

## **ALASKA BEHAVIORAL HEALTH REFORM 1115 WAIVER CONCEPT PAPER**

### **Preface: Martha’s Story**

Martha<sup>1</sup> is a 30 year old Alaskan. She lives in a remote community on an island in the far western part of Alaska. The nearest healthcare facility is located nearly 300 miles away when traveling by plane, and the nearest acute behavioral health services are located more than 1,000 miles by air.

When Martha was 16 years old, she was diagnosed with a fetal alcohol spectrum disorder (FASD). She experiences chronic consequences of trauma and multiple Adverse Childhood Experiences including her parents’ addiction, sexual abuse, neglect, witnessing domestic violence, her parents’ separation, and her father’s incarceration. Martha was in and out of foster care and the juvenile justice system while growing up. Eventually, she entered the adult corrections system due to several charges of driving under the influence and acts of domestic violence. Martha’s two children are currently in child protective services custody.

Martha experiences a chronic polysubstance use disorder, along with serious and recurring depression. She has attempted suicide several times. She has a history of very poor self-care and extensive health issues: obesity, borderline diabetes, chronic migraines, and an overall sense of “not feeling well.” Martha receives individual counseling for her behavioral health disorders *via* telemedicine – when the equipment is working – along with occasional in-person treatment with her clinician during periodic field visits. Martha has had three different counselors in the past year due to staff turnover, and that has made it hard for her to make any progress. The only health provider in her community is a Community Health Aide.<sup>2</sup> There are no social services other than the Village Public Safety Officer available to respond to crises.

Martha goes to the primary care clinic frequently with somatic complaints of stomach aches and headaches. She often feels like she is dying and seeks medical attention, requesting pain medication to cope. When she is denied a prescription, she requests referrals to providers only available in Anchorage. (Anchorage is Alaska’s largest city and the medical services hub for the state.) On more than one occasion, Martha arrived in Anchorage and met with the specialist, only to have her somatic complaints be unsubstantiated after bloodwork and invasive procedures.

Martha recently disclosed to her new counselor that she has been using opioids for a long time. She shared that she has come close to experimenting with heroin when pills aren’t available on demand. She wants to quit, but she is scared of the awful effects of withdrawal. Martha is ready to take action and admit herself to in-patient treatment. Her counselor is having difficulty referring her to a withdrawal management program because there is no treatment locally and long waits at the few options available in Alaska. Even if she was able to find an open withdrawal management bed, it would be critical to also find a place in a residential treatment

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<sup>1</sup> Martha is a hypothetical behavioral health consumer whose story is based on the experiences of people throughout Alaska.

<sup>2</sup> The Community Health Aide Program is a network of about 550 Community Health Aides/Practitioners (CHA/Ps) in more than 170 rural Alaska villages. CHA/Ps are part of an established referral relationship that includes mid-level providers, physicians, regional hospitals, and the Alaska Native Medical Center.

facility that could provide treatment appropriate for someone also experiencing mental health disorders and intellectual disabilities. Martha will also need quality aftercare and supportive services to help her maintain her sobriety.

Eventually, Martha gives up waiting. She no longer wants to seek treatment. She is avoiding her counselor and continues to use opioids. Martha remains unemployed. She has been unable to make the progress needed in order to reunite with her children.

***Martha's story is all too common in Alaska.*** This concept paper aims to describe how the State of Alaska will transform its behavioral health system to better serve people like Martha. Alaska's unique geography, diverse population, lack of infrastructure, struggling economy, and limited healthcare resources make it extremely challenging to provide a person-centered and culturally responsive system. However, the 1115 Behavioral Health Waiver Demonstration Project ["Demonstration Project"] will support more effective, cost-efficient, integrated care that ensures access to the right services at the right time in the right setting.

## **I. Introduction: The Need for Behavioral Health Transformation in Alaska**

Alaska is navigating a period of dramatic adversity and opportunity. After years of prosperity from the state's oil wealth, the State of Alaska faces a fiscal crisis precipitated by the decline of oil prices and production. In just two years, the State of Alaska has reduced its budget 22% (with further cuts expected in SFY2018) and cut almost 1,500 state employees (with more proposed for SFY2018). The state economy is in recession, creating greater demand for publicly-funded safety net services like Medicaid. The Department of Health and Social Services (DHSS) budget has been reduced by more than \$200 million dollars in state general funds over the past two years, restricting the ability to address increasing needs.

The Behavioral Health Medicaid system does not meet the demands of Alaskans who experience mental health and substance use disorders. For individuals like Martha, with complex co-morbidities or dual diagnoses of intellectual, developmental, or sensory disabilities, the current system is seriously inadequate. Behavioral health services are difficult to access due to geography, long wait times, lack of workforce, and high costs of service. Access to services varies widely depending on clients' needs, their location, and their ability to pay. Many of Alaska's remote communities are medically underserved for both primary care and mental health services. Many of these communities are located hundreds of miles from a regional medical center, and individuals like Martha have to travel for services.

Until Medicaid Expansion on September 1, 2015, Alaskans had to be categorically eligible (usually due to federal-determined disability status or having dependent children) to qualify for Medicaid, leaving out many adult Alaskans experiencing significant behavioral health disorders. As of November 30, 2016, 25,695 Alaskans have enrolled in Medicaid as a result of Expansion. Of Medicaid claims paid for Expansion enrollees, \$17.92 million (6.2% of all Expansion population claims) were for behavioral health treatment services.

Alaska has significant challenges with recruitment and retention of a qualified behavioral health workforce due to high turnover in the field. Recruitment/retention of professionals and direct service providers in the more rural parts of the state is particularly difficult, as seen in how often Martha has had to start over with a new counselor due to turn over. Psychiatry and other behavioral health specialties pose unique recruitment and retention problems. This, compounded with low numbers entering the behavioral health field, results in a trajectory of continued workforce shortages. Alaska's workforce is predicted to become even more essential given enrollment growth through Expansion. The workforce will need retraining to become proficient in a changing behavioral health environment.

Technology is both an asset and a source of stress for Alaska's behavioral health system. Tribal health organizations in Alaska have pioneered telemedicine and tele-behavioral health services. The Alaska Medicaid program currently pays for services through telemedicine if the service is covered under traditional, non-telemedicine methods and is provided by an eligible provider. Unfortunately, broadband capacity is limited in rural Alaska. Electronic health record (EHR) systems vary across the state and do not always communicate well with one another. Not all health care providers use the health information exchange (HIE), which the State of Alaska is actively working to expand. Complicating matters further, state-funded behavioral health providers report data *via* a separate system which does not communicate with Alaska's Medicaid Management Information System (MMIS).

