THE STATE of ALASKA
GOVERNOR MIKE DUNLEAVY

Department of Health and Social Services

OFFICE OF THE COMMISSIONER

Anchorage
3601 C Street, Suite 902
Anchorage, Alaska 99503-5923
Main: 907.269.7800
Fax: 907.269.0060

Juneau
PO Box 110601
350 Main Street, Suite 404
Juneau, Alaska 99811-0601
Main: 907.465.3030
Fax: 907.465.3068

Alaskans Together for Medicaid
Executive Order 119 Roundtable Discussion Questions

1. **Can you explain the timeline on EO119 and when it could become effective? When did the clock start for the legislature's review, and when must they take action if desired? And howdoes stakeholder engagement fit within this timeline?**

   Once an Executive Order is introduced, the legislature has sixty days to disapprove the Executive Order by resolution concurred on by a majority of the members in joint session. During this time, the legislature can hold hearings, take public comment, and otherwise engage with the public regarding the proposal. If the legislature takes no action or does not disapprove the resolution by a majority, the Order becomes law. In the case of Executive Order 119, this date is March 21. The provisions of the Executive Order, namely the division of the Department of Health and Social Services into two departments, will be effective July 1, 2021. The Executive Order has transition provisions to ensure the continuity of important items such as state plans and waivers, department agreements, legal settlements, the Tribal Child Welfare Compact, and confidentiality of information are not interrupted.

2. **When the Administration decided to proceed with this proposal, why was an Executive Order selected as the vehicle? Why not do it through the budget process, allowing for amplecommittee review?**

   An executive order (EO) is the proper constitutional authority available to the Governor under Article III, Section 23 of the state constitution, which holds that

   > [t]he governor may make changes in the organization of the executive branch or in the assignment of functions among its units which he considers necessary for efficient administration. Where these changes require the force of law, they shall be set forth in executive orders.

   No substantive law can be changed through an executive order. It is simply a mechanism to better align functions for better services to constituents. Every statute referenced in EO 119 is current law, and the EO just points each existing statute to the name of the appropriate department (once DHSS becomes two departments).

   A bill would have been needed if we were proposing adding new services or deleting services, which we are not doing. Had we proposed a more complicated approach – such as changing and/or combining different

functions and duties of many different divisions into new divisions – legislation may have been the appropriate tool for that purpose.

Although it is not a bill, the Executive Order process still provides opportunity for legislative review, committee hearings, and public input. The Executive Order was referred to the Health and Social Services Committee and the Finance Committee in both the House and the Senate. Rep. Zulkosky has indicated that she will hold public testimony on the Executive Order, and we believe that the Senate Finance Committee will as well. Comments may be submitted to both committees verbally or in writing. As it has been part of formal legislative proceedings, documentation of these submissions will be part of the record for the Executive Order and will be archived as such.

DHSS has committed to engaging with stakeholders and actively soliciting input. This dialogue, which has been valuable throughout the town halls and other communications thus far, will continue throughout the transition.

3. **Why propose making these major changes now, in the midst of a pandemic?**

Reorganization of DHSS has been a topic of discussion by previous administrations and legislatures for many years. As currently structured, DHSS is one of the only "mega-agencies" left in the United States.

The State of Alaska arrived at the decision to reorganize DHSS into two departments after over a year of analysis and dialogue with our legal team and division directors. This decision was not made in haste or without significant time and consideration of how to address the needs of Alaskans without disrupting services and internal processes.

Prior to putting forth the Executive Order, meaningful engagement was had with all division directors, who are the subject matter experts in DHSS programs and processes. These discussions informed the final decision to keep all divisions except our Finance and Management Services Division intact and able to conduct their business without significant change to their day-to-day operations. Future potential changes to divisional structure or programs would take place separately from the departmental reorganization (for example, the current consultations regarding potential internal reorganization at OCS). Future potential changes to actual operations will be made through ongoing dialogue with community partners, providers, boards, commissions, and professional associations.

