COMMENTER / *AGENCY*	PUBLIC COMMENT	RESPONSE
Nina Kantarzis / *Providence Medical Group Behavioral Health*	Hello, I am hoping that you can provide some clarity for us. I am part of an MHPCS and we accept Medicaid patients, in fact they make up a significant amount of our patient population. Yesterday we were told by a Conduent staff member that changes had been made to treatment plan review timeframe and that this change was already in effect, but they didn't have many details. Looking at the link below it is confusing as there appears to be two effective dates. 4/24/2020 and July 2020. Can you confirm for me if the treatment plan review timeframe has been reduced to every 90 days and if so what the effective date of that change is? Meaning when we will be denied service authorizations and billing based on this new shorter review period? We have not heard about this change through the normal channels I would have expected and the billing manual, state website and service authorization form still list 135 days as the treatment plan review period. Can you help clarify this for us? https://aws.state.ak.us/OnlinePublicNotices/Notices/Attachment.aspx?id=122019 Thank you, **Nina Kantarzis |Clinic Manager** Providence Medical Group Behavioral Health 3760 Piper Street Suite 1108 **| Anchorage, AK 99508** tell: 907-212-6933 | fax: 907-212-6936	The "Medicaid Services, Behavioral Health Provider Revised Requirements" regulation project went into effect on April, 24, 2020. This regulations project amended treatment plan requirements in 7 AAC 135.120, "…a face to face treatment plan review must be conducted at least every 90 days." Please review the amendment for a complete list of changes. The new regulations went into effect April 24, 2020.

	Internet: **alaska.providence.org** PROVIDENCE Medical Group Behavioral Health	
John Regitano	I started to look at the 1115 regulations yesterday and was surprised to see that there was no MH residential day rate for adolescents/children only adults. John	Thank you for the comment. The department expects to add that service to the regulations found in 7 AAC 139.300
Chris Bragg / *South Central Foundation*	Good afternoon. We have two questions concerning the attachment Alaska Behavioral Health Provider Service Standards & Administrative Procedures for SUD Provider Services: 1) Since this is a revision to the previous edition dated 10/7/2019, is it possible to publish the 5/27/2020 version with updates noted? The format used in regulation changes, with a. **bolded and underlined font** to indicate new language b. identification of new or amended sections as such, and c. [ALL CAPS TEXT WITHIN BRACKETS] indicating deleted language would be helpful. 2) A new service, Outpatient Substance Use Disorder Treatment Services, has been added to this manual. The effective date is listed as 7/1/2019, with	Thank you for the request, we do not have the capacity to publish the 5/27/2020 version with the updates suggested.

	revisions 10/7/2019 and 5/27/2020, although this service has not been listed in the manual before. We would appreciate clarification of the effective date for this service. Thank you very much.	
Anna Nelson / *Interior AIDS*	Farina, The regulation changes that are up for public comment are somewhat disturbing. Are you aware, given the current version of the regs, whether we will lose the state plan codes we have been billing that are not replaced in the in new regs? H0007 includes "medication" in a 15 minute unit. $25 and change. This is untenable for a nurse to be tracking time for this. Some administration episodes take 5 minutes (not billable) and some take 30 minutes and include a drug screen-all for $50? We bill H0020 and H0033 for medication administration. IF these are going away to be replaced by a code that will not serve OTPs- Opioid Treatment Programs, we need to know soon, because our business model will have to change. Reimbursement will be worse that it was before the rate rebasing. 1115 will never make up for the lost revenue. In an era that MAT is supposed to be the standard of care for opioid dependence-that would, pardon my language, suck. I am preparing comments on the proposed regulations. For these comments to be meaningful, we need to know how the STATE and the Medicaid auditors are interpreting the service descriptions. In my case, it is the H0007 code-outpatient services-that causes the most concern. You realize, don't you, that it includes assessments, medication, drug screens, and CRSS. CRSS has its own code,	Thank you for the comment. Please review appendix D of the 1115 Demonstration application. http://dhss.alaska.gov/dbh/Pages/1115/default.aspx

	but pays less there. The fate of the state plan behavioral health codes is also critical to a meaningful dialog on the proposed regulations. If not you, or any of the people receiving this e-mail, who should I ask for clarification? Or should I simply send this email to the person identified for receipt of comments? Will I get clarification or will it just be added to the pile of comments.	
Anna Nelson Interior AIDS	Ms. Wooden, An email that I wrote on 6/15/20 was submitted as a comment on the proposed regulations. One of my questions has been answered. Question "The regulations changes that are up for public comment are somewhat disturbing. Are you aware, given the current version of the regs, whether we will lose the state plan codes we have been billing that are not replaced in the new regs" *This was clarified in a TA session on 6/18/20. The list of state plan behavioral health codes being delated are listed in Appendix B of the state's application for the 1115 waiver.* *P.62 This resolves my issue with State Plan codes H0020 and H0033 for medication administration. We will continue to bill the state plan for these services.* I still have questions and comments about ASAM 1.0 Outpatient Services, page 9 of the *Alaska Behavioral Health Provider Service Standards and Administrative Procedures for SUD Provider Services.* 1. "Adult outpatient includes regularly scheduled services provided to beneficiaries at a maximum of 8 hours per week.	Thank you for the comments. Regularly scheduled means reoccurring event to take place at a particular time. All services not otherwise contraindicated may be provided. A provider should select the billing procedure code that meets the clinical activity occurring. Yes, SUD Care Coordination is an adjunct when MAT is delivered. Please refer to the Alaska Behavioral Health Provider Service Standards & Administrative Procedures for SUD Provider Services for a detailed service description.

	a.what is the definition of" regularly scheduled"? b. "Component Services" include i. "**Biopsychosocial Assessment**" – does this mean cannot bill the single unit code H0001 in the state plan? ii. "**Medication services**" Is there a definition? iii. "**Community Recovery Support Services"** This services is also listed as H2021 V1, etc. It pays better in H00 (0)7. (The Chart has 3 zeros, the Administrative Standards document has two H007.) Is the inclusion of CRSS in H0007 an Error or do we choose which code to bill? If it Is a choice, on what basis should we make that Choice? iv. **"SUD Care Coordination"** This service is also listed as H0047 V1. Given that this is clearly intended to be a unit based "monthly" code, and is almost always going to be duplicative of other services delivered, then I am guessing it occurs with outpatient services, but is not a "component" of the code H0007. It is an adjunct when MAT is delivered. Thank you for presenting these comments to the appropriate committee Respectfully, Anna Nelson	
Winn Davis / *Alaska Native Health Board*	Dear Ms. Wooden,	

	The ANHB is submitting the below questions as part of the public comment process on the noticed Emergency Regulations for the Medicaid 1115 Behavioral Health Waiver Services (Project/Regulation # 2020200364). Would you please confirm receipt of this email, and if possible provide an estimated date when the Department expects to post the responses to submitted questions? Questions: 1. Home-Based Family Treatment Services (All levels): a. Is a Service Authorization required for more than 40 units per week (under Level I, for example), for more than six weeks, for both, or for a second full complement of service later in the year? Gap between Levels 1 and 2 of 8 hours (40 and 48). Level 3 is 56 max with another gap of 8 hours. 2. Intensive Case Management Services: a. A Peer Support Specialist is listed as a provider type but presumably cannot bill for the service because "…at least a behavioral health clinical associate" must facilitate the service for it to be reimbursable. What is the reasoning? Where in the hierarchy does a Behavioral Health Aide fall in relation to a Clinical Associate or are they considered the same level? b. What is the definition of "facilitated?" Can a CA refer a service component to a PSS with	Thank you for your comments. The department recognizes that the service authorization requirement for more than 40 units per week may be confusing. The department will clarify the requirements found in the Alaska Behavioral Health Provider Service Standards & Administrative Procedures for Behavioral Health Providers. Thank you for the comment. The department will consider revising the list of allowable qualified renders for intensive case management services. A behavioral health aide meets the requirements listed in 7 AAC 70.990 for behavioral health clinical associate. Facilitated means provided.

	that component being reimbursed or does the CA have to provide the actual component?	The department will consider the use of telehealth.
	3. Assertive Community Treatment: a. With geographic barriers in some areas, will telehealth outreach be considered "in the community" for the 75% requirement? Will telehealth be acceptable for all or part of the 1.5 hours of contact and 3 hours of services a week?	
	b. Providers may spend a lot of time assessing a person who would benefit from ACT services, and many resources are pulled together to be a part of the team for that particular person; that said, ACT services are only reimbursable when a treatment plan is in place. The preparation should be an allowable reimbursable.	Thank you for the comment.
	4. Peer-Based Crisis Services: a. Under "Service Requirements/Expectations," it indicates "Peer-based crisis services *should* be provided by a peer support specialist…" while under "Additional Information" it says that "…each unit of service *must* be facilitated by a peer support specialist." Please clarify the requirement vs. option. What is the definition of "facilitated?" Can a different provider type provide a reimbursable service if coordinated by a Peer Support Specialist?	Thank you for the comment. The department recognizes that the language "should" is confusing. The department will clarify the requirements found in the Alaska Behavioral Health Provider Service Standards & Administrative Procedures for Behavioral Health Providers. Thank you for the comment. The department acknowledges the typo.
	5. 23 Hour Crisis Observation and Stabilization: a. Why is a "Bachelor's" Behavioral Health Clinical Associate required? Is this a typo, as no other	

	service has this educational requirement associated with a Clinical Associate? b. Four check-ins within 15 days limitation. Sometimes, a person is brought in by police who do not have any other option to take the person, or the person may arrive by rescue squad with a crisis condition; if this occurs after four services have been implemented and it's the 12th day, we cannot deny service. c. In "Additional Information," what is the definition of "facilitate?" A Behavioral Health Clinician may be requested by a physician to provide an intervention. Is that BH service reimbursable if the physician facilitated the referral and contact? d. Is the State Plan Crisis Intervention service sun setting? If an organization does not have immediate access to a hospital, what service can be provided? 6. Mobile Outreach and Crisis Response Services: a. Is the requirement to follow-up within 48 hours a billable service? Is a Progress Note used to document this? b. If called-out and the crisis is over once the provider arrives, is the call-out still billable? c. A service authorization is required for a service beyond 12 calls per SFY. Can the service be provided and be reimbursed if provided prior to the service authorization being completed and approved? Waiting for an SA while a	Thank you for the comment. Facilitated means provided. The department will consider revising the list of allowable qualified renders noted under Additional Information for 23-Hour Crisis Observation and Stabilization found in the Alaska Behavioral Health Provider Service Standards & Administrative Procedures for Behavioral Health Providers for clarity. Yes, a provider should select the billing procedure code that meets the clinical activity occurring. Please clarify the documentation question. Yes, the service is still billable if the provider arrives and the crisis is over. Thank you for the comment.

	person is in crisis should not be the intention of this Service Frequency/Limits.	At this time psychotherapy will remain a State Plan service.
	7. General Questions/Statements:	
	a. Will Psychotherapy remain in the State Plan services since it is not in the waiver?	Thank you for the comment.
	b. Contraindications are long and not always appropriate. If someone is receiving Intensive Outpatient Services, he/she might benefit from skills development that comes with "Community Recovery Support Services," yet it is contraindicated. Not contraindicated in SUD IOP, but it is in MH IOP.	Home and home-like setting have been used synonymously. The department recognizes the confusion.
	c. For Service Locations, there is "Home" and "Home-like setting." What is the difference and are there times when they are synonymous? PHP has 99 OTHER e.g. home-like, other appropriate community setting (ACT), 23 hour has 99 OTHER but specific locations, 12 is HOME	Due to the complexity of the Four Walls Rule, this will be treated as a separate topic apart from the scope of the comments being consider for the 1115 Medicaid BH regulations.
	d. We believe services in the home and other locations are important; however, with this 1115 Waiver offering services that allow for and demand home-based service delivery, we are concerned about the restrictions of the Four Walls Rule forthcoming from Indian Health Services and how it will make some services unavailable. What are your thoughts on how people can get the services they need within the confines of this rule?	Thank you for the comment.
	e. Greater flexibility around telehealth after pandemic has passed.	Thank you for the comment. The department will consider the recommendation.

	8. 1115 SUD Waiver: a. Ambulatory Withdrawal Management Level I – telehealth? This would be appropriate for this service. Thank you, Winn Davis *Policy Analyst* Alaska Native Health Board (907) 885-8337 WDavis@anhb.org	
Kevin Munson / *Mat-Su Health Services, Inc. (MSHS)*	Ms. Wooden: Mat-Su Health Services, Inc. (MSHS) would like to take this opportunity to make comment on the proposed regulations governing the Medicaid 1115 behavioral health waivered services. MSHS is both a federally qualified community health center and a community behavioral health provider offering integrated primary care, dentistry, behavioral health, psychiatry, medically assisted treatment, substance use disorder treatment as well as specialty behavioral health services with psychiatric emergency services, services to the severely mentally ill adult, and services to the seriously emotionally disturbed child/adolescent. Overall, MSHS is of the opinion that the expansion of services and the expansion of eligibility for those services is a positive step; however, the inattention to the implication of these sweeping changes, the failure to appreciate the market forces (workforce needs and constraints; pricing vs. actual cost of service delivery; the absence of capital to start up the new lines of business; and the timeline for systemic change), the larger economic	

	drivers, and the failure to properly finance the systemic change threaten the success of the effort and will lead to , slow, limited and poor adoption of the new services. MSHS sees the use of emergency regulations to implement services for which neither the State nor the provider community is ready to implement rapidly is a misuse of its authority in that there is not, in our opinion, an emergency, nor did the extraordinary adoption of the regulations fix, facilitate or ameliorate any critical health safety issues in the community. The proposed changes are massive in both scale and scope and should have enjoyed the full public review process. As it is, providers both had to figure out how to comply at the same time as they were trying to figure out if the regulations where a good idea to begin with. The regulations propose a massive overhaul to our service delivery system, yet there is no funding available to make necessary changes or build the capacity to deliver the services. Cuts and flat funding over the past several years has diminished our ability to pivot our service delivery system. The threat of cuts to Medicaid reimbursement rates and behavioral health treatment and recovery grants makes it risky for providers to invest in what is needed to make this a success. To help ensure that the proposed changes launch successfully we need to maintain the Medicaid benefits array, maintain full funding for Medicaid reimbursement. Treatment and recovery grant funding, the primary resource for capacity development and change, should be increased. Finally, we need to do a better job of identifying the costs of implementing the proposed changes and make dedicated resources available to providers to reduce risk and help ensure success.	

	The 1115 calls for some of the waiver services to replace current state plan services. It appears that the current plan is to pick a drop dead date after which providers must use the 1115 services and end the use of the state plan services. Instead, the State should gradually phase out services as their replacement services are phased in and not simply discontinue state plan services at some arbitrary date. The transition should be gradual to help ensure service continuity, minimal disruption to the recipient of services, and a smoother transition. If done properly, this gradual transition should result in minimal or no additional cost to the State. However, if the State insists on an arbitrary date it would be best for the state have meaningful discussions with the provider community to plan the transition The State supports the notion of universal screening. MSHS is support of the concept of screening. We currently use tools like the PHQ-2 and PHQ-9, the GAD, the AUDIT and other tools to screen and assess our patients. We believe that allowing maximum flexibility to providers to choose screening tools, presuming that they are nationally normed and accepted is in the best interest of the State, our patients and providers. There will be a cost associated with the adoption and implementation of universal screening. Costs such as licensing, EHR development and programming, workflow development and staff training are not trivial. As it stands, these will be unrecoverable unfunded mandate costs to the provider. The Alaska Behavioral Health Providers Services Standards & Administrative Procedures for Behavioral Health Provider Services which is adopted by reference by the proposed regulations. It proposes complex matrices of services and	

	defines those services which can and cannot be delivered together. It is a far more complex set of exclusionary criteria than has ever existed before. It creates cracks and crevices for patients to fall between that did not previously exist. It creates an administrative burden of epic proportions on agencies to manage the mechanics of what can and cannot be done and makes both treatment planning and execution much more difficult all in the name of increasing access-it will have just the opposite effect. It fails to appreciate the fluid and organic manner in which patients move through the levels of support they may need on a given day, or hour. The manual is unclear about the time frames around what cannot be delivered when. Is it at the same time? Same day? Week? Episode of care? This needs simplification and clarification. Aside from the more general comments, MSHS concurs with ABHA in its concerns about specific opportunities to help improve the proposed regulations and our service system: 1. Section 138.200(a)(1) references department approved screening tools. MSHS would like the opportunity to suggest screening tools to include in the department approved list including, but not limited to, Recovery Needs Level and the PROMIS/NIH Toolbox screening list. Please also keep in mind that providers will need time to work with their EHR/ECR vendors and to provide the training necessary for clinical and business practice changes required. 2. The 1115 included brief interventions, brief therapy, and coordination to treatment based on the level of risk identified by the screener. These services are omitted from the regulations currently posted for	Thank you for the comments. The Division of Behavioral Health anticipates that technical assistance will be available for providers regarding regulation requirements. Thank you for the comment. The division anticipates hosting a series of workgroups with behavioral health providers to identify a list of suggested screening tools.

	public comment. Please confirm that the state intends to issue regulations for screeners and risk based brief interventions, brief therapy, and coordination to treatment with reimbursement for these services.	Thank you for the question. The department will assess over time what additional services may be added as data from the 1115 waiver demonstration becomes available.
	3. 23-hour Crisis Observation and Stabilization.	
	a. Many good crisis stabilization programs in other states report that this service may, at times, extend past 24 hours. For example, this could occur when a transfer to another level of care is pending (like to API), and the Crisis Stabilization center needs to continue to provide care until the transfer can be completed. We recommend allowing payment beyond 23 hours and 59 minutes when necessary.	Thank you for the recommendation. 23-Hour Crisis Observation and Stabilization billed under Medicaid must be provided and documented according to 139.350.
	b. "Bachelor's Level Clinical Associate" is listed as a provider type. The Department's Aggregated Questions and Responses (released 07/06/20) identified this as a typo. Please correct.	Thank you, the department acknowledges the typo and will correct the error.
	c. We are concerned with the limit of 4 check-ins within 15 days and the requirement for service authorization for more. It would be unlikely that someone would have more than 4 check-ins in 15 days, but it is clinically possible. The nature of this crisis service requires immediate access and waiting for authorization is not feasible. For example, the Crisis Now model purports that police officers can bring people to 23 Hour Crisis Stabilization and are guaranteed check-in 100% of the time in a	Thank you for the comment. The department agrees the limit of 4 check-ins within 15 days is

	matter of minutes. For this to work, we need to remove service authorization requirements. d. Clinicians should be able to draw down the rate for these services. e. Many programs function with distance delivered medical prescribing. Remove reference to on-site requirement for medical providers.	problematic. The department will consider a change to the service limit.
	4. 7 AAC 139.030(b) and (c) seems to say that a provider must get a prior authorization to deliver an 1115 service and a state plan service to the same person. This will cause practical problems when a provider is delivering an 1115 service and then also needs to deliver a crisis service using a state plan crisis code. The crisis service, because it is due to a crisis, does not align with a prior authorization process. Remove the prior authorization requirement.	The department will consider revising the list of allowable qualified renders noted under Additional Information for 23-Hour Crisis Observation and Stabilization found in the Alaska Behavioral Health Provider Service Standards & Administrative Procedures for Behavioral Health Providers for clarity. Thank you for the comment. The department will consider the recommendation.
	5. Assertive Community Treatment: a. Change the regulation to allow for the 24-hour requirement to be met by another function, service, or contractor. b. The non-Tribal rate is not viable to run this service. The rate is only $2.54 more than ICM and requires significantly more expensive providers and teams. We suggest increasing the rate and allowing for addiction reimbursement for medical provider services.	Thank you for the comment. The department will consider the recommendation. Over the course of the demonstration Project there will be ongoing analysis around the efficacy of the rate structure.
	6. The description of Intensive Outpatient Mental Health at 7 AAC 139.250(2) that "significant functional impairment that interferes with an individual's ability ... " is a good description. 7 AAC 139.250(2)(d) then	Thank you for the comment. The department agrees with the recommendation and acknowledges a revision will be made.

		lists "activities of daily living" which is inappropriate for this service. Please delete activities of daily living.	
	7.	"Daily schedule of treatment" as included at 7 AAC 139.250 (2)(A) implies that IOP is operating 7 days a week. IOP generally operates 5 days a week. Please revise to say: "weekly schedule of treatment."	Thank you for the comment. The department will consider the recommendation.
	8.	We are concerned with "high service needs" as defined at 7 AAC 139.300 (d} by three or more acute hospitalizations, psychiatric emergency services, or involvement with criminal justice." We think it is very possible that a person could have three or more events in the past calendar year, but there are reasons why a person might not including living in a village without public safety, living in a village where emergency visits are coded as outpatient visits, needing API but not able to be admitted, had a long stay at API (many months) rather three separate stays, etc. Access should be based on clinical need, not prior utilization. Revision could either remove "high service needs" from the regulation, or revise to say "may have had high service needs" rather than requiring high service needs.	Thank you for the comment. The department will consider the recommendation.
	9.	Thank you for confirming in the Aggregated Questions and Responses released on 07/06/20 that the crisis codes currently in the state plan will continue. These are not listed in the 1115 as codes that would sunset and these codes will be needed in addition to the new 1115 crisis services.	Thank you for the comment.
	10.	We are concerned with the language in the Alaska Behavioral Health Providers Service Standards & Administrative Procedures for Behavioral Health	

		Provider Services at page 4 that says " ... some children between ages 18 and 21 may be eligible as adults for certain waiver services." All adults ages 18 or over who are Medicaid eligible should be able to receive adult waiver services if clinically appropriate. We suggest deleting this section entirely.	Thank you for the comment. The department acknowledges the language is confusing and will provide clarity to the requirement.
	11.	The proposed regulations state "Services must be drawn down by at least 'X' provider." This is confusing language because it is not clear what type of provider is ranked above or below another provider. For example, how does a BHA compare to a Clinical Associate or an RN? It would be clearer if these sections stated, "any listed eligible provider type may draw down this service."	Thank you for the comment. The department acknowledges the language is confusing and will provide clarity to the requirement.
	12.	Home Based Family Treatment level 1:	
	a.	No clinical logic is included to support the 6-week timeframe. We recommend the currently allowable units (240), without the 6-week cap. This would allow for a longer duration of less frequent interventions at the same cost. We believe this would allow for better outcomes for this exciting new early intervention.	Thank you for your comments. The department recognizes the service authorization requirement for more than 40 units per week may be confusing. The department will clarify the requirements found in the Alaska Behavioral Health Provider Service Standards & Administrative Procedures for Behavioral Health Providers.
	b.	Because eligibility is based on family risk factors, we would like this service to be possible at the time of conception. We can see great benefit from providing HBFT1 to high risk families during pregnancy.	
	c.	We are excited that this is a service in the home, but home is not always the only viable location. At times, we may want to include facility based interventions (for example, if the home is unsafe or if the family is otherwise unwilling) or community-based interventions (for example, when a child is struggling	Thank you for the comment and recommendation.