Costs for the Behavioral Health Medicaid program have grown since 2005, but at a slower rate than other Medicaid programs in Alaska. Until Expansion, Behavioral Health Medicaid primarily covered mental health services. Costs rose 43% between 2005 and 2011. Cost containment and quality improvement efforts since 2011 helped reduce that growth, so that the 2015 Behavioral Health Medicaid spend was only 23% more than that in 2005. Despite these efforts, many Alaskans with behavioral health disorders utilize more costly hospital-based services, with 18% of individuals with five or more hospitalizations between 2012 and 2015 having a behavioral health diagnosis – the most common disease category across all admissions.<sup>3</sup> It is important to note that the system's lack of capacity to meet the growing demand for services has been a *de facto* utilization control contributing to lower growth. Efforts to manage utilization and control cost, while effective, have been hindered by a lack of integration and coordination in the behavioral health system and among other systems serving individuals experiencing behavioral health disorders.

In 2016, the Alaska Legislature passed two monumental reform mandates. Senate Bill 74 (SB 74) is a multi-dimensional Medicaid reform package that includes direction to apply for an 1115 Waiver under 42 USC 1315(a). The State of Alaska is directed to efficiently manage a comprehensive and integrated behavioral health system that partners with diverse providers and disciplines to provide evidence and data-driven practices, with the goal of achieving positive outcomes for children, youth, and adults experiencing behavioral health disorders. SB 74 includes direction to reduce operational barriers, minimize administrative burden, and improve the behavioral health system's effectiveness and efficiency.

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<sup>3</sup> The Menges Group. *Assessment of Medicaid Reform Options*. Report for Alaska Legislative Budget and Audit Committee. March 24, 2016.

The second large reform mandate, Senate Bill 91 (SB 91), is a comprehensive criminal justice reform effort based on a number of strategies, including reducing sentencing lengths for non-violent offenders and reinvesting savings into programs that increase the likelihood of success outside of the correctional system. Of particular concern is how the mandates in SB 91 will change the demand for behavioral health services. An expanded need for mental health and substance use disorder treatment, as well as additional community-based recovery supports, will add pressure to an already limited behavioral health system.

All of these activities require action now to transform our Medicaid-supported behavioral health system of care. Alaska has worked diligently over the past year to prepare for this challenge and, with the assistance of a Demonstration Project, the State will develop a data-driven, integrated system of care that focuses on quality, outcomes, and costs. The following represent efforts to lay the foundation for change in Alaska's behavioral health system:

- In 2015-2016, the Division of Behavioral Health (DBH) contracted for two readiness assessments – one for DBH staff and one for 29 community behavioral health providers – for the purpose of identifying capacities and infrastructures necessary to succeed in a transformed system of care. Both assessments have been completed and DBH is initiating training and technical assistance to prepare Alaska for the impending transformation.
- The Alaska Medicaid Coordinated Care Initiative (discussed in Goal #2 below) and the Medicaid Pharmacy and Therapeutics Committee (responsible for the preferred drug list and drug utilization review process) are established programs that will provide experience and guidance for the utilization control efforts planned for the demonstration project.
- Extensive training and technical assistance to embed trauma-informed practices in community behavioral health, corrections, domestic violence, and juvenile justice settings will support efforts to integrate systems and improve the quality of services.
- Years-long research and planning supported the statewide Early Childhood Comprehensive Systems (ECCS) Plan currently serving Kodiak, Nome and surrounding villages, and the Matanuska-Susitna Borough. This plan and lessons learned from implementation will support the effort to enhance early intervention services.
- The 2016 Tribal/State comprehensive strategic plan to transform child welfare outcomes for Alaska Native and American Indian children, including the provision of culturally specific services and supports to children in state custody, provides context for aligning behavioral health reform efforts.
- The Alaska Mental Health Board, Advisory Board on Alcoholism and Drug Abuse, and Alaska Behavioral Health Association gathered stakeholders in 2014 to conduct an in-depth review of reporting and administrative requirements on community behavioral health providers. Eleven concrete recommendations were made to alleviate some of the administrative burden on providers; of these, DBH has implemented three and made significant progress on four others.

## **II. Vision for Alaska’s 1115 Behavioral Health Waiver Demonstration Project**

**Vision:** Alaskans will have a transformed Behavioral Health Medicaid system that provides effective, cost-efficient, and high-quality integrated care and ensures access to the right services at the right time in the right setting.

Alaska envisions a system that is integrated and coordinated to help people like Martha earlier, and more easily, so that they are able to achieve a higher level of functioning and better quality of life. Parents like Martha’s (and like Martha became) will have access to the primary and behavioral health care services they need to support their children’s healthy development. Children like Martha will have access to early childhood screening and referrals to early childhood mental health services – especially for childhood trauma – as well as services through adolescence so that acute emotional disturbances and mental illnesses can be avoided. Children, youth, and adults who have complex needs like Martha’s will be able to access specialty services, directly and through telemedicine. Adults who need substance use disorder treatment will be able to get in when they have that readiness for treatment – they won’t have to wait, and risk eventually giving up, like Martha. All services will be culturally appropriate and provided in a way that honors clients’ cultures.

Alaska has established five goals for this Demonstration Project to achieve the vision of a transformed behavioral health system of care (presented in Section V):

1. Expansion of treatment capacity and improved access to services;
2. Integration of care;
3. Cost and outcomes reform;
4. Provider payment and accountability reform; and
5. Delivery system reform.

These goals, and the articulation of the vision for the Demonstration Project, are aligned with Alaska’s broader redesigned Medicaid system, as the demonstration project is part of a larger effort to improve the efficiency and effectiveness of the entire Medicaid system. Together with other redesign efforts, the Demonstration Project will ensure Medicaid recipients have access to the appropriate levels of care, coordinated across sectors to improve health and contain costs. (See Appendix A for an overview of the comprehensive Medicaid Redesign effort.)

## **III. Target Populations for the 1115 Behavioral Health Waiver**

The exact target population(s) to be proposed are pending full analysis of claims data and other ongoing Medicaid initiatives. (There are sixteen Medicaid redesign initiatives from SB 74, and the Demonstration Project target populations must take these initiatives into consideration to align with these comprehensive Medicaid Redesign and Reform efforts.) Discussions of the target populations for the Demonstration Project have included both broad and narrow service populations.