The State is making every effort to provide transparency and meet concerns by participating in legislative hearings, town halls with all employees, meetings with union leadership, and upcoming meetings with external stakeholders.

The pandemic itself has highlighted the need for this change. The split into two separate departments will improve operations and delivery of services and will provide each department with a commissioner who has expertise in the work of that department. It is impossible to find one commissioner with expertise in Medicaid, public health, child welfare, and running 24-hour facilities like API, Juvenile Justice, and the Pioneer Homes.

Simply put, there is never an easy time for major change at DHSS. The breadth of DHSS' work is such that aside from the pandemic, at any given moment it will be grappling with one or more other crises (such as earthquakes or fires). Every such need deserves adequate attention, and we can no longer afford to postpone taking the steps to give all divisions strategic leadership with the capacity to focus on innovative solutions.

4. **It would be helpful to better understand why you split the departments in this way. Can youshare how you arrived at this current configuration for the split?**

The decision to split DHSS is to better align the services that each new department will provide. The configuration was based on the core functions of each divisions and aligning similar services. The divisions that will be a part of DOH are the regulatory, compliance, and claims processing divisions within DHSS. Divisions that will be a part of DFCS are those that operate 24/7 facilities and/or provide direct services to Alaskans 24/7.

The Department of Health (DOH) will have focus and oversight on health care services, payment, and public health, as well as more time to work with all stakeholders to improve and implement innovation for the single largest budget item in the state, Medicaid. The Divisions of Behavioral Health, Health Care Services, and Senior and Disability Services, provide regulatory oversight, claims processing, facility licensing and the enforcing of Medicaid and state regulations. The Division of Public Health aligns with these other divisions with its important focus on chronic conditions and other efforts that together with Medicaid can help reduce the cost of health care overall.

The Department of Family and Community Services (DFCS) will have an aligned focus of supporting and improving our child welfare system and our facilities that serve Alaskans around the clock. DFCS divisions provide 24/7 care for specific populations and are in the role of a direct care provider. For example, Alaska Psychiatric Institute (API) and the Alaska Pioneer Homes (AKPH) provide care for patients and elders, and when eligible can bill Medicaid for the services provided – in much the same way that hospitals and clinics work. The involvement of Health Care Services (HCS) is to process those claims to Medicaid, the same as they would for any other provider in the state.

5. **We understand you hope to create efficiencies within State operations. That aside, how do you envision this reorganization benefitting individuals who depend on State services? How will our communities benefit from this proposal? How will this help improve service delivery?**

The split into two separate departments will improve operations and delivery of services, and will provide each department with a commissioner and staff who have expertise in the work of that department. This will provide the expanded capacity and ability of the Commissioner and team to focus on a consistent mission set of Medicaid and public health or child welfare, and running 24-hour facilities like API, Juvenile Justice, and the Pioneer Homes.

The benefit to communities can be illustrated with two specific examples. First, each department will have increased capacity to identify opportunities for systems improvement, which will create more efficient delivery of services. Second, the capacity of departmental leadership to engage with stakeholders and

individual beneficiaries will be greatly expanded. The recent town hall discussions that have been held with provider and advocacy groups have clearly demonstrated the value of direct engagement between stakeholders and department leadership. Continuing feedback, including suggestions for improvement, will allow each department to improve service delivery.

This is only the first step to improving services and outcomes for those we serve. After July 1, both departments will continue to have robust dialogue and insight from beneficiaries and provider groups on how we can innovate and change the system of care together. Only with the reorganization created in the Executive Order is there enough bandwidth created to sustain long-term such truly meaningful dialogue for all divisions and departmental leadership.

6. **Could you help walk us through what would occur with a patient who experiences acute stress and has behavioral health needs? For example, if they are in crisis and picked up forevaluation, but there is no room at API. How would their care be coordinated between thetwo departments?**

Each of the divisions will continue to function as they do currently for patient care and coordination. The Division of Behavioral Health (DBH) uses grant funds to help support placement for individuals that are transitioning out of institutional care.