	at daycare or at soccer or in other community locations). This home-base service is exciting because it allows us to work in real life locations, but these locations could be home, clinic, or community. Please include these as possible service locations.	Thank you for the comment. The department agrees and will consider your recommendation.
	13. Home Based Family Treatment level 2 and 3 would require including clinic and community locations. See 13(c) above.	
	14. We are unsure if the Service Components listed for each 1115 service means that the components "can" be part of the service or "must" be part of the service. For example, Home Based Family Treatment level 1 has a long list of service components. It is a great list, but it would not be possible (or appropriate) to deliver every listed component to every family. Please confirm that service components can be delivered as part of a service as clinically appropriate.	Thank you for the comment.
	a. Providers also raised concerns that state plan services may be provided (and billed separately) concurrent with 1115 services. Unless this is possible, some 1115 services may be cost-prohibitive to operate.	Thank you for the comment. Yes, service components can be delivered as part of the service as clinically appropriate.
	15. ACT and ICM services:	Thank you for the comment. Please refer to 7 AAC 139.030, provision of State Plan services, for clarity.
	a. A significant amount of clinical care delivery during the engagement stage. The engagement stage is prior completion of a treatment plan. Reimbursement for clinical care during the engagement state is essential for these services to work. Please include a reference to 7 AAC 105.230 to allow reimbursement for care delivered prior to treatment plan.	Thank you for the recommendation. ACT and ICM services billed under Medicaid must be provided and documented according to 139.200.

	b. These services have great potential to provide cost-effective interventions for people experiencing homelessness and/or at risk of psychiatric emergency care. We are concerned that conformance with high fidelity models, given Alaska's unique geography and workforce challenges, will be a barrier to operating these services. We suggest removing reference to high fidelity compliance.	Thank you for your comment.
	c. Many providers have expressed concern with the rates for these programs. ACT and ICM are effective interventions and prevent the need for psychiatric emergency care and AMHR but that is only possible if the rates provide for viable operations.	Thank you for your comment. Over the course of the 1115 Waiver demonstration project there will be ongoing analysis around the efficacy of the rate structure.
	16. Behavioral Health Aides should be included as provider types for ICM. We think this was an error that can easily be corrected.	Thank you, the department acknowledges the oversight and will correct the error.
	17. CRSS service limits for behavioral health are ½ of the CRSS limits for SUD. There is no clinical reason for less CRSS for behavioral health. Please increase the BH service limits to match the SUD service limits.	Thank you, the department acknowledges the oversight and will correct the error with the updated revision to the Alaska Behavioral Health Provider Service Standards & Administrative Procedures for Behavioral Health Providers.
	18. Peer-Based Crisis Services: a. The documentation reference is to care delivered under a treatment plan. Due to the nature of a crisis intervention, Peer-Based Crisis Services will need to be delivered in real time without treatment plan. Please change the documentation reference to 7 AAC 105.230.	Thank you, the department acknowledges the service limit difference and will correct the error with the updated revision to the Alaska
	19. Mobile Outreach and Crisis Response:	

	a. The rate is very low for this service. Please re-evaluate this rate.	Behavioral Health Provider Service Standards & Administrative Procedures for Behavioral Health Providers.
	b. Thank you for paying for each "call out." It will be common that a "call out" cannot be completed because the person in crisis has left, refuses the intervention, or the situation escalates, and police intervention is needed. When this happens the cost for the "call out" can still be covered because this service is paid per "call out" rather than based on care delivered. It would be helpful to make this clearer in the regulations.	Thank you for the comment and suggestion. Thank you for the comment. Thank you for the comment and suggestion.
	c. Please clarify that telephonic crisis response can be reimbursed through this code. This call center function, which includes telephonic crisis services, is a vital part of the Crisis Now model. The crisis call is not triage. The goal is to deliver real time, telephonic crisis interventions reducing the need for further immediate care.	
	d. We appreciate that this service will include post-crisis follow up interventions. Please confirm that the MOCR code will be reimbursed again for the follow up intervention post crisis.	Thank you for the question, T2034 V1/V2 cannot be billed for the follow up care.
	20. ASAM 1.0 service limits lists telehealth separately. Telehealth should be a normal route of delivery with no additional or unique authorization required. Please remove reference to telehealth.	Thank you for the comment and question. T2034 V1/V2 cannot be billed for the follow up care.
	21. SUD Care Coordination will often occur in non-behavioral health settings (such as medical care settings) and by a variety of provider types. To	

	accomplish this, please change the documentation reference to 7 AAC 105.230. 22. The definition of adolescent in the 1115 SUD wavier should define adolescent services as the following ages: "12-17 and youth 18-21 with a substance use disorder diagnosis when determined to be medically necessary and in accordance with an individualized treatment plan demonstrating clinical justification as to why they are best served in adolescent programming." Additionally, any age range for residential levels of care should align with DHSS Residential Licensing ages that allow services for youth to individuals aged 19 who are approved through regulation 7 AAC 50.300(c). This would align with the age ranges currently used in best practices, existing state and ASAM definitions of adolescent, definition of youth in the BH 1115 waiver, and the allowance for service in appropriate developmental settings, and will not decrease access to care for these youth. 23. We appreciate that the State recognizes the concern about the forthcoming Four Walls Rule impacting tribal providers and are committed to working with providers to reduce any negative impact on service delivery in Alaska. MSHS appreciates the opportunity to offer comment and recommendations concerning the proposed regulations. Thank you. Kevin Munson, CEO	Thank you for the comment. A separate authorization is not required for telehealth. Thank you for the comment and suggestion. Thank you for the comment, the department agrees a revision will provide clarity to the requirement. Thank you for the comment.

		Thank you for the detailed comments and questions.
Tommy Glanton / *SeaView Community Services*	Ms. Wooden: SeaView Community Services appreciates the opportunity to provide comment on the proposed regulations governing Medicaid 1115 behavioral health waiver services and the work that has gone into these proposed regulations. We provided oral comment at the hearing on 6/18, expressing our enthusiasm about offering 1115 behavioral health waiver services and the benefit these new services will have for Alaskans in our community. We also expressed our support for the implementation of emergency regulations due to the critical need in our community, especially with the additional challenges we face as a result of the COVID-19 pandemic. These written comments supplement our oral comments at the June 18th public hearing. SeaView Community Services is a nationally accredited behavioral health provider whose mission is to provide community-based services that strengthen families, foster self-sufficiency and enhance quality of life. SeaView is led by a team of professionals who are passionate about access to mental health care, freedom from addiction, and building healthy families. Our mission is achieved by regularly assessing the needs of the community and providing a full continuum of local behavioral health programs that address mental health and substance use disorders. SeaView owns and operates three facilities: the main office plaza for outpatient services, a 24/7 behavioral health assisted living home and a recovery housing facility that provides transitional housing and treatment services for those	Thank you for the detailed comments and questions.

	experiencing substance use disorders and co-occurring mental health conditions. Overall, we believe these regulations greatly enhance our ability to provide care and help to Alaskans in need of behavioral health treatment and recovery supports. We wanted to bring specific opportunities to your attention that could help improve the proposed regulations. 1. Supporting use of emergency regulations SeaView Community Services supports the State's use of emergency authority to implement the proposed regulations. Alaska Law at A.S. 44.62.250 et. seq. allows the State to immediately implement regulatory changes only if it is in response to an emergency and it is necessary to do so to preserve public peace, health, safety, or general welfare. We support the State's position that the behavioral health needs of Alaskans constitute an emergency and that critical changes to service delivery are required to address current barriers to needed care. The lack of treatment options available for individuals experiencing acute behavioral health needs has long been an issue in our state that has left many Alaskans without needed services and created unnecessary suffering. The proposed Medicaid 1115 behavioral health waiver services directly address these service gaps and provide community organizations the ability to better respond to acute behavioral health needs locally and improve the quality of services we can provide to our most vulnerable populations. The use of emergency regulations is further supported by the impact of the COVID-19 pandemic on our community's behavioral health and wellbeing. Many community members have experienced job losses, school and childcare instability,	Thank you for the comment.

	lack of housing, and increased tensions in strained families, all which impact an individual's mental health. For those with substance use concerns, increased stress, worry and restrictions created by the pandemic have resulted in increased substance misuse and have created barriers to accessing treatment. Even before the current public health crisis, limited options were available locally for treating acute mental health and substance use needs due to critical gaps in services. With the increased stressors on individuals and family systems, significant change is needed now. The proposed Medicaid 1115 behavioral health waiver services will allow us to enhance our current continuum of care, establishing a system which more responsively meets the needs of individuals impacted by COVID-19 and allows for the right level of service to maintain them in the community. 2. Increased support for organizations implementing new services The State issued the emergency regulations on May 20, 2020 with the changes going immediately into effect. SeaView supports that decision as it has allowed us to begin moving forward with implementation on new Medicaid 1115 behavioral health waiver services that are critical to the health of our community. However, as a result of the proposed changes being concurrently out for public comment, the State has been limited in how they could respond to key questions we have regarding these new services. This creates a barrier to success as we are actively seeking to partner with the State in the establishment of these services both to ensure our understanding of them is accurate and to avoid issues arising in future audits as a result of lack of clarity.	Thank you for the comment.

	To assist organizations like SeaView who are moving forward with early implementation, we request that the state establish a mechanism for providing consultation and support. The proposed regulations represent a massive change to the behavioral health service delivery system in Alaska and without partnership between providers and that State, efforts to achieve our shared goal of more effectively meeting the behavioral health needs of our community will not be successful. SeaView looks forward to the opportunity of working with the state on implementation of the Medicaid 1115 behavioral health waiver services and helping to craft models of how many of these services can be established in smaller communities across Alaska. 3. Bundling medication management with other services SeaView requests the State reconsider the decision to bundle medical services like medication management with other behavioral health services for some Medicaid 1115 behavioral health waiver services. The cost of providing these critical medical services to our community in rural Alaska is very high due to workforce shortages. The reimbursement rate offered for these bundled services does not adequately compensate the medical and behavioral health professionals required to be involved and presents sustainability issues for these new services. We urge the Division of Behavioral Health to decouple medical and behavioral health services in the bundled reimbursement rate proposed. 4. Requirements to be eligible for Adult Mental Health Residential Treatment Level 1 services runs counter to the goal of the 1115 waiver (increasing access to services)	Thank you for the comments. The department agrees a revision will provide clarity to the requirements. Thank you for the comment.

	The overarching goal of the 1115 waiver is to increase access to behavioral health treatment and support. This goal recognizes that clinically indicated behavioral health families from unnecessary heartache. When examining the current services offered at SeaView, one critical gap has historically been providing treatment for individuals who require a higher level of care than outpatient treatment but do not need the intensity of inpatient care at API. Significant wait times for beds at API have also complicated this service gap and created a strain on both our local emergency department and our organization as we attempt to meet the needs of this individuals without access to appropriate services. The established of the Adult Mental Health Residential (AMHR) Treatment Levels 1 and 2 directly responds to this service gap that has existed across the State and should assist in decreasing the overutilization of inpatient psychiatric beds due to lack of other clinically appropriate levels of care. SeaView is excited about the impact this service will have for individuals in our community who present with acute mental health needs and require a structured treatment environment in which to access stabilization and long-term recovery. Being able to clinically assess and place individuals in the appropriate level of care at AMHR is key to the success of this service. We are concerned that the Medicaid 1115 behavioral health waiver services unintentionally limit access to AMHR Level 1 with the requirement of a prior history of "high service needs" as defined by three or more acute hospitalizations, psychiatric emergency services or involvement with criminal justice". We think it is very possible that an individual could have 3 or more events in the past calendar year but there are reasons	

	why a person might not, including: living in a village without public safety, living in a village where emergency visits are coded as outpatient visits, having needed API but couldn't get in, or having a long stay at API (many months) rather three separate stays. For success in getting Alaskan's the right service at the right time, access should be based on clinical need, not prior utilization. We know that when a crisis strikes, people need treatment options that adequately respond proportionally to their need. Our community needs this service as evidenced by historical unnecessary long stays in our local emergency department by individuals awaiting a bed at API that have resulted in lack of adequate services and suffering on the part of the individuals and their families. SeaView knows that by expanding the local continuum of care for managing acute behavioral health needs, we will prevent unnecessary hospitalization/emergency department stays and provide pathways to treatment that both mitigate and manage crisis situations through local treatment services. SeaView will only be successful if adults are able to access the right level of residential treatment for mental health needs that allows them to slowly integrate back into their lives through a step-down process, with longer-term stabilization available when necessary. We urge the Division to remove this requirement and allow access to this service to be based on clinical need. 5. Relationship between State Plan and 1115 waiver services In the Medicaid 1115 behavioral health waiver services (7AAC139.030 b and c) appear to say that a provider must get a prior authorization in order to deliver an 1115 service and a state plan service to the same individual. We are concerned that this will cause practical problems when a provider is	Thank you for the comments. The department agrees that the recommended revisions will provide clarity to the requirements.

	delivering an 1115 waiver service and then also needs to deliver a crisis service using a state plan crisis code. The crisis service, because it is due to a crisis, does not align with a prior authorization process. SeaView asks for removal of this prior authorization requirement. Again, SeaView would like to express our appreciation to the Division of Behavioral Health for the extensive effort and thought that has gone into the Medicaid 1115 behavioral health waiver services and these proposed regulations. We are excited about the new services and new ways of delivering care provided in these regulations which will support our organization in better meeting the behavioral health needs of our community. SeaView looks forward to partnering with the State as we implement these services and create a comprehensive system of care within our community. Our comments are offered in the sincere hope that they will improve our collective efforts to provide improved access to behavioral healthcare across Alaska. Sincerely, [digital signature] Tommy Glanton, LCSW Chief Clinical Officer Cc: Tom Chard, Alaska Behavioral Health Association	Thank you for the detailed comments and questions.
Charlie Woodcock	Ms. Wooden: Youth Advocates of Sitka appreciates the opportunity to provide comment on the proposed regulations governing Medicaid 1115 behavioral health waiver services and the	

/ *Youth Advocates of Sitka*	work that has gone into these proposed regulations. These written comments supplement our oral comments at the June 18th public hearing. Youth Advocates of Sitka have been providing services in residential setting since 1975. The agency has been providing community-based services for around 20 years to Alaska youth and their families. Overall, we believe these regulations support our ability to provide care and help Alaskans in need of behavioral health treatment and recovery supports. We wanted to bring specific opportunities to your attention that could help improve the proposed regulations. Youth Advocates opposes the State's use of emergency authority to implement the proposed regulations. Alaska Law at A.S. 44.62.250 et. seq. allows the State to immediately implement regulatory changes only if it is in response to an emergency and it is necessary to do so to preserve public peace, health, safety, or general welfare. Despite the fact that the State's 1115 waiver has been developed over the past few years, the State elected to implement regulations governing 1115 Substance Use Disorder Waiver Services under the guise of an emergency and is now electing to do the same for these 1115 Behavioral Health Waiver Service regulations. Proper notice and comment helps strengthen the proposal. Behavioral health providers are uniquely positioned to be able to offer informed perspective on the proposed changes. The diversity of Alaska's behavioral health provider community offers insight into how the proposals will work in their communities and how they might impact the people they serve. Given the time to understand the change, the desired objective, and some of the contextual factors involved, providers can offer opportunities and spot challenges that	

	might not otherwise be readily apparent. The value of that is lost when the process is rush. Beyond the value of provider input, proper notice and comment allows providers and stakeholders the time they need to implement the changes necessary to help ensure success. There are a lot of changes proposed in these regulations. It takes time to understand the changes and the impact. Shortening the regulatory process and implementing these changes immediately, create system issues that may affect the long term implementation of the process. The proposed regulatory changes are massive in both their scale and scope. These regulations will transform behavioral health services delivery in Alaska. A change this significant needs to have the full benefit of normal public notice and comment. Stakeholders are being asked to comment on these proposed regulations without knowing the details of other significant changes planned for the service delivery system. We understand that it is the State's intention to phase out certain state plan services, but we do not know which services or when. We also understand that the State intends to release proposed regulations governing children's 1115 waiver services, but again we do not what will be included or when they will be made effective. Some of the 1115 Waiver Services are meant to replace current state plan services. The State should gradually phase out services as their replacement services are phased in and not simply discontinue state plan services at some arbitrary date. To illustrate the concern, the State has long sought to discontinue Recipient Support Services	Thank you for the detailed comments regarding the use of emergency regulations.

	(RSS) despite its importance in keeping Alaskans safe and out of higher acuity settings. Although it is unclear exactly which state plan services will be phased out and when, the 1115 Waiver application approved by CMS did include the State's explicit intention to remove RSS from the state plan. The proposed regulations create new services (in this case Community Recovery Support Services) that appear to be intended to replace some existing state plan services. It is difficult to meaningfully comment on the potential benefit of these new services without knowing the extent of the detriment of losing the services they are replacing. There has been very little discussion and no planning with providers about phasing out RSS or any other of the 'sun-setting' services. If the State intends to replace an existing service with a new waiver service, they should do so gradually to help ensure service continuity, minimal disruption to the recipient of services, and a smoother transition. If done properly, this gradual transition should result in no additional cost to the State. The State should not include medical services like medication management with other behavioral health services in a bundled reimbursement rate. The regulations propose coupling these services and there is strong evidence to suggest that doing so would result in increases to both overutilization and underutilization of the medical services. The proposal is also complicated because the reimbursement rate offered for these bundled services does not adequately compensate the medical and behavioral health professionals required to be involved.	Thank you for the detailed comments regarding the sunsetting services. The department intends to hold a series of listening sessions to ensure we properly understand the challenges facing providers.

	We urge the Division of Behavioral Health to decouple medical and behavioral health services in the bundled reimbursement rate proposed. The State of Alaska's 1115 waiver was approved by the Centers for Medicare and Medicaid Services (CMS) as part of a 5-year demonstration project starting on September 3, 2019 and scheduled to end on December 31, 2023. Many states successfully apply for extensions to their demonstration projects based on prior results, but those extension are not guaranteed. The State of Alaska has reduced the budget for treatment and recovery grants with justification that the 1115 waiver services will replace lost revenue and no treatment capacity will be lost in the refinancing. Last year, the State used the pending 1115 waiver services to support their decision to reduce behavioral health provider Medicaid reimbursement rates by 5%. We know the State is planning on discontinuing some state plan services. We are concerned that grant funding will continue to be cut and Medicaid will continue to be under pressure to change the array of services available or reduce reimbursement for services delivered. We urge the Division of Behavioral Health, the Department of Health & Social Services, and other behavioral health leaders to exercise caution and consider the risks to our system of care. The need for behavioral health treatment in Alaska requires us to commit to funding a full Medicaid benefit array at 100% and increasing grant funding for capacity development and treatment services. We cannot let the 1115 waiver services be used as justification to shrink our efforts or endanger our ability to provide care into the future.	Thank you for the comment. The department agrees with the recommendation and acknowledges a revision will be made. Thank you for the comments.

	Creating the regulatory authority to deliver the service without providing reimbursement rates adequate to deliver the service means that service component will not be delivered, limits the options available to Alaskans in need of the service, and threatens the strength of the behavioral health continuum of care. To illustrate the problem, the rate for Assertive Community Treatment (ACT) is only $2.54 more than ICM and requires significantly more expensive providers and teams. Looking at the same problem through a slightly different lens, the family engagement work is reimbursed at only a slightly higher rate than individual therapy, yet when you consider the volume of interventions likely to occur, the rates do not support increased access to the treatment that is needed. Again, we are excited about some of the new services and new ways of delivering care provided in these regulations. Our comments are offered in the sincere hope that they will improve our collective efforts to provide improved access to behavioral healthcare. Charlie Woodcock Executive Director, Youth Advocates of Sitka	Thank you for the comments. Over the course of the 1115 Waiver demonstration project there will be ongoing analysis around the efficacy of the rate structure. Thank you for the detailed comments and questions.
Paul Ingram / *Hope Community Resources Inc.*	Hope Community Resources acknowledges and appreciates that efforts the Division of Behavioral Health has made moving our state toward the current behavioral health system reform through the use of the 1115 demonstration project. Further, we appreciate the opportunity to engage in dialogue and voice concerns noted by the provider group as a whole and by individual provider agencies.	

	Like many of our community counterparts, Hope Community Resources has identified several areas of concern contained within the proposed regulations approved through the emergency regulation process, with intent to make them permanent. Though the regulations are now out for review providing some detail into the different service categories, there seems to be a large degree of uncertainty contained within the regulation language and how the regulation will be interpreted. Without specifics of interpretation of the 1115 BH regulations from either DBH or Optum leaves our agency with uncertainty regarding how best to evaluate each service, and whether to develop a plan to either implement, stand up, or choose not to implement specific services. This level of uncertainty, occurring amidst the expectation provider agencies will be implementing 1115 services without adequate dialog on the intricacies of the services contained within the 1115 waiver demonstration project make giving accurate feedback challenging. We are strongly recommending that that the deadlines associated with removing equivalent services from the state plan be postponed until adequate dialog/training on specific concerns with the 1115 regulation language can be clarified to provider agencies and an adequate time period is afforded to provider agencies after that training as been provided to sufficiently be able to evaluate from a business perspective what the true costs will be to implementing the treatment services planned.	Thank you for your comments. Thank you for the comments regarding the sunsetting services. The department intends to hold a series of listening sessions to ensure we properly understand the challenges facing providers.