It is essential to include high needs populations. These include individuals who experience serious mental illness and/or chronic substance use disorders who also have had more than three hospitalizations per year, or who are involved with the justice, homelessness, and child protection systems. Alaska's population level data supports the need to also include Medicaid recipients experiencing mild-to-moderate behavioral health needs, to avoid the costs and consequences of chronic and acute disorders later:

- 66% of Alaskan adults report one or more adverse childhood experiences growing up;
- 21.4% of Alaskan adults report growing up in a household with one or more adults experiencing mental illness;
- 29.7% of Alaskan adults report growing up in a household with one or more adults abusing alcohol and/or other drugs;
- 19.5% of all Alaskan adults – and 28.4% of Alaska Native adults – report four or more adverse childhood experience growing up;<sup>4</sup>
- Alaska children are twice as likely to be in foster care, compared with children nationwide;<sup>5</sup>
- 11% of Alaskan adults experience a diagnosable substance use disorder each year;
- 20% of Alaskan adults experience a diagnosable mental health disorder each year;<sup>6</sup>
- Alaska's suicide rate of 27.1/100,000 (2015) is more than twice the national rate (12.32 per 100,000);<sup>7</sup>
- 22% of the Alaska Corrections population in SFY2012 experienced a mental health disorder; and
- 19% of the Alaska Corrections population in SFY2012 experienced a chronic substance use disorder.<sup>8</sup>

The current Behavioral Health Medicaid service population includes children and youth experiencing severe emotional disturbance, adults experiencing serious mental illness, and youth and adults experiencing acute and chronic substance use disorders (7 AAC 135.020). In SFY2016, the Behavioral Health Medicaid system served 42,123 individuals in SFY2016.<sup>9</sup> Of these, 9,799 (23%) were children or youth under age 18; 1,997 (5%) were youth age 18-20; and 30,327 (72%) were adults over 21. Of adults, 2,477 were over age 65.

Of the 42,123 Medicaid recipients served in SFY2016, 28,937 received mental health disorder treatment and 19,282 received substance use disorder treatment. Of these, 6,075 (14%) received treatment for co-occurring behavioral health disorders. In all three categories, adults made up the

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<sup>4</sup> Adverse Childhood Experience data is a three year average of 2013-2015 Alaska Behavioral Risk Factor Surveillance System responses, reported by the Alaska Division of Public Health.

<sup>5</sup> The Alaska Office of Children's Services reports that, between 2006 and 2013, almost 1% of Alaskan children were in foster care, compared with approximately 0.5% of children nationally.

<sup>6</sup> Prevalence data is derived from a special report run for the State of Alaska by SAMHSA's Center for Behavioral Health Statistics and Quality using 2009-2011 National Survey on Drug Use and Health data.

<sup>7</sup> Bureau of Vital Statistics, Alaska Division of Behavioral Health (provided September 2, 2016).

<sup>8</sup> Corrections population data is reported in *Trust Beneficiaries in Alaska's Department of Corrections*, Hornby Zellar Associates, Inc. for the Alaska Department of Corrections, May 2014.

<sup>9</sup> Medicaid claims information is based on analysis of data downloaded and analyzed September 2-4, 2016. The number may change, as Medicaid providers have one year to file a timely claim for payment

majority of the client population. Children and youth were more likely to receive mental health disorder treatment (comprising 32% of that client population).

#### **IV. Alaska’s Current Behavioral Health System of Care**

The State of Alaska does not provide a continuum of behavioral health care – it provides a spectrum of services which expands and contracts based on time, geography, and funding. Medicaid supports behavioral health services delivered in community behavioral health centers, federally qualified health centers, tribal health organizations, hospitals, specialty clinics, and primary care practices. The predominant providers in Alaska’s behavioral health Medicaid system are community behavioral health centers, hospitals, and specialty clinics.

Alaska defines Behavioral Health Medicaid services as medically necessary and clinically appropriate active treatment services delivered by eligible providers (acting within their scope of practice) to eligible recipients (7 AAC 135.010(a)). Behavioral health clinic services include: behavioral health assessments, psychotherapy, short-term crisis intervention, and pharmacologic management (7 AAC 135.010(b)). Most substance use disorder treatment services are considered “rehabilitation services” rather than clinical services. Behavioral health rehabilitation services include: behavioral health screening, substance use intake assessment, case management, withdrawal management (detoxification), comprehensive community supports for adults, therapeutic behavioral health services for children, recipient support services, medication administrations, developing and reviewing treatment plans, conducting a medical evaluation, methadone/antabuse, peer support, day treatment for children, residential substance use disorder treatment, daily behavioral rehabilitation, short-term crisis intervention, and facilitating telemedicine encounters (7 AAC 135.010(c)).

The Behavioral Health Medicaid system serves the most acutely disabled children, youth, and adults. Community behavioral health services include clinic and rehabilitative services, as well as peer support. Some community behavioral health providers also offer residential treatment for youth and/or supportive housing for adults. Acute inpatient mental health services (primarily involuntary at admission) are limited to:

- Alaska Psychiatric Institute in Anchorage (80 beds);
- two mental health Designated Evaluation and Treatment/Stabilization units under contract with DHSS in community hospitals in Fairbanks (20 beds) and Juneau (12 beds);
- one for-profit inpatient adolescent hospital in Anchorage; and
- two acute adult (12 beds) and adolescent (15 beds) units in Anchorage’s largest medical center.

Alaska also has one hospital-based residential psychiatric treatment center in Anchorage, leaving the rest of the state without this service. Primary care providers are an important *de facto* part of the overall service system.

Outpatient substance use disorder treatment is available through community behavioral health providers statewide. Residential treatment is available in less than ten communities statewide.

Limited withdrawal management (detoxification) services are available in Juneau, Fairbanks, and Anchorage. In some communities, emergency departments can serve patients needing medically monitored withdrawal management, if required. Medication Assisted Treatment (MAT) is available in some communities. MAT is provided by Office Based Opioid Treatment (OBOT) providers, tribal health organizations, and federally qualified health centers. There are three methadone providers in Fairbanks, Anchorage, and Wasilla. Clearly there are many gaps in our statewide continuum of services.

Tribal health organizations are a critical part of Alaska’s health care delivery system. Alaska is home to 229 of the 566 federally recognized tribes in the United States. The tribal health system of thirteen tribally owned and operated health organizations serves more than 158,000 Alaska Native and American Indian people across the state. Tribal behavioral health providers serve approximately 27,000 Alaska Native and American Indian clients, as well as non-native clients in rural Alaska. Tribal health organizations serve about 6% of all Behavioral Health Medicaid recipients.

Medicaid is the primary source of funding for acute mental health services in Alaska. Peer support, certain recovery supports, and services for adults not enrolled in Medicaid have relied on state general funds. Until Medicaid Expansion in September, 2015, state general funds and the SAMHSA Substance Abuse Prevention and Treatment Block Grant were the primary (almost exclusive) sources of funding for adult substance use disorder treatment and recovery services.

In SFY2016, a total of 42,123 Medicaid recipients received behavioral health services totaling \$311,630,030 in Medicaid claims payments across all health care settings.<sup>10</sup> Of total payments, services for children/youth under age 21 accounted for 51%, and services for adults age 21 years and older accounted for 49%. Services for adults 65 and older comprised 2.4% of the total adult payments.

Of Medicaid claims payments for behavioral health services provided in SFY2016, community behavioral health centers received 41% (\$128,740,347), providing services to 12,464 Medicaid recipients. Non-tribal inpatient hospitals received 12% (\$38,055,993), providing services to 2,726 Medicaid recipients. Non-tribal outpatient hospitals received 9.5% (\$29,859,543), providing services to 14,283 Medicaid recipients. Primary care providers (physicians, nurse practitioners, physician assistants who may or may not be affiliated with community behavioral health centers or hospitals) received 9.5% (\$29,623,732), serving 23,422 Medicaid recipients.

