Tribal Consultation Concerns | Recommendations

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

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

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

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			system. It is counter to the intended purpose of enhancing the availability of mental health treatment and prevention services. Tribes agree that prevention is the key. Our vulnerable recipients need to have services as close to home as possible; this is the most cost-effective approach and ensures the best outcomes. Tribes are also concerned about Medicaid recipients who do well receiving services under the waiver: if their use of emergency and high intensity services is reduced, will recipients lose their eligibility for these waiver services?	o Three Behavioral Health Crisis Services (S9484 Crisis Intervention or H2011 Crisis Stabilization) provided by a BH Provider (including BHA/Ps) • Referral from primary care or medical home, including ER/Urgent care/specialist (not everyone has a primary care provider) • Positive screening on a behavioral health screening (PMD, GAD-7, etc.) and/or positive screening for suicidal ideation/intent (CSSR or PMD #9, for example) • Referral by Behavioral Health Clinician, Behavioral Health Aide/Practitioner or Community Health Aide/Practitioner • Referral by federal, state, or tribal court. Once initial eligibility for waiver services is met, recipients may continue to receive waiver services as long as is clinically necessary. Recipients will not lose eligibility while receiving a waiver service.
6	17	Eligibility Group 2 – Diagnoses – • "A Diagnostic and Statistical Manual of Mental Disorders (DSM-5) mental disorder including bipolar disorder, depression, eating disorder, generalized anxiety disorders, obsessive-compulsive disorder,	A partial list of example diagnoses could be construed as a limited set of diagnoses that are eligible. The DSM is updated regularly.	It would be clearer to remove the examples and simply require a DSM diagnosis. Change "DSM-5" to "the most current version of the DSM".

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		panic disorder, postpartum depression, post-traumatic stress disorder, psychotic disorders, or social anxiety phobia; or "		
7	17, 19	Eligibility of Adults over age 64. Eligibility Group 2 – "The individuals in this target population are between 18-64 years of age and have:" Eligibility Group 3 – "This waiver proposal seeks to enhance the availability of and provide a more comprehensive continuum of substance use disorder treatment for adults, as well as adolescents and children enrolled in Medicaid in Alaska. The waiver will target individuals between 12 and 64 years of age who:"	Society in general, and especially Native cultures, take care of children and elders, yet elders would be excluded from waiver services. Although persons 65 and older are eligible for Medicare, Medicare will not cover the behavioral health needs of this population adequately: it covers only a limited array of behavioral health therapy services if these are delivered by a licensed clinical social worker or licensed psychologist. Although the new 1915(k) waiver services may be a valuable option for some, not all persons 65 and over will be eligible for these, and the existing state plan services such as comprehensive community support and case management, which do so much to address behavioral health needs of all adults in both rural and urban settings, are identified as state plan services to be deleted on page 53 of the application. Further, Medicare does not recognize rural services (CHA/P and BHA/P). For much of the rural Alaska population, LCSW or licensed psychologist services are not available on a regular basis: Medicare simply does not cover the services that are available in rural areas During the in-person Tribal consultation, we heard that one concern related to the	Remove the upper age limit for adults.

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			population 65 and older is cost. Cost for any age group is a concern in Alaska: however, we would submit that it will be costlier to the state to fund the services that will be required if basic behavioral health services are no longer covered by Medicaid for these individuals.	
8	18-19	Group 3 Eligibility Bullet 2 – "Meet the American Society of Addiction Medicine (ASAM) treatment criteria for addictive, substance-related, and co-occurring conditions definition of medical necessity."	The way this is worded, it looks like having a co-occurring condition is required to receive Group 3 services. As clarified by the State during in-person consultation, a co-occurring condition is not intended to be a requirement.	Delete the second bullet.
9	20-23	"Evidence based clinical assessment" and "comprehensive family assessment"	"Evidence based clinical assessment" and "comprehensive family assessments" do not actually exist. It is unclear how a family assessment and family treatment plan would work. How would it bill? Clarity is needed.	Provide a clear path for parents, caregivers, and other family members to receive services. Because no "evidence-based clinical assessment" or "comprehensive family assessment" exists, we recommend striking this language from 1115 Waiver Application rather than creating workgroups that create these instruments. A simpler path would be: 1. Expand all current Medicaid-reimbursable services to include "Family" modifiers. 2. Allow a treatment plan be written based on the integrated assessment of any member of the family.