	Some specific concerns can be briefly outlined here: Contraindications: It is necessary to clearly outline and define the specifics of contraindicated services as listed in the various services within the 1115 waiver regulations. Example: If a particular service is listed under contraindications, what is the time frame under which that service is not allowed to be provided? HBFT I list Community Recovery Support Services as contraindicated. Does that mean that CRSS cannot be provided while providing the 15 minute units of HBFT, but could say be delivered later during that day? Or, is it that if HBFT is being provided, then the patient is not eligible to receive CRSS at any other time as long as HBFT is prescribed?	Thank you for the question. Contraindicated services cannot occur on the same date of service.
	Service Components: We understand the theory that components of service, as detailed in the individual descriptions, is intended to indicate each of the components listed is captured underneath the given service when considering the rate and unit for that service. However, we are concerned with a couple of intricacies with how this might play out. Example, if medication services are a component part of a service (as is the case for several of the 1115 services) is then it required of an agency to have a prescriber on staff that provides that service to the patient served? Also, if it is not incumbent upon the agency, but rather those services can be provided by a 3rd party prescriber, then does that prescriber have to bill through the 1115. Additionally, a general question then becomes, do service components require an agency to provide the services listed in the service component section, or do they allow the provision thereof at the discretion of the agency? Moreover, when a service	Thank you for the comments. The department agrees a revision will provide clarity to the requirements. Thank you for the question. Service components must be available and can be delivered as part of the service as clinically appropriate.

	component lists say clinical services (including "clinical assessment and treatment planning) as a component (as in HBFT), but clinical services are supposed to remain under the state plan, then how should billing proceed given that the same service is under two different agents? Finally, if it is the informed intention of DBH to continue to support clinical services being components of HBFT, we are strongly recommending that the rates associated with HBFT levels 1-3 be reevaluated and increased given a notable discrepancy between what is approved under the state plan for clinic services and what the very clear decrease is as outlined in the 1115.	Thank you for the question. Service components must be available and can be delivered as part of the service as clinically appropriate. Thank you for the comment.
	Staff Qualifications: Replicated across the majority of the 1115 services are combinations of renderer types ranging from Licensed Physicians to Peer Support Specialists as individuals able to implement the services listed in the service components. The indication is taken to mean that a combination of those professionals are required to provide the service as listed in the 1115, but there does not seem to be · indication of what the team must actually resemble. Taken literally, the service may be implemented with as little as 2 of the least qualified professionals listed (i.e., a peer support specialist and a behavioral health aide), but that seems as though it moves away from the spirit of the interdisciplinary team.1! Would be helpful to gain clarity regarding the required makeup of an interdisciplinary team.	It is not the intent of the department to require that services must be staffed by an interdisciplinary team for all services. The division will clarify the specific services which must be staffed by an interdisciplinary team. It is not the intent of the department to prescribe the makeup of an interdisciplinary team.
	Service location: In several instances service location is highly specified, though in others it appears to be less so, especially with concern to the location 99-Other (Other appropriate	Thank you for the question. Place of service codes indicate the location a service can be

	setting in the community (e.g., work, school, or home)). This seems to be unclear given that there is a location (12 Home) that already specifically identifies the home as a viable location for services in other regulations. It would be helpful to understand what the function of adding another category to address the home environment when there is a specific code already active for that service location. Also, it would be helpful to understand then which agent has the authority to determine where an appropriate location of the given service to occur is. If that distinction lies with Optum or DBH, will prior authorization be required to approve locations that fall under 99-other? Example: CRSS details that the service can be used for skill building services that can include daily living skills, a treatment intervention that likely has a large component of in home work to better assist a patient in managing their daily life and symptoms. Since 12-home is not listed in the services location in lieu of listing 99-other, does that indicate that if we want to utilize the home location for CRSS that we have to get a PA first? The 1115 waiver demonstration project provides a great deal of expansion to the continuum of care allowing for the reach of behavioral health providers to extend greatly beyond the walls of the clinic like never before. However, that expansion increases the need for logistical support as programs begin to reach further from center of operations and into the homes or community locations of the patients we treat. Additionally, it seems likely there will be increasing variability with regard to the duration of treatment sessions which likely will result in increased frequency of shifts for a given staff during the course of a day. Each of those contribute to increased need	provided. Appropriate location is determined by the agency consistent with the list of place of service options provided in the Alaska Behavioral Health Providers Service Standards & Administrative Procedures for Behavioral Health Provider Services. Thank you for the question. Place of service codes indicate the location a service can be provided. Appropriate location is determined by the agency consistent with the list of place of service options provided in the Alaska Behavioral Health Providers Service Standards & Administrative Procedures for Behavioral Health Provider Services.

	for transportation and the increased likelihood that an individual shift will be canceled (i.e., patient is not home for an in home service, they are not at the location identified when a call comes in to a crisis call center, etc.) Is there a mechanism either within the 1115 or within the state plan to provide reimbursement for missed appointments or for transportation with regard to traveling to or from existing treatment shifts? Expansion of community services, increased likelihood of missed or canceled services, provision for driving time, billing for partial or missed services? Is there a mechanism to bill for partial services when patients are not available despite deploying staff resources at agreed upon times?	Thank you for the questions. No mechanism exists within the 1115 Waiver or the State Plan for transportation or missed appointments.
	Recommendation: Hope Community Resources is looking forward to the expansion of behavioral health services in the state of Alaska to reach previously unreached youth and adults in need of treatment and supp01i. However, it has proven to be very difficult to truly evaluate carefully what it would take to stand up or expand current programs to implement the services in the 1115 waiver demonstration project. The recommendation that we make is for the state to provide detailed training on the services and intent behind those services in the 1115 waiver demonstration project, before those regulations are made to be permanent. Additionally, we strongly recommend that the timeline for terminating the state plane service in lieu of similar services covered in the 1115 waiver be commensurately extended until such a time when the questions outlined herein and those other relevant questions from community providers be sufficiently addressed. We feel it is unreasonable to ask a	Thank you for the recommendation.

	provider group to make comments on a system that has not been adequately discussed or trained to. We do truly appreciate the Division of Behavioral Health in undertaking the most comprehensive behavioral health service reform that our state has experienced in many years. We acknowledge and value the hard work and dedication that the Division clearly has in assuring that Alaskan's who experience mental illness are able to receive the help that they need at the time that they are identified as needing that help. We look forward to taking part in this vision to promote the health and wellbeing of Alaskan's in partnership with the Division and Optum. Thank you for your time and consideration on this matter, Paul Ingram, LPC Director of Mental Health Hope Community Resources Inc.	Thank you for the detailed comments and questions.
Polly-Beth Odom / *Daybreak Incorporated*	Ms. Wooden: Daybreak, Incorporated appreciates the opportunity to provide comment on the proposed regulations governing Medicaid 1115 behavioral health waiver services and the work that has gone into these proposed regulations. Daybreak provides case management and home and community based mental health recovery services to adults who live in the Matanuska Susitna Borough and Anchorage communities. As an agency we believe our role is to ensure the consumer is actively involved in their recovery process and that all members of their recovery team (housing, physical health care, behavioral health care, etc.) are communicating with	

	one another, and that the consumer is aware of all their treatment plan goals and objectives. Overall, we believe these regulations support our ability to provide care and help Alaskans in need of behavioral health treatment and recovery supports. We wanted to bring specific opportunities to your attention that could help improve the proposed regulations. Daybreak opposes the State's use of emergency authority to implement the proposed regulations. Alaska Law at A.S. 44.62.250 et. Seq. allows the State to immediately implement regulatory changes only if it is in response to an emergency and it is necessary to do so to preserve public peace, health, safety, or general welfare. The statute explicitly states that "it is the state policy that emergencies are held to a minimum and are rarely found to exist." Despite the fact that the State's 1115 waiver has been developed over the past few years, the State elected to implement regulations governing 1115 Substance Use Disorder Waiver Services under the guise of an emergency and is now electing to do the same for these 1115 Behavioral Health Waiver Service regulations. Proper notice and comment are not just legally required, it helps strengthen the proposal. As a behavioral health provider, Daybreak are uniquely positioned to be able to offer informed perspective on the proposed changes. The diversity of Alaska's behavioral health provider community offers insight into how the proposals will work in their communities and how they might impact the people they serve. Given the time to understand the change, the desired objective, and some of the contextual factors involved, providers can offer opportunities and spot challenges that might not otherwise be readily apparent. The value of that contribution is lost when the process is rushed.	

	Beyond the value of provider input, proper notice and comment allows providers and stakeholders the time they need to implement the changes necessary to help ensure success. There are a lot of changes proposed in these regulations including new services and new clinical interventions, changes to client eligibility, and changes to service authorization and billing. It takes time to understand the changes and the impact on service delivery, inform the practitioners and clients about the changed practice, and modify systems and processes. Shortening the regulatory process and implementing these changes immediately, robs those affected stakeholders of the time necessary to adequately prepare, provide for a smooth transition, and help ensure success. Finally, the State issued the emergency regulations on May 20, 2020 with the changes going into effect that day. Because the proposed changes were concurrently out for public comment, the State was limited in how they could respond to stakeholders' questions. The regulations propose a massive change to the behavioral health service delivery system. While we recognize and appreciate that the phased-in approach the Division of Behavioral Health is using to implement the changes allows providers some flexibility, the decision to implement these changes using emergency regulations means that those providers who do want to start delivering these services immediately are left without the benefit of guidance that might otherwise be available by their state partners. The proposed regulatory changes are massive in both their scale and scope. These regulations will transform behavioral health services delivery in Alaska. A change this significant	Thank you for the detailed comments regarding the use of emergency regulations.

	needs to have the full benefit of normal public notice and comment. There is no funding available to build capacity to deliver the 1115 waiver services or implement the required changes Funding needs to be made available to build the capacity and implement the changes required to deliver the proposed 1115 waiver services. The proposed regulations represent a massive change to the behavioral health service delivery system in Alaska. They change criteria for eligibility, define new services and new ways to intervene, change what concurrent support is permissible, and change required authorization and billing processes. The regulations overhaul our service delivery system. A lot of the changes are necessary to accomplish the goal of the 1115 waiver to improve access to care, but these changes do not come without a cost. For example, Daybreak has been working with Health TEI to find a solution to provide after-hours response to assist in meeting the needs of consumers in crisis. Cloud 9 has written a proposal for a cloud-based product that removes barriers, increases efficiency and creates actionable engagement. The cost of the proof of concept is $49,000 for the annual fee and initial set up. Daybreak is motivated to work with local law enforcement and our community to assist Alaskans in connecting to needed services, but the agency does not have the reserves to engage in a full crisis now model. This challenge is especially difficult because of cuts to other funding sources that we rely on to deliver care. Despite increased demand for behavioral health treatment services, and after years of flat funding and cuts to the behavioral health treatment & recovery grants, we once again saw a $2.0	

	million cut to the grant line this year. In addition to cuts by the Legislature and the Governor, the behavioral health treatment and recovery grant line is under increased pressure to fund a broader array of initiatives, efforts, and supports. Consequently, funding available to behavioral health providers has been greatly reduced over the past several years. Grant funding helps behavioral health providers stand-up and support the infrastructure needed to provide treatment services. We need funding for the front-end investment to be able to deliver the reimbursable services and that funding is not available. Finally, the lack of funding required to make the changes necessary to deliver 1115 waiver services is especially problematic given concerns over our future fiscal sustainability. Increased reliance on Medicaid due to COVID-19 and growing unemployment has created a lot of concern that changes might be proposed to limit the safety net program. Federal restrictions accompanying the CARES Act funding mean that the benefit array and reimbursement rates for services are particularly at risk. Additionally, given State revenue concerns brought about by the drop in oil prices, behavioral health grant funding will once again likely be the target of efforts to reduce costs. With such a high level of uncertainty about our fiscal future, building new services is financially risky. The regulations propose a massive overhaul to our service delivery system, yet there is no funding available to make necessary changes or build the capacity to deliver the services. Cuts and flat funding over the past several years has diminished our ability to pivot our service delivery system. The threat of cuts to Medicaid reimbursement rates and	

	behavioral health treatment and recovery grants makes it risky for providers to invest in what is needed to make this a success. To help ensure that the proposed changes launch successfully we need to maintain the Medicaid benefits array, maintain full funding for Medicaid reimbursement. Treatment and recovery grant funding, the primary resource for capacity development and change, should be increased. Finally, we need to do a better job of identifying the costs of implementing the proposed changes and make dedicated resources available to providers to reduce risk and help ensure success. We are commenting with limited information (not knowing state plan services scheduled to be phased out of the plan) As a provider, Daybreak is being asked to comment on these proposed regulations without knowing the details of other significant changes planned for the service delivery system. We understand that it is the State's intention to phase out certain state plan services, but we do not which services or when. We also understand that the State intends to release proposed regulations governing children's 1115 waiver services, but again we do not what will be included or when they will be made effective. Our behavioral health continuum of care is a system. Changes to part of that system of care affect other parts. We cannot provide thorough or comprehensive comments on the probable impact of the proposed changes without knowing what other changes are in store. State Plan services should be phased out gradually as replacement services in the 1115 waiver are shown to be working	Thank you for the detailed comments regarding funding needs to build capacity.

	Some of the 1115 Waiver Services are meant to replace current state plan services. The State should gradually phase out services as their replacement services are phased in and not simply discontinue state plan services at some arbitrary date. If the State intends to replace an existing service with a new waiver service, they should do so gradually to help ensure service continuity, minimal disruption to the recipient of services, and a smoother transition. If done properly, this gradual transition should result in no additional cost to the State. If the State is unyielding in its desire to discontinue certain state plan services by some arbitrary date, we implore state leadership to engage in meaningful discussion to plan the transition. Overreliance on the 1115 waiver services at the expense of the state plan services and grant-funded services is risky The State of Alaska's 1115 waiver was approved by the Centers for Medicare and Medicaid Services (CMS) as part of a 5-year demonstration project starting on September 3, 2019 and scheduled to end on December 31, 2023. Many states successfully apply for extensions to their demonstration projects based on prior results, but those extension are not guaranteed. The State of Alaska has reduced the budget for treatment and recovery grants with justification that the 1115 waiver services will replace lost revenue and no treatment capacity will be lost in the refinancing. Last year, the State used the pending 1115 waiver services to support their decision to reduce behavioral health provider Medicaid reimbursement rates by 5%. We know the State is planning on discontinuing some state plan services. We are concerned that grant funding will	Thank you for the detailed comments regarding the sunsetting services. The department intends to hold a series of listening sessions to ensure we properly understand the challenges facing providers.

	continue to be cut and Medicaid will continue to be under pressure to change the array of services available or reduce reimbursement for services de live red. We don't want to find ourselves down the road having become overly reliant on the 1115 waiver services because of cuts to other resources only to find that the waiver extension is not approved or that we were not able to satisfy the budget neutrality requirement of the waiver. We urge the Division of Behavioral Health, the Department of Health & Social Services, and other behavioral health leaders to exercise caution and consider the risks to our system of care. The need for behavioral health treatment in Alaska requires us to commit to funding a full Medicaid benefit array at 100% and increasing grant funding for capacity development and treatment services. We cannot let the 1115 waiver services be used as justification to shrink our efforts or endanger our ability to provide care into the future. It is evident that a lot of thought and effort went into these proposed regulations. We are excited about some of the new services and new ways of delivering care provided in these regulations. Our comments are offered in the sincere hope that they will improve our collective efforts to provide improved access to behavioral healthcare. Polly-Beth Odom Executive Director, Daybreak Incorporated Cc: Tom Chard, Alaska Behavioral Health Association	Thank you for the detailed comments regarding the sunsetting services. The department intends to hold a series of listening sessions to ensure we properly understand the challenges facing providers. Thank you for the detailed comments and questions.
Jim Myers / *Alaska*	Ms. Wooden: Alaska Behavioral Health appreciates the opportunity to provide comment on the proposed regulations governing	

Behavioral Health	Medicaid 1115 behavioral health waiver services and the work that has gone into these proposed regulations. Alaska Behavioral Health provides outpatient services primarily in the Anchorage and Fairbanks areas. Overall, we believe these regulations support our ability to provide care and help Alaskans in need of behavioral health treatment. We wanted to bring specific opportunities to your attention that could help improve the proposed regulations. 1. There is no funding available to build capacity to deliver the 1 115 waiver services or implement the required changes Funding needs to be made available to build the capacity and implement the changes required to deliver the proposed 1115 waiver services. The proposed regulations represent a massive change to the behavioral health service delivery system in Alaska. They change criteria for eligibility, define new services and new ways to intervene, change what concurrent support is permissible, and change required authorization and billing processes. The regulations overhaul our service delivery system. A lot of the changes are necessary to accomplish the goal of the 1115 waiver to improve access to care, but these changes do not come without a cost. For example, while we recognize the benefit of Adult Mental Health Residential Services, it will take more than a year to create the capacity for clients who currently rely on RSS services to remain in community treatment. It will cost millions of dollars to build 16 bed residential facilities to treat this patient population. Grant funding helps behavioral health providers stand-up and support the infrastructure needed to provide treatment	Thank you for the detailed comments regarding funding needs to build capacity. Thank you for the comment regarding the capacity challenges associated with Adult Mental Health Residential services.

	services. We need funding for the front-end investment to be able to deliver the reimbursable services and that funding is not available. Finally, the lack of funding required to make the changes necessary to deliver 1115 waiver services is especially problematic given concerns over our future fiscal sustainability. Increased reliance on Medicaid due to COVID-19 and growing unemployment has created a lot of concern that changes might be proposed to limit the safety net program. Additionally, given State revenue concerns brought about by the drop in oil prices, behavioral health grant funding will once again likely be the target of efforts to reduce costs. With such a high level of uncertainty about our fiscal future, building new services is financially risky. The regulations propose a massive overhaul to our service delivery system, yet there is no funding available to make necessary changes or build the capacity to deliver the services. Cuts and flat-funding over the past several years have diminished our ability to pivot our service delivery system. The threat of cuts to Medicaid reimbursement rates and behavioral health treatment and recovery grants makes it risky for providers to invest in what is needed to make this a success. To help ensure that the proposed changes launch successfully we need to maintain the Medicaid benefits array and maintain full funding for Medicaid reimbursement. Treatment and recovery grant funding, the primary resource for capacity development and change, should be increased. Finally, we need to do a better job of identifying the costs of implementing the proposed changes and make dedicated resources available to providers to reduce risk and help ensure success.	

	2. Please consider a different service code structure for Intensive Outpatient Programs. Effective IOP programs are usually structured in a way that is not conducive to billing in 15 minute increments. Many State Medicaid programs (Indiana, Nevada, Virginia and Iowa as examples) structure IOP reimbursements using a per diem rate using S9480 for Mental Health and H0015 for SUD. Most commercial insurance uses this same structure. There are downsides to using billing structures that are not consistent with commercial payers. For patients with commercial insurance and Medicaid secondary claims that are billed using the Medicaid structure are usually denied by insurance and Medicaid ends up paying for a service that could have been covered by commercial insurance if the structures were aligned. 3. State Plan services should be phased out gradually as replace ment services in the 1115 waiver are shown to be working Some of the 1115 Waiver Services are meant to replace current state plan services. The State should gradually phase out services as their replacement services are phased in and not simply discontinue state plan services at some arbitrary date. To illustrate the concern, the State has long sought to discontinue Recipient Support Services (RSS) despite its importance in keeping Alaskans safe and out of higher acuity settings. Although it is unclear exactly which state plan services will be phased out and when, the 1115 Waiver application approved by CMS did include the State's explicit intention to remove RSS from the state plan. The proposed regulations create new services (in this case Community	Thank you for the detailed comments regarding funding needs. Thank you for the comments, the department will consider the recommendation.

	Recovery Support Services) that appear to be intended to replace some existing state plan services. It is difficult to meaningfully comment on the potential benefit of these new services without knowing the extent of the detriment of losing the services they are replacing. There has been very little discussion and no planning with providers about phasing out RSS. If the State intends to replace an existing service with a new waiver service, they should do so gradually to help ensure service continuity, minimal disruption to recipients of services, and a smoother transition. If done properly, this gradual transition should result in no additional cost to the State. If the State is unyielding in its desire to discontinue certain state plan services by some arbitrary date, we implore state leadership to engage in meaningful discussion to plan the transition. 4. Overreliance on the 1115 waiver services at the expense of th e state plan services and grant-funded services is risky The State of Alaska's 1115 waiver was approved by the Centers for Medicare and Medicaid Services (CMS) as part of a 5-year demonstration project starting on September 3, 2019 and scheduled to end on December 31, 2023. Many states successfully apply for extensions to their demonstration projects based on prior results, but those extension are not guaranteed. The State of Alaska has reduced the budget for treatment and recovery grants with justification that the 1115 waiver services will replace lost revenue and no treatment capacity will be lost in the refinancing. Last year, the State used the pending 1115 waiver services to support their decision to	Thank you for the detailed comments regarding the sunsetting services. The department intends to hold a series of listening sessions to ensure we properly understand the challenges facing providers.

	reduce behavioral health provider Medicaid reimbursement rates by 5%. We know the State is planning on discontinuing some state plan services. We are concerned that grant funding will continue to be cut and Medicaid will continue to be under pressure to change the array of services available or reduce reimbursement for services delivered. We don't want to find ourselves down the road having become overly reliant on the 1115 waiver services because of cuts to other resources only to find that the waiver extension is not approved or that we were not able to satisfy the budget neutrality requirement of the waiver. We urge the Division of Behavioral Health, the Department of Health & Social Services, and other behavioral health leaders to exercise caution and consider the risks to our system of care. The need for behavioral health treatment in Alaska requires us to commit to funding a full Medicaid benefit array at 100% and increasing grant funding for capacity development and treatment services. We cannot let the 1115 waiver services be used as justification to shrink our efforts or endanger our ability to provide care into the future. 5. Some of these rates are not adequate Creating the regulatory authority to deliver a service without providing reimbursement rates adequate to deliver the service means that service component will not be delivered, limits the options available to Alaskans in need of the service, and threatens the strength of the behavioral health continuum of care. Under the state plan, most rates were differentiated between provider types. Services that were delivered by licensed masters' level clinicians were reimbursed higher than services	Thank you for the detailed comments regarding funding needs.

	delivered by unlicensed bachelors' level clinical associates. In the new regulations, many services can be delivered by providers ranging from licensed physicians to peer support specialists with the same reimbursement rate regardless of provider. Examining who is delivering the care, what is expected, what overall volume can be supported, and realistically setting reimbursement rates is the only way the goal of the 1115 waiver and these proposed regulations will work. It is evident that a lot of thought and effort went into these proposed regulations. We are excited about some of the new services and new ways of delivering care provided in these regulations. Our comments are offered in the sincere hope that they will improve our collective efforts to provide improved access to behavioral healthcare. Jim Myers, CEO, Alaska Behavioral Health	Thank you for the comments. Thank you for the detailed comments and questions.
Beverly Schoonover / *Alaska Mental Health Board (AMHB)*	Dear Ms. Wooden; The Alaska Mental Health Board (AMHB) and the Advisory Board on Alcoholism and Drug Abuse (ABADA) advise the Governor, Legislature, and state agencies on behavioral health services funded by the State of Alaska. The joint mission of our citizen advisory boards are to advocate for programs and services that promote healthy, independent, productive Alaskans. For many years our boards have participated in statewide behavioral health reform efforts including serving on multiple subcommittees to develop the 1115 Waiver application, drafting the 1115 concept paper, assisting with statewide	

	public comment efforts and hosting consumer and stakeholder conversations around the state on behavioral health system reforms. From the very beginning AMHB/ABADA advocated for improved and integrated access to behavioral health services for Alaskans with severe mental illness and substance misuse disorders, and it is with gratitude that we thank the Alaska Division of Behavioral Health (DBH) for their tireless efforts to establish these new Medicaid waiver services for the Alaskans we serve. While we are in strong support of these proposed regulations, below are some general comments and considerations. The following are based on review of the regulations and discussions with board members, stakeholders, advocates and planning partners: 1. We encourage DBH to continue to support a continuum of care that is responsive to clinically appropriate services and service needs. There are concerns about service limitations and frequency limits throughout the proposed regulations, particularly regarding acute behavioral health residential services. With the shortage of psychiatric crisis and treatment services statewide, the requirement of three or more acute interactions to access residential behavioral health services creates a barrier to treatment. There will be Alaskans who would qualify for residential services in this waiver that may have needed multiple acute interactions, but due to their geographic location or service waitlists, no services were available.	Thank you for the comments.