Residential psychiatric treatment centers and other residential treatment settings for children and youth received 10.5% (\$32,624,063) for services to 772 Medicaid recipients. Tribal clinics and rural health clinics received 3% and 1%, respectively, of all behavioral health payments. Tribal

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<sup>10</sup> Medicaid claims information is based on analysis of data downloaded and analyzed September 2-4, 2016. The data includes behavioral health claims with a service date in SFY2016 where the payment date was in SFY2016 or by the date that the claims data were downloaded. This number is unduplicated across all provider types and service settings. Individuals may have received services in multiple settings—for example, one Medicaid recipient may have received outpatient behavioral health treatment, primary care medication management, and had an inpatient hospitalization in the same year.

outpatient hospitals received 2.3% of all payments, serving 6,106 Medicaid recipients, and tribal inpatient hospitals received 2.4% of all payments for 792 Medicaid recipients.

API received 1% of the total claims payments for behavioral health services in SFY2016, for services to 240 Medicaid recipients. Psychologists received 1% of all payments. Physician (psychiatrist) mental health clinics received less than 1% of all payments for services to 1,663 Medicaid recipients. Payments for school-based services, community health aides, and licensed clinical social workers were *de minimus*.

Based on data from the National Survey on Drug Use and Health,<sup>11</sup> approximately 25% of all Alaskans (145,000) have a diagnosable behavioral health condition. The Behavioral Health Medicaid system described above served at least 42,000 unique individuals (adults and youth) in SFY2016. This suggests that over 100,000 Alaskans did not seek treatment or were served by grant programs, corrections centers, private/for-profit or faith-based behavioral health providers, primary care practices, 12-step or other self-help programs, or other services.

The current system lacks integration and coordination not only with different provider types but also across state service systems. Primary care, child protection, juvenile justice, corrections, public assistance, housing and homelessness, and public safety systems all interact with behavioral health consumers in different ways – yet the services provided are often delivered in silos. This fragmentation makes it difficult to manage and coordinate the system, and nearly impossible for consumers and families to navigate.

The wait for treatment services is generally long for all but the highest priority populations. Someone like Martha can spend months waiting for access to treatment, especially higher intensity substance use disorder treatment. Referrals from courts, primary care, schools, police, and clergy are bottlenecked in a behavioral health service system that is overworked. Criminal justice reform efforts will soon increase that bottleneck, by expanding referrals as behavioral health clients are released and/or diverted from the corrections system to treatment.

While state and federally funded clinical and rehabilitation services are the core of behavioral health in Alaska, the system branches out to include a far more diverse and equally essential system of private providers. This system incorporates a significant number of private physicians, psychiatrists, psychologists, other licensed clinical professionals, and private substance abuse professionals offering rehabilitation services. People who are unable to endure the long wait at community behavioral health providers often seek help from private providers. These agencies collect fees from third-party health plans or directly out-of-pocket from clients. DBH provides significantly less support and oversight to these providers. Data from these providers is not accurately counted or included in most state reports. Estimates from tracked Alaska court referrals, the only current data available, suggest that upwards of 50-75% of outpatient substance abuse treatment services are provided by private provider types. It is unknown what portion of mental health services they provide.

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<sup>11</sup> Prevalence data is derived from a special report run for the State of Alaska by SAMHSA's Center for Behavioral Health Statistics and Quality using 2009-2011 National Survey on Drug Use and Health data.

The behavioral health system also includes limited prevention, screening, and brief intervention and education services. State funded community prevention services are managed separately from the treatment system, presenting yet another opportunity for service integration and continuum of care expansion. Prevention grantees enhance Strategic Planning Framework community coalition efforts to address issues such as fetal alcohol spectrum disorders, suicide, underage drinking, opioid addiction, and other substance abuse related issues. DBH also manages the Alcohol Safety Action Program (ASAP), a statewide network of screening, monitoring and technical assistance providers supporting misdemeanants referred by the courts for substance abuse screening, education, and referral to assessment and treatment. ASAP also oversees a statewide network of therapeutic courts that support more intensive case management for both special populations and for those that have failed to succeed in meeting their court ordered requirements.

In sum, Alaska's needs are great, the geography and cultural issues are unique, the spectrum of behavioral health services has large gaps, and resources are dwindling. The Demonstration Project, along with the larger Medicaid Redesign, will change the current system of care to identify those at risk, intervene earlier in a variety of service settings, move a crisis-focused system to a recovery-focused system, and develop the necessary infrastructures to manage the system of care based on quality, outcomes, and costs.

## **V. Behavioral Health Reform – A Transformed Behavioral Health System of Care**

The transformed Behavioral Health Medicaid system will evolve over the course of the Demonstration Project to offer Martha and every other recipient effective, cost-efficient, high-quality integrated care. Services will be available when people seek care, wherever and whenever that care will be most effective. This will ultimately reduce the need for and costs of acute care services due to untreated or ineffectively treated mental health and substance use disorders.

Alaska is committed to providing individualized, person-centered services that promote recovery, recognizing that physical, mental, emotional, social, spiritual, and cultural elements are all integral to overall health. Alaska is committed to providing trauma informed care that addresses the needs of victims of violence, as well as the unique needs of peoples who have experienced historical trauma. Recovery is possible for everyone – though how that recovery is defined and achieved is as unique as the individuals being served. The redesigned system of care will honor the dignity and worth of every individual and is committed to informed and shared-decision making *with* patients (as opposed to making decisions *for* them). Every goal and strategy described in this section is based on these commitments and beliefs. The goals are part of a greater whole; none is isolated from the others. Recognizing the interdependence of these goals is important – an improvement in one goal can affect the others.

The foundation of Alaska's transformed system will be the partnership with the Administrative Services Organization (ASO). The completed readiness assessments indicate that Alaska does not currently possess the capacities necessary to manage the system of care envisioned. An ASO will provide the specialized expertise to manage a comprehensive behavioral health system. The ASO will have explicit contractual responsibilities for each Demonstration Project goal. As

described in Goal #5, the ASO will provide services such as utilization management, claims processing, network management and provider recruitment, quality and data management, cost management, and other functions.

### **Goal #1: Expand Treatment Capacity and Improve Access to Services**

The transformed behavioral health system will provide improved access to care for:

1. prevention and early intervention services to individuals at-risk of developing behavioral health disorders;
2. mild to moderate behavioral health disorders;
3. serious mental illness and chronic substance use disorders;
4. complex co-occurring mental health and substance use disorders;
5. complex dual diagnoses of intellectual/developmental disabilities and behavioral health disorders; and
6. chronic co-morbid conditions (diabetes, hypertension, Hepatitis C, physical disabilities, etc.) along with behavioral health disorders.