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				3. Allow the services called for in the family treatment plan be provided to any family member and reimbursable under the Medicaid number of the person with the integrated assessment. If this edit is not acceptable, then Tribes will require participation in workgroups for the identification or creation of "evidence-based clinical assessment" and "comprehensive family assessment."
10	20, 21, 23, 24, 53, 55	Screening, Assessment, and SBIRT Services	1. The waiver application provides that screenings, assessments, and SBIRT services would be covered for waiver recipients. It also states that universal screenings utilizing the Alaska Screening Tool will be phased out when the waiver is implemented. Taken together, this seems to mean that screenings, assessments, and SBIRT services will be covered only for the waiver population, and not for all Medicaid recipients under the State Plan. Limiting these services to waiver recipients makes no practical sense, would frustrate the waiver's purposes, and would be contrary to the public health. First, screenings and assessments are required in order to identify individuals who are eligible to receive waiver services. As a practical matter then, they must be provided before waiver eligibility is determined, and consequently they should be covered under the State Plan.	1. Cover screenings, assessments, and SBIRT services under the State Plan for all recipients, rather than limiting them to those eligible for waiver services. Revise the waiver application to clarify that Medicaid should cover screenings, assessments, and SBIRT services under the State Plan for all Medicaid recipients. 2. Work with Alaska Tribal Behavioral Health Programs to identify or develop culturally-appropriate screening and assessment tools. 3. Clarify that all screenings and assessments will be administered by providers, not by the Department or the ASO. 4. Permit providers to choose the assessment and screening tools they deem most appropriate for their patients,

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			Second, universal screening of all Medicaid recipients, not just those eligible for the waiver, is essential to achieve the waiver's stated goals of intervening early and providing recipients with the right service, at the right time, in the right setting. Finally, when a screening identifies the need for them, brief intervention and treatment services (SBIRT) should be provided immediately and on-the-spot, to protect the recipient. For all these reasons, screenings, assessments, and SBIRT services should all be covered under the State Plan for all Medicaid recipients, and not limited to the wavier populations. 2. It is important that screenings and assessments be culturally appropriate for our Alaska Native and American Indian recipients. 3. It is not always clear in the waiver application whether screenings and assessments will be administered by providers or by the Department or ASO. All screenings and assessments should be administered by the recipient's provider. In our face-to-face consultation, the Department stated this is its intent, but we ask that the waiver application be clear on this point. 4. There are a variety of screening and assessment tools available, and many providers have carefully selected those that best suit their patients and programs. The choice of screening	programs, and accreditation requirements. If a list of approved screenings and assessments is created, create a workgroup comprised of tribal and non-tribal providers to identify or create them. Include on the approved list any screenings and assessments that providers indicate they already use, or grandfather their use by those providers.

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			and assessment tools should be left to the provider's professional judgment. If a list of approved tools is required, tribal and other providers should be involved in their selection. Tools currently used should be included and their use should be grandfathered for the providers who use them.	
11	21	Services – Group 1 "**Home-based family treatment services** are unique services proposed for this target population. Services include individual and family therapy, crisis intervention, medication services, parenting education, conflict resolution, anger management, and ongoing monitoring for safety and stability in the home. Two different levels of home-based family treatment would be offered: Level 1 home-based family treatment services are provided for children at moderate risk of out-of-home placement, and Level 2 home-based family treatment services are provided for children at high risk of out-of-home placement. Level 3 services would focus on family therapy. These home-based family treatment services are designed for children at high risk for residential placement – pre-residential treatment or post- residential treatment."	Home-based family treatment services are a welcome addition and we support their addition to the 1115 waiver proposal. It appears, however, that the levels of home-based family treatment will prevent clinical judgment from determining the specific, individual services that a family might receive. It appears that these services would be required to be "bundled" and delivered to recipients by a single provider agency. Bundling services would preclude Tribal providers from offering specific services that might be called for based on clinical determination, if they do not provide all the services included in the "bundle." This would needlessly separate recipients from the tribal providers who are most familiar with their needs and best able to provide culturally-competent care. It would also be costly to the State, since most services furnished by tribal providers are reimbursed at 100% FMAP. For these reasons, we recommend eliminating the levels within this new service category, and allowing providers to use clinical judgment to determine which individual services should be	We recommend eliminating the levels within this new service category, and allowing providers to use clinical judgment to determine which individual services should be included in treatment plans. We also recommend clarifying that home-based family services will not be a bundled payment, allowing multiple providers to provide services.

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			included in treatment plans. The levels of home-based family treatment services are not clear. The home-based service need should be clinically driven. The three levels do not seem to have clinical rationale.	
12	21, 23	Services – Group 1 – "**Mental health day treatment** services are outpatient services specifically designed for the diagnosis or active treatment of a mental disorder when there is a reasonable expectation for improvement or when it is necessary to maintain a child's functional level and prevent relapse or full hospitalization. Mental health day treatment will be based on the ASAM Patient Place Criteria Level 2.5." Services – Group 2 –"Mental health day treatment for adults will also use the ASAM Patient Place Criteria Level 2.5."	ASAM is not an appropriate criterion for day treatment eligibility. The American Society for Addiction Medicine (ASAM) Criteria are level of care guidelines that recognize six dimensions relevant to the successful treatment of individuals with substance use (or co-occurring substance abuse and mental health) disorders. They are not guidelines for mental health treatment. Reference to ASAM under mental health-only services is inappropriate and should be removed.	Remove ASAM criteria from service description.
13	21, 23, 24	Waiver service eligibility post successful intervention.	The waiver application proposes to provide specific services to each of three target populations. It is not clear what will happen if a recipient begins receiving a service and the successful intervention results in loosing eligibility. Examples include, but are not limited to, Intensive Case Management, ACT and Community and Recovery Support services. Tribal behavioral health providers have explained that eliminating these services to	We recommend that the waiver continue to cover these services for recipients who have improved to the point that they no longer meet eligibility criteria, in order to prevent future readmissions to hospitals and save costs. Add to the waiver: Once initial eligibility for waiver services is met, recipients may continue to receive

