Public Comment from the Mat-Su Health Foundation (MSHF)

The MSHF appreciates the opportunity to make comments on the Alaska 1115 Medicaid Waiver application. MSHF is in a unique position to offer comments as a co-owner of Mat-Su Regional Medical Center and a place-based health funder in the geographic center of Region 5 - Mat-Su Borough, as noted in the application. Therefore, we have a vested interest ensuring that Mat-Su residents receive the care they need and in supporting Mat-Su providers now and in the future in helping them to adapt to the potential changes resulting from the 1115 waiver. To this end we stay focused on building a complete system of behavioral health care in Mat-Su, i.e. a full range of services that matches the *SAMSHA Good and Modern Mental Health and Addiction Services Model*. We support a seamless and integrated continuum of care in Mat-Su that is accessible to all Mat-Su residents, no matter their level of need. The 1115 waiver application can provide an opportunity to realize this goal. We are seeking to build a system that incorporates prevention and early intervention services and strategies that can avert the onset of more complex problems over time.

The Mat-Su Health Foundation supports the goal of the 1115 waiver application to create a data-driven, integrated behavioral health system of care for Alaskans with SMI, SED and SUD that accomplishes the triple aim. However, we would like to see this goal expanded slightly.

In order to prevent new cases of SMI, SED, and SUD, the waiver target population Group 1 needs to include children who do not have an official behavioral health (BH) diagnosis of SUD or SED or who are in contact with the Office of Children's Services (OCS) or the Alaska Department of Juvenile Justice (DJJ). The application states that early intervention is important and this should include intervening with children and youth before they reach the point of having a SUD or SED diagnosis. This suggestion will be discussed further in the text below. This would expand the goal to be "*To create a data-driven, integrated behavioral health system of care for Alaskans with SMI, SED and SUD and children at-risk for SED/SUD."* Preferred language to fully include the early intervention approach with the Group 1 population would describe Group 1 as *"individuals in the custody….. or children who have not had contact with these agencies but are showing warning signs for developing mental health and substance abuse diagnosis and live in complicated life circumstances including inadequate housing, negative family circumstances, or other psychosocial complications.*" We believe this expands this population slightly and could deliver a significant cost savings overall. Most importantly it will lead to improvement in the quality of life for these children because they can have assistance with their individual and family circumstances early and in a less expensive and intrusive treatment environment.

These comments are related to Intervention Strategies and Benefit Design for Group 1:

If there is an effort to reduce the length of long-term care/residential services for this Group 1, the step-up and step-down services that provide a good transition either way will need to be in place locally. It is crucial if the region does not have this step-up and step-down services that the residential stay not be shortened and provisions for successful re-entry to the community be taken while in residential care until the local infrastructure is built out in a way the implements the Waiver strategy. This concept is important for the "roll-out" of all waiver services – that the infrastructure for the delivery of new services is in-place before existing services are restricted or curtailed.
We would caution against any cap on the length of long-term residential services for adolescents or adults. Long-term residential care (9-12 months) is an important part of the continuum of care that is

referred to in the Introduction section of the waiver application. This is not saying that lengthy stays are needed by all clients, but a "one-size fits all rule" is never appropriate when caring for a large group with varying severity level of need. The amount and type of care needs to be fit to the individual.

The emphasis on expanding the early intervention services and screenings should also include the expansion of the provider group who can perform screenings and other early detection services outside of a clinical setting (i.e. in a school setting, churches).

In Mat-Su, we are finding that an effective setting for early intervention is the school setting (both in terms of increased access and cost-savings). By providing behavioral health counseling in the schools for emergent family and child problems - barriers to access to care, such as lack of transportation and not knowing where to get care, can be avoided. If this waiver could support this through ensuring that BH providers can screen and provide counseling for undiagnosed children and families in the school setting, this would truly function as early intervention for Group 1. If our suggestion that Group 1 is expanded to include children and families at risk who have not had contact with OCS and DJJ, the escalation of minimal and moderate BH problems could be averted. School-based services for those with Medicaid allows for very early detection by teachers and school nurse who see children on a daily basis.

It is very beneficial for providers to be able to exchange standardized screening and assessment results in cases where patients are accessing multiple providers – this should be facilitated with this waiver.