Strategies for improving the system's capacity to provide services for these individuals include:

1. integration of behavioral health and primary health care (*see Goal #2*);
2. increased screening, assessment, and early intervention services;
3. increased provider types and service settings;
4. access to community-based crisis intervention and stabilization services;
5. increased access to peer support services for youth, families, and adults;
6. expanded access to medication assisted treatment and withdrawal symptom management (detoxification) services, particularly ambulatory detoxification services;
7. expanded access to intensive outpatient treatment and partial hospitalization services (sub-acute and step-up and step-down treatment);
8. expanded use of Assertive Community Treatment in communities with high utilizers of emergency department and inpatient hospital services;
9. culturally appropriate wrap-around behavioral health treatment and rehabilitative services where the client is (*in vivo*) as well as clinic settings;
10. increased coordination of services with tribal health providers (*see Goal #2*); and
11. increased use of telemedicine and use of digital and mobile technologies in delivery of services.

Critical to transforming Alaska's crisis-driven behavioral health system is to expand capacity to provide services before chronic and acute conditions develop. Uniform evidence-based screening, assessment, and early intervention services offered in diverse health care settings will help identify at-risk individuals and those with early stages of behavioral health disorders, and allow for early intervention and referral to treatment when appropriate — addressing an important gap in our current system. These are services that can be effectively provided in community-based settings, both rural and urban, reducing use of more costly acute care. Requiring use of common evidence-based screening and referral tools will make accessing treatment and coordination of care easier. Increasing utilization of Screening, Brief Intervention,

Referral to Treatment (SBIRT) and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services, especially through adolescence, is also essential.

Just as important as identifying and addressing behavioral health disorders before they become acute conditions will be providing crisis intervention and stabilization services to avoid self-harm or harm to others, hospitalization, or incarceration. Mobile crisis intervention will augment facility-based and telephonic crisis intervention and stabilization services where the need is greatest. Availability of more community-based crisis respite services will improve outcomes, allow individuals to remain in their communities for stabilization, and reduce costs. Peer support specialists will be an integral component to these services. These services will reduce the incidence of psychiatric boarding in emergency departments, jails, and other inappropriate settings, especially in smaller communities and outlying villages where safe alternatives are not available. By intervening to de-escalate crises and connect individuals to community-based treatment and supports, individual outcomes will be improved and costs will be controlled.

The State of Alaska is currently expanding access to MAT with support from federal grants in order to address an important gap in the substance use disorder treatment system. Tribal health organizations are also implementing or expanding existing MAT programs, often in integrated settings. Withdrawal symptom management (detoxification) has received heightened scrutiny from Alaskans, in the context of the opioid epidemic afflicting our communities (and the entire nation). Extremely limited access to facility-based withdrawal symptom management for opioids has fueled discussion of widening access to ambulatory detoxification as well as traditional facility-based withdrawal symptom management. While there is a role for both to address the diversity of individuals' readiness levels and clinical needs, DBH will prioritize ambulatory detoxification services where appropriate.

Expanding access to partial hospitalization and intensive outpatient treatment complements crisis intervention and stabilization improvements. Short-term step-up and step-down services will help individuals transition between levels of care and between treatment and the community. These services will be provided in a supportive and gradual way to reduce the likelihood of relapse, mitigate the impact of relapse, and improve recovery outcomes. Greater partial hospitalization and intensive outpatient treatment options also complement the planned expansion of withdrawal symptom management services by supporting access to MAT along with psycho-social treatment and rehabilitative services and provides more appropriate step-up services when outpatient services alone are not working. Rural residents should have wider and timelier access to the full continuum of behavioral health care.

Assertive Community Treatment (ACT) is currently being provided in Anchorage in conjunction with a peer support services organization. Recognizing that outreach and relationship building are fundamental to helping homeless and at-risk individuals experiencing serious mental illness and chronic substance use disorders successfully access and benefit from treatment, ACT will be expanded in three important ways:

- As an adjunct to crisis stabilization services designed to reduce the high use of emergency departments and inpatient care;
- In communities with significant homeless populations; and

- By developing forensic ACT models for mentally ill individuals involved in so-called “nuisance crimes.”

ACT can also serve as a bridge for those leaving the corrections system, reducing costs to the corrections and public safety net systems and reducing recidivism. For these reasons, ACT is envisioned to be an important part of ensuring positive health outcomes for the potential target populations.

To truly transform Alaska’s behavioral health system, there will need to be culturally appropriate wrap-around treatment and rehabilitative services, as well as recovery supports, in communities statewide. No Alaskan should have to move away from his or her home and family to receive the services needed to live safely and productively. No child should be denied a meaningful opportunity to learn and explore at school due to a mental or emotional disability. Providing evidence- and research-informed treatment and rehabilitative services at school, at home, at work, and in the community will result in better outcomes and more stable recovery for individuals. Expanding these services outside of Alaska’s urban centers is critical.

Alaska’s geography, weather, workforce limitations, and resources will not allow the continuum of services envisioned to be in every community. These limitations will not impede the ability to provide **access** to those services in every community. Alaska’s tribal health system has designed and developed telehealth solutions to provide general and specialty health care services in rural Alaska. Tribal and community behavioral health providers have increased use and expertise of telepsychiatry over the past 15 years. The Demonstration Project will build on these successes to expand access to psychiatry and other treatment services. It will also provide capacity for remote monitoring and support for individuals with severe needs and in isolated villages through use of digital and mobile technologies. Building bridges with state licensing agencies and boards will ensure that important professional roles and responsibilities related to telemedicine are addressed and improve access to care, rather than limit it.

## **Goal #2: Integration of Care**

Just as a person’s health is the result of the effective operation of interdependent systems, the health care system must operate in the same way. The Demonstration Project will build upon existing efforts to integrate mental health and substance use disorder treatment systems, as well as efforts to integrate behavioral health and primary care systems. Learning from the integration processes undertaken by tribal health organizations and rural health care centers can further the goal of a health care system that provides whole person as well as person-centered care. Supporting the integration of care will be an explicit contractual requirement of the ASO.

The Demonstration Project will include multidimensional integration within and across health care settings and across social service systems (education, child protection, public safety, corrections, homelessness, juvenile justice, tribal, etc.). This will build upon and expand the array of integration models in Alaska, such as health homes, patient centered medical homes, and others. It will also strengthen connections between behavioral health providers and the senior and disability service systems to foster integration of care for complex, medically fragile, and dually diagnosed individuals.

The Demonstration Project will focus on providing services earlier and more consistently to individuals like Martha who experience complex co-occurring and/or co-morbid conditions that contribute to overutilization of emergency departments and acute inpatient services, as well as interactions with legal systems. This will expand upon the benefits already realized by patients and the State through the Alaska Medicaid Coordinated Care Initiative.<sup>12</sup>

The Demonstration Project will help coordinate tribal and non-tribal health care delivery systems. Updated federal policy regarding circumstances in which 100% federal funding is available for services “received through” facilities of the Indian Health Service, including tribal health organizations, is already improving coordination between tribal and non-tribal health care providers. Alaska will continue to work together with tribal and non-tribal Medicaid providers to avoid duplication of services. Outcomes will be improved through the use of culturally appropriate and informed care and community-based care that can include family, extended kinship systems, and Elders.