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			those individuals who no longer meet the waiver eligibility criteria (e.g. 3 or more acute intensive services in the past year) is not practical and does not make sense if the service helps the recipient avoid relapse and prevents future inpatient hospital admission, and also saves costs. It is counter-intuitive and counter-productive to stop providing waiver services to recipients who respond well to them.	waiver services as long as is clinically necessary. Recipients will not lose eligibility while receiving a waiver service.
14	22	Services – Group 1 – "**Therapeutic foster care** is a new service unique to this target population that will be made available for youth who are in state custody or foster care. These services are clinical interventions that include placement in specifically trained foster parent homes for children ages 0-18 who are in foster care or in the custody of the juvenile justice system and have severe mental, emotional, or behavioral health needs. Therapeutic foster care includes medically necessary treatment interventions based on an individualized treatment plan guided by a state-selected level of care assessment tool. Services include individual and family therapy, medication services, crisis services, and care coordination. "	The service description includes additional eligibility criteria – children in state custody and foster care. This service is presently available to children who are not in state custody or already in foster care. This waiver service should also be available to children who are in DJJ custody, OCS custody, tribal custody, foster care, parent or guardian care, or voluntary kinship placements. Clinical delivery of care is not typically what would happen in a foster home. There are not too many therapeutic foster parents who can provide the services listed. "Therapeutic Foster Care" is appears to describe a bundled Behavioral Health services, this time including compensation for room, board, and supervision of the service recipient by a foster family. It is important to acknowledge that the foster family is rarely, if ever, the provider of "individual and family therapy, medication services, crisis services, and care coordination." Therefore, this service is an attempt to include	Require connection to cultures as part of the delivery of foster care. Define eligibility as: Children who are in DJJ custody, OCS custody, tribal custody, foster care, parent or guardian care, or voluntary kinship placements. Include respite services for resource families. Include kinship providers. Design an unbundled service such that clinical behavioral health work can be provided by a T.H.O. for tribal recipients. Rename this service omitting the word 'foster'. Perhaps Therapeutic Family Care. We suggest gathering input from THOs and

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			currently separated services into one new service. This approach puts Tribes at a distinct disadvantage because it favors those agencies that already have licensing capabilities for "foster homes". The term "foster care" has historically negative connotations for Tribal people and therefore Tribes do not currently have this capability, nor do they want to. Changing the way this service is named and referenced will be an important first step in getting Tribal involvement in the out-of-home care of children. Until those changes are made, and "foster care" is renamed and re-conceptualized, there will be a gap where this service will only be provided by non-Tribal agencies. These agencies will also provide the currently separate services of "individual and family therapy, medication services, crisis services, and care coordination." As some of these services could be provided now by Tribes, it will cost the State more money to bundle them into a service provided by a non-Tribal agency than if the State allowed for separate billing of services. A "bundled" service provided by a non-Tribal agency will also cut off the connection to the natural, culturally-competent treatment provider that the child should return to once "foster care" ends.	providers on the new name.
15	22, 23	Services Group 1 and 2 – **"23-hour crisis stabilization services** will also be made available for children and adolescents in	We support this service to be provided across all three of the waiver's target population groups. This can be accomplished by including	1. In order for eligible Alaska Native and American Indian peoples to have adequate access to waiver services we recommend