These comments are related to Intervention Strategies and Benefit Design for Group 2:

The intervention strategies proposed for Group 1 should be mirrored (as age-appropriate) for Group 2.

Nationally, as well as In Mat-Su, we have seen that Peer Support Services have proven to be a crucial component for people in recovery (MH/SUD). These specialized services need to be incorporated and funded along the entire continuum of care including intervention, treatment and long-term recovery services. These type of service provision should not be limited to crisis intervention.

These comments are related to Intervention Strategies and Benefit Design for Group 3

Adult Residential Services for Group 3 (clinically managed ASAM Level 3.5) are to be shortened with increased reliance upon step-up and step-down programming which is community-based. The shortening of long-term residential services is probably not in the best interest of building a complete continuum of care as some patients with SUD/MH problems will continue to require longer term residential treatment. This places tremendous emphasis on providing peer support and seeing to a person's social needs in the community which may not be as well coordinated or funded in all areas of Alaska. Capping residential lengths of stay should only be done with respect to the other non-clinical conditions in a patient's life that effect the clinical progress made while in treatment. Capping should also be contingent on the existence of the build-out of the outpatient supports in the region the individual lives in to support them when they are released after a shorter stay.

These comments are related to the 2.4 Waiver Goals and Objectives

1. Rebalance the current behavioral health system of care to reduce Alaska's over-reliance on acute, institutional care and shift to more community and regionally-based care.
2. Intervene as early as possible in the lives of Alaskans to address behavioral health

The activities associated with this goal are related to primarily shifting the location that care is delivered for individuals who have severe behavioral health needs from a more expensive setting to a less costly setting. ***This approach would be doubly effective if the focus was to intervene and address needs early – in essence shifting the need level of the population from more intense to less intense***. Although this is the second cross-cutting goal it appears that the major activity related to this goal is to provide universal screening to identify symptoms. Our experience in Mat-Su has shown us that historically the Division of Behavioral Health has focused grant funding and the selection of services to be reimbursed on the SMI, SED, and SUD populations. This created a market situation where providers developed services and a workforce focused around these populations. The resulting system does not adequately meet the needs of children with mild to moderate BH problems – those children and youth with Medicaid coverage often have to wait between 1-6 months to get into counseling. While in the early stages of their behavioral health struggles their care can be managed easily in the outpatient setting through individual and family counseling. Since immediate access to this type of outpatient care is not available, this group goes untreated and, often, ultimately needs to utilize expensive crisis care.

Decreased access to care for children and parents with mild to moderate problems will inhibit the effectiveness of universal screening. In the waiver application it states that universal screening is being planned for all care settings. While this is very important it is not enough. Unless access to early care is opened up this will not create meaningful change for the individual. It is crucial for this early intervention to be effective that primary care clinics and individual providers be able to employ and bill for behavioral health providers. There are currently barriers related to credentialing and psychiatric oversight that limit this from happening. There are providers in Mat-Su who see this need and employ Licensed Professional Counselors who cannot bill for Medicaid because their type of credential cannot bill for Medicaid. It is crucial that there be an expansion in types of providers who can bill for Medicaid order to eliminate waiting lists and expand the settings where those with mild to moderate needs can be seen.

To make the first two cross-cutting goals more effective it is crucial to ensure that the needs of those with mild to moderate needs can be met. In this waiver, this could be part of the focus on Group 1 by ensuring that children with mild to moderate needs can have immediate access to care both in a school setting and primary care setting. We don't see anything in this plan that facilitates the delivery of services in these settings. What is needed is immediate access to care for those who are caught in early screening efforts. What limits this immediate access to care is the location that care is delivered, payment structures, and limited workforce. We have found in Mat-Su that delivering access to this early counseling in schools is very effective. This has also been seen in Kodiak where there are school-based BH services which has the lowest teen suicide rate in the state. However, there are aspects of this in-school care that are not covered like the communications between the counselor and parents/teachers which is crucial to making counseling more effective. In Mat-Su and Anchorage these services are provided by linkages between the provider community and the school system. Several schools in Mat-Su have contracts with providers to see their students who are showing early signs of BH issues. The private for-profit counseling clinic that contracts with a school cannot bill Medicaid currently because they don't have a grant with DBH and they don't have a psychiatrist on-site. The non-profit DBH grantee

organization contracting with another school can bill Medicaid if they have a clinician with the correct credentials. Additionally, the FQHC can bill Medicaid if they expand their service provision site to include the school. Waiver services should fund service provision (not just screening) for at-risk children in the school setting.