Achieving effective integration will require reforming and strengthening infrastructure to improve coordination of care. Alaska’s partnership with the ASO will allow the State to move quickly to mandate uniform evidence-based screening and assessment tools, which will be used in all settings. Conducting root cause analyses to determine why certain individuals are frequently admitted to emergency and/or inpatient services and then identifying and addressing those causes will help reduce the frequency of acute care episodes. Identified services, social supports, and rehabilitation options can then be provided in the right setting, rather than expensive emergency and acute care settings. Enhancing EHR capabilities (specifically including integrated clinical records and use of the HIE) between health care providers will support better outcomes for patients through efficient coordination and effective clinical practice. It will also support the goals of reduced administrative burden for providers and reduced costs to the State of Alaska.

An essential component of integration is ensuring that all health care services are trauma-informed. The Demonstration Project will build upon the extensive trauma-informed training investments in the Alaska behavioral health system to extend that professional capacity in pediatric practices, general family practices (including advance-practice clinical practices), certain specialty practices that focus on high frequency co-morbid conditions, and others. The Demonstration Project will also support continuing education and training in team-based health care practice.

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<sup>12</sup> The Alaska Medicaid Coordinated Care Initiative (AMCCI) began in 2014 to reduce the costs of overutilization of emergency department services by Medicaid recipients. A voluntary program offering individualized case management, care coordination and referral to specialty health care (including but not limited to behavioral health treatment) and social services, the AMCCI serves approximately 5,500 Medicaid recipients. In SFY 2016, AMCCI saved \$2.5 million by reducing emergency department use by 25% and reducing costs by 20%. AMCCI is being expanded to more than 80,000 Medicaid recipients (many of whom experience primary or secondary behavioral health diagnoses) in SFY 2017.

### **Goal #3: Cost and Outcomes Reform**

The transformed behavioral health system will reduce overall Medicaid expenditures by reducing costs due to over-utilization of high intensity services. This will be achieved by reducing the need for expensive acute and emergency services by providing increased access to more cost-effective treatment, crisis intervention and stabilization, and sub-acute services before the individual is in crisis. The ASO's care management infrastructure will ensure cost-effectiveness and accountability across all levels of care. Health outcomes will be improved through earlier interventions and better coordination of care and the system will, by the end of the Demonstration Project, be managed on the basis of outcomes.

The transformed system of care must be managed through data-driven decision making. While the MMIS provides service utilization and cost by provider, service recipient, and population, it does not provide outcomes data by provider, service recipient, and population. State-funded providers report data *via* a separate system that generates limited outcomes data, but not systematic reports by provider/service recipient or population. Therefore, we cannot analyze statewide utilization/cost/outcomes patterns. The two data systems do not communicate with each other. They do not have the capacity to track long-term client outcomes, relapse and recidivism, or recovery after discharge.

The current data systems do not provide the accountability envisioned for the transformed system of care. Data, outcomes, and cost management capacities need to be improved. This is another important reason to contract with an ASO with established data systems that report service utilization, costs, and outcomes. Data, cost, and outcomes management, like service integration and access management, will be contract requirements of the ASO.

Evidence- and research-informed practices, which support the outcomes management function, will also be an ASO priority. Despite a long-standing commitment to the use of evidence-based practices, the provider readiness assessment indicated that not all behavioral health providers rely on them. The Demonstration Project will identify the best ways to deliver and reimburse evidence-based practices system-wide. DBH will work with the ASO to improve patients' outcomes by defining and supporting evidence- and research-informed practices *that produce successful outcomes*, so that individuals receive the highest quality and most effective services relevant to their diagnosis, culture, and life situation.

### **Goal #4: Provider Payment and Accountability Reform**

The Demonstration Project will build upon streamlining efforts initiated by the Alaska Behavioral Health Association and state behavioral health planning councils in 2014. Easing the administrative burden imposed on Alaska's Medicaid behavioral health and primary care providers is essential to successful reform. Screening, assessment, and documentation will be standardized to reduce duplication of effort and facilitate coordination of care across all providers.

Simultaneously, Alaska will reform its provider payment systems by moving from a fee-for-service method to a value-based method by the end of the Demonstration Project. This will

eliminate duplicate data entry which currently places significant staffing burdens on providers. Providing training and technical assistance to improve financial management infrastructures in order to succeed in a value-based payment environment is critical, as indicated in the provider readiness assessment results. Understanding the current infrastructure capacity as well as the infrastructure needs will help the Demonstration Project to align training and support services for providers. The provider readiness assessments indicate that few providers have experience with performance and value-based payment methods. Specialized training will be offered to providers in the Spring of 2017. Support from the ASO over the course of the Demonstration Project will develop provider infrastructures in this area.

Alaska's current fee-for-service Medicaid payment system incentivizes volume over value, which continues to result in long waits and unmet need. This payment system lacks the tools and incentives that drive improved health outcomes, effective discharge planning, and overall efficiency. By the end of the Demonstration Project, our transformed behavioral health system will pay for value, not volume. Tribal behavioral health providers already receive an encounter rate, providing insight to the State of Alaska and community behavioral health providers as we move from fee-for-service reimbursement to standardized and transparent performance-based payment. Alaska is considering Delivery System Reform Incentive Payments (DSRIP) to implement some delivery system and payment reforms, such as the expansion of primary care services or implementation of telehealth. DSRIP could also incentivize reductions in avoidable hospital use. Various health care delivery models can be used to help providers work together to coordinate care, achieve quality measures, and receive performance bonuses for improved patient outcomes. The gradual evolution of the transformed payment models will build upon behavioral health rate adjustment and rebasement efforts currently underway. Important criteria for selection of the ASO will be the ASO's experience with performance-based payment methods.

#### **Goal #5: Delivery System Reform**

Delivery system reform will be based in a contractual partnership with an ASO to manage the transformed behavioral health system of care. The Demonstration Project goals and strategies are aligned with stakeholder expectations and the overall Medicaid system redesign mandated by the Alaska Legislature. Careful consideration has been given to a variety of options over the past year, including onsite visits to two states with ASOs to learn how they operate and are managed.

The ASO, performing according to specified standards and contractual requirements, will provide the staffing and expertise to implement and manage the reforms described herein. The readiness assessments of DBH and 29 behavioral health providers makes clear that the division and many behavioral health providers simply do not have the infrastructure necessary to succeed in the transformed system of care envisioned. The ASO will have a clear focus on infrastructure development during the Demonstration Project.