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		crisis. These are services for up to 23 hours and 59 minutes of care in a secure and protected environment. The program is clinically staffed, psychiatrically supervised, and includes continuous nursing services. The primary objective is for prompt evaluation and/or stabilization of individuals presenting with acute symptoms or distress. Services include a comprehensive assessment, treatment plan development, and crisis intervention services necessary to stabilize and restore the individual to a level of functioning that does not require hospitalization."	telemedicine and Behavioral Health Aides/Practitioners (BHA/P) as a mode of service delivery and reimbursement. Unless this is changed it will be extremely difficult for Alaska Native and American Indian people to access this service in the Alaska Tribal Health System. There are very few psychiatrists in Alaska and fewer still in Alaska Native villages and likely none in very remote locations. Psychiatric services are capably furnished by other providers like BHA/Ps and by telemedicine. Tribal behavioral health providers have also expressed concerns about the continuous nursing services requirements, which would make it impossible to furnish this service in rural and remote locations. We also note that, in certain locations and instances, a jail or detention facility may be the safest and only location to provide this service.	that the waiver add and specify that telemedicine and distance delivery are acceptable methods of psychiatric supervision. 2. We further recommend that the waiver be amended to include additional professionals who can furnish psychiatric supervision (psychiatric nurse practitioners and physician assistants, behavioral health professional clinicians, and BHPs). 3. In order to address the very rural and remote situations of Alaska Native villages, we recommend that the waiver be amended to allow and include that CHA/P and BHA/P services meet the "continuous nursing" requirement.
16	22, 23, 25	Services – Groups 1, 2, and 3 – "**Residential treatment services** will be modified based on clinical standards aimed at shortening lengths of stay due to the availability of new step-up and step-down services."	While the waiver aims to create new services levels that will be appropriate step-up and step-down services, this will be a challenge in Alaska's many small and remote communities. Many of the services described in the waiver might be possible in urban locations but will not be possible in the hundreds of village communities across Alaska during the 5-year demonstration. This is a situation unique to Alaska given the small size of villages and the distance between villages and hubs, which most	Alaska Native people will be adversely impacted by reductions to lengths of stay because it is not possible for appropriate step-up and step-down services to be developed in all local villages during the 5 years of the 1115 demonstration. Due to this adverse impact, exempt Alaska Native people and THOs from length of stay limits. Thank you for clarifying during in-person consultation that the actual length of stay for all individuals receiving residential care

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			often requires air travel. This creates a unique problem if lengths of stays in residential care are limited and 'step-down' services are not available in small home communities.	will be based on a clinical determination of medical necessity. Lengths of treatment should be clinically determined. We recommend adding the following statement to the 1115 to provide this clarity: "Actual length of stay for all individuals receiving residential care will be based on a clinical determination of medical necessity" Savings realized through reduced residential care should be based on decreasing the number of people needing residential care by creating step-up and step-down services. Calculate savings for cost neutrality based on reducing the number of people in residential care, not the length of residential stays.
17	22, 23, 24, 25	Services – Groups 1, 2, and 3 – **23-hour stabilization and residential programs** are described as 10-15 bed facilities	There are existing residential programs with fewer than 10 beds. Requiring a minimum of 10 beds does not allow these services to be provided in smaller communities where the population demand and/or existing facilities are less than 10 beds. Allow each community to provide these services and be reimbursed regardless of the number of beds. Allowing each community to provide this service as locally as possible (without a minimum bed	Delete "10-15 beds"

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			requirement) will save Medicaid travel costs for transporting to larger hub communities.	
18	23	Services – Group 2 – "**Assertive Community Treatment (ACT)** services are unique to this target population. ACT services are designed to provide treatment, rehabilitation, and support services to individuals who are diagnosed with a severe mental illness and whose needs have not been well met by more traditional mental health services. The ACT team provides services directly to an individual that are tailored to meet his or her specific needs. ACT teams are multi-disciplinary and include members from the fields of psychiatry, nursing, psychology, social work, substance abuse treatment, and vocational rehabilitation. Based on their respective areas of expertise, the team members collaborate to deliver integrated services of the recipients' choice, assist in making progress toward goals, and adjust services over time to meet recipients' changing needs and goals. The staff-to-recipient ratio is low (one clinician for every 10 recipients), and services are provided 24 hours a day, seven days a week, for as long as they are needed."	The typical ACT model will be challenging to create in rural/smaller population areas. In order to deliver this service successfully, it will need to be modified to include distance delivery, local provider types and flexibility on the hours of the services (24-hour would not be possible in many small communities). The ACT model is designed specifically to help overcome patient deficits in trust, relationship and the overall process of engaging in health services by reaching into the community to make connections. The ACT team caters to a patient population that's often unable to navigate traditional health service systems due to reduced cognitive capacity or an inability to perceive reality accurately. These cognitive challenges affect a patient's ability to provide accurate history often leaving the ACT team with very limited information, particularly at initial engagement. For these reasons, the ACT team eligibility should not be based on number of ED visits (information that will neither be knowable or meaningful at time of enrollment) and instead should be based on functioning, homelessness, or the presence of significant cognitive impairment.	Continue to furnish this service to waiver recipients who improve to the extent that they no longer meet waiver criteria. Include in the waiver that modified ACT teams will be supported in rural areas. By nature of the intervention, delivery of an ACT service should not have eligibility criteria.