For individuals with SED, SUD, and SMI - from a cost-savings point of view the "rebalancing " of the system of care from acute/residential services toward community-based services makes sense; however, from the patient-need point of view does the re-balanced system make sense for the patient? It will make sense if there is an infrastructure build out in that community that has sufficient outpatient services, social services, and recovery spaces and support. Mat-Su is currently working toward the goal of reducing emergency department (ED) visits and jail placements with a couple of different programs. We are quickly discovering that providing community-based services such as medical, behavioral health and social supports (including legal assistance) for patients with complex needs is challenging and requires long term commitments to also support related services such as housing, legal assistance, transportation, etc. Mat-Su is currently learning more about this with the recent launch of the High Utilizer Mat-Su (HUMS) program which is focused on providing care coordination and support for frequent users of the ED to help them get their needs met in the outpatient setting and reduce the use of the ED for BH related visits.

Recent experience with the Lazarus Project[1] in Mat-Su has shown that although the patients in this ambulatory detox program had peer support and access to treatment they were still living in environments which are not conducive to sobriety surrounded by family and friends who were involved in substance abuse. This inhibited the effectiveness of the outpatient programming and made relapse inevitable for some. If these patients could have had access to transitional sober housing, and other components of a recovery community their chance at success would have been improved. The same is true for those with SMI who experience a crisis and find themselves at API. Currently, Mat-Su residents do not have access to "step down" facilities or MH recovery services – these individuals find themselves in a revolving door to the emergency service system. Services included in this Waiver application should include adequate access to transitional housing and other recovery services.

Even if the step-down and recovery infrastructure exists – the length of stay for residential must be monitored to find the "sweet spot" for the time for release and integration back into the community. A re-balanced system should include residential services for as long as they might be clinically indicated to increase the likelihood successful reintegration of patients into the community.

These comments relate to the 2.5 Partnership with Administrative Services Organization

We strongly recommend that providers have input at every stage of work/negotiation with ASO which should include the RFP proposal evaluation committee work, etc. Post award, the contract negotiations will be an important time to include providers in setting the function and responsibility of the ASO. DBH should invite providers from each region as partners in this process of selecting and eventually

[1] Lazarus Project– is a pilot project testing an ambulatory non-narcotic detox model which utilizes the 'Bridge,' - an external medical neuro-stimulation device (cleared by FDA) and over-the-counter medication to minimize opioid withdrawal symptoms. The device is placed behind the earlobe for five days. On the seventh day, a Vivitrol (Naltrexone) injection is administered, which interferes with the reward effects of opioids in the brain. Both of these agents allow the suffering individual to begin outpatient substance abuse treatment while preventing relapse. Peer support workers are in contact supporting patients through the project.

contracting with an ASO. This is a value add for DBH. We recommend that DBH seek to ensure the ASO goal of "More efficiently and effectively managing the cost of BH services in Alaska…." not come at the expense of patients and their need for appropriate services. What safeguards will be in place to make sure patient care is not compromised?

These comments are related to the 2.7 Quality and Performance Measurement

The quality measures listed in the application are important for tracking how the system is working; however, it is crucial that since this is a regionally focused initiative the ASO should be required to map out the continuum of care in each region. By mapping out the way residents in that region can access a complete outpatient care and recovery community the ASO will ensure that the changes in services reimbursed and the shortening of residential stays will not have a negative effect on residents. This mapping should be similar to that mapping conducted in the *Mat-Su Behavioral Health Environmental Scan* and the Alaska Mental Health Trust Authority, *Behavioral Health System Assessment*. Both of these reports utilized *The SAMSHA Good and Modern System of Care for Mental Health and Addictions.* This waiver will only be effective if individuals can ACCESS the care that is being proposed. This is important for every region, but especially important for rural regions which will not be able to build out a complete continuum of care. "Work-arounds" will need to be created for those areas to ensure their residents have a system that works for them.

The ASO should be required to collect feedback from beneficiaries regionally to assess how the system they have created is working and to be able to tweak as needed to make it more effective. This could be in the form of a community advisory committee with representation from community providers and beneficiaries. Also, there should be an immediate feedback mechanism for direct reporting of suggestions, complaints, and requests for assistance when the system is not meeting the individual's needs.