DHSS will contract with an ASO with experience supporting similar state transformations, with specific experience managing a Medicaid-funded behavioral health system based in strong community based services. The ASO will assure access to behavioral health screening and interventions, treatment and recovery supports. It will also have expertise in care management

for individuals with serious mental illness and chronic substance use disorders. The ASO will support integration efforts through coordination of care and network development, while also ensuring continued access to appropriate specialty behavioral health care. While it has not been decided which functions Alaska wants the ASO to provide, it is being considered that the ASO will provide utilization management, network management, quality management, data management – including outcomes and performance management, claims processing, cost management, and coverage services to manage the State’s behavioral health system of care.

## **VI. Demonstration Financing and Budget Neutrality**

The State of Alaska has invested time, energy, and money to lay the groundwork for the Demonstration Project. In SFY2017, the Alaska Mental Health Trust Authority contributed \$10 million to Medicaid Redesign efforts. This funding has allowed DBH to hire contractors, funded site visits to two states with ASOs, and supported technical assistance and training (beginning in the Spring of 2017) for DBH staff and providers. Additional site-visits to two states with ASOs are being planned for April 2017.

Also in SFY2017, the Alaska Legislature appropriated \$6 million to be invested over three years in acute substance use disorder treatment services (withdrawal management, residential treatment, and/or sobering centers). The Legislature has invested in additional child protection services workers over the past three years, and appropriated an additional \$1.7 million to the base budget in SFY2017 for family preservation and child welfare services.

The State can bend the cost curve, achieve sustainability, and achieve budget neutrality by reinvesting savings and cost offsets from the Demonstration Project. The ASO will help to create savings by reducing duplication of services, better coordinating care, and helping to avoid relapse and readmissions to Alaska Psychiatric Institute and other inpatient treatment settings. Savings are also expected to come from enhanced preventative care and early intervention services, to further reduce hospitalizations and unnecessary emergency department visits, arrests and incarcerations, and child protection interventions.

The State of Alaska also plans to request the full allotment of Disproportionate Share Hospital payments (something historically not received). These funds will be used as an additional incentive for hospitals to work with behavioral health providers to implement care management strategies to decrease emergency department and inpatient hospital utilization. As discussed in Goal #4, Alaska is considering DSRIP to implement some of the identified reform efforts. Alaska is also exploring the use of safety net care pools, designated state health programs, cost sharing, etc. as a way to reduce costs.

## **VII. Potential Authorities to be Waived**

At this point in time, Alaska will consider requesting the following Medicaid Act provisions be waived:

- Freedom of Choice, 42 U.S.C. § 1396a(a)(23) – to allow the ASO to assign particular people to particular providers, and to allow those providers to be those people’s primary care providers or patient-centered health homes.
- Comparability and Amount, Duration, and Scope, 42 U.S.C. §§ 1396a(a)(10)(B) and (10)(C), 42 C.F.R. §§ 440.230 and 440.240 – to allow particular behavioral health services to be provided to the target population without requiring that the same level of services be provided to people who are not part of the target population.
- Services with Reasonable Promptness, 42 U.S.C. § 1396a(a)(8) – to the extent necessary to allow services to be provided to the target population without requiring services to go to “all [Medicaid-]eligible individuals.”
- Single State Agency, 42 U.S.C. § 1396a(a)(5) – to allow the ASO to make final, judicially reviewable decisions about coverage, medical necessity and provider participation without a complete re-review by DHSS.

### **VIII. Public Notice and Comment Process**

Tribal health organizations are essential partners in our statewide health care system, often operating the only health care services in rural communities. Tribal health representatives have been invited to participate in every level of the Medicaid reform and redesign efforts, and are active contributors to the planning and development of the Demonstration Project. The State of Alaska will continue to partner with tribal health organizations throughout this process. Formal tribal consultation will also be conducted. DHSS will, not less than 60 days prior to submission of the application, provide an electronic and hard copy of the Demonstration Project Application and invitation to comment to the Alaska Native Health Board, tribal health directors, members of the State/Tribal Medicaid Task Force and the Director of the Alaska Area Indian Health Services.

DHSS will, not less than 60 days prior to submission of the application, publicly notice and post the Demonstration Project Application and invitation to comment so that Medicaid recipients, providers, and the public can contribute their input.

The Alaska Mental Health Board and Advisory Board on Alcoholism and Drug Abuse, the state behavioral health planning councils, actively engage Medicaid recipients, health care providers, and community members in the Medicaid Redesign and in planning for the 1115 Waiver. The state planning councils’ efforts augment the extensive stakeholder engagement undertaken by DHSS and its contractors. The state planning councils will continue to provide this level of interactive stakeholder engagement throughout the development of the application and during implementation if the waiver.

## **Appendix A – Medicaid System Redesign**

An overview of the comprehensive Medicaid System Redesign effort, and progress made in the first year of implementing Senate Bill 74, is available online at:

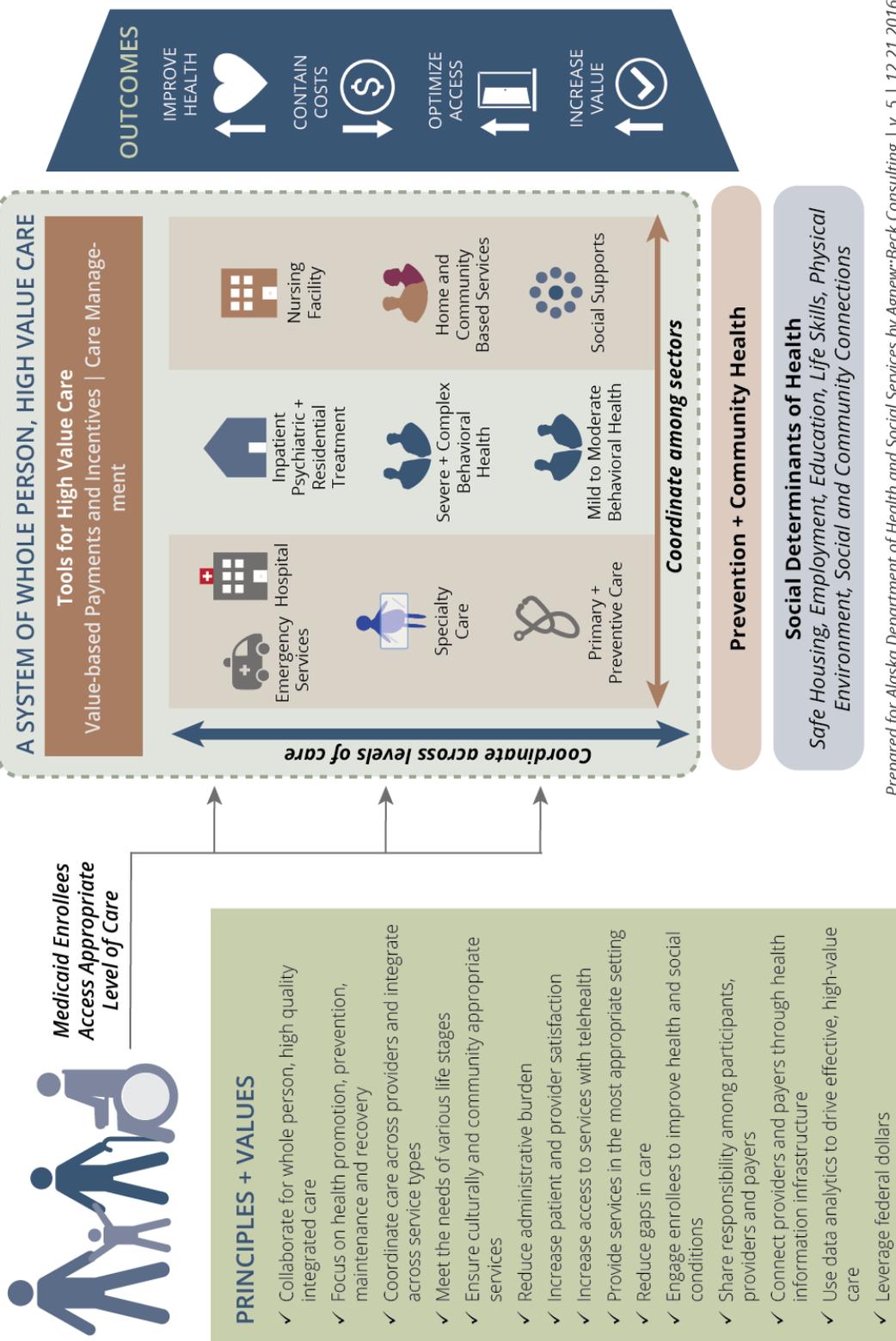
[http://dhss.alaska.gov/HealthyAlaska/Documents/2\\_FY2016\\_Annual\\_Medicaid\\_Reform\\_Report\\_11152016.pdf](http://dhss.alaska.gov/HealthyAlaska/Documents/2_FY2016_Annual_Medicaid_Reform_Report_11152016.pdf)