DBH also contracts with an administrative services organization (ASO) for utilization management, referrals, and care management. The proposed reorganization does not change that. DBH will continue to oversee the ASO vender, Optum, and there will be no change in how the ASO does business as a result.

Currently, DHSS has a complex placement team with employees from multiple divisions including DBH, HCS, SDS, OCS and DJJ to assist in finding placement for both youth and adults that have complex needs. In addition, the Complex Behavior Collaborative (CBC), which is a part of DBH, helps providers meet the needs of Medicaid clients with complex needs who are often aggressive, assaultive, and difficult to support. The CBC program offers consultation and training to providers and clients' natural supports, including family members.

Cross-divisional and cross-departmental collaboration would be used to help find this person a placement, if needed, and ensure that they receive the best level of care for their needs. In many instances, this could result in a person moving to a voluntary placement at a more suitable level of care than API. If placement at a DET (such as API) is needed, the team works together to facilitate transfer.

Planning for the reorganization has prioritized continuity of service, and there should be no disruption to data sharing or patient coordination between the divisions in the Department of Health (DOH) and the Department of Family and Community Services (DFCS). There are multiple mechanisms in place to ensure this work and collaboration will continue without interruption, including:

- Current law – which is not being changed substantively under the EO – will continue to provide for the cooperation and coordination between divisions and departments. These provisions are in effect and will remain in effect should the EO be approved.
- Business associate agreements (BAA) are used when different departments and divisions need to

share information to ensure beneficiaries receive services. When required, under HIPAA, DOH and DFCS will have these business associate agreements in place.

- Memorandums of agreement (MOA) and memorandums of understanding (MOU) are also currently used, which allow divisions to share information and collaborate on behalf of beneficiaries. When required, these will continue to be used to ensure there is no interruption in services to beneficiaries.
- Additional documents that will be used to assist in the continuation of services if the EO is approved, include court orders and releases of information. While some of the releases may point to DHSS, most if not all are directed to individual divisions or programs and since those names are not changing, there will be no need to update those documents prior to the change to the two departments.

In the example given of a person experiencing an acute behavioral health crisis, the systems currently in place would be utilized while receiving increased support at the Commissioner level. For example, a specific team for DES/DET coordination will be placed in the DCFS Commissioner's office. We offer the following specific high-level overview:

> In general, when an individual is picked up for evaluation, arrives at a hospital on their own, or is brought in by family/friends, they are typically admitted to the emergency room and evaluated by a licensed clinician. The clinician is often the one to complete the Petition for Order Authorizing Hospitalization for Evaluation, also known as the MC100. Upon review and approval of a MC100 Petition by the courts, an MC305 Order Authorizing Hospitalization for Evaluation is signed by a judge. Once the MC305 is signed, it is sent to the Designated Evaluation and Stabilization / Designated Evacuation and Treatment Coordinator (DES/DET Coordinator) and all facilities the patient is being referred to. Peace Health in Ketchikan is a DES facility. API, Bartlett Regional Hospital, Fairbanks Memorial Hospital, and Mat-Su Regional Medical Center are the DET facilities in the state.
>
> Once the DES/DET Coordinator receives a copy of the MC305 Order they begin tracking the patient's current location and bed availability at each facility. The DES/DET Coordinator communicates with each facility daily and completes a Status Report for Transportation for the Courts for any individual that is not able to get into a facility within 24 hours of the Order being signed. The individual might experience a delay due to weather, waitlists, medical concerns, or alternative reasons which are identified on the Status Report that is turned into the Court every day. While the individual is waiting for placement, they typically remain in the petitioning facilities emergency room until they can be transported. The DES/DET Coordinator continues to communicate with the DES/DET facilities they are being ordered to as well as the hospital to ensure the individual still meets criteria for a Title 47 legal status hold. If there are continued delays or concerns, the Coordinator can work with the emergency room staff to add additional facilities to the Order, assist with travel, or ensure a secondary evaluation is completed as needed. The Coordinator has also been able to work with Petitioners to ensure that a patient is able to go to a DET that best fits the needs of the patient, even if that facility is not the closest facility to the patient's current location.