	2. We encourage DBH to continue to work on providing clear and consistent regulatory language and communications to behavioral health providers on provider types, provider qualifications, screenings and assessments, service frequency limits and other process flows. We recommend that DBH and Optum Alaska continue to engage providers in regular and collaborative communications to help improve process and system flows for the successfully implementation of these new services.	Thank you for the comments.
	3. We encourage DBH to add Medicaid billing codes to the regulations for the proposed statewide crisis response call center in support of the Crisis Now model. Medicaid is a cornerstone in existing and successful Crisis Now projects and these dollars are needed to encourage private and public investment in statewide crisis system improvements.	Thank you for the comments.
	4. We have heard from multiple providers their concerns about bundling payment rates for medication management and drug testing, including concerns about the proposed rates compared to the actual costs of these services and concerns about service provision. This is an area that we encourage DBH to revisit in the ongoing development of waiver services.	Thank you for the comments.

	5. We heard from several stakeholders that the reimbursement rates for Assertive Community Treatment (ACT) are too low and are a barrier to agencies who plan to develop this program.	Thank you for the comments. Over the course of the 1115 Waiver demonstration project there will be ongoing analysis around the efficacy of the rate structure.
	6. There are concerns that DBH has set an arbitrary date for existing behavioral health state plan services to end. Again, in order to support a continuum of care that is responsive to the clinical needs of the Alaskans we serve, we advise that DBH continue to work with Center for Medicare & Medicaid Services (CMS) to allow state plan services to stay in place until the majority of providers are billing 1115 services.	Thank you for the detailed comments regarding the sunsetting services. The department intends to hold a series of listening sessions to ensure we properly understand the challenges facing providers.
	7. We look forward to additional regulations and billing codes for youth residential treatment services.	Thank you for the comments.
	We greatly appreciate the efforts of DBH staff to develop and stand up these incredibly important and needed regulations. We would also like to thank DBH staff for creating new opportunities to engage with behavioral health providers in order to answer questions and allow feedback on the waiver implementation process. We want to encourage DBH leadership to continue to prioritize the staffing, time and resources needed for meaningful engagement and collaborative communications with behavioral health providers, behavioral health consumers and other stakeholders. We feel this consultation is going to be a key factor in the support of the evaluation phase and reapplication to CMS to extend the 1115 Waiver in the future.	Thank you for the detailed comments.

	Respectfully, Beverly Schoonover	
Tom Chard / *Alaska Behavioral Health Association (ABHA)*	July 7, 2020 Ms. Alysa Wooden State of Alaska, Division of Behavioral Health 3601 C Street, Suite 878 Anchorage, AK 99503 BY EMAIL: alysa.wooden@alaska.gov Ms. Wooden: ABHA appreciates the opportunity to provide comment on the proposed regulations governing Medicaid 1115 behavioral health waiver services and the work that has gone into these proposed regulations. These written comments supplement our oral comments offered at the June 18, 2020 public hearing. The Alaska Behavioral Health Association (ABHA) is a member-driven, member-led Alaska nonprofit supporting over 70 mental health and substance abuse treatment providers across the state in pursuit of our common vision of access to quality, cost-effective behavioral health treatment and recovery support services for all Alaskans in need. Overall, we believe these regulations support our ability to provide care and help Alaskans in need of behavioral health treatment and recovery supports. We wanted to bring specific opportunities to your attention that could help improve the proposed regulations and stand by as ready partners in their successful implementation. ABHA has shared, and would like to reiterate, that implementing major system changes using emergency regulations is problematic. While we appreciate the Divisions	

	phased-in approach to implementing these changes and acknowledge that this mitigates some of the problems somewhat by allowing providers a choice of whether to initiate services immediately, we also see the confusion using emergency regulations creates. The Division of Behavioral Health is limited in the guidance they can provide while the proposed regulations are out for public comment and, as a result, we cannot rely on our partnership as much as we might otherwise to initiate new services and implement changes. ABHA strongly recommends that the Department exercise its authority to issue emergency regulations minimally as is provided in statute and, if it is necessary to promulgate emergency regulations, the State considers how best to support stakeholders while maintaining the intent and integrity of the notice and comment process. The development of the 1115 waivers has been a massive years-long process. The State had to develop its proposal and apply to the Centers for Medicare and Medicaid Services (CMS), modify the waiver based on negotiations with CMS, develop an implementation plan, and issue these proposed regulations governing the services. To help make this more manageable, the waivers for substance use disorder services, for behavioral health services (mental health services), and for children's services were approached separately. Similarly, changes to state plan services corresponding to the changes brought about by the 1115 waivers are being taken up separately. Complex problems are often solved by breaking down the problem into its simpler parts and breaking this up into more manageable pieces provides the time and focus	Thank you for the detailed comments regarding the use of emergency regulations.

	stakeholders need to better understand subcomponents of the larger system wide change, but this is done at the expense of understanding some of the broader issues that affect the entire system. We also believe the behavioral health system of care will continue to be fragmented along service lines if we continue to approach system thinking by service component. ABHA recommends that the Department and Division consider additional approaches in the future and support discussion and meaningful collaboration on some of the broader issues that bridge the component parts of the larger system change. We could do this with guidance documents and partner discussions before the proposed regulations have been issued for notice and comment and through public hearings, properly noticed, that take place during the comment period that offer more than a simple venue for stakeholders to provide comment. ABHA urges the Department to explore improvements to the regulatory process that enhance opportunities for meaningful dialog. Behavioral health providers knew some state plan services would be eliminated with replacement services being made available in the 1115 waiver. Several providers have been asking for a comprehensive list of which services the State planned to phase out. Yesterday, the State responded that the complete list was included at Appendix B of the State's application to CMS for waiver authority (reference: DHSS/DBH Aggregated Questions and Responses 7/6/20). Prior to yesterday's response, there has not been meaningful dialog about the impact of sun setting some services and replacing them with waiver services. Appendix B of the State's	

	application also includes that the services will be eliminated "as new services become available." ABHA recommends the State slowly transition away from services they plan to phase out only as successful implementation of the new services allows. For continuity of care and the least disruption to Alaskans reliant on the existing state plan services, that will mean that we will have a system where, for example, Residential Support Services (RSS) and Community Recovery Support Services (CRSS) are both being delivered whenever the respective client's needs require, and that RSS would only be phased out as CRSS is shown to be a suitable substitute that does not deny the client the clinical care they require or disadvantage them in any way. Appendix B of the State's 1115 waiver application also states that the state will make these decisions in conjunction with Tribes, the ASO, and stakeholder representatives including providers. ABHA looks forward to the opportunity to engage in meaningful dialog with the State to ensure continuous quality care is provided to Alaskans in need of treatment and recovery support services. The 1115 waivers offer new services and new ways of delivering care that will hopefully help produce cost savings for the State of Alaska while not jeopardizing access to quality services when Alaskans need them. The behavioral health treatment and recovery grant line has been reduced significantly in anticipation of some of these cost savings. State plan services are planned to be phased out as 1115 waiver services are implemented. We are shifting a lot of our service delivery away from grant-funded services and our	Thank you for the detailed comments and recommendations regarding the sunsetting services. The department intends to hold a series of listening sessions to ensure we properly understand the challenges facing providers.

	state plan Medicaid program to the 1115 waivers. The 1115 waivers are based on a 5-year demonstration project that requires, among other things, federal budget neutrality. Although most states 1115 waivers are extended beyond the original 5-year period, there is no guarantee. With all the changes happening to the Medicaid program at the state and federal level, overreliance on any one program is risky. ABHA encourages the State to continue to support a full array of Medicaid services reimbursed at the cost of care. Recognizing that grant funds help provide and support our state€™s capacity to deliver services, ABHA also asks the State to increase grant funding to help meet the need for behavioral health treatment and recovery support services. Aside from the more general comments, ABHA wanted to draw your attention to more specific opportunities to help improve the proposed regulations and our service system. ABHA has solicited input from members and offers the following summary of the issues they identified: 1. Thank you for confirming verbally to ABHA members that the regulations governing child and adolescent residential services are in progress and will be issued when ready. Comments offered by ABHA and many of its members on the comprehensive system and interrelated impact are limited, but ABHA looks forward to reviewing and providing public comment when these regulations are issued. 2. Section 138.200(a)(1) references department approved screening tools. Providers would like the opportunity to suggest screening tools to include in the department approved list including, but not limited to, Recovery Needs Level and the PROMIS/NIH Toolbox screening list. Please also keep in mind that providers will need time to	Thank you for the detailed comments regarding funding needs. Thank you for your comment. Thank you for your comment. The department anticipates hosting a series of workgroups with

	work with their EHR/ECR vendors and to provide the training necessary for clinical and business practice changes required. 3. The 1115 included brief interventions, brief therapy, and coordination to treatment based on the level of risk identified by the screener. These services are omitted from the regulations currently posted for public comment. Please confirm that the state intends to issue regulations for screeners and risk based brief interventions, brief therapy, and coordination to treatment with reimbursement for these services. 4. 23-hour Crisis Observation and Stabilization. a. Many good crisis stabilization programs in other states report that this service may, at times, extend past 24 hours. For example, this could occur when a transfer to another level of care is pending (like to API), and the Crisis Stabilization center needs to continue to provide care until the transfer can be completed. We recommend allowing payment beyond 23 hours and 59 minutes when necessary. b. "Bachelor's Level Clinical Associate" is listed as a provider type. The Department's Aggregated Questions and Responses (released 07/06/20) identified this as a typo. Please correct. c. We are concerned with the limit of 4 check-ins within 15 days and the requirement for service authorization for more. It would be unlikely that someone would have more than 4 check-ins in 15 days, but it is clinically possible. The nature of this crisis service requires immediate access and waiting for authorization is not feasible. For example, the Crisis Now model purports that police officers can bring people to 23 Hour Crisis Stabilization and are guaranteed	behavioral health providers to identify a list of suggested screening tools. Thank you for the question. The department will assess over time what additional services may be added as data from the demonstration becomes available. Thank you for the recommendation. 23-Hour Crisis Observation and Stabilization billed under Medicaid must be provided and documented according to 139.350. Thank you, the department acknowledges the typo and will correct the error. Thank you for the comment. The department agrees the limit of 4 check-ins within 15 days is problematic. The department will consider a change to the service limit.

	check-in 100% of the time in a matter of minutes. For this to work, we need to remove service authorization requirements. d. Clinicians should be able to draw down the rate for these services. e. Many programs function with distance delivered medical prescribing. Remove reference to on- site requirement for medical providers. 5. 7 AAC 139.030(b) and (c) seems to say that a provider must get a prior authorization to deliver an 1115 service and a state plan service to the same person. This will cause practical problems when a provider is delivering an 1115 service and then also needs to deliver a crisis service using a state plan crisis code. The crisis service, because it is due to a crisis, does not align with a prior authorization process. Remove the prior authorization requirement. 6. Assertive Community Treatment: a. Change the regulation to allow for the 24-hour requirement to be met by another function, service, or contractor. b. The non-Tribal rate is not viable to run this service. The rate is only $2.54 more than ICM and requires significantly more expensive providers and teams. We suggest increasing the rate and allowing for addiction reimbursement for medical provider services. c. For Tribal providers, please confirm that this service may include both a behavioral and a medical intervention on the same day resulting in the possibility of two Tribal encounter rates for one patient on the same day. 7. The description of Intensive Outpatient Mental Health at 7 AAC 139.250(2) that "significant functional impairment that interferes with an individual's ability…" is a good	Thank you for the comment, the department will consider your recommendation. Thank you for the comments. The department agrees a revision will provide clarity to the requirements. Thank you for the comment. The department will consider the recommendation. Thank you for the recommendation. ACT and ICM services billed under Medicaid must be provided and documented according to 139.200. Thank you for the comments. Over the course of the 1115 Waiver demonstration project there will be ongoing analysis around the efficacy of the rate structure. Thank you for the question. A tribal provider may provide a behavioral health intervention and a medical intervention on the same day resulting in two tribal encounters for one patient on the same day.

	description. 7 AAC 139.250(2)(d) then lists "activities of daily living" which is inappropriate for this service. Please delete activities of daily living. 8. "Daily schedule of treatment" as included at 7 AAC 139.250 (2)(A) implies that IOP is operating 7 days a week. IOP generally operates 5 days a week. Please revise to say: "weekly schedule of treatment." 9. We are concerned with "high service needs" as defined at 7 AAC 139.300 (d) by three or more acute hospitalizations, psychiatric emergency services, or involvement with criminal justice." We think it is very possible that a person could have three or more events in the past calendar year, but there are reasons why a person might not including living in a village without public safety, living in a village where emergency visits are coded as outpatient visits, needing API but not able to be admitted, had a long stay at API (many months) rather three separate stays, etc. Access should be based on clinical need, not prior utilization. Revision could either remove "high service needs" from the regulation, or revise to say "may have had high service needs" rather than requiring high service needs. 10. Thank you for confirming in the Aggregated Questions and Responses released on 07/06/20 that the crisis codes currently in the state plan will continue. These are not listed in the 1115 as codes that would sunset and these codes will be needed in addition to the new 1115 crisis services. 11. We are concerned with the language in the Alaska Behavioral Health Providers Service Standards & Administrative Procedures for Behavioral Health Provider Services at page 4 that says "…some children between ages 18 and 21 may be eligible as adults for certain waiver services."	Thank you for the comments. The department will consider including recommended revisions to 7AAC 139.250. Thank you for the comment and recommendation. Thank you for the comment and recommendation. Thank you for the comment.

	All adults ages 18 or over who are Medicaid eligible should be able to receive adult waiver services if clinically appropriate. We suggest deleting this section entirely.	Thank you for the comment and recommendation. The department agrees a revision will provide clarity to the requirement.
	12. The proposed regulations state "Services must be drawn down by at least 'X' provider." This is confusing language because it is not clear what type of provider is ranked above or below another provider. For example, how does a BHA compare to a Clinical Associate or an RN? It would be clearer if these sections stated, "any listed eligible provider type may draw down this service."	Thank you for the comments. The department will consider including recommended revisions to the Alaska Behavioral Health Provider Service Standards & Administrative Procedures for Behavioral Health Providers.
	13. Thank you for including Home Based Family Treatment level 1 in the 1115 waiver. We are VERY excited about these new services. We have a few suggestions to make this service more practical to operate:	
	a. No clinical logic is included to support the 6-week timeframe. We recommend the currently allowable units (240), without the 6-week cap. This would allow for a longer duration of less frequent interventions at the same cost. We believe this would allow for better outcomes for this exciting new early intervention.	Thank you for the comment and recommendation. The department will consider including recommended revisions to the Alaska Behavioral Health Provider Service Standards & Administrative Procedures for Behavioral Health Providers.
	b. Because eligibility is based on family risk factors, we would like this service to be possible at the time of conception. We can see great benefit from providing HBFT1 to high risk families during pregnancy.	
	c. We are excited that this is a service in the home, but home is not always the only viable location. At times, we may want to include facility based interventions (for example, if the home is unsafe or if the family is otherwise unwilling) or community-based interventions (for example, when a child is struggling at daycare or at soccer or in other community locations). This home-base service is exciting because it allows	Thank you for the comment and recommendation. Thank you for the comment. The department agrees and will consider your recommendation.

	us to work in real life locations, but these locations could be home, clinic, or community. Please include these as possible service locations. 14. Home Based Family Treatment level 2 and 3 would require including clinic and community locations. See 13(c) above. 15. We are unsure if the Service Components listed for each 1115 service means that the components can be part of the service or must be part of the service. For example, Home Based Family Treatment level 1 has a long list of service components. It is a great list, but it would not be possible (or appropriate) to deliver every listed component to every family. Please confirm that service components can be delivered as part of a service as clinically appropriate. a. Providers also raised concerns that state plan services may be provided (and billed separately) concurrent with 1115 services. Unless this is possible, some 1115 services may be cost-prohibitive to operate. 16. We have a few change recommendations for ACT and ICM services: a. A significant amount of clinical care delivery during the engagement stage. The engagement stage is prior completion of a treatment plan. Reimbursement for clinical care during the engagement state is essential for these services to work. Please include a reference to 7 AAC 105.230 to allow reimbursement for care delivered prior to treatment plan. b. These services have great potential to provide cost-effective interventions for people experiencing homelessness and/or at risk of psychiatric emergency care. We are concerned that conformance with high fidelity models, given Alaska's unique geography and workforce challenges, will be a	Thank you for the comment. Thank you for the comment. Yes, service components can be delivered as part of the service as clinically appropriate. Thank you for your comment. Thank you for the recommendation. ACT services billed under Medicaid must be provided and documented according to 139.200.

	barrier to operating these services. We suggest removing reference to high fidelity compliance. c. Many providers have expressed concern with the rates for these programs. ACT and ICM are effective interventions and prevent the need for psychiatric emergency care and AMHR but that is only possible if the rates provide for viable operations. 17. Behavioral Health Aides should be included as provider types for ICM. We think this was an error that can easily be corrected. 18. CRSS service limits for behavioral health are ½ of the CRSS limits for SUD. There is no clinical reason for less CRSS for behavioral health. Please increase the BH service limits to match the SUD service limits. 19. Please add 'Tribal Facility' to all service location sections. It has been omitted on a few of the sections. 20. We are VERY excited about the new proposed Peer-Based Crisis Services. Thank you for including it in the 1115. We have a few suggestions to make this service more practically possible to operate: a. The documentation reference is to care delivered under a treatment plan. Due to the nature of a crisis intervention, Peer-Based Crisis Services will need to be delivered in real time without treatment plan. Please change the documentation reference to 7 AAC 105.230. b. We are excited that this service can be reimbursed when delivered by peers and we look forward to seeing more peer work in Alaska. At times we think other provider types might deliver these services as well. For example, in small communities you may not have multiple provider types so a BHA might deliver many services. Please allow all listed	Thank you for the comment and recommendation. Thank you for the comment. Over the course of the 1115 Waiver demonstration project there will be ongoing analysis around the efficacy of the rate structure. Thank you, the department acknowledges the oversight and will correct the error. Thank you, the department acknowledges the service limit difference and will correct the error with the updated revision to the Alaska Behavioral Health Provider Service Standards & Administrative Procedures for Behavioral Health Providers. Thank you for the comment and recommendation. Thank you for the comment and recommendation.

	provider types to be eligible for reimbursement for this service. 21. Mobile Outreach and Crisis Response a. The rate is very low for this service. Please re-evaluate this rate. b. Thank you for paying for each "call out." It will be common that a "call out" cannot be completed because the person in crisis has left, refuses the intervention, or the situation escalates, and police intervention is needed. When this happens the cost for the "call out" can still be covered because this service is paid per "call out" rather than based on care delivered. It would be helpful to make this clearer in the regulations. c. Please clarify that telephonic crisis response can be reimbursed through this code. This call center function, which includes telephonic crisis services, is a vital part of the Crisis Now model. The crisis call is not triage. The goal is to deliver real time, telephonic crisis interventions reducing the need for further immediate care. d. We appreciate that this service will include post-crisis follow up interventions. Please confirm that the MOCR code will be reimbursed again for the follow up intervention post crisis. 22. The 1115 Substance Use Disorder Waiver services regulations are open for comment and we need to share concern about the QAP requirement. This is proving to be a significant obstacle for providers. One Anchorage provider shared that they currently run their IOP with ½ Clinicians and ½ CDCs. Unfortunate CDCs are so hard to find that they are reclassifying CDC vacancies to Clinician positions. This is a huge problem for the success of the 1115 because all the new	Thank you for the comment and recommendation. Thank you for the comments. Over the course of the 1115 Waiver demonstration project there will be ongoing analysis around the efficacy of the rate structure. Thank you for the recommendation, the service is reimbursed per call-out. A service provider is eligible for reimbursement if the crisis is over when the provider arrives. Thank you for the question, the department acknowledges a revision will provide clarity to the requirement. Thank you for the comment and question. T2034 V1/V2 cannot be billed for the follow up care.

	1115 services require Clinicians. The new QAP requirement is creating shortages for CDCs and Clinicians and has become the rate limiting factor for growing programs and providing good access. Please extend the expected date of full implementation for this new service provider.	
	23. Several SUD services include "interim services" which are provided when waits are long. These interim services are good harm reduction interventions that would help keep acuity steady and allow for less costly interventions when access is available, however they can only be provided if there is reimbursement. Please add a reimbursement code and rate for SUD interim services.	Thank you for the comments.
	24. ASAM 1.0 service limits lists telehealth separately. Telehealth should be a normal route of delivery with no additional or unique authorization required. Please remove reference to telehealth.	
	25. ASAM 2.1's Target Population sections says "2. Individuals experiencing a mental health disorder…" This seems to say that 2.1 service can only be provided to people with a SUD and a co-occurring mental health disorder. This is very concerning. This service needs to be possible based on the SUD alone.	Thank you for the comment and recommendation. Thank you for the comment and recommendation.
	26. Adult Partial Hospitalization includes reference to forthcoming Evidence Based Practice requirements. Requiring conformance to a specific EPB is concerning because the EBP may not have been tested in specific cultures, the EPB might have been tested only in urban settings, and the EBP might require provider types that are scarce or not possible across all Alaskan communities. We support learning about EBPs, but we would not want to limit care by requiring compliance with a specific EBP.	Thank you for the comment. Thank you for your comment.

