Comments C/O Alaska Mental Health Board/ Advisory Board on Alcoholism and Drug Abuse PO Box 110608 Juneau, AK 99811-0608	courtney.king@alaska.gov Courtney O'Byrne King 4501 Business Park Boulevard Building L Anchorage, AK 99503

Dear Commissioner Davidson, Deputy Commissioner Sherwood, Division of Behavioral Health Director Burns, Ms. King, and Staff:

On behalf of the Bristol Bay Area Health Corporation, and as a member of the Alaska Native Health Board, and the Alaska Tribal Health System, we are writing to provide the following Tribal Consultation comments and Public 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 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.

Conclusion

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.

Sincerely,

BRISTOL BAY AREA HEALTH CORPORATION

Robert J. Clark
President & Chief Executive Officer