Figures 1 and 2 on the following pages provide visual representations of the comprehensive Medicaid System Redesign effort.

Figure 1. Vision for Medicaid Redesign in Alaska

# Vision for Medicaid Redesign

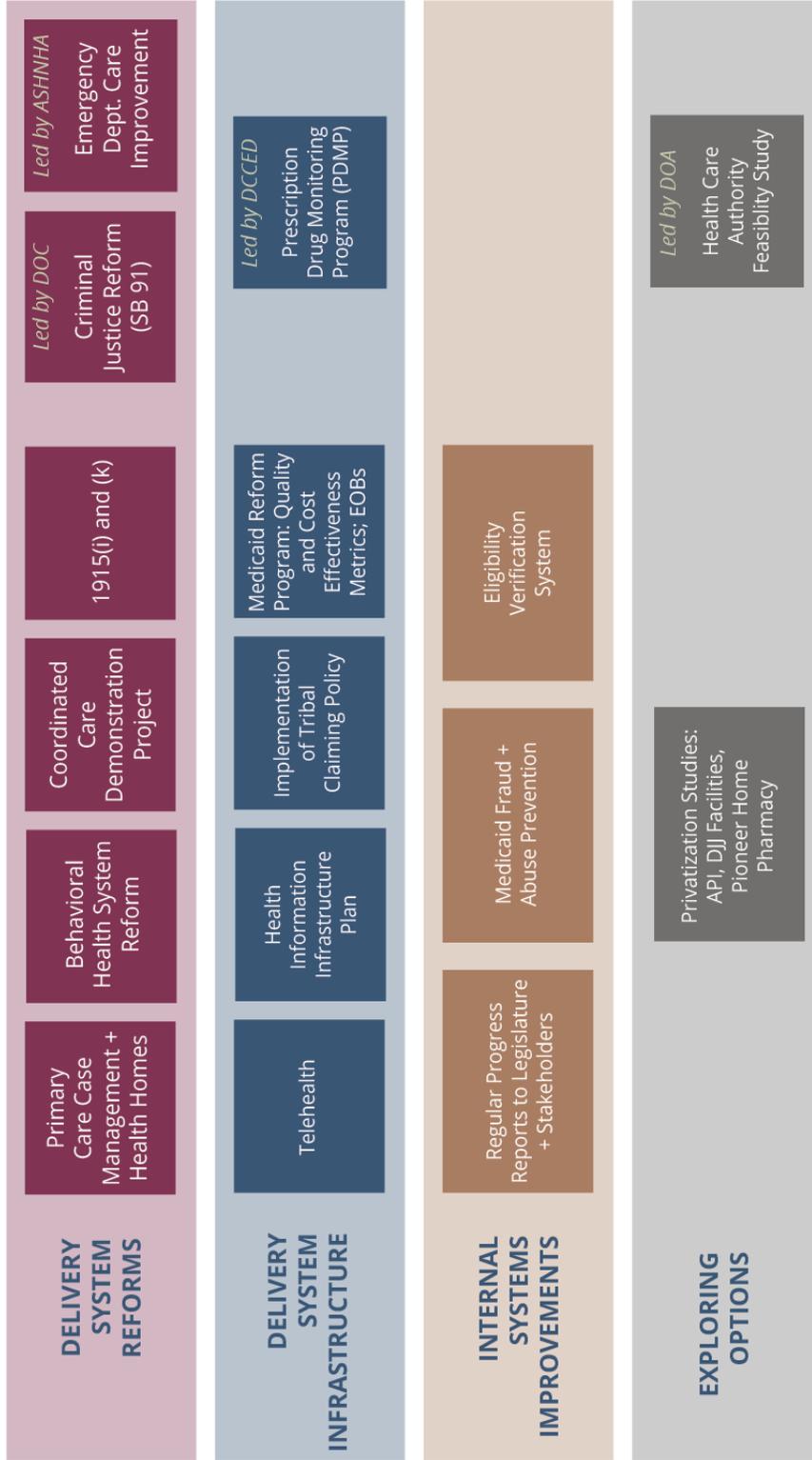
The Alaska Medicaid Program improves health and pays for value.



Prepared for Alaska Department of Health and Social Services by Agnew::Beck Consulting | v. 5 | 12.21.2016

Figure 2. Components of Medicaid Redesign in Alaska: Current Initiatives

# Alaska Medicaid Redesign: Components of SB 74



**Acronyms List**

API: Alaska Psychiatric Institute | ASHNHA: Alaska State Hospital and Nursing Home Association | DCCED: Alaska Department of Commerce, Community and Economic Development | DHSS: Alaska Department of Health and Social Services | DJJ: Alaska DHSS, Division of Juvenile Justice  
 DOA: Alaska Department of Administration | DOC: Alaska Department of Corrections | EOB: Explanation of Benefits

*Prepared for Alaska Department of Health and Social Services by Agnew::Beck Consulting, September 2016*