	27. SUD Care Coordination will often occur in non-behavioral health settings (such as medical care settings) and by a variety of provider types. To accomplish this, please change the documentation reference to 7 AAC 105.230.	Thank you for the comment and recommendation.
	28. We recommend adding a service for Therapeutic Treatment Homes for youth with substance use disorders.	
	29. The definition of adolescent in the 1115 SUD wavier should define adolescent services as the following ages: "12-17 and youth 18-21 with a substance use disorder diagnosis when determined to be medically necessary and in accordance with an individualized treatment plan demonstrating clinical justification as to why they are best served in adolescent programming." Additionally, any age range for residential levels of care should align with DHSS Residential Licensing ages that allow services for youth to individuals aged 19 who are approved through regulation 7 AAC 50.300(c). This would align with the age ranges currently used in best practices, existing state and ASAM definitions of adolescent, definition of youth in the BH 1115 waiver, and the allowance for service in appropriate developmental settings, and will not decrease access to care for these youth.	Thank you for the comment and recommendation.
	30. We appreciate that the State recognizes the concern about the forthcoming Four Walls Rule impacting tribal providers and are committed to working with providers to reduce any negative impact on service delivery in Alaska. ABHA appreciates the opportunity to offer recommendations for how to improve these proposed regulations and the process by which stakeholder comment improves the changes to our system of care. It is obvious that a lot of time and attention has been spent developing these proposed regulations and we offer these comments in the sincere hope	Thank you for the comment, the department agrees a revision will provide clarity to the requirement.

	that they will advance our shared goal of quality, cost-effective care. Thank you, Tom Chard Alaska Behavioral Health Association (ABHA)	Thank you for the detailed comments and questions.
David G Branding / *JAMHI Health & Wellness*	July 7, 2020 Ms. Alysa Wooden BY EMAIL: alysa.wooden@alaska.gov Ms. Wooden: The purpose of this correspondence is to provide formal written comments on the proposed Medicaid 1115 behavioral health waiver service regulations. We appreciate the opportunity to comment and also are very thankful for the substantial work that has gone into developing the proposed regulations. JAMHI Health & Wellness is a community behavioral health center serving Juneau, Gustavus, Tenakee Springs and Elfin Cove and was recently awarded a SAMHSA Certified Community Behavioral Health Clinic (CCBHC) expansion grant. We provide a comprehensive range of Alaska Medicaid state plan behavioral health services from psychiatric emergency services to clinic and rehabilitation services, community housing services and support, prevention and wellness services to adults with mental illness and/or substance use disorders. As a CCBHC we will provide an even more comprehensive range of services,	

	expanding to serve youth and families. JAMHI Health & Wellness also provides primary (physical) healthcare to anyone in the community who needs affordable healthcare. We are in the midst of enrolling as a designated Federally Qualified Health Center (FQHC) look-alike through the Health Resources Services Administration (HRSA). Our model of specialty behavioral health and primary care services is integrated and all documented through a single electronic health record and our commitment to high quality services should be clear: from our same-day access capacity for non-emergent BH services to a range of demonstrable positive outcomes published annually on our website, we care deeply about serving people and our communities well. Overall, we believe the proposed regulations will challenge our organization's ability to provide sustainable high quality care. Specific concerns include: • Absence of funding for organizations to retool processes, people and practices in support of delivering the proposed waiver services. The proposed regulations represent substantial change to the system including criteria for eligibility, new service definitions and contraindicated services; none of these come without additional cost at a time when other funding sources are uncertain and certainly threatened. • The planned phase-out of critical existing state plan services threatens the fiscal stability of the system	Thank you for your comments. Thank you for the comments regarding funding needs.

	overall and the continued availability of services locally. The clearest example of this is Recipient Support Services which JAMHI and others use to serve people with the most complex treatment and support needs safely in community housing and is used statewide to prevent more costly and potentially traumatizing episodes of care. The combination of the proposed service description, elimination of room and board and elimination of medication administration will reduce necessary revenue used to provide this cost-saving service so substantially, it's unclear whether community housing capacity can be preserved under the proposed regulations. • Respectfully, some reimbursement rates simply do not appear adequate in amount or structure to fund the delivery services described in any sustainable way. For many years our local stakeholders have implored us to deliver Assertive Community Treatment (ACT) services. For the first time this will be possible, which is great. Also, we have been very fortunate to recently be notified of a one-year state permanent supported housing ACT grant. However the proposed rate for ACT is just slightly more than Intensive Case Management, yet requires significantly more expense to deliver with any degree of model fidelity what-so-ever, let alone the high model fidelity required by state's standards. Further the reimbursement model requires 15-	Thank you for the detailed comments regarding the sunsetting services. The department intends to hold a series of listening sessions to ensure we properly understand the challenges facing providers.

	minute interval billing which significantly increases cost and compliance risk for providers when compared with a daily rate. • We are also concerned about the use of emergency authority to promulgate these regulations. A shortened regulatory processes reduces time necessary to adequately prepare, provide for a smooth transition and reduces that likelihood of successful implementation. In closing, thank you again for your work and leadership resulting in these proposed regulations. It is evident that considerable thought and effort has been expended and that is commendable. Still, while we are excited about the direction of some of the new services described, our concerns about our own capacity to navigate the additional administrative burden, regulatory complexity and inadequacy of reimbursement rates causes us to have grave concerns about the ability of other providers statewide, many of whom may have less capacity and resources than we, to make the proposed transition to an 1115 waiver environment well, further threatening the system as a whole. These comments are offered in the sincere hope that they might improve our collective efforts to provide improved access to high quality behavioral healthcare in Alaska during such a critical time in history. Please let us know what we can be doing to help. Sincerely, David G Branding, PhD	Thank you for the comments. Over the course of the 1115 Waiver demonstration project there will be ongoing analysis around the efficacy of the rate structure. Thank you for the detailed comments and questions.

	Chief Executive Officer	
Chris Gunderson / *Denali Family Services*	To Whom it may concern, I am writing on behalf of Denali Family Services in response to the emergency regulations implementing the 1115 behavioral health waiver and in anticipation of the permanent adoption of an amended version of these regulations. Denali Family Services fully supports the Alaska Division of Behavioral Health's efforts to reform the behavioral health system in Alaska: furthermore, we believe that the service array presented in the 1115 waiver provide an excellent opportunity to fill existing gaps in the continuum of care and improve existing service lines to better meet the needs of vulnerable Alaskan's. As an organization that is significantly dependent on Medicaid fee-for-service reimbursement, we are committed to fully implementing the 1115 services appropriate to our populations and reducing or eliminating our use of state plan service codes that are either no longer the most appropriate to our service needs or which are scheduled to sunset. That said, given that full implementation of the 1115 service codes will require not only administrative effort to secure enrollment and approval of agency personnel and service sties, but also programmatic changes to fully capture the spirit and requirements of the 1115 regulations, we ask that all due consideration be given to the timing of state plan service code sunsets to ensure that there is sufficient time to fully implement 1115 services. Of	

	particular concern to Denali Family Services are the therapeutic behavioral health service codes, for which there is not an exact corollary amongst the 1115 service codes, and the daily behavioral health rehabilitation code, which is commonly used in therapeutic foster care. We are in the process of training and reorienting our 130+emplyees and 70+therapeutic foster homes to the new codes, and are completing the requisite steps to ensure eligibility for all service personnel to bill 1115 services. We anticipate having this process completed by the end of Q1 of the current fiscal year; however, we anticipate that an administrative and programmatic transition of this size and scope will present unforeseen challenges and we want to be sure that the necessary state plan codes are available until such time as they are unnecessary. A second, but related concern, is that we have not yet experienced Optum's approach to reconciling level-of-care (LOC) determinations with service authorizations relative to the 1115 service codes. It seems inevitable that there will be a fine-tuning process throughout FY21 as additional agencies on-board waiver services while adopting their own LOC tools and interpreting the regulations I their own way. We do not yet know what Optum will or will not approve and, ultimately, the project team at Optum probably does not have a clear sense of that either, given that Optum is new to the service system and provider community in Alaska. In order to reduce the possibility of service gaps for families and revenue gaps for providers, we ask that the Division consider maintaining the existing state plan codes until the end of the current fiscal year to ensure a glide path	Thank you for the detailed comments regarding the sunsetting services. The department intends to hold a series of listening sessions to ensure we properly understand the challenges facing providers. Thank you for the comments. Optum has and will continue to host bi-monthly trainings on a variety of topics including level-of-care tools.

	for providers and recipients to fully adjust to the 1115 regulations and service array. This will also allow providers more time to make strategic decisions about 1115 implementation, rather than trying to reactively implement new services before critical state plan codes sunset. Thank you for taking this feedback into consideration and feel free to contact me at your convenience if you have any questions or would like additional clarification Sincerely Chris Gunderson CEO	Thank you for the detailed comments regarding the sunsetting services. The department intends to hold a series of listening sessions to ensure we properly understand the challenges facing providers. Thank you for the comments and recommendations.
Bruce Van Dusen / Polaris House, Inc.	Ms. Wooden: Polaris House appreciates the opportunity to provide comment on the proposed regulations governing Medicaid 1115 behavioral health waiver services and the work that has gone into these proposed regulations. Polaris House serves adults age 18 and older. We provide supports and services to assist clubhouse members in the improvement of self-esteem and development of a sense of purpose, by combating isolation and providing opportunities for meaningful activity. Clubhouse members are active in all the work of the clubhouse as a business. We ensure members have supports and services to obtain and maintain housing of their choice; have access to a variety of employment programs; have access to supports to continue and complete education; as well as, services and supports to find and secure all relevant behavioral health provider services in Juneau. Overall, we believe these regulations support our ability to provide care and help Alaskans in need of behavioral health treatment and	

	recovery supports. We wanted to bring specific opportunities to your attention that could help improve the proposed regulations. There is no funding available to build capacity to deliver the 1115 waiver services or implement the required changes Funding needs to be made available to build the capacity and implement the changes required to deliver the proposed 1115 waiver services. The proposed regulations represent a massive change to the behavioral health service delivery system in Alaska. They change criteria for eligibility, define new services and new ways to intervene, change what concurrent support is permissible, and change required authorization and billing processes. The regulations overhaul our service delivery system. A lot of the changes are necessary to accomplish the goal of the 1115 waiver to improve access to care, but these changes do not come without a cost. To illustrate this problem, while we recognize the benefit of transitional housing for persons living with a mental illness who do not thrive in traditional care settings, there are simply no resources to make the changes required to deliver the service in our community. Budget cuts to CBHTR grants in recent years eliminated our ability to provide transitional housing for this population. This challenge is especially difficult because of cuts to other funding sources that we rely on to deliver care. Despite increased demand for behavioral health treatment services, and after years of flat funding and cuts to the behavioral health treatment & recovery grants, we once again saw a $2.0 million cut to the grant line this year. In addition to cuts by the Legislature and the Governor, the behavioral health	Thank you for your comments.

	treatment and recovery grant line is under increased pressure to fund a broader array of initiatives, efforts, and supports. As a consequence, funding available to behavioral health providers has been greatly reduced over the past several years. Grant funding helps behavioral health providers stand-up and support the infrastructure needed to provide treatment services. We need funding for the front-end investment to be able to deliver the reimbursable services and that funding is not available. Community Behavioral Health Treatment and Recovery grants are crucial to providing services not reimbursed by Medicaid.	Thank you for your comments.
	Finally, the lack of funding required to make the changes necessary to deliver 1115 waiver services is especially problematic given concerns over our future fiscal sustainability. Increased reliance on Medicaid due to COVID-19 and growing unemployment has created a lot of concern that changes might be proposed to limit the safety net program. Federal restrictions accompanying the CARES Act funding mean that the benefit array and reimbursement rates for services are particularly at risk. Additionally, given State revenue concerns brought about by the drop in oil prices, behavioral health grant funding will once again likely be the target of efforts to reduce costs. With such a high level of uncertainty about our fiscal future, building new services is financially risky.	Thank you for your comments.
	The regulations propose a massive overhaul to our service delivery system, yet there is no funding available to make necessary changes or build the capacity to deliver the services. Cuts and flat-funding over the past several years has diminished our ability to pivot our service delivery system. The threat of cuts to Medicaid reimbursement rates and	

	behavioral health treatment and recovery grants makes it risky for providers to invest in what is needed to make this a success. To help ensure that the proposed changes launch successfully we need to maintain the Medicaid benefits array, maintain full funding for Medicaid reimbursement. Treatment and recovery grant funding, the primary resource for capacity development and change, should be increased. Finally, we need to do a better job of identifying the costs of implementing the proposed changes and make dedicated resources available to providers to reduce risk and help ensure success. We are commenting with limited information (not knowing state plan services scheduled to be phased out or the plan, or Children 's regs) Stakeholders are being asked to comment on these proposed regulations without knowing the details of other significant changes planned for the service delivery system. We understand that it is the State's intention to phase out certain state plan services, but we do not which services or when. We also understand that the State intends to release proposed regulations governing children's 1115 waiver services, but again we do not what will be included or when they will be made effective. Our behavioral health continuum of care is a system. Changes to part of that system of care affect other parts. We cannot provide thorough or comprehensive comments on the probable impact of the proposed changes without knowing what other changes are in store. State Plan services should be phased out gradually as replacement services in the 1115 waiver are shown to be working	Thank you for the detailed comment.

	Some of the 1115 Waiver Services are meant to replace current state plan services. The State should gradually phase out services as their replacement services are phased in and not simply discontinue state plan services at some arbitrary date. To illustrate the concern, the State has long sought to discontinue Recipient Support Services (RSS) despite its importance in keeping Alaskans safe and out of higher acuity settings. Although it is unclear exactly which state plan services will be phased out and when, the 1115 Waiver application approved by CMS did include the State's explicit intention to remove RSS from the state plan. The proposed regulations create new services (in this case Community Recovery Support Services) that appear to be intended to replace some existing state plan services. It is difficult to meaningfully comment on the potential benefit of these new services without knowing the extent of the detriment of losing the services they are replacing. There has been very little discussion and no planning with providers about phasing out RSS. If the State intends to replace an existing service with a new waiver service, they should do so gradually to help ensure service continuity, minimal disruption to the recipient of services, and a smoother transition. If done properly, this gradual transition should result in no additional cost to the State. If the State is unyielding in its desire to discontinue certain state plan services by some arbitrary date, we implore state leadership to engage in meaningful discussion to plan the transition. Do not bundle medication administration with other services	Thank you for the detailed comments regarding the sunsetting services. The department intends to hold a series of listening sessions to ensure we properly understand the challenges facing providers.

	The State should not include medical services like medication management with other behavioral health services in a bundled reimbursement rate. The regulations propose coupling these services and there is strong evidence to suggest that doing so would result in increases to both overutilization and underutilization of the medical services. The proposal is also complicated because the reimbursement rate offered for these bundled services does not adequately compensate the medical and behavioral health professionals required to be involved. We urge the Division of Behavioral Health to decouple medical and behavioral health services in the bundled reimbursement rate proposed. Overreliance on the 1115 waiver services at the expense of the state plan services and grant-funded services is risky The State of Alaska's 1115 waiver was approved by the Centers for Medicare and Medicaid Services (CMS) as part of a 5-year demonstration project starting on September 3, 2019 and scheduled to end on December 31, 2023. Many states successfully apply for extensions to their demonstration projects based on prior results, but those extension are not guaranteed. The State of Alaska has reduced the budget for treatment and recovery grants with justification that the 1115 waiver services will replace lost revenue and no treatment capacity will be lost in the refinancing. Last year, the State used the pending 1115 waiver services to support their decision to reduce behavioral he□lth provider Medicaid reimbursement rates by 5%. We know the State is planning on discontinuing some state plan services. We are concerned that grant funding will	Thank you for the comment. The department agrees with the recommendation and acknowledges a revision will be made.

	continue to be cut and Medicaid will continue to be under pressure to change the array of services available or reduce reimbursement for services delivered. We don't want to find ourselves down the road having become overly reliant on the 1115 waiver services because of cuts to other resources only to find that the waiver extension is not approved or that we were not able to satisfy the budget neutrality requirement of the waiver. We urge the Division of Behavioral Health, the Department of Health & Social Services, and other behavioral health leaders to exercise caution and consider the risks to our system of care. The need for behavioral health treatment in Alaska requires us to commit to funding a full Medicaid benefit array at 100% and increasing grant funding for capacity development and treatment services. We cannot let the 1115 waiver services be used as justification to shrink our efforts or endanger our ability to provide care into the future. Again, it is evident that a lot of thought and effort went into these proposed regulations. We are excited about some of the new services and new ways of delivering care provided in these regulations. Our comments are offered in the sincere hope that they will improve our collective efforts to provide improved access to behavioral healthcare. Sincerely, Bruce Van Dusen Executive Director, Polaris House, Inc.	Thank you for the comments. Thank you for the detailed comments and questions.
Renee Rafferty	Dear Ms. Wooden, Providence Health & Services, Alaska welcomes the opportunity to provide comment on the Emergency Regulations for the 1115 Waiver Services noticed by the	

/ *Providence Health & Services*	Department on May 20, 2020. The behavioral health service line leaders have compiled a series of comments and recommendations based on the proposed changes, and we present them below for the Department's consideration. We applaud the State's efforts to create a data-driven integrated behavioral health system of care for Alaskans with serious mental illness, severe emotional disturbance, and /or substance use disorders. The feedback we have provided below supports this effort and ensures the success of the 1115 waiver. Implementation. Service Delivery changes We request to have a deeper understanding the potential changes planned for the service delivery system. We understand that it is the State's intention to phase out certain state plan services, but we do not understand what services and when. Understanding how the 1115 services and rates relate to other behavioral health services currently in the State Plan, and which of these will continue to be available during the 5-year 1115 demonstration period would allowed clarity and clear business planning. Without this clarity, providers will likely not be able to develop dependable business models to launch and sustain new services that are necessary to fill gaps in the continuum of care. Crisis Intervention Early intervention or engaging individuals who are resistant to treatment, providers must perform outreach and provide some services prior to the client agreeing to engage in the full treatment planning process. To develop dependable business models and to expand the number of individuals receiving early engagement and crisis services, providers require clarity on which reimbursement and other funding is available to	Thank you for the comments.

	support this work. Requiring a treatment plan prohibits true crisis services and causes a burden to providers.	Thank you for your comments and recommendation. The department will consider the recommendation.
	Medication Services We recommend that payment for medical services should be separated from daily rates. Medication services, including continuity of medications, prescriptions and medication review, administration, and management is a service component of many of the 1115 services, including HBTS, TTHS, ACT, IOP, PHP. If providers are expected to cover the cost of delivering medical services by a qualified practitioner as part of the interdisciplinary team prevent the development of the 1115 services and potentially decrease access. There is a severe shortage of providers in our country and Alaska has a uniquely difficult challenge of recruiting providers to both rural and urban areas. This shortage of providers will prevent programs from being able to launch quickly because recruiting a provider can take up to 18 months, delaying implementation of the waiver services. Additionally, many clients will want to continue to see their own medical providers while receiving services. It would be better to require that providers coordinate medical care and ensure child or adult receives necessary care but not included in 1115 rates.	Thank you for the comments. The department agrees a revision will provide clarity to the requirements.
	Universal Screening We appreciate the Division of Behavioral Health's interest in early identification of behavioral health concerns and quick access to treatment and support through universal screening. Providence is part of a large system investing in developing universal screening throughout many points of access. This	

	process is challenging and a lengthy approval process. In addition to the time and money required to change our electronic health record system to incorporate the new screener, we would need time and resources to train our staff and update our clinical practices. Please include behavioral health providers in the selection process, provide adequate notice, and make resources available so we can incorporate the necessary changes.	Thank you for the comment. The division anticipates hosting a series of workgroups with behavioral health providers to identify a list of suggested universal screening tools.
	Behavioral Health Grants We know the State is planning to discontinue state plan services but have not been given information as to what services will be discontinued. We are also concerned that grant funding will continue to be cut and Medicaid will continue to be under pressure to change the array of services available or reduce reimbursement for services delivered. The need for behavioral health treatment in Alaska requires us to commit to funding a full Medicaid benefit array at 100% and increasing grant funding for capacity development and treatment services. We cannot let the 1115 waiver services be used as justification to shrink our efforts or endanger our ability to provide care into the future.	
	Home-Based Family Treatment Services a. We are excited that this is a service in the home, but home isn't always the only viable location. At times, we may want to include facility based interventions (for example if the home is unsafe or if the family is unwilling otherwise) or community based interventions (for example, when a child is struggling at daycare or at soccer or in other community locations. This home base service is exciting	Thank you for the comment.

		because it allows us to work in real life locations but these locations could be home, clinic or community. Please include these as possible service locations.	Thank you for the comment and recommendation.
	b.	We are unsure if the Service Components listed for each 1115 service means that the components "can" be part of the service or "must" be part of the service. For example, HBFTl has a long list of service components. It is a great list, but it wouldn't be possible (or appropriate) to deliver every listed component to every family. Please confirm that service components can be delivered as part of a service as clinically appropriate.	Thank you for the question. Service components can be delivered as part of the service as clinically appropriate.
	c.	State plan services may be provided (and billed separately) concurrent with 1115 services. Unless this is possible, some 1115 services may be cost-prohibitive to operate. We recommend the currently allowable units (240), without the 6 week cap. This would allow for a longer duration of less frequent interventions at the same cost. We believe this would allow for better outcomes for this exciting new early intervention. Because eligibility is based on family risk factors, we would like this service to be possible at the time of conception. We can see great benefit from providing HBFT1 to high risk families during pregnancy.	Thank you for the comment and recommendation.
	23-hour Crisis Observation and Stabilization		
	a.	In a hospital setting, Medicaid allows presumptive eligibility so that a person who is	

	likely eligible for Medicaid but not yet enrolled can still receive services and the provider can still be reimbursed for the services once enrollment is complete. Particularly for behavioral health crisis care, this policy as well as the various stipulations about service limits and service authorizations will have a strong impact on whether these services will increase access.	Thank you for the comment.
	b. Many good Crisis Stabilization programs in other states report that this service may, at times, extend past 24 hours. For example, this could occur when a transfer to another level of care is pending (like to API), and the Crisis Stabilization center needs to continue to provide care until the transfer can be completed. We recommend allowing payment beyond 23 hour, 59 minutes	Thank you for the recommendation. 23-Hour Crisis Observation and Stabilization billed under Medicaid must be provided and documented according to 139.350.
	b. We are concerned with the limit of 4 check-ins within 15 days and the requirement for service authorization for more. It would be unlikely that someone would have more than 4 check-ins in 15 days, but it is clinically possible. The nature of this crisis service requires immediate access and waiting for authorization isn't feasible. For example, the Crisis Now model pro ports that police officers can bring people to 23 Hour Crisis Stabilization and are guaranteed check-in 100%of the time in a	

	matter of minutes. For this to work, we need to remove service authorization requirements. d. Remove reference to on-site requirement for medical providers. Many programs function with distance delivered medical prescribing. Crisis Residential and Stabilization Services a. This service appears confusing and lacks clarity around type of service. The intent of this service is to provide, "a medically monitored, short-term, residential program in an approved facility that provides 24/7 psychiatric stabilization." The description suggests the service should be in a residential setting and that it is applicable to clients who do not need psychiatric inpatient care. This indicates that this service is not an inpatient service. However, service locations include hospitals. Service locations do not offer residential housing or supportive housing as an option for service provision. It would be helpful to clarify whether the intent of this service is for inpatient care for a more residential setting while recognizing that this is a short-term stay and that residential level of care likely will not provide the necessary treatment and supports for the acuity of the clients that need this service. b. Rates for this service are $665.15 per day for a maximum of seven days, with extensions	Thank you for the comment. The department agrees the limit of 4 check-ins within 15 days is problematic. The department will consider a change to the service limit. Thank you for the comment and recommendation. Thank you for the comment and recommendation. Crisis residential and stabilization services are meant to provide an

	allowed if medically necessary. Initial financial modeling indicates that if the service is offered with inpatient level staffing, the daily rate is not sufficient to cover the cost of providing the service. A rate closer to the Alaska Psychiatric Institute (API) daily Medicaid rate of $1,421 is closer to a breakeven rate for this service.	alternative to inpatient hospitalization – please see 7 AAC 138.450.
	c. We recommend clarifying the type of care setting this service should be provided in (inpatient or residential) and revising the daily rate upward if an inpatient care setting is the intent.	Thank you for the comments. Over the course of the 1115 Waiver demonstration project there will be ongoing analysis around the efficacy of the rate structure.
	d. We recommend expanding the service locations if a residential setting is the intent; other modifications may be necessary to provider levels for a residential setting.	Thank you for the comment.
	Mobile Outreach and Crisis Response	
	a. Mobile Outreach and Crisis Response Services (MOCRS) is reimbursed at $175.64 per callout. Initial financial modeling, indicates that the rates for MOCRS are not sufficient to cover the costs of the program. Consider increasing the callout rate or adjusting the rate structure to a daily rate with performance measures for number of crisis episodes responded to do on a quarterly basis, for example.	Thank you for the comment and recommendation.
	b. Thank you for paying for each "call out". It will be common that a "call out" can't be completed because the person in crisis has left, refuses the intervention or the situation	

		escalates and police intervention is needed. Cover the "call out" regardless of the care provided rather than based on care delivered.	Thank you for the comment.
	c.	Please clarify that telephonic crisis response can be reimbursed through this service. This call center function, which includes telephonic crisis services. The crisis call is not triage. The goal is to deliver real time, telephonic crisis interventions reducing the need for further immediate care.	Please see the department's previous response.
	d.	We appreciate that this service will include post crisis follow up interventions. Please confirm that the MOCR code will be reimbursed again for the follow up intervention post crisis.	
	e.	This is an excellent addition to the behavioral health continuum. In other states, mobile teams are dispatched by a Crisis Call Center. We recommend adding a crisis call center (a component of the Crisis Now model) to complete the crisis continuum of care. We would further recommend ensuring that crisis call center services are explicitly mentioned as an allowable and reimbursable service setting that allows a call centers to deliver services via text, chat, and peer-to-peer warm phone line services.	Please see the department's previous response.
	f.	Inefficiencies in transportation and non-billable time. A mobile response team that operates 24/7 requires time for transport to crisis episodes, operations and administrative	Thank you for the comment and recommendation.