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			The ACT model does not include checking 'eligibility'. Rather an ACT team should have no barriers or obstacles. ACT customers do not 'enroll' in the ACT service. The ACT service should include frequent in person interactions over time to build relationship, trust and motivation in further engagement with the behavioral health system. Given this model, the eligibility criteria are problematic to the ACT model. All Medicaid eligible people in need of the ACT team should be reimbursed without barrier.	
19	23	Services – Group 2 – "the state plans to offer Group 2 **mobile crisis response services**, **23-hour crisis stabilization services,** and **continue residential treatment services** (modified to clarify clinical standards aimed at shortening lengths of stay due to the new step-up and step-down services)."	We learned in tribal consultation that adult mental health residential services are not included in the early stages of the1115 waiver services, but will be built out as there are system savings to reinvest. There is a reference to adult mental health residential services in the waiver application itself. Adding capacity for adult residential mental health services is a crucial need given extremely limited access to API. Even if this service will be phased in, we recommend including adult mental health residential in the waiver service package.	Add adult mental health residential services to the waiver.
20	23-25, 29	Services – Group 3 Service compendium Table 2 – Proposed Alaska SUD Services by ASAM Level of Care	Many ASAM levels are missing, for example, 1.0 (non-MAT services), 2.5, 3.4, and 3.7). How are SUD ASAM levels not listed in this table reimbursed if they are not included in the waiver service package and the Comprehensive Community Support Services under which these services are currently reimbursed are deleted?	Clarify that all appropriate SUD services are available to Target Group 3 recipients including the appropriate service for all ASAM levels. In order to remain faithful to the ASAM Criteria and its suggestions, references to it

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			The ASAM Criteria is a standardized conceptualization of levels of care based on the evaluation of six dimensions of a person's life. It is intended help the addiction professional determine the least restrictive environment of care that a person requires for successful addiction recovery. It is not a list of services or a specific treatment approach. Within the 1115 Waiver application, the term "ASAM Criteria" seems to be used as a description of services or a specific treatment approach. It appears that the intention of this 1115 Waiver application is to create new service/CPT codes that are "bundles" of currently separate, individual services. We believe this is a mistake. There are currently a number of Tribal providers with the capacity to provide some of the separate, individual services who might not be able to provide the new "bundled" service. While the intention of the Waiver might be to encourage providers to create full "bundled" services, the result will be either a gap in services while Tribal agencies adjust their programs (hiring and retaining providers is already difficult for Tribes based on remote locations) or non-Tribal providers with more options will step in and take over the services previously provided by the Tribal provider. This will require the State to pay the Medicaid match for Tribal members who access services through non-Tribal agencies, ultimately costing the State	throughout the 1115 Waiver application need to be removed, or reviewed and edited. The Tribal Behavioral Health system does not recommend that the State use the ASAM levels of care as "bundles of services". Reference is made within the ASAM Criteria of using the guidelines with managed care organizations. This section should be reviewed by State staff prior to submitting the 1115 Waiver application. Substance abuse treatment providers, Tribal as well as non-Tribal, should be able to use the ASAM Criteria as intended to create treatment plans based on individual service provision, not "bundles".

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			more money. Maintaining the current model of billing for services provided allows Tribes to be part of a continuum of care which includes non-Tribal community providers.	
21	24	Services – Group 2 – "**Peer-based crisis intervention** services are services provided in a calming environment by people who have experienced a mental illness or substance use disorder and are designed for individuals in crisis. They are delivered in community settings with medical support and can be used in the event that there is a wait list for services."	Rural Alaska communities are staffed primarily by CHA/Ps who are the only medical responders to local emergencies. CHA/Ps may provide crisis intervention services for days or weeks in the health clinic or jail when the weather is bad and planes cannot make it into the community.	Medical support should include CHA/Ps so that the service can be possible in a smaller or more rural location.
22	24-25	Group 3 Services	There is often a need for 23-hour crisis stabilization services for Group 3. For example, suicidal people who are intoxicated would need this service.	Add 23 hour crisis stabilization to the services available to Target Group 3.
23	25	Services - Group 3- "**Medication-Assisted Treatment (MAT)** (ASAM Level 1.0) service will include injectable Naltrexone or any other medication that is currently approved with consultation with the state Medicaid pharmacist for alcohol and opioid abuse."	The intent of "consultation with the state Medicaid pharmacist" isn't clear. Requiring a consult with the state's pharmacist would create an unneeded bottle neck in the prescribing processes.	Delete the phrase "with consultation with the state Medicaid Pharmacist for alcohol and opioid abuse.
24	25	Services – Group 3 – "MAT Services would also include **MAT care coordination** services, which is the deliberate organization of patient care activities between two or more participants involved in a patient's care to facilitate the appropriate delivery of integrated SUD and primary health care services. The patient must be in attendance. Care coordination involves a team that provides a wide range of services	MAT care coordination is a valuable service and we are glad to see this in the waiver. We have two concerns: 1. There is growing evidence that MAT alone as an intervention is beneficial even without behavioral health treatment. The waiver should allow but not require MAT care coordination.	1. In the phrase "MAT Service would include MAT care coordination" replace 'would' with 'could'. 2. Delete the sentence "The patient must be in attendance"

