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Comments re: Alaska's 1115 Waiver Application

The Alaska Behavioral Health Association (ABHA) has represented mental health and substance abuse treatment providers throughout the state for over 30 years. With over 60 member organizations, ABHA helps inform policy with the direct experience of behavioral health providers operating across Alaska. The Association includes members who share perspective from for-profit and nonprofit corporations, tribal and non-tribal health providers, secular and religious-based organizations, and the smallest to largest mental health, substance abuse, co-occurring, dual diagnosis, and integrated healthcare providers in Alaska.

We appreciate that the Centers for Medicare and Medicaid Services (CMS) are soliciting public input on Alaska's 1115 waiver application. We strongly believe that meaningful opportunities for collaboration will help improve the waiver application and consequent service delivery. ABHA submitted comment on December 29, 2017 during the State's public comment process, and we are resubmitting that comment for reference and consideration through this opportunity in addition to the comments below.

Healthcare services in Alaska are delivered through somewhat unique systems of care that have evolved over time. Funding requirements, availability of resources, and federal and state policy have been primary drivers of change in these systems. Certain aspects of these separate delivery systems bear scrutiny when considering how best to meet the healthcare needs of Alaskans. While these comments focus on the Medicaid and the behavioral health grant-based system of care primarily, the tribal health system, private insurance market, and federal systems of care (including Medicare, Federally Qualified Health Centers, and healthcare for active duty military and veterans) each deserve careful analysis when considering broad system changes like those proposed in Alaska's 1115 waiver application. Additionally, behavioral healthcare often requires a more holistic approach beyond a medical intervention model and involves systems such as education, child protection and welfare, housing, criminal justice, and employment. The consideration of the proposed 1115 waiver's impact on each of these systems will also help ensure success.

Prior to 1992, the State of Alaska provided mental health and substance abuse treatment services to Alaskans through a predominately state-funded, competitive, grant-based program. These grants were offered to private, nonprofit corporations to deliver healthcare services to Alaskans as efficiently and effectively as possible. In 1992, the State encouraged mental health treatment providers to shift their reliance from grants to Medicaid. Following Medicaid expansion in Alaska in September 2015, substance abuse treatment providers were similarly encouraged to shift their reliance from grants to Medicaid. This shift also required providers to offer care determined by the State to be "medically necessary," and to build the administrative capacity necessary to document services in order to properly bill Medicaid.

Unlike almost all other healthcare services, Medicaid reimbursement rates for behavioral health services do not currently have a methodology in place to update reimbursement rates. Without a regular methodology, the Medicaid reimbursement rates for behavioral health treatment services fell short of the cost of providing the services. Over time, providers began to rely more heavily on remaining grant funds to help subsidize inadequate Medicaid reimbursement rates.

Providers struggled (and are still struggling) to meet the increasing demand for behavioral health treatment services with the resources provided. As the situation grew worse, the State responded by requiring behavioral health providers to prioritize available resources to a limited focus on individuals with Serious Mental Illness (SMI), Serious Substance Use Disorders (SUD), and Severe Emotional Disturbance (SED). Under this new focus, those with mild to moderate disorders often went without the care they needed. Additional reductions to available resources over time left behavioral health treatment providers with even more restricted options to serve their communities.

Inadequate resources affect both the volume and array of services providers are able to offer, and have been eroding the system's capacity to deliver services for years. Perhaps the most illustrative example of this is the long-term impact inadequate resources are having on Alaska's behavioral health workforce. Faced with flat funding and cuts to the resources available to deliver services, providers largely respond first by eliminating staff serving administrative functions. This increases the risk associated with compliance, reduces the capacity of the organization to report quality data to decision makers, reduces the capacity to apply for additional funding opportunities, and reduces the providers' overall ability to engage in continuous quality improvement. As funding grows more constrained, direct care providers take on more responsibilities and more clients. Over the past several years, providers have been forced to discontinue certain services, close programs, and severely restrict access to care (via waitlists, restricting referral patterns, etc.) regardless of community need. Funding makes it difficult to recruit, train, and retain the staff necessary to deliver the services and, in turn access to quality, cost effective care is severely hampered.

There are gaps in Alaska's behavioral health continuum of care. Inadequate resources tied to uncertain funding and a constantly changing, high-risk, overly regulated environment are largely responsible for those gaps. These gaps and challenges have contributed to a system of care that has become so fragmented and difficult to navigate, that those in need of behavioral health treatment services far too frequently find it challenging to get the care they need when they need it.

Alaska's 1115 waiver application included some of the behavioral health indicators and described some of the challenges we continue to struggle with as a state. Extraordinary challenges we face involving some of the social determinants of health, trauma, and adverse childhood experiences manifest as high rates of suicide, incidents of interpersonal violence, alcohol and drug abuse, and child welfare concerns. The degree to which the behavioral health system is insufficiently resourced to help prevent and intervene in these problems is directly related to prisons overcrowded with people who are suffering from behavioral health disorders, emergency departments overwhelmed with individuals seeking care, and our 80-bed state psychiatric hospital (API) consistently being filled to capacity and unable to admit individuals in need of care.

In 2016, the Alaska Legislature passed Senate Bill 74 – an omnibus Medicaid Reform bill – to improve the healthcare system and control the unsustainable cost of the Medicaid program. Alaska's Department of Health & Social Services (DHSS) worked closely with legislators to develop provisions in the bill.