		responsibilities. This limits the average number of responses that can be reasonably assumed for each team; thereby limiting the potential revenue necessary to cover expenses.	
	d.	The call-back requirement that is included in the Mobile Crisis Service should be removed from this service and added as a service under Peer-based Crisis Services. This will make tracking the service simpler and incentivize the use of peers in these roles.	Thank you for the comment.
	e.	Consider eliminating the provision that services be provided 24/7 in urban areas, not just in rural areas. We have heard from providers that they prefer to provide these services 24/7. However, we recommend that the rate structure not preclude less than 24/7 coverage. For example, there may be opportunities for organizations to partner in such as ways as to provide 24/7 coverage together but if each provider must provide 24/7 coverage in order to be reimbursed, this would not be feasible.	Thank you for the comment and recommendation.
	f.	Currently, there is a limit of 12 calls per SFY with a service authorization bypass. The nature of a service provided in a crisis situation reduces the feasibility of service authorizations. Including presumptive eligibility for these services will increase their adoption and feasibility and be more successful in reducing the need for higher levels of care. We recommend eliminating the service limitation of 12 calls per SFV.	Thank you for the comment and recommendation.

	Peer-Based Crisis Services a. The documentation reference is to care delivered under a treatment plan. Due to the nature of a crisis intervention, Peer-Based Crisis Services will need to be delivered in real time without treatment plan. Please change the documentation reference to 7 AACl0S.230. b. We look forward to seeing more Peer work in Alaska. At times, we think other provider types might deliver these services as well. For example, in small communities you may not have multiple provider types so a BHA might deliver many services. Please allow all listed provider types to be eligible for reimbursement for this service. CRSS service limits for behavioral health areÂ½ of the CRSS limits for SUD. There is no clinical reason for less CRSS for behavioral health. Please increase the BH service limits to match the SUD service limits. Intensive Case Management (ICM) a. The rate does not appear adequate. We recommend completing a rate study to determine feasibility and potentially funding some pilot programs to identify costs and adequate rate structures. This is an excellent addition to the behavioral health service array; there is significant community need for this service to help individuals retain housing and maintain themselves in community settings. To be effective, it will need to be available at a broad scale.	Thank you for the comments. The department agrees a revision will provide clarity to the requirements. Thank you for the comments. The department agrees a revision will provide clarity to the requirements. Thank you for the comments. The department agrees a revision will provide clarity to the requirements.

	b. Many services for ICM require transportation costs both to the client and to the agency, which are not adequately covered in the billable rates and covered services. This will limit feasibility of this service, especially in non-urban communities.	Thank you for the comments. Over the course of the 1115 Waiver demonstration project there will be ongoing analysis around the efficacy of the rate structure.
	c. At the proposed rate, it will be difficult to maintain the client ratios recommended to make this intensive level of service effective.	
	d. Services are required to be facilitated by a behavioral health clinician. To make this service available and effective in limiting recidivism to higher levels of care, a social service organization will either need to hire a behavioral health clinician or contract with an individual or agency to offer this service. This may limit the availability of this service.	Thank you for the comment and recommendation. Thank you for the comment.
	e. It is not clear if this service could be delivered by telehealth. This method may be preferable to some clients and would help with limiting transportation time, making the rate more feasible.	
	Assertive Community Treatment Services	Thank you for the comment.
	a. The Assertive Community Treatment (ACT) is only $2.54 more than ICM and requires significantly more expensive providers and teams. Please re-evaluate the rate.	Thank you for the comment.
	b. A significant amount of clinical care delivery during the engagement stage. The engagement stage is prior completion of a treatment plan. Reimbursement for clinical care during the	

	engagement state is essential for these services to work. Please include a reference to 7 AAClOS.230 to allow reimbursement for care delivered prior to treatment plan. c. These service have great potential to provide cost-effective interventions for people experiencing homelessness and/or at risk of psychiatric emergency care. We are concerned that conformance with high fidelity models, give Alaska's unique geography and workforce challenges, will be a barrier to operating these services. We suggest removing reference to high fidelity compliance. Therapeutic Treatment Home Services a. Medical or psychiatric care should be billed separately from the daily rate especially because children would be seeing a regular physician outside of the services supported by the behavioral health provider. This is not clear in the service components section. b. The reimbursement rate appears adequate if it applies to the services provided by the foster parent in the foster home, with other medical and therapeutic services billed separately. To determine if the rate is feasible, we recommend completing a per member per month cost analysis. 1115 SUD regulations 1. QAP -The SUD regulations are open for comment and we need to share concern about	Thank you for the comment. Over the course of the 1115 Waiver demonstration project there will be ongoing analysis around the efficacy of the rate structure. Please see the department's previous response. Please see the department's previous response. Thank you for the comment, the department agrees a revision will provide clarity to the requirement.

		the QAP requirement. The new QAP requirement is creating shortages for CDCs and Clinicians and has become the rate limiting factor for growing programs and providing good access. This is proving to be a significant obstacle for providers. Unfortunate CDCs are so hard to find that they are reclassifying CDC vacancies to Clinician positions. This is a huge problem for the success of the 1115 because all of the new 1115 services require Clinicians Please use this opportunity to ELIMINATE the QAP requirement and replace it with Clinical Associate.	Thank you for the comment.
	2.	Several SUD services include "interim services" which are provided when waits are long. These interim services are good harm reduction interventions that would help keep acuity steady and allow for less costly interventions when access is available, however they can only be provided if there is reimbursement. Please add a reimbursement code and rate for SUD interim services.	Thank you for your comments.
	3.	ASAM 1.0 service limits separately lists telehealth. Telehealth should be a normal route of delivery with no additional or unique authorization required. Please remove reference to telehealth.	
	4.	ASAM 2.l's Target Population sections says "2. Individuals experiencing a mental health disorder ... ". This seems to say that 2.1 service can only be provided to people with an SUD	Thank you for your comments.

		and a co-occurring mental health disorder. This is very concerning. This service needs to be possible based on the SUD alone.	Please see the department's previous response.
	5.	Adult Partial Hospitalization includes reference to forthcoming Evidence Based Practice requirements. While EBPs are a good way to learn about effective clinical models, requiring conformance to a specific EPB is concerning because {a) the EBP may not have been tested in specific cultures, (b) the EPB might have been tested only in urban settings and {c) the EBP might require provider types that are scares or not possible across Alaskan communities. We supporting learning about EBPs, but we would not want to limit care by requiring compliance with a specific EBP.	Please see the department's previous response.
	6.	SUD Care Coordination will often occur in non-behavioral health settings {such as primary care) and by a variety of provider types. To accomplish this, please change the documentation reference to 7 AAC105.230.	
	7.	It is our recommendation that the definition of adolescent in the 1115 SUD wavier define adolescent services as the following ages: "12 - 17 and youth 18-21 with a substance use disorder diagnosis when determined to be medically necessary and in accordance with an individualized treatment plan demonstrating clinical justification as to why they are best served in adolescent programming". In addition, it is our recommendation that any	Thank you for the comment. Thank you for the comment and recommendation.

	residential levels of care age range align with DHSS Residential Licensing ages that allow services for youth through age 19 who are approved through regulation 7 AAC 50.300(c). This would align with the age ranges currently used in alignment with best practices, existing state and ASAM definitions of adolescent, definition of youth in the BH 1115 waiver, allowance for service in appropriate developmental settings, and will not decrease in an immediate reduction in access to care for these youth. 8. Four Walls Rules impacts tribal providers negatively. This restriction, currently scheduled for January 29, 2021, will prevent or greatly limit tribal health organizations from providing at least 8 of the new services which occur outside the four walls of a clinic. Providence supports the request of Tribal Behavioral Health Directors as outlined in the Alaska Native Health Board's public comments. In their letter, ANHB requests working meetings with the State to work toward resolution on this issue. Additional recommendations {7AAC139.250 (2)) The description of Intensive Outpatient Mental Health in (2) "significant functional impairment that interferes with an individual's ability ... " is a good description. (2)d then lists "activities of daily living" which is inappropriate for this service. Please delete activities of daily living 2(d).	Please see the department's previous response. Thank you for your comments.

	{7 AAC139.030 b and c) This section seems to say that a provider must get a prior authorization in order to deliver an 1115 service and a state plan service to the same person. This will cause practical problems when a provider is delivering an 1115 service and then also needs to deliver a crisis service using a state plan crisis code. The crisis service, because it is due to a crisis, does not align with a prior authorization process. Please removal of this prior authorization requirement. (7 AAC139.300 (d)) We are concerned with "high service needs" as defined by three or more acute hospitalizations, psychiatric emergency services or involvement with criminal justice". Access should be based on clinical need, not prior utilization. Revision could be either: Remove "high service needs" from the regulation; or revise to say "may have had high service needs" rather than requiring high service needs. Conclusion We are excited about the new services and new ways of delivering care provided in these regulations. Our comments are offered in the sincere hope that they will improve our collective efforts to provide improved access to behavioral healthcare. Thank you for your consideration, Renee Rafferty Regional Director of Behavioral Health Services Providence Health & Services	Please see the department's previous response. Thank you for the comments and recommendation.

		Thank you for the detailed comments and questions.
Anne Dennis-Choi / *AK Child & Family*	Ms. Wooden: AK Child & Family appreciates the opportunity to provide comment on the proposed regulations governing the Medicaid 1115 behavioral health waiver services. These written comments supplement our oral comments at the June 18th public hearing and our written questions submitted June 26th. We understand that the department intends to adopt final regulations governing the 1115 behavioral health wavier services, informed by public comment, before the emergency regulations expire on September 23, 2020. AK Child & Family provides a continuum of trauma informed care for vulnerable, high risk youth and their families. Services include Community Programs (outpatient clinic based, home based, school based, case management and wrap around services), Treatment Foster Care (recruitment, licensing and provision of TFC homes) and Residential Psychiatric Treatment Services on two campuses - Maplewood and Jesse Lee. The purpose of Alaska's 1115 Waiver Demonstration is to "enhance the set of behavioral health services available under Medicaid for individuals with serious mental illnesses, severe emotional disturbances and/or substance use disorders. The waiver aims to improve access, reduce operational barriers,	Thank you for the comments.

	minimize administrative burden and improve the overall effectiveness and efficiency of Alaska's behavioral health system (AK Behavioral Health Providers Service Standards & Administrative Procedures for Behavioral Health Provider Services, May 2020)". While we support the vision and goals of the 1115 Waiver and appreciate the work that has gone into developing them, through the public testimony process we wanted to bring specific opportunities to your attention that could help improve the proposed regulations. We hope that through a collaborative process with behavioral health providers the aspirational goals and vision of the 1115 waiver can be achieved, for the benefit of all Alaskans. This will only occur through a successful roll out and implementation of the second phase which includes behavioral health services. We have concerns about portions of the 1115 emergency regulations that appear to impede access to certain levels of care, reduce consumer choice, don't adequately take into account workforce shortages, reduce the ability of behavioral health providers to provide individualized care based upon each consumers' unique needs (right service, at the right time in the right setting) and for some services codes are proposing reimbursement rates that are not sustainable. 1. Opposing use of emergency regulations The proposed regulatory changes are massive in both their scale and scope. These regulations will transform behavioral health services delivery in Alaska. A change this significant needs to have the full benefit of normal public notice and .comment. Additionally, providers have been grappling with the COVID pandemic which has significantly impacted both the	Thank you for the comments.

	workforce and service delivery system, requiring quick pivots. To implement emergency 1115 waiver regulations on top of the COVID pandemic particularly through the emergency regulation process puts additional administrative burden and strain on a behavioral health system that is tackling a pandemic while still ensuring continued access to essential services to our community. Proper notice and comment helps strengthen the proposal. Behavioral health providers are uniquely positioned to be able to offer informed perspective on the proposed changes. Given the time to understand the change, the desired objectives, and some of the contextual factors involved, providers can offer opportunities and spot challenges that might not otherwise be readily apparent. The value of that contribution is lost when the process is rushed. A successful roll out and implementation of the 1115 waiver requires proper notice for business planning and program development so that providers and stakeholders have the time they need to implement the changes necessary to help ensure success. The changes proposed in these regulations are massive. Shortening the regulatory process and implementing these changes immediately, does not provide stakeholders with the opportunity to adequately prepare business plans and program development that would allow for a smooth transition and help ensure success. AK Child & Family opposes the State's use of emergency authority to implement the proposed regulations. Alaska Law allows the State to immediately implement regulatory changes only if it is in response to an emergency and it is necessary to do so to preserve public peace, health, safety, or general welfare. The statute explicitly states that "it is the	

	state policy that emergencies are held to a minimum and are rarely found to exist." Despite the fact that the State's 1115 waiver has been developed over the past few years, the State elected to implement regulations governing 1115 Substance Use Disorder Waiver Services under the emergency regulatory process and is now electing to do the same for these 1115 Behavioral Health Waiver Service regulations.	
	2. There is no funding available to build capacity to deliver the 1115 waiver services or implement the required changes The proposed regulations represent a massive change to the behavioral health service delivery system in Alaska. They change criteria for eligibility, define new services and new ways to intervene, change what concurrent support is permissible, and change required authorization and billing processes. The regulations overhaul our service delivery system and these changes do not come without a cost. Please see specific agency examples below and recommendations to reduce that cost for agencies: The service requirements expectations for Community Recovery Support Services state "CRSS must be provided according to the criteria listed in 7 AAC 138.400(a)(l)" which means CRSS can only be provided by Peer Support Specialist. AK Child & Family is requesting more flexibility regarding who can provide CRSS and also how the State defines Peer Support Specialist. The State of Alaska has a work force shortage, and by limiting this service to only be provided by a peer support specialist would have a detrimental impact on access to care. Also by requiring that this service is provided by a peer support specialist, the State is displacing other staff who have been providing skill building services under state plan codes to clients, who may not meet the lived experience criteria to qualify to provide services.	Thank you for your detailed comments. Thank you for the comment. If a rendering provider meets the qualification, they may render the 1115 Behavioral Health Medicaid Waiver service.

	When there is already a workforce shortage, it is counter intuitive to displace staff who have been providing skill building services to clients just because they do not have lived experience. Having to hire specific peer support specialists to meet this requirement increases the cost to the agency to be able to provide this service. Finally, in regards to peer support specialists, many in the field have lived experience but may not have declared at time of hire because they were hired based primarily on their volunteer, school or work experience/education. While we see the benefit and value of lived experience, depending upon how it's defined and how agencies are required to track, this may not only cause additional administrative burden but may also create an unnecessary additional workforce issue leading to operational barriers and access to care issues - particularly if providers have difficulty hiring peer support specialists.	Thank you for the comments.
	• For Intensive Outpatient and Community Recovery Support Services, it costs the agency more to establish and run two separate programs for youth that need these service. Therefore, AK Child & Family requests that Intensive Outpatient and Community Recovery Support groups be offered concurrently (mixed population of youth) but billed under the different codes. This will allow providers to be more efficient in providing services when able to. This is especially important as the State is not providing extra resources to establish services and agencies have to take on the fiscal responsibly to establish these new lines of service themselves.	Thank you for the comment.
	• To reduce administrative burden, and cost to agencies, AK Child & Family is requesting, that for youth who may be receiving concurrent services (e.g. Home Based Family Treatment Services Level 2 and Intensive Case Management)	

	that one treatment plan is permissible versus adding administrative burden of having providers complete 2 or more concurrent treatment plans for the same youth. • AK Child & Family requests that NPI numbers not be required for contract Therapeutic Treatment Home Parents. This is an additional administrative burden to ensure contract· Therapeutic Treatment Parents obtain NPI numbers. If an NPI number is required to be submitted with the TTHS claim, AK Child & Family suggests that the NPI number of the directing clinician be attached to the claim. The State is not providing extra financial resources to help with these additional administrative tasks This challenge is especially difficult because of cuts to other funding sources that we rely on to deliver care. Despite increased demand for behavioral health treatment services, and after years of flat-funding and cuts to the behavioral health treatment & recovery grants, we once again saw a $2.0 million cut to the grant line this year. In addition to cuts by the Legislature and the Governor, the behavioral health treatment and recovery grant line is under increased pressure to fund a broader array of initiatives, efforts, and supports. As a consequence, funding available to behavioral health providers has been greatly reduced over the past several years. Between Medicaid and grant reductions, AK Child & Family had to absorb a nearly $500,000 reduction in revenue last year, creating significant budget constraints despite inflation and increased costs in most areas of the budget (ex: healthcare premiums). Grant funding helps behavioral health providers' stand-up and support the infrastructure needed to provide treatment services. We need funding for the front-	Thank you for the comment and recommendation. Thank you for the comment and recommendation.

	end investment to be able to deliver the reimbursable services and that funding is not available. Finally, the lack of funding required to make the changes necessary to deliver 1115 waiver services is especially problematic given concerns over our future fiscal sustainability. Increased reliance on Medicaid due to COVID-19 and growing unemployment has created a lot of concern that changes might be proposed to limit the safety net program. With state revenue concerns brought about by the drop in oil prices, behavioral health grant funding will once again likely be the target of efforts to reduce costs. Cuts and flat-funding over the past several years has diminished our ability to pivot our service delivery system. To help ensure that the proposed changes launch successfully we need to maintain the Medicaid benefits array, maintain full funding for Medicaid reimbursement. Treatment and recovery grant funding, the primary resource for capacity development and change, should be increased. 3. We are commenting with limited information (not knowing state plan services scheduled to be phased out or the plan, or children's regs} Stakeholders are being asked to comment on these proposed regulations without knowing the details of other significant changes planned for the service delivery system. We understand that it is the State's intention to phase out certain state plan services, but we do not which services or when. We also understand that the State intends to release proposed regulations governing children's 1115 waiver services, but again we do not what will be included or when they will be made effective.	Thank you for the comment. Thank you for the comments.

	Our behavioral health continuum of care is a system. Changes to part of that system of care affect other parts. We cannot provide thorough or comprehensive comments on the probable impact of the proposed changes without knowing what other changes are in store. 4. State Plan services should be phased out gradually as replacement services in the 1115 waiver are shown to be working Some of the 1115 Waiver Services are meant to replace current state plan services. The State should gradually phase out services as their replacement services are phased in and not simply discontinue state plan services at some arbitrary date. Even if there is uncertainty on deadlines, having projected plans will help providers with essential business planning and preparation. It is challenging to prepare a budget for fiscal year 2021, without having the timeline of when state codes will sunset. Additionally, providers need advance notice ensure adequate resources are available to make the transition to 1115 waiver services. One way the State can help agencies is that during the transition time to 1115 when both current state plan codes and 1115 are active, allow providers to bill a la carte for a selection of current state services as well as 1115 wavier services. For example: providers could bill Therapeutic Treatment Home from 1115 service codes and Rehab services from current state codes. If the State intends to replace an existing service with a new waiver service, they should do so gradually to help ensure service continuity, minimal disruption to the recipient of services, and a smoother transition. AK Child & Family requests the State provide a cross walk regarding what state	Thank you for the comment.

	plans codes that will be sunsⷮt correspond with 1115. For example, it is unclear if the State intends Community Recovery Support Service or Intensive Outpatient Service codes to replace Therapeutic Behavioral Health Service Group codes. It is an additional administrative burden to agencies to figure out what 1115 waiver services need to be provided to replace existing state plan services to maintain stability of clients in care. Also ensuring that service is in place prior to state codes sun setting is important to prevent disruption in service to clients, however communication and support from the State is essential to help this occur. If done properly, this gradual transition should result in no additional cost to the State. If the State is unyielding in its desire to discontinue certain state plan services by some arbitrary date, we implore state leadership to engage in meaningful discussion to plan the transition. 5. Do not bundle medication administration with other services The State should not include medical services like medication management with other behavioral health services in a bundled reimbursement rate. The regulations propose coupling these services and there is strong evidence to suggest that doing so would result in increases to both overutilization and underutilization of the medical services. The proposal is also complicated because the reimbursement rate offered for these bundled services does not adequately compensate the medical and behavioral health professionals required to be involved. Many youth may be admitted with their own medication providers, or not will need to be connected to community providers if 1115 wavier services are short in duration.	Thank you for the detailed comments regarding the sunsetting services. The department intends to hold a series of listening sessions to ensure we properly understand the challenges facing providers.