Currently, the Division of Behavioral Health (DBH) manages agreements with the DES/DET facilities and manages the contract for secure transportation for those on a Title 47 legal hold. The DES/DET Coordinator

is in the Commissioner's Office. Under the EO, the management of DES/DET agreements, secure transportation, and the DES/DET coordinator will be in the DFCS Commissioner's Office.

7. **How will this reorganization be beneficial from a provider perspective? How will it bebeneficial from a patient's perspective?**

   Providers will have more frequent opportunities for direct engagement with department leadership, in settings such as continued town halls between providers and the Commissioner's office. This ongoing dialogue will allow the department to be more attuned to provider needs with more capacity to respond quickly.

   Additionally, due to the expanded capacity and ability of the Commissioner to focus on a consistent mission set, there will be more time and resources to support innovation in Medicaid and other areas. This will allow us to invest in vital work including long term Medicaid sustainability and pilot projects such as health homes, global budgets, and other provider led initiatives.

   Providers often experience uncertainty and cycles based in part on the limited capacity to plan long-term while addressing immediate problems. This needs to change. Due to federal suspension of certain requirements during the public health emergency, we are uniquely positioned at this moment in time to interrupt one such cycle. Typically, every 2-3 years immediate rate cuts are demanded of the Medicaid program so the department pulls the lever of provider rate cuts and/or withholding of inflation. Once this happens then takes a year more to rebuild relationship, then the cycle starts over again as administrations and legislatures change. Our goal is to break this cycle by working together this year to put forward regional based solutions and innovations that move our healthcare system forward.

8. **With the proposed cut to DPA staffing and the bifurcation of the department – how will vulnerable Alaskans receive the application support they need to maintain their benefits aswe move into a recovery phase? How will Alaskans who rely on Medicaid, SNAP, senior benefits, child care, other assistance programs be impacted by the proposed department split? How will you assure this will not result in additional access barriers?**

   There is no proposal for reduced staffing as part of the reorganization. Additionally, while DPA has reduced staffing in its budget, the services provided will remain the same. By changing training structures, implementing enhanced systems, and improving alignment of programs and support functions within the divisions, DPA will be able to maintain the same level of support for Alaskans.

   DPA is consolidating three Anchorage Offices to one location at the University Center Mall to provide consistent and efficient management and oversight of the eligibility work. The offices that are conciliated at the University Center Mall are the Long-Term Care Office, Muldoon Office, and Gambell Office.

   Regarding the reorganization of the department, communication between DPA and other divisions, including those at other departments, will continue through the use of appropriate agreements and existing

communication paths. Since there will be no change in division operations due to the reorganization, the divisions' move to another department should be essentially invisible to beneficiaries – that is, members of the public will see no change in who they contact, methods of contact, or systems used for assistance.

9. **What other avenues did you consider to achieve your goals, other than this particular reorganization?**

In the second session of the 31st Alaska State Legislature, the department did propose the addition of a Deputy Commissioner position and support staff. Ultimately, this request was not approved, although one executive support position was approved. Afterwards, department leadership reflected on the feedback from the ten divisions that support the operations, programs, and services that the department provides to Alaskans on a daily basis. With this in mind, leadership returned to the concept of reorganizing DHSS into two departments which would align functions of programs and services.