Senate Bill 74 instructed DHSS to initiate a Coordinated Care Demonstration project. The Request for Information (RFI) for that project was posted on September 15, 2016, with responses due by October 17, 2016. A summary of responses to the RFI was posted in November 2016. The Request for Proposals was posted on December 30, 2016, with responses due by April 28, 2017. While the Request for Proposals was out, the State was unable to speak about the project. After the deadline to submit proposals, the State claimed it was involved in the procurement process and again unable to speak about the project. We anticipate that there will not be an opportunity for collaboration or additional input on this project and that the implementation plan and details will be announced only after they have been finalized. The Coordinated Care Demonstration project will be implemented concurrent to the 1115 waiver demonstration.

Senate Bill 74 also instructed the Department of Health & Social Services to seek authority from CMS to contract with an Administrative Services Organization (ASO). It was a deliberate decision to focus the ASO on the behavioral health system first, with the intention of addressing system shortfalls, before taking on large scale integration with the physical health system, especially given that medical providers can already bill for low-acuity behavioral health services such as Screening, Brief Intervention Referral and Treatment (SBIRT); Early, Periodic Screening, Diagnosis and Treatment (EPSDT); Medication Assisted Treatment (MAT), and prescribing necessary medication.

While the 1115 waiver is being used, in part, to authorize Alaska to contract with an ASO for the management of the behavioral health system, not enough detail about the ASO's proposed scope and operations in Alaska has been made available to provide comment specific to the ASO during this process. Alaska's Department of Health & Social Services issued a Request for Information for the ASO on February 27, 2017 to help prepare a Request for Proposal. A summary of the responses received by the State was posted in May 2017. It is ABHA's understanding that the Request for Proposals for the Administrative Services Organization will be released after the public comment period for Alaska's 1115 waiver application closes with CMS to allow the State to modify the RFP as necessary. Again, it is anticipated that the State will not be able to communicate while the RFP is out, or afterward during the procurement process until a contract with the ASO has been finalized.

In addition to uncertainty stemming from overlap with the Coordinated Care Demonstration project and Administrative Services Organization, we understand changes to the service system from the 1115 waiver demonstration will also happen concurrently with proposed changes to the Alaska State Medicaid Plan and State regulations governing behavioral health services in Alaska along with other ongoing initiatives aimed at system reform.

These changes involve varying levels of required public participation and, unfortunately, depend on each other to such a degree that it makes commenting on any one set of proposals extremely difficult. There is too much uncertainty and there are too many variables at play to speak definitively about the impact of the Alaska's proposed 1115 waiver at this point in time. That being said, we realize this may be one of our last opportunities to share our perspective to help inform the process. We believe the perspective of those charged with implementing the plan is critical to its success, and it is our desire that these efforts succeed.

Generally, the new services proposed in the 1115 waiver application are ambitious and, as presented, almost wholly beneficial to individuals, families, and communities. There is a lot to like about the proposal. ABHA appreciates the focus on building capacity to provide early intervention as close to the individual's home as possible. We also appreciate that Alaska's 1115 waiver application acknowledges the value of peer support and recovery support services. It is evident that a lot of time and attention was spent on developing services to try and fill gaps in our continuum of care to help people access the care they need.

The application begins to fall short at the more detailed level. As was mentioned in our previous comment, the plan itself focuses largely on *what* it is that is hoped to be achieved and lacks critical details on *how* it might be achieved. Questions to this effect that have been put to the Department have been met with responses such as "This level of detail will be addressed through the waiver implementation plan." In fact, it does not take much in the way of detail to solicit that response. The State's approach to financing services included in the 1115 waiver application is largely predicated on savings from more acute settings. When asked during the State's public comment period what the State means by the term "acute," the response that was provided was "This level of detail will be addressed through the waiver implementation plan."

It is entirely possible that the purpose of the waiver application was simply to describe what the State intends to do. The challenge providers face in commenting on the likely impact of these proposals is that the broader goals and objectives of the demonstration do not provide enough detail to predict the potential impact on individuals, their families and communities, and the state. For example, the waiver application includes an eligibility threshold that requires three emergency room/hospital stays. It is unclear how the State proposes to make that work in communities without emergency rooms or hospitals. That detail affects how providers serve individuals and families living in those communities, and will likely involve significant cost, quality, and access considerations.

ABHA respectfully requests that the approval of Alaska's 1115 waiver be contingent on opportunities for public comment after a summary of responses from the Request for Proposal for the A can be made available to help inform the selection of the ASO and after the Master Service Agreement has been materially developed, but before it has been finalized, to help inform implementation. Ideally, there would be additional opportunities for meaningful collaboration, but we are hoping these pivotal points in the process will be aided with the input of those charged with implementing the proposed changes.

ABHA's vision is that "Alaskans have access to quality, cost-effective behavioral healthcare." We appreciate the State's interest in improving the behavioral health system and their ongoing effort to do so. We stand ready to assist leaders who share our vision. ABHA appreciate the leadership and support CMS has already lent this process and equally extend the offer to you to assist in any way possible.

Sincerely,

Tom Chard
Alaska Behavioral Health Association