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		addressing patients' health needs, including medical, behavioral health, social, and legal services, as well as long-term supports and services, care management, self-management education, and transitional care services."	2. The description requires that "the patient must be in attendance" for MAT care coordination. MAT care coordination is needed and, like other care coordination services, can effectively occur with or without the patient in attendance.	
25	31	Waiver goals and objectives – "1. Develop community-based, culturally appropriate behavioral health workforce capacity (i.e., implement additional Medicaid-reimbursed behavioral health provider types) to address existing workforce deficits."	One of the waiver's cross-cutting goals is to develop the capacity for a community-based and culturally-appropriate behavioral health workforce. The most effective strategy to do this in the waiver is to build on the success of CHA/P and BHA/P programs and to also to include traditional healers as eligible service providers and allow their services to be reimbursed. In 1978, with the passage of the American Indian Religious Freedom Act, the Indian Health Service (IHS) policy required their programs and staff to comply with requests by patients seeking the services of traditional healers, to provide a private space to accommodate the services, and to be respectful of a person's religious and native beliefs. In 1994, IHS updated the policy indicating that IHS would facilitate access to traditional medicine practices, recognizing that traditional health care practices contribute to the healing process and help patients maintain their health and wellness. The Indian Health Care Improvement Act (U.S. Code Title 25 Chapter 18) contains several sections noting the acceptance and respect for these practices, with	1. We recommend the Waiver be amended to specify that new services offered under the Waiver may be provided by Community Health Aides/Practitioners and Behavioral Health Aides/Practitioners providers as long as they meet general applicable requirements as determined by their certification by the CHAPCB; 2. Tribal health providers should not be subject to ASO provider certification or credentialing requirements. 3. Workforce medical providers should include the following: • Physician (MD/DO)/Nurse • Practitioner/Physician • Assistant/Community Health Aide/Practitioner (under support of MD/DO) • Masters Level/Psychologist – Licensed Clinical Social Worker, Licensed Professional Counselor, Licensed Psychological Associate, Licensed Marriage and Family Therapist, PhD,

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			requirements to incorporate them into various preventative service categories, including behavioral health services and treatment. In recognition of this authority, both Arizona and New Mexico have included and authorized traditional healers to provide services and be reimbursed under 1115 waiver authority.[1] [2]	PsyD • Paraprofessional – Behavioral Health Case Manager/Behavioral Health Technician - Unlicensed providers working under the supervision of Masters Level Clinician, • Chemical Dependency Counselor • Behavioral Health Aide/Practitioner – under support of Masters Level Therapist We recommend that the waiver include services and support reimbursement for Traditional healing services provided in, at, or through Indian health facilities operated by Tribal organizations under the Indian Self-Determination and Education Assistance Act (P.L. 93-638). Peer Support – Under the new certification and regulations being drafted for peer support billing.
26	33	Waiver goals and objectives 2.5 "Partnership with Administrative Service Organizations. Health outcomes will be improved through earlier interventions and better coordination of care and the system will, by the end of the	The waiver describes how DHSS will contract with an Administrative Services Organization (ASO) to manage the service delivery reform efforts described in the waiver. During the Tribal consultation session held on December 20, 2017, DHSS also explained that it will contract with the ASO for all publicly- funded	1. We recommend that the State exempt Alaska Native/American Indian (AN/AI) people from auto-assignment to the ASO, and that it continue to allow them to receive all waiver and state plan services from any qualified tribal or non-tribal provider.

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

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		demonstration, be managed based on health outcomes supported by real-time data collection and reporting. The ASO will be required to work closely with Tribal Health Organizations, honoring the unique government-to-government relationship of Tribes with the State of Alaska." "2.7 Quality and performance measures."	behavioral health services administered by the Department, including both waiver and non-waiver Medicaid services. The Alaska Tribal Health System (ATHS) has previously communicated its concerns about the State's partnership with an ASO (See ANHB RFI Comment Letter dated March 30, 2017; and "Tribal ASO Discussion Matrix" dated August 29, 2017 previously provided to the State at the Pre-Consultation Meeting on August 31, 2017). We attach those materials and specifically incorporate them here by this reference. The ATHS continues to request that DHSS exempt ANs/AIs eligible for the waiver services from mandatory enrollment into the ASO, and that they continue to be allowed to receive all waiver and state plan services from any qualified tribal or non-tribal provider. Such an exemption recognizes the significant AN/AI behavioral health disparities that are explained in the waiver and recognizes the importance of the Alaska Tribal Health System that provides culturally appropriate care through its regional referral networks. This is critically important since the full scope of responsibility that will be assigned to the ASO is not known at this time; nor will it likely be known when the waiver is submitted to CMS. Tribal health providers cannot support this	2. We recommend that the State exempt tribal health providers as defined under the Indian Health Care Improvement Act from enrollment, licensing, certification, and credentialing requirements managed by the ASO. 3. The ASO's compensation for data collection, care management, and health outcomes managed by the ASO should be tied to its success in reducing the administrative burden to behavioral health providers. 4. The ATHS recommends that the waiver clearly describe that the State will continue its government-to-government responsibility with Tribes in managing the Medicaid program; and it will continue to consult with Tribes on those responsibilities that will be assigned to the ASO. Neither of these responsibilities may be delegated to the ASO.