With the reorganization of DHSS, a department that serves hundreds of thousands of Alaskans daily, there will be a cabinet level position in the Department of Health with a direct focus on health care services, payment, and public health. There will be a cabinet level position in the Department of Family and Community Services with a direct focus on our child welfare system and our facilities that serve Alaskans around the clock. Each of these departments require a different skill set of their Commissioners. As stated in another portion of this response, it is impossible to find one commissioner with depth of expertise in Medicaid, public health, child welfare, and running 24-hour facilities like API, Juvenile Justice, and the Pioneer Homes. The Alaskans that we serve deserve Cabinet level focus and expertise for all programs. The leadership of each department will have the opportunity to focus on work processes, maximizing efficiencies, incorporating innovative ideas, with the mission of improving outcomes for the Alaskans that we serve.

10. **It would be helpful to understand the evaluation process that led you to take this direction. What is your statement of need? What are the costs and benefits of this plan, and what are the expected outcomes?**

As previously stated, DHSS is stretched too thin over too many subject areas. No other department in the state comes close to the number of personnel, budget, or services that DHSS is responsible for. For example, the DHSS budget is equivalent to that of 12 other state departments, the court system, the legislature, and the Governor's office. The number of personnel in DHSS equals that of 7 other state departments combined.

In our research, it became clear that it is not standard practice to have this type of "mega-agency" providing health and community services. Wyoming, for example, breaks these services into two departments. South Dakota spreads them across four departments.

There is an undeniable need in this state to improve outcomes. With OCS, there is a 52% turnover rate for case carrying workers. Conservative estimates show that this costs $13 million a year to the state and the high turnover results in children staying in foster care too long while families are delayed in working plans, decreasing family resiliency. In Medicaid, we have 4-5% annual growth for the most expensive budget item in the state. Alaska is one of last remaining fee for service states, and we must collaborate on solutions for

value-based care. SB 74 (2016 law) provided authorities to implement many innovations – but these goals have not been achieved because of the lack of bandwidth to work effectively with stakeholders and federal partners.

The work that is done at DHSS touches nearly all Alaskans. The breadth and span of this work is tremendous. To truly improve outcomes in a variety of areas, we must narrow the focus for the leadership team in order to better support each division.

The two departments will have different missions and tasks.

The Department of Health (DOH) will have focus and oversight on health care services, payment, and public health, as well as more time to work with all stakeholders to improve and implement innovation for the single largest budget item in the state, Medicaid. The Divisions of Behavioral Health, Health Care Services, and Senior and Disability Services, provide regulatory oversight, claims processing, facility licensing and the enforcing of Medicaid and state regulations.

The Department of Family and Community Services (DFCS) will have an aligned focus of supporting and improving our child welfare system and our facilities that serve Alaskans around the clock. DFCS divisions provide 24/7 care for specific populations and are in the role of a direct care provider. For example, Alaska Psychiatric Institute (API) and the Alaska Pioneer Homes (AKPH) provide care for patients and elders, and when eligible can bill Medicaid for the services provided – in much the same way that hospitals and clinics work. The involvement of Health Care Services (HCS) is to process those claims to Medicaid, the same as they would for any other provider in the state.

The Alaskans that we serve deserve this attention. By narrowing the span of control, by aligning the divisions and focusing on long term system improvements and stakeholder engagement, this will allow us the opportunity to work better for Alaskans. The leadership of each department will be able to focus on work processes, maximizing efficiencies, incorporating innovative ideas, with the mission of improving outcomes for the Alaskans that we serve.

We will measure success in several different ways. We expect to see a decrease in the turnover rate for OCS case carrying employees. We expect to devote more resources to working with Tribal partners on the implementation of the Alaska Tribal Child Welfare Compact, which can help to transform the child welfare system. We expect that API will return to full capacity and have a more stable workforce so that it is no longer relying on locums to provide care. We expect that DOH will be able to focus more on chronic health prevention.

On the Medicaid side, we can take advantage of more opportunities for innovation due to increased leadership capacity and time spent with ongoing stakeholder engagement. Additionally, we will continue our efforts with efficiencies at DPA that include a new training structure to include peer level supports and increase case review processes, fully implement the Electronic Document Management (EDM) and ongoing enhancements, and online applications for assistance programs.