	Additionally, there is a workforce shortage in the State of Alaska and expecting all providers to obtain their own medication provider would be both unrealistic and an unstainable fiscal expense. The State would not ask a medical provider to provide behavioral health services as part of their bundled rate. The medical provider would still have the option to bill separately. We urge the Division of Behavioral Health to decouple medical and behavioral health services in the bundled reimbursement rate proposed. 6. Screenings The State's 1115 waiver and these proposed regulations both support the concept of universal screeners as a strategy to improve access to services and efficiency. While we maintain screening is part of the clinical practice that should not be overly prescribed, we appreciate the Division of Behavioral Health's interest in early identification of behavioral health concerns and quick access to treatment and support. AK Child & Family has adopted a new electronic health record system (Qualifacts: Carelogic) over the past 18 months. This has been an intensive process both in terms of labor and funding. We ask that behavioral health providers are included in the selection process and are provided with adequate notice to ensure resources are available to incorporate any necessary changes. Additionally, AK Child & Family requests that the proposed Adverse Childhood Experiences (ACEs requirement of having 4 of more to qualify for Home Based Family Treatment Service Level 2 and 3 be revised. Adverse Childhood Experiences are being increasingly recognized as important predictors of poor health outcomes. And while true that a higher ACES score can	Thank you for the comments. The department agrees a revision will provide clarity to the requirements.

	predict poorer outcomes in general, this does not mean that each individual ACE carries equivalent weight. High ACE scores determine a likelihood of a negative outcome, but not the severity of response to any individual ACE category. ACES covers a wide range of experiences: Physical, mental and sexual abuse, neglect, exposures to domestic violence, living with a household member who was mentally ill, incarceration of a household member, parental separation or divorce, household alcohol abuse, and household drug use, feeling bullied, etc. By determining levels of care based on a predetermined number of ACES scored (i.e. scoring 4 or higher on ACES to access HBFT2 services, while no like measure is required for HBFTl or 3), as opposed determining the level of care based on the severity of response to the Adverse Childhood Experience, could negatively impact a consumer's access of the right service to the right person at the right time. Requiring 4 ACESs is unnecessarily limiting, as trauma responses cannot be predicted 100% of the time with a standardized checklist. ACES is intended to determine the likelihood of a negative response to trauma; but does not identify or consider resiliency factors, the severity of response, or the intervention needed for any individual ACE exposure. As an example: Under these criteria is could be possible that a child who was exposed to multiple sexual abuse episodes over their lifetime to score a "1" on the ACES measures if no other areas of a child's life domains were impacted. At the same time, a child with exposure to a divorce, had a parent pass away, felt unloved at home and bullied at school one time could have a score "4". Both of these children may benefit	

	from the services- highlighted under HBFT2, but under the current criteria only the child with "4" ACES would be considered. Without considering the child's resiliency factors or success and struggles in various life domains, determining a child is "high risk" and eligible the HBFT2 based on an arbitrary number on a screening tool could potentially fail to provide the right service to the right person. 7. Stepping Down from Higher Levels of Care and Access to Services The overarching goal of the 1115 waiver is to increase access to behavioral health treatment and support. This goal recognizes that behavioral health treatment, especially early intervention and community-based care, has better outcomes, is less costly, and saves individuals and families from unnecessary heartache. Promoting early intervention and community-based care does not have to involve creating obstacles to inpatient more acute care when it is needed. The proposed regulations install eligibility requirements that hinders providers from providing care at the appropriate level to reduce access to higher levels of care. In Home Based Family Treatment Services level 1, there is the exception that level 1 HBFT may be billed concurrently for up to 12 calendar days as part of discharge days from a PRTF. However, HBFT level 2 and 3 do not have this exception. Youth transitioning from PRTF may need more intensive supports in the home to ensure successful transition in to the community. AK Child & Family requests that all levels of Home Based Family Treatment Services have this option of 12 transitions days, so the youth can access the clinically indicated level of care upon discharging out of a PRTF.	Thank you for the comments and recommendations.

	Also if the intent is to increase access and decrease utilization of higher levels of care, then the 6-week limit on service frequency does not make sense in Home Based Family Treatment Services. Allowing providers to provide services up to a maximum number of units during a fiscal year, and the provider can determine intensity. For example, of instead having a maximum of 40 units over 6 weeks, a provider could utilize that total number of units (240) for Home Base Family Treatment Services Level 1 over the entire fiscal year, to better meet the needs to the family. Part of the intent of the waiver is to streamline service so we would assume we wouldn't require both a family service plan and treatment plan for Homebased Family Treatment Services level 1. AK Child & Family assumes that in the State's goal to streamline services that if HBFTS level 1 and clinic services are provided by the same provider agency, we wouldn't be required do both treatment plan and family service plan. Additionally, limits to location services, can prevent access to services. AK Child & Family is recommending that additional service locations be included in service locations allowed for all Home Base Family Treatment Services levels. Having home as the only service 1ocation (as it is currently written) is very limiting and does not fit with current practice, for example not all clinical therapy or medication management services are clinically indicated to occur in the home even if the majority of services are occurring in the home. This would create additional operational barriers. In the questions the State answered the State stated it would provide clarity around Four Walls Rule in a separate topic. AK Child & Family requests the State provide clarity not just in context for Indian	Thank you for your comments and recommendations. Thank you for the comments.

	Health Services, but for general providers, as 4 Walls Rules applies to more than IHS. For Intensive Outpatient Services, AK Child & Family is requesting the State remove the regulation that states 7AAC 139.250 (b) states that in this section that activities of daily living means bed mobility, transferring, walking, dressing, eating and drinking, toileting, personal hygiene, and bathing. These skills are more relevant to developmental services instead of behavioral health services. The State is encouraged to identify functional impairments not by only activities of daily living issues but by more general guidelines related to functional impairment. It is recommended that requirement be this section of the procedure manual "significant functional impairment that interferes with the individual's ability to participate in one or more life domains, including home, work, school, and community" which lets providers identify how to measure the functional impairment. Having the specific activities of daily living limits potential client's access to this service, if their mental health impairments are not specifically tied to activities of daily living. As part of access, AK Child & Family request that clarity be provided, procedure manual cites regulations that define children eligible for services as "under 21, some children between ages 18-12 may be eligible as adult for certain waivers, and eligibility is dependent on EPSDT benefit in Medicaid." This sections states to contact DPA if there are question regarding eligibility. AK Child & Family requests that the State provide the information on what youth are eligible for both adult and youth services and what is exclusionary criteria for ages 18-21. It creates an administrative burden for	Please see the department's previous response.

	agencies to have to contact DPA to obtain eligibility information for each youth that falls in this age range. 8. Overreliance on the 1115 waiver services at the expense of the state plan services and grant-funded services is risky The State of Alaska's 1115 waiver was approved by the Centers for Medicare and Medicaid Services (CMS) as part of a 5-year demonstration project starting on September 3, 2019 and scheduled to end on December 31, 2023. Many states successfully apply for extensions to their demonstration projects based on prior results, but those extension are not guaranteed. The State of Alaska has reduced the budget for treatment and recovery grants with justification that the 1115 waiver services will replace lost revenue and no treatment capacity will be lost in the refinancing. Last year, the State used the pending 1115 waiver services to support their decision to reduce behavioral health provider Medicaid reimbursement rates by 5%. We know the State is planning on discontinuing some state plan services. We are concerned that grant funding will continue to be cut and Medicaid will continue to be under pressure to change the array of services available or reduce reimbursement for services delivered. We don't want to find ourselves down the road having become overly reliant on the 1115 waiver services because of cuts to other resources only to find that the waiver extension is not approved or that we were not able to satisfy the budget neutrality requirement of the waiver. We urge the Division of Behavioral Health, the Department of Health & Social Services, and other behavioral health leaders to exercise caution and consider the risks to our system of care. The need for behavioral health treatment	Thank you for the comment and recommendations.

	in Alaska requires us to commit to funding a full Medicaid benefit array at 100% and increasing grant funding for capacity development and treatment services. We cannot let the 1115 waiver services be used as justification to shrink our efforts or endanger our ability to provide care into the future. 9. Rate Reimbursement Creating the regulatory authority to deliver the service without providing reimbursement rates adequate to deliver the service means that service component will not be delivered, limits the options available to Alaskans in need of the service, and threatens the strength of the behavioral health continuum of care. Requiring all service components to be required, regardless of clinical recommendation, is cost prohibitive for agencies. AK Child & Family recommends the State aligns expectations with best practices. Best practice would dictate that is only service components that are medically indicated be required, verses a one size fits all approach. For example -new clients who have previously established relationships with medical providers should for continuity of care and again through a best practices lens be able to remain with their established providers. If new clients are required to switch from their established providers for things like medication services not only is it disruptive to their care but it would also significantly increase administrative burden on providers. Also requiring all services on a prescribed list impacts how individualized care can occur, as not all service components may be clinically appropriate for each client. For Intensive Case management the standard states "biweekly a minimum monitoring of behavioral health services", but then service requirements expectations state "must also have	Thank you for the comments and recommendations.

	capacity to furnish the following: multiple contacts with client per week with a frequency of at least 2 to 3 times a day". Having services 2 to 3 times a day may not be clinically appropriate, especially with the under 18 populations. AK Child & Family requests that the biweekly monitoring includes contact with client specifically and also teams/family and coordination of services. Having the staffing pattern to meet frequency of 2 to 3 times a day, even if a client does not consistently need that level, increases cost to agency. Also, it is recommended to have flexibility included to be able to taper down the service over time. Having concrete expectation of a minimum number of contacts a week (or day) makes it challenging to assess how a client will do with less intensive services prior to services being complete discontinued. Having expectations like this increases costs to agencies.	Thank you for the comments.
	In regards to providing Intensive Case Management while a youth is in Therapeutic Treatment Home Services, is recommended that agencies are allowed to bill ICM for contact with the TTHS parent. Currently, under the state plan case management is a non-billable services when case management is provided to a therapeutic foster parent under contract with the agency. This creates additional cost to the agency, who may have to increase services to foster parents to preserve placement when acute behaviors are occurring. To maintain fiscal sustainability, it is requested that Intensive Case Management be billable to all clients and individuals involved in youth's care. It is also requested that family therapy be a billable service for Therapeutic Treatment Home parents. The State says it is recommending to have a professional clinician provide clinical	Thank you for the comment and recommendation.

	supervision of the foster parents. Providing a billing mechanism for this support is request, and family therapy with foster parents would make sense. Expecting this cost to be absorbed in to the TTHS rate is unrealistic, as often the clinical supervision is more therapy in nature, as we work with the entire family unit when helping the youth recover from Trauma. Another aspect that is not clear is if family services under Intensive Outpatient service and Community Recovery Support services is billable. This question was asked during the question period and the State responded that the billing mechanism for family work is under CRSS procedure code H2021 with applicable modifiers. However, the rate chart provided by the State does not include that item. It is requested that the sate update the procedure code to match what the intent is, or to ensure there is a billable mechanism to bill family work for these services. Examining who is delivering the care, what is expected, what overall volume can be supported, and realistically setting reimbursement rates is the only way the goal of the 1115 waiver and these proposed regulations will work. We appreciate the work and look forward to helping transform the services delivery system. Our comments are offered in the sincere hope that they will improve our collective efforts to provide improved access to behavioral healthcare. Sincerely, Anne Dennis-Choi, President & CEO	Thank you for the comments and recommendations. Thank you for the comment. Thank you for the detailed comments and questions.
Lindsay Prunella /	Good Afternoon Alysa,	

R.O.C.K. Mat-Su	I would like to submit the below questions/comments for the Behavioral Health Component Of The 1115 Waiver. **Home-Based Family Treatment Services** **1.** Under all three levels of Home-Based Family Treatment Services the target populations for services include "at high risk of out of home placement" and should include children who are already in the custody of the state. **2.** Service location for all three levels of Home-Based Family Treatment Services should include community (i.e. grocery store, park, etc) and clinic. **3.** What is a family service plan under Home-Based Family Treatment Services Level 1? **4.** For Home-Based Family Treatment Services Level 2 and 3 does there have to be a clinical assessment or is it possible to do a functional assessment and use Z-Codes? We are concerned that without this flexibility it will create a workforce issue due to limited qualified staff throughout the state. a. If a treatment plan is based on a functional assessment, which does not require a Master's Level Clinician to complete, does a Master's Level Clinician need to review and sign the individualized treatment plan? We are	Thank you for your comments and recommendations. Thank you for your comments and recommendations. Thank you for the question, a family services plan is a detailed plan with information about the service recipient and their family. Please refer to the service requirements in the Alaska Behavioral Health Providers Services Standards & Administrative Procedures for Behavioral Health Providers for detail on the required elements. Thank you for the question, a clinical assessment is required.

	concerned that without this flexibility it will create a workforce issue due to limited qualified staff throughout the state. **5.** Comprehensive case management should be a component of all levels of Home-Based Family Treatment Services. **Community Recovery Support Services (CRSS)** **1.** Under Community Recovery Support Services, the target populations for services include "at high risk of out of home placement" and should include children who are already in the custody of the state. **2.** Community Recovery Support Services would be an optimal place to provide parent coaching and feedback for family contact services. In order to do that the target population needs to be expanded to include children that are already in the custody of the state. Additionally, if this is done, services should be provided in accordance with a family contact plan rather than a treatment plan and service frequency will need to be increased. **3.** Under Community Recovery Support Services, if a treatment plan is based on a functional assessment, which does not requirement Master's Level Clinician to complete, does a Master's Level Clinician need to review and sign the individualized treatment plan? We are concerned that without this flexibility it will create a workforce issue due to limited qualified staff throughout the state.	Thank you for the comment and recommendation. Thank you for the comment. Thank you for the comment and recommendation. Thank you for the comment and recommendation.

	4. Under Community Recovery Support Services does there have to be a clinical assessment or is it possible to do a functional assessment and use Z-Codes? We are concerned that without this flexibility it will create a workforce issue due to limited qualified staff throughout the state. Thank you so much for coordinating this effort! We greatly appreciate it. Lindsay Prunella, MSW, CPS *R.O.C.K. Mat-Su Operations Manager*	Thank you for the question, the use of Z-codes is limited to HBFT Level I. Thank you for the detailed questions and comments.
Dr. Marti Romero / *Assets, Inc.*	On behalf of Assets, Inc. Leadership team, we would like to thank the Division for all of their efforts with regards to the 1115 behavioral health waiver – we know that this has been an enormous undertaking. We look forward to the day that all Alaskan's mental health needs can be met within our community service delivery continuum. We offer the following comments for consideration: • Please define the word "facilitated" as it is used throughout the regulations and the Service Standards and Administrative Procedures document (now referred to as SSAP). • Page 9 of the regulations, under 7AAC139.030(b), states that a provider may only provide clinic services and rehabilitation services from the state plan concurrently with services under this chapter if the provider first obtains an authorization. We were under the impression that clinic services would remain in the state plan (it appears that many of the new	Please see the department's previous response.

	1115 services have attempted to bundle these services in). For many of our clients with established providers, this will be contra-indicated to their wellbeing. More understandable is the prior authorization for rehab services under the state plan AND the 1115, but not clinic. This seems to create unnecessary administrative burden. • Page 15 of the regulations, under 7AAC139.300, states that Behavioral Health Residential Treatment services must be provided in a facility approved by the department. Clarification is needed as to the licensing requirements of the facility. Can the service be provided by an appropriate licensed provider who contracts with a provider agency? ○ On page 16 it states that a psychiatric assessment must be conducted for an adult receiving this service; what is the clinical rationale for this requirement? Is this an error? It seems that the directing clinician would have the most relevant information regarding the needs of the consumer. In addition, we are already strapped in our community to find psychiatric providers. ○ On page 16 "high service needs" are defined as using the same or a combination of three or more of the following in the past year: acute psychiatric hospitalization, psychiatric emergency services, or involvement with the criminal justice system. We would request that the Division consider that often clients are in need of psychiatric hospitalization, or even	Thank you for the comments and recommendation. Thank you for the question, the department acknowledges clarity to the requirement is needed. Thank you for the comments and recommendations.

	psychiatric emergency services, and due to lack of space in our communities they do not receive the needed services. Lack of utilization does not equate to lack of need. ○ In serving individuals for decades, who experience serious and chronic mental illness (i.e. schizophrenia, schizoaffective disorder, bipolar disorder, and frequently an intellectual disability with a history of inappropriate sexual behavior) for whom care provided in an assisted living home will no longer be adequate, but do not meet the "high service needs" description, we fear will fall through the cracks and lose the long term stability that treatment focused assisted living homes have been able to offer. • Page 5 of the SSAP states that all behavioral health waiver services must be provided by a qualified behavioral health professional, and they must have an NPI number and enroll as an Alaska Medicaid program provider. Does this mean that direct support staff can no longer provide services (and agencies bill for those services) under the agency global NPI number? • Throughout the SSAP document there is a list of staff qualifications for each service. For example, on page 16 there is such a list for Intensive Case Management. On page 17 there is a section titled "additional information." It states that services must be facilitated by at least a behavioral health clinical associate to draw down the per unit rate. However, in the staff qualifications there are behavioral health	Thank you for the comments and recommendations. Thank you for the comments. Thank you for the question. All rendering providers of 1115 Waiver services must have an NPI number.

	aides and peer support specialists listed. Perhaps these are individuals who can be on the interdisciplinary team, but cannot necessarily provide the service. This is confusing and clarification necessary. In addition, specific criteria for each of those staff would be helpful. I.e., what constitutes a Behavioral Health Clinical Associate, etc.? The words "must be staffed by an interdisciplinary team…" Please clarify what this means and what documentation is required.	Thank you for the question. It is not the intent of the division to require that all services be staffed by an interdisciplinary team. The division will clarify the specific services which must be staffed interdisciplinary team. Thank you for the question, the department agrees this is confusing and a revision will provide clarity to the requirement.
	• Page 29 of the SSAP, regarding Adult Mental Health Residential Treatment (AMHR), Level 1 and 2 (this is not unique to these services). Medication services are listed here; we currently have all of our clients established with either private psychiatric providers or they receive care from a contracted psychiatrist who is willing to serve a specialized population (individuals who experience intellectual disabilities in addition to their serious mental illness). Requiring this as a bundled service would not only be challenging as providers are sparse, but would be contra-indicated for the wellbeing of our clients. Not to mention, the rate would not cover the costs of these services if they were bundled in.	Thank you for the comment.
	• Page 29 indicates that Community Recovery Support Services are contraindicated with AMHR Level 1. It seems that individuals receiving services in the home would also benefit from ancillary community based CRSS services; we would appreciate reconsideration of this.	Thank you for the comment and recommendation.

	• Page 31, under the section of Service Frequency/Limits, states that for AMHR Level 1 (similarly with Level 2) there are two hours of clinical or medical services required at minimum, one hour of individual mental health treatment, and five hours of treatment services per week. It was our understanding that individuals would be able to continue to receive their clinic services through the state plan – is this not the case? If not, therapeutic alliances that have been built and are successful would have to end. This would be potentially harmful and we would request that clients be given an option to remain with their current providers and eliminate the clinical or medical service requirements from this service. In addition, the rate would not cover these services being bundled in.	Thank you for the comment and recommendation.
	• Please make clear if AMHR services (both levels); can be provided to more than one service recipient at a time, by a single staff member.	Thank you for the comment.
	• In general it appears that screening is missing from these regulations. It would be our hope that screening tools will be left up to the discretion of the directing clinician, based on client population and individual needs, as long as they are evidenced based tools.	Thank you for the comments and recommendations.
	• We would ask that a specific date that any state plan services will end, be published as soon as possible to allow for a planful and smooth transition for treatment planning and budgeting purposes.	Thank you for the comment.
	• Finally, the State issued the emergency regulations on May 20, 2020 with the changes going into effect that day. Because the proposed changes were concurrently	

	out for public comment, the State was limited in how they could respond to stakeholders' questions. The regulations propose a massive change to the behavioral health service delivery system. While we recognize and appreciate that the phased-in approach the DBH is using to implement the changes allows providers some flexibility, the decision to implement these changes using emergency regulations means that those providers who do want to start delivering these services immediately are left without the benefit of guidance that might otherwise be available by their state partners. The proposed regulatory changes are massive in both their scale and scope. These regulations will transform behavioral health services delivery in Alaska. A change this significant needs to have the full benefit of normal public notice and comment. We sincerely thank you for your time and consideration. Marti Romero, Psy.D., L.P.C.-S. On Behalf of the Assets, Inc. Leadership	Thank you for the detailed comments and questions.
Jerry A. Jenkins / *Innovative Services of Alaska*	Dear Ms. Wooden: First, I appreciate the opportunity to comment on the proposed regulations governing the implementation of the Medicaid 111 behavioral health waiver services and the tremendous amount of work that has gone into the development of the proposed regulations. These written comments supplement my oral comments provided at the June 18, 2020 public hearing. I am writing based on some	

	consulting work currently engaged in as well as over thirty-eight years of experience working in behavioral health care with the last seventeen years being in Alaska. Overall, I think these regulations provide a great opportunity to provide more comprehensive care to Alaskans in need of behavioral health treatment and recovery supports and I very much appreciate the efforts of the Division in crafting them. The focus of my comments today will be 7 AAC 139.300. Behavioral health residential treatment services. Comments are specific to adults with serious mental illness (SMI) and/or co-occurring substance use disorders (SUD). 1. Re 7 AAC 139.300 (a), recommend specifying the Alaska Behavioral Health Providers Standards and Administrative Procedures are referenced at 7 AAC 160.900 (64). 2. Re 7 AAC 139 .300 (b), recommend clarifying language on meaning of'' ... a facility with 16 or fewer beds ... '' allowing various levels of care within a facility. The reason for recommendation is that some potential adult residential providers may have more than 16 beds in a facility and provide various kinds of care. Examples include providing assisted living (not funded by Medicaid or other federal dollars) and/or transitional housing in different parts of a building. I recommend the definition be '' ... provided in a facility providing 16 or fewer beds of this level of care by.. . '' According to this section, the department will be approving the facility and can insure the site is in compliance with 1115 waiver	Thank you for the comment and recommendation.

		requirements and any other applicable regulation(s). Re 7 AAC 139.300 (d), recommend adding one caveat allowing for exceptional cases. An example might be a person with a history of suicidal ideations and attempts that are periodic, say every two - three years. Once activated, serious suicidal attempts follow and may result in extensive ICU care before it abates. The ability to access Level 2 for a period would allow a tool for providers not previously available that could/may help stem/arrest the suicidality. This person may not reach any of the thresholds currently stated due to seriousness of a suicide attempt and need for medical care over psychiatric care for restorative purposes.	Thank you for the comment and recommendation.
	3.	It is recognized that 7 AAC 139.300 provides levels of care not previously available in Alaska to help fill in continuum gaps. Doing so addresses Olmstead and other initiatives focusing on providing services/supports that help citizens live in the least restrictive environment in which they and the community are safe. Last, these levels of care provide a way of eliminating the need for Recipient Support Services (RSS) as it has evolved during the downsizing of the Alaska Psychiatric Institute (API). With that background, recommend the current utilization of adults receiving RSS be evaluated to determine the extent of condition. This includes knowing where recipients are and transition plans. The purpose is to plan with providers transitions to new services in an	

	attempt to minimize disruption with potential negative outcomes such as readmissions to API. This process will also help guide DBH's determination of a reasonable timeline to implement the new residential treatment services for current clients. Please let me know if there any questions regarding comments/recommendations. Again, thank you again for the opportunity to comment and thank the Division for efforts at trying to improve behavioral health care in Alaska. Jerry A. Jenkins, M.Ed., LADAC, MAC Innovative Services of Alaska Principal Cc: Tom Chard, Chief Executive Officer, Alaska Behavioral Health Association (ABHA)	Thank you for the comment and recommendation. Thank you for the detailed comments and recommendations.
Amy L. Simonds / Juneau Youth Services	Ms. Wooden: Juneau Youth Services appreciates the opportunity to provide comment on the proposed regulations governing Medicaid 1115 behavioral health waiver services and the work that has gone into these proposed regulations. With a mission of *"responding to the behavioral health needs of Alaska's children"*, Juneau Youth Services has been providing residential, school, and community based therapy and case management services to children and families for over 50 years. Overall, we believe these regulations harm our ability to provide care and hurt Alaskans in need of behavioral health treatment and recovery supports. We wanted to bring specific	

	opportunities to your attention that could help improve the proposed regulations. I am dismayed by the process the Division is using. Last year, the Division used the Emergency Regulations process and received significant feedback from Stakeholders indicating the process was problematic. The Division has been discussing an overhaul of the behavioral health system for years, so it is by no means an emergency. Using the emergency process only serves to obfuscate and damage the relationship the Division has with Stakeholders. I believe the Division Stakeholders share a common vision of a modernized behavioral health system. Withholding important information providers need in order to engage with the Division protracts the process, even if the intention is to speed it up. With that stated, it is important to note my feedback is limited by what I have been made aware of. For example, it's important for me to know the definition of medical services when medical services are bundled into rate packages. Instead, the Division has indicated that definition will emerge at an undisclosed time in the future. Furthermore, it's important to know the rates of substantial service lines I provide: children's residential treatment. Additionally, despite repeated requests for more information, the Division remains silent on a timeline for phasing in and phasing out of services. We have been told different services will be phased in and out at different times in different sites throughout the State. We can only hope these changes will be gradual and allow enough time and information for planning. With the use of emergency regulation processes to make substantial changes, I'm nervous the Division will continue making very abrupt	Thank you for the comments.

	changes, hurting providers and recipients of behavioral health services. Last year, I participated in a Coordination of Care team responding to the 1115 Waiver Services. In so doing, the Division established what they referred to as "listening sessions" with behavioral health leaders. We made abundantly clear that bundling medical services into other services, such as home based family services and therapeutic foster care would cause those programs to be unaffordable for us to provide. Now that rates have been published, I can confirm, the bundled services at the rates proposed are not feasible. Please, ***do not bundle medical, medication, medication administration, or psychiatric services with other services***. I am concerned about the Division's decisions to reduce grant funding while bundling services. This leaves providers without seed money to begin new programs in the 1115 Waiver, while experiencing a reduction in reimbursement, since high cost services are bundled into a package. While the Division states the rates are higher for these services, when tallying the cost of the bundled services along with a cut in grant funding, providers are actually taking an overall cut. Providers are already financially stretched and will not be able to absorb this cut for long. Our only choice is to avoid providing certain needed services, limiting the ability for Alaskans to obtain needed care. In closing, I appreciate the amount of work and care the Division has put into developing, negotiating and finally launching the 1115 Waiver Services. Juneau Youth Services is	Please see the department's previous response. Thank you for the comments and recommendations.

	thrilled with the ability to provide a full range of children's services, especially in home and community based settings. It is my fervent hope the Division will re-consider using the emergency regulations process, and takes to heart the feedback contained herein so we may continue a partnership serving Alaskans. Sincerely, [digital signature] Amy L. Simonds, LPC Executive Director, Juneau Youth Services Cc: Tom Chard, Alaska Behavioral Health Association	Thank you for the detailed comments and recommendations.
Kristin K'eit	Dear Ms. Wooden, Gunalchéesh, quyanaqpak, thank you for the opportunity to comment on the 1115 Waiver. As you fully understand, behavioral health treatment is a necessity for the immediate safety and future success of an individual, their circle of support, and their community. Successful treatment is known to positively impact all those with whom a person interacts. We all support the primary goal of the 1115 waiver – to increase access to effective behavioral health treatment and support. The State of Alaska (the State) and our behavioral health providers (Providers) know that early intervention and community-based care, have better outcomes, are less costly, and save individuals and families from unnecessary trauma	

	and distress. This has the ripple effect for the future success noted above. First of all, I oppose the use of Alaska Law at A.S. 44.62.250 et. seq. to implement 1115 Behavioral Health Waiver Service regulations (the Regulations) as if there is an emergency required to "preserve public peace, health, safety, or general welfare." Rather, by imposing these massive regulations without proper notice and opportunity for comment, the State is causing and contributing to impaired health and safety and reduced services for those affected by the Regulations. The State is also preventing the process to strengthen and improve the Regulations without accepting comment. Had the State used the appropriate process, you would have heard from behavioral health providers (Providers), those most knowledgeable of how the Regulations will impact those receiving behavioral health services, and those who must implement the Regulations. Furthermore, the emergency imposition of the Regulations is like a tsunami, it is happening too sudden and too fast. By rushing the Regulations into implementation, you have severely impacted Providers and are hindering the successful implementation of the large number of changes caused by the Regulations. Not only do Providers now have to contend with the safety of clients and staff during the COVID-19 pandemic, but they must also divert 100's of hours of staff time to evaluate the new services, new clinical interventions, changes to client eligibility, and changes to service authorization and billing. After evaluation, providers then have to inform practitioners and clients, and, especially time-intensive for	Thank you for the detailed comment.

	some Providers, modify existing systems and processes. It seems as if the State has "set up" Providers to fail by preventing the time needed to evaluate, prepare, and modify, in order to successfully implement the Regulations. Second, the State is not taking into account the costs to Providers for implementing these changes in such a short, frenzied amount of time. You must see how the treatment and recovery grant funding is the primary resource for capacity development which helps Providers to put in place the structure needed to implement State regulatory changes. These funds must be available and increased if you want the successful implementation of the Regulations. Likewise with the Medicaid benefits array and full funding for Medicaid reimbursement. Please do not further constrain Providers by ignoring the costs of implementation and pushing out an unfunded mandate akin to federal policies or regulations. Doing so will repeat history, and we cannot see our children sent out of state again to receive substandard, further traumatizing treatment. Third, let us take into account the strong evidence that bundled reimbursement rates of medication management with other services cause increases to both overutilization and underutilization of the medical services. We know that Alaska is a difficult setting for the health insurance market, that residents needing medical services for a whole host of maladies pursue cheaper rates in other states, and that many health services providers are not fully compensated for the cost of care they provide. Do not give further cause to drive residents to seek "Outside" medical care. By keeping the	Thank you for your comments.

	medical and behavioral health services discrete from each other, the State can prevent this. Last, knowing the common goal for the State, Providers, and clients is to provide adequate (and even utmost) behavioral health care, we can look to successful past implementation processes which were rooted in equilibrium, a balance of phasing out the old while phasing in the new. To suddenly discontinue certain state Medicaid services is like trying to suddenly stop a speeding vehicle. It causes injury and damage. By using a gradual phase-in and phase-out process, the State will support service continuity and stability for patients during times that are already chaotic and disruptive. Again, gunalchéesh, quyanaqpak, thank you for the opportunity to comment. Let's work together to provide successful behavioral health treatment, including early intervention, community-based care, and services that effectively respond to the level of treatment needs. Respectfully, Kristin K'eit	Please see the department's previous response. Thank you for the detailed comments regarding the sunsetting services, specifically therapeutic treatment home. The department intends to hold a series of listening sessions to ensure we properly understand the challenges facing providers. Thank you for the detailed comments and recommendations.
Corey Goheen / *Community Connections*	Hi Alysa, I have great concern over the 90 day rule in therapeutic foster care. This is not realistic for so many reasons and we are greatly concerned about this for the future of our children in care and their attachments, the system (as it will break OCS	

	also as it is not equipped to handle this yet), and will serve to force a child to move back and forth throughout the already difficult system they are in. I am very concerned on how this will affect the children in our care and how it will be detrimental to their connections, attachments, growth and ability to be resilient and therefore worried they will then be unable to successfully overcome their adverse childhood experiences. We want the best for our youth and care deeply about their healing from trauma, their growth and their future. Some, but not all, of the obstacles this 90 day rule will create for the child and system are the following: 1) OCS infrastructure is not yet ready to handle moving children in and out of tfc for several reasons: lack of access to traditional homes, already overwhelmed workers, etc.). Currently even when children are ready to move to a lower level of care and agencies advocate for this, the workers are many times unable to actually find this home that will take our children unfortunately. Therefore we have many homes that are tfc that adopt our children as they grow strong connections, this sometimes takes years for the system to get them to be ready for them to be adopted and this is not the child nor the therapeutic preadoptive homes fault. 2) Children would move back and forth, making this very unstable for the children's lives. Many times children go thru what is called a "honeymoon stage." Afterwards they begin to show behaviors as they begin to work on their connections with the tfc parents they begin to heal and work on their traumas. This many	Thank you for the comment. Thank you for the comment.

	times is not for the first couple of months, so if the 90 day rule went into effect, it would derail the actual process of healing for the child who has experienced trauma.	
	3) Many of our children are only able to be successful once they learn resilience skills through building connections as they many times have such high ACE (Adverse Child Experience- please see the ACE study for reference) scores from their past. In order to overcome the trauma they have experienced in their lives, the number one tool they can have is positive connections with nurturing adults. If we are to break this connection due to a 90 day rule, this could be truly devastating for many children who are just learning to trust at 90 days in a new home, while working on their behavioral health needs in a positive nurturing environment.	Thank you for the comment.
	4) Adoptions would be derailed. We have several adoptions that occur in therapeutic foster homes in this state that would not be able to occur if this 90 day rule goes into effect.	Thank you for the comment.
	5) Siblings would be separated. The majority of our sibling groups in our agency are able to stay together currently. However, we were only able to bring them together as a result of finding them and getting them back together, many times at different times in their lives and from different places such as DJJ, Northstar, or residential treatment facilities. If we were to have this 90 day in affect, nearly all of the sibling groups we have been able to keep together would not have been able to stay together or even overlap in the same	Thank you for the comment.

	home to try to reunify them. This would be just devastating to the wellbeing of the bio family and its ability to try to stay intact or even get adopted together. I very humbly as you to please reconsider and move forward with removing this 90 day rule from the 1115 as this would devastate the child's growth, sibling and family ties, possibility for the "difficult to place" child to get adopted into a loving, experienced in behavioral health home, as well as would cut important ties they grow to trained foster parents as they heal from trauma and become resilient. Thank you for your time and consideration. Corey Goheen Foster Care Manager II (907)826-3891	Thank you for the comment. Thank you for the detailed comments regarding therapeutic treatment homes.
Philip Licht and Mandy Zeppa / *Set Free Alaska*	Gen, I hope this email finds you doing well. I also hope you have been able to find a little time this summer for yourself. I know you have had a crazy first few years doing great things and dealing with major crisis but don't forget to take care of your most important asset (yourself☺). I am forwarding along an email from our clinical director who reached out to me with some concerns about the new waiver limitations surrounding Z codes. We were so excited for this portion of the waiver and looking forward to providing more preventative services for kids and families at our clinic and especially at the schools (we are currently in 3 schools in Mat-	

	Su). However, after looking closer it appears that Z Code services can only be provided within the home setting and not within the clinic (which is how we have to designate the schools in order to bill. Are we understanding this right? If so, it appears to be a major limitation to at least some of the intent of what we were dreaming of for this waiver. Any insights would be helpful and maybe this is just an oversight we could tweak in regulation? Thanks for all you do and I hope to see you soon. In reviewing the regulations within the 1115i it has become clear that mild to moderate (z codes) services for children can only be delivered within the client's home. This eliminates our ability as a community behavioral health provider to allow for more preventive treatment options for at risk children and adolescents. Those presenting with z codes that we know can range from sexual abuse to death of a parent are not able to receive in clinic or school based services. Z codes indicate that a life stressor has occurred but does not yet meet criteria for a full Mental health diagnosis. The z codes are where prevention is at a prime operating within the strengths of the family and other systems to support the client in coping, processing and adapting to change. By not being able to offer these services in the clinic or school Settings under the waiver we are essentially missing our most accessible opportunity at prevention.	Thank you for the question. The department will review the place of service list for HBFT. Thank you for the detailed comments and questions.
Barbara Rodriquez /	Ms. Wooden:	

Arc of Anchorage	The Arc of Anchorage appreciates the opportunity to provide comment on the proposed regulations governing Medicaid 1115 Behavioral Health waiver services and the work that has gone into these proposed regulations. Overall, we believe these regulations harm The Arc's ability to provide services for Alaskans in need of behavioral health treatment and recovery supports. We want to bring specific concerns to your attention that could assist in improving the proposed regulations. 1. **<u>Use of Emergency Regulations –</u>** The Arc opposes the State of Alaska's use of emergency authority to implement the proposed regulations. We understand there is a need to make changes, but the State should let providers take the lead in offering professional positions and perspective on proposed changes, not just move forward with emergency regulation imposed by state administrators. Those with boots on the ground, service providers like The Arc, are best suited to know how proposals will work in the actual communities and what impacts to the population they serve may have on that community. Providers can also identify opportunities and challenges the State may not have considered – the value of such important insight and information is lost when an emergency order is enacted and regulations are rushed. In addition, such rushed regulations leaves little to no time for service providers to prepare and implement procedures and changes needed to ensure their programs success under this new waiver. Large	Thank you for the comment. Thank you for the comment.

	changes are expected out of these new proposed changes while simultaneously being pushed through an emergency order – that is an incredibly tall order for service providers of all sizes. While we recognize and appreciate that the phased-in approach the Division of Behavioral Health is using to implement the changes allows providers some flexibility, the decision to implement these changes using emergency regulations means that those providers who do want to start delivering these services immediately are left without the benefit of guidance that might otherwise be available by their state partners. The proposed regulatory changes are massive in both their scale and scope. These regulations will transform behavioral health services delivery in Alaska. A change this significant needs to have the full benefit of normal public notice and comment. Service providers need time and more information to prepare, transition and implement these changes. The Arc proposes moving the effective date from January 1, 2021 to July 1, 2021 to provide that extra time for agencies to be trained and prepare for implementation. 2. **<u>Need for Implementation Funding for 1115 Waiver -</u>** The regulations overhaul our service delivery system. Many of the changes are necessary to accomplish the goal of the 1115 waiver to improve access to care, but these changes are costly for service providers. Simply, funding needs to be made available to build the capacity and implement the changes required. This	Thank you for the comments. Thank you for the comment and recommendation.

		challenge is especially difficult because of cuts to other funding sources that we rely on to deliver care. Despite increased demand for behavioral health treatment services, and after years of flat-funding and cuts to the behavioral health treatment and recovery grants, we once again saw a $2 million cut to the grant line this year. In addition to cuts by the Legislature and the Governor, the behavioral health treatment and recovery grant line is under increased pressure to fund a broader array of initiatives, efforts, and supports. As a consequence, funding available to behavioral health providers has been greatly reduced over the past several years. The Arc has not only had a difficult time retaining and hiring front line staff such as Direct Support Professionals (DSPs), but key positions such as our clinicians in our Behavioral Health Services program. Paying competitive wages for these important roles within our agency is a constant challenge. State reimbursement rates leave agencies like ours to figure out ways to increase revenue from other sources in the middle of a pandemic and statewide economic downturn. We are short-staffed and therefore, can't run our programs at full capacity. The lack of funding required to make the changes necessary to deliver 1115 waiver services is especially problematic given concerns over our future fiscal sustainability. Increased reliance on Medicaid due to COVID-19 and growing unemployment has created a	Thank you for the comments. Thank you for the comments.

	lot of concern that changes might be proposed to limit the safety net program. Federal restrictions accompanying the CARES Act funding mean that the benefit array and reimbursement rates for services are particularly at risk. Additionally, given State revenue concerns brought about by the drop in oil prices, behavioral health grant funding will once again likely be the target of efforts to reduce costs. With such a high level of uncertainty about our fiscal future, building new services is financially risky.	Thank you for the comments.
	3. **<u>Bundling Medication Administration –</u>** The Arc also strongly opposes the proposed changes from the State to bundle services, including medication administration. This not only will increase overutilization/underutilization of services, but limits agencies' ability to meet individual's needs should they only need one service, not all. Flexibility is key for agencies like The Arc to best meet the needs of Alaskans. Additionally, the reimbursement rate offered for these bundled services does not adequately compensate the medical and behavioral health professionals required to be involved. We urge the Division of Behavioral Health to decouple medical and behavioral health services in the bundled reimbursement rate proposed.	Please see the department's previous response.
	4. **<u>We Need Time –</u>** Agencies, including The Arc, use health record systems and platforms to manage and operate their services to ensure service delivery to Alaskans. It takes time and resources to update	

	agencies to new processes, possibly new technology or programs, and implement new screeners. Rapidly adjusting to an overhaul of an agency's procedures takes time, training of staff and clinicians, and an overwhelming amount of information has to be digested and transposed to fit agencies' needs and processes. Agencies have not had to work with the 1115 Waiver until now, and many are just trying to learn at this point in time how they could come up with a plan to implement. They are not ready or able to move so quickly with the timeline the State has given of January 1, 2021. The Arc asks that the State include providers in the selection process, giving us adequate notice, time and funding to incorporate any necessary changes. On behalf of The Arc of Anchorage, our board of directors and staff, I want to thank you for your role in the public comment process and considering what service providers are sharing with you and your department at the State. We know that effort went into these proposed regulations and we look forward to new services and new ways of delivering care provided in these regulations. Our comments are sincerely offered as part of the process for the State and service providers to work together, and that they will ultimately improve Alaskans' access to behavioral healthcare. Sincerely,	Thank you for the comments and recommendations. Thank you for the detailed comments and recommendations.

April Kyle / *Southcentral Foundation*	Dear Ms. Wooden, Southcentral Foundation provides these questions in response to the emergency regulations released May 20, 2020 Southcentral Foundation is the Alaska Native tribal health organization designated by Cook Inlet Region, Inc. and eleven Federally-Recognized Tribes-the Aleut Community of St Paul Island, Igiugig, Illiamna, Kokhanok, McGrath, Newhalen, Nikolai, Nondalton, Pedro Bay Telida, and Takotna-to provide healthcare services to beneficiaries of Indian Health Service pursuant to a compact with the United states government under the authority of P.O. 93-638, as amended, the Indian Self Determination and Education Assistance Act. Southcentral Foundation provides services to more than 65,000 Alaska Native and American Indian people living in the Municipality of Anchorage, the Matanuska –Susitna borough and 55 rural Alaskan villages. Services provided by Southcentral Foundation include outpatient medical care, home health care, dentistry, optometry, psychiatry, mental health counseling, and substance abuse treatment, residential treatment facilities for adolescents and for women, suicide prevention and domestic violence prevention. We employ numerous staff, all of whom work in harmony to treat patient for the best access to quality care. **Question?** 1. Will children's residential treatment level 1 be added as an amendment to the 1115 waiver service package? One of the department-approved screening tools listed in the Alaska Behavioral Health Providers Service Standards & Administrative Procedures for SUD Provider Services (ALASKA BEHAVIORAL HALTH PROVIDERS SERVICE STANDARDS AND	Thank you for the question. The department will address children's residential in this project.

	ADMINISTRATIVE PROCEDURES), adopted by reference in 7 AAC 160.900; and (Eff. 7/1/2019, Register 231; am 11/10/2019, Register 232; am//2020; Register). **Question?** 2. Will providers have an opportunity to provide input into the screeners that will be approved by the department?	Please see the department's previous response.
	Question? 3. The 1115 includes new requirements for screeners and interventions based on risk levels identified in screeners. We do not see reimbursement for screeners and the resulting brief interventions, brief therapy and coordination to treatment based on identified risk. Will codes be added for this service? Assertive Community treatment (ACT) services. **Question?** 4. A significant portion of ACT work takes place in establishing a relationship with the client and gathering information to inform a treatment plan. Will there be a mechanism to bill for ACT services during the engagement phase?	Please see the department's previous response. Please see the department's previous response.
	7 AAC 139.250. Structured treatment services (a) The structured treatment services may be provided to a recipient listed in 7 AAC 139.010 if the service is provided according to the following criteria: (1) partial hospitalization program services provided to treat a recipient's assessed psychiatric disorder to prevent relapse or the need for higher level of hospitalized care; partial hospitalization program services must (A)be provided in a therapeutic environment that maintains daily scheduled treatment activities by providers qualified to treat individuals with significant mental health and co-occurring disorders; (B) include direct access to psychiatric and medical consultation and treatment, including medication services; and (C) provide a range of component services identified for partial hospitalization program services in the Alaska Behavioral Health Providers Service Standards &	

	Administrative Procedures for Behavioral Health Provider Services, adopted by reference in 7 AAC 160.900; **Question**? 5. The service in 7 AAC 139.250 implies that the service should be available 7/week. We would like the department to clarify our reading of the regulations. Can you clarify if this is a 5/day week intervention? **Question**? 6. We note that crisis services are listed in the regulations package, but not crisis intervention or stabilization codes. Are the crisis intervention and stabilization codes remaining in the state plan? **Questions**? 7. Will providers be able to continue to bill state plan outpatient psychotherapy services? We thank the Department again for allowing us to provide question on these proposed regulations. If the Department would like further dialogue on any of the questions we have provided we would be happy to clarify and support the Department in its question review. If you have any questions about our comments, please contact April Kyle @ (907) 729-4981or akyle@scf.cc.	Thank you for the question, the department acknowledges the confusion. The PHP services can be provided 7 days per week if a provider chooses to do so. Please see the department's previous response. Thank you for the question. Yes, providers will be able to continue to bill State Plan outpatient psychotherapy services. Thank you for the detailed comments and questions.
Andrew Jimmie / *Alaska Native Health Board*	Dear Ms. Wooden, The Alaska Native Health Board (ANHB) welcomes the opportunity to provide comment on the Emergency Regulations on Medicaid 1115 Behavioral Health Waiver Services noticed by the Department of Health & Social Services on May 21, 2020. Tribal Behavioral Health Directors have compiled a series of comments and recommendations based on the proposed changes, and we present them below for the Department's consideration.	

	ANHB was established in 1968 with the purpose of promoting the spiritual, physical, mental, social, and cultural well-being and pride of Alaska Native people. ANHB is the statewide voice on Alaska Native health issues and is the advocacy organization for the