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			process without understanding the full breadth of what this change will mean on Alaska Native/American Indian beneficiaries and the providers that serve them. It is noted that the waiver indicates that, at a minimum, all waiver services would be coordinated, authorized, and managed by the ASO. Consequently, CMS's Medicaid Managed Care Rules and CMS managed care policies come into play. These rules—and in related informational bulletins on the subject—CMS has made clear that States have the option to exempt Alaska Native/American Indian from mandatory managed care, "in light of the special statutory treatment of Indians in federal statutes concerning Medicaid managed care." Exempting AN/AIs from mandatory enrollment in the ASO, and allowing their care to continue to be coordinated and arranged by the ATHS, is supported by a number of federal laws and long-standing CMS policies that recognize the importance of ensuring that AN/AIs have access to culturally appropriate services furnished by tribal health programs focused on their unique needs. It is also supported by CMS's recognition of Indian health providers as a unique provider and facility type, and reimbursement for the services they provide in approved uncompensated care waivers in AZ, CA, and OR. Any Section 1115 Demonstration Waiver must	

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			be "likely to assist in promoting the objectives" of the Medicaid statute. We are concerned that unless exemptions are made for the ATHS, the waiver will not advance the objectives of the Medicaid statute with regard to Indian health. It is noted that Congress authorized IHS and tribal health care facilities to access the Medicaid program through Section 1911 of the Social Security Act in order "to enable Medicaid funds to flow into IHS institutions" (H.R. Rep. 94-1026 at p. 20). It was intended "as a much needed supplement to a health care program which for too long has been insufficient to provide quality health care to the American Indian" (H.R. Rep. 94-1026 at p. 21). We are concerned that eligibility criteria such as requiring three inpatient stays will limit access to waiver services for the patients we serve who do not have the same access to hospital services as others in the State. We are equally concerned that an ASO with no background in the ATHS will seek to impose care coordination and prior authorization requirements that are inconsistent with the ATHS' proven methods of coordinating care through our integrated health care delivery system. Unless exceptions are made, these and other requirements in the waiver will reduce access to Medicaid resources by the ATHS compared to other providers in the State.	
27	34	"2.6 As part of the implementation process,	"ASAM requirements" isn't clear. ASAM is a	Delete the phrase "including ASAM

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		Alaska DHSS will require that all providers of behavioral health and SUD services meet specified criteria, including ASAM requirements, prior to participating in the Medicaid waiver program."	clinical assessment tool, not a provider requirement. Furthermore, ASAM is not applicable to mental health services for target groups 1 and 2.	requirements".
28	41	**8. "If fee-for-service payment will be made for any services, specify any deviation from State plan provider payment rates. If the services are not otherwise covered under the State plan, please specify the rate methodology."** 9. "Payment methodologies under this waiver will be consistent with those approved in the State plan. If any changes are made to State plan payment methodologies, waiver payment methodologies will also be updated"	The waiver would allow or require many services to be provided in a recipient's home or other community settings. We agree this will improve both access to care and outcomes for many patients. But under a recent clarification by CMS, the Medicaid clinic benefit excludes services provided outside a clinic's "four walls," which means that tribal clinics cannot be reimbursed for them at the applicable encounter rate after January 2021. To address this place of service limitation, Alaska Tribal Health Providers are evaluating the possibility of reenrolling as FQHCS under a State Plan Amendment that would adopt the encounter rate for tribal FQHC services. However, regardless whether such a SPA is adopted, tribal providers should be reimbursed at the encounter rate for their services, whether they are furnished within the facility's four walls, or offsite at the patient's home, school, or other appropriate location.	Include FQHCS as authorized providers of waiver services. Seek waiver authority to allow payment at the encounter rate for offsite services, whether furnished by a tribal clinic, tribal FQHC, or other specified tribal provider type.
29	42	"Impact of Demonstration on Delivery System **10. If quality-based supplemental payments are being made to any providers or class of providers, please**	Any reimbursement structure needs to include full payment in the initial payment amount. Providers cannot sustain delayed reimbursement.	Any incentive payments should supplement Medicaid encounter rate payments and not delay the full encounter rate payment.

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		describe the methodologies, including the quality markers that will be measured and the data that will be collected. The state is considering use of a fixed price incentive contract for the ASO procurement, which would allow the state to quantify ASO performance in terms of costs and services and/or deliverables. If this happens, the ASO will pass those performance incentives on to providers over the course of the waiver, once provider infrastructures are developed."		
30	43	"The Department is considering a three-year phase in plan to implement services included in this demonstration proposal. DHSS will seek further stakeholder input and request CMS guidance on the implementation plan."	New waiver services need to be available to all regions. No region should have services that are not available to others. At this point, it is highly unlikely that service providers have the capacity to furnish these services. There is concern that providers will be penalized for not furnishing services.	We encourage implementation of services equally across the regions to the extent this is possible. The tribal health system will gladly participate in the development process.
31	43, Reference C	Regions	Given the geographical size and remote nature of Alaska, the Waiver proposes to divide the State into 9 or 14 regions whose hub communities will serve as geographical centers for the provision of services. The regions will be organized by population size, so that each region has a population of at least 20,000 and considers Tribal hubs/hospitals; and transport and referral patterns across the state for all providers and hospitals. The ATHS is an established affiliation of Tribal	The ATHS recommends that the waiver's proposed regional system correspond to tribal health system regions or Treat the ATHS as one state-wide region in recognition of the ATHS' uniqueness as a tribal health provider that contracts to carry out health programs from the federal government under the Indian Self-Determination and Education Assistance Act.

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			health organizations that provide health care to over 153,000 Alaska Native/American Indian people throughout Alaska. The ATHS is a diverse and multifaceted health care delivery system that has evolved over the last 30 years. The ATHS has its own service delivery regions that include 180 small community primary care centers in village clinics, 25 sub-regional mid-level care centers, 7 multi-physician health centers, 6 regional hospitals, and tertiary care provided by the Alaska Native Medical Center. This system is interconnected via an established and sophisticated referral system through each of the Tribal regions. Tribal health organizations are concerned that the waiver's proposed regions will not align with the established Tribal service delivery regions and system of referrals and will disrupt care provided to patients. It is very important that the Waiver's proposed regions be aligned with the Alaska Tribal Health System to avoid any disruption in patient care.	
32	43	"The Department is considering a three-year phase in plan to implement services included in this demonstration proposal. DHSS will seek further stakeholder input and request CMS guidance on the implementation plan."	New waiver services need to be available to all regions. No region should have services that are not available to others. At this point, it is highly unlikely that service providers have the capacity to furnish these services. There is concern that providers will be penalized for not furnishing services.	We encourage implementation of services equally across the regions to the extent this is possible. The tribal health system will gladly participate in the development process.
33	47-	"Residential SUD treatment services:	We would welcome the elimination of the IMD	Specify that services for individuals

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	48	Alaska also seeks expenditure authority under Section 1115(a)(2) of the Social Security Act to claim expenditures made by the state for services not otherwise covered or included as expenditures under Section 1903 of the Act, such as services provided to individuals residing in facilities that meet the definition of an Institution for Mental Disease (IMD), and to have those expenditures regarded as expenditures under the State's Title XIX plan. Alaska Psychiatric Institute services: • Alaska also seeks expenditure authority under Section 1115(a)(2) of the Social Security Act to claim expenditures made by the state for services not otherwise covered or included as expenditures under Section 1903 of the Act, such as services provided to individuals residing in facilities that meet the definition of an Institution for Mental Disease (IMD), and to have those expenditures regarded as expenditures under the State's Title XIX plan."	restriction for services under both the Medicaid state plan and the 1115 waiver.	covered by both the state plan and the 1115 waiver can be regarded as expenditures under the State's Title XIX plan.
34	53	"The following services will be deleted from the state plan array of behavioral health services: Behavioral rehab services H0018 Case Management services T1016	Many existing Behavioral Health Services will be deleted from the state plan per page 53 of the waiver application and these are not adequately replaced by waiver services. Examples of services that will be terminated and not replaced by waiver services include:	

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		Recipient support services H2017 Comprehensive Community Support Services H2015 & HQ Therapeutic behavioral services H2019, HR, HQ, HS Alaska screening tool T1023 Client Status review H0046 “	Children: We do not have clarity on the eligibility criteria for group 1. It is unclear if the four bullets on page 16 are each ‘or’ statements or if multiple bullets must be met in order for a child to be eligible for group 1 services. If the criteria are NOT ‘or’ statements, we are concerned that the following services will be terminated per page 53: Children and Adolescents: • All skill building, case management, clinical associate led groups and other clinical associate interventions provided under a treatment plan. This includes programs like Southcentral Foundation’s TRAILS youth program and services offered to support children in school. • Residential treatment for both children and adolescents who do not meet the waiver criteria and for those who receive residential services in a facility that has fewer than 10 or more than 15 beds. Adults: The reactionary nature of the Group 2 criteria (interventions post 3 acute intensive services) raises concern about adult services listed on	

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			page 53 such as: • SCF's Quyana Clubhouse – adult services including therapy, groups and clinical associate led skill building, along with. Group and non-clinician individual Comprehensive Community Support Services, are listed on page 53 as going away. • Outpatient therapy – Group Comprehensive Community Support Services are often part of a treatment plan in outpatient therapy and are commonly led by clinical associates. Adolescents and Adults with SUD (Group 3): Some, but not all ASAM levels are included in the waiver. Unless all ASAM levels are added the following services, all Comprehensive Community Support Services, would go away per page 53: • All services delivered by chemical dependency counselors • All services delivered by clinical associates • All groups led by CDCs and CAs.	
35		Communication	What is the public process for notifying recipients of the new waiver services and eligibility?	Partner with the ATHS on a communication plan for Alaska Native/American Indian recipients.