Section 5: Demonstration Hypothesis and Evaluation Plan

As described in the waiver application, the evaluation appears to be mostly a summative evaluation focused on measuring success. It would be helpful to also include developmental and formative evaluation. Developmental evaluation is focused on assessing the development of the waiver administration and system of care. This assessment examines how closely the actual administration/system of care resembles the model that is proposed and monitors how the actors carrying out the change and those affected by the change are doing through the process. This is essentially a monitoring system with continuous feedback given to the creators and implementers (DBH and ASO) to ensure the project is headed in the anticipated direction. Further formative evaluation, which informs for midstream strategic changes in development and approach, should be included. This would focus on the outcomes and impact of the waiver. This approach would include frequent check-ins with evaluators should be held to be able to tweak the approach as needed to ensure success.

<u>Closing comments</u>

This waiver application represents only a portion of the Medicaid reform that is underway. Additionally, there are other healthcare reform efforts (such as a statewide ACO) being discussed and considered in Alaska. It is crucial that all of this reform is coordinated and focused on achieving the same ultimate goal. A unified overarching vision for all of these reform efforts has not been clearly presented to BH providers, the medical community, or the general public. This waiver application does not adequately

describe the other reform efforts underway and how they will interact with the reform described in the waiver application. This vision needs to be presented in the waiver.

While we presented many comments on different sections of the waiver application, there are several key suggestions that stand out.

1. The theme of shifting funding from more expensive interventions to less expensive ones is a logical concept from a funding standpoint. However, a complete system of care that is responsive to the needs of the people of Alaska where patient needs are a priority, will require all levels of care, no matter the cost. For example, this is not saying that lengthy residential stays are needed by all clients, but a "one-size fits all rule" is never appropriate when caring for a large group with varying severity level of need. The amount and type of care needs to be fit to the individual.

2. The recent rise in out-of-home residential or psychiatric placements for children and adolescents by state agencies is most likely driving Medicaid spending up but responding to this situation should not take away from the need or availability of this service for other populations considered in this application. A full continuum of care requires long term residential services. Some rural regions will not be able to support such a continuum. For rural Alaska, the State of Alaska should examine an inter-regional approach to the relationship between residential care and the step-up/step-down services which are intended to support either side of a residential stay.

3. There exists tremendous value in working "upstream" with detection efforts to address problems experienced by young people early on. It is refreshing to read in the application that there is focus on mobile and community-based services at a lower level of need for those with early symptoms. The question remains however, are these efforts far enough "upstream?" It is important to include treatment services for at-risk children with mild/moderate problems regardless of whether they have been involved with OCS or DJJ in Group 1. By providing behavioral health counseling in the schools for emergent family and child problems - barriers to access to care, such as lack of transportation and not knowing where to get care, can be avoided. If this waiver could support this through ensuring that a wide variety of BH provider-types can screen and provide counseling for at-risk children and families in the school setting, this would truly function as early intervention for Group 1.

4. Nationally, as well as In Mat-Su, we have seen that Peer Support Services have proven to be a crucial component for people in recovery (MH/SUD). These specialized services need to be incorporated and funded along the entire continuum of care including intervention, treatment and long-term recovery services. These type of service provision should not be limited to crisis intervention.

5. This waiver application describes a new strategy for addressing the BH needs of struggling Alaskans. While the strategy laid out in the application represents a well-thought out effort, it is important to realize that there will be theoretical assumptions that prove incorrect and efforts that will not work for all areas and population groups in Alaska. The State and the ASO need to

be nimble enough in their quality assurance and feedback mechanisms to learn about these problems and make course corrections immediately. The Quality Performance Measurement System is not fully described to meet these needs in this waiver application.

6. We strongly recommend that providers have input at every stage of work/negotiation with ASO which should include the RFP proposal evaluation committee work, etc.

7. It is crucial for the "roll-out" of all waiver services – that the infrastructure for the delivery of new services is in-place before existing services are restricted or curtailed.

Thank you for the opportunity to comment on this waiver application. As we move through these changes together as funders, providers and administrators, our support to the Alaskan people should remain at the forefront when considering changes in services funding and delivery. We strongly encourage the division to partner with advocacy groups, associations, providers and health funders in their pursuit in achieving the goals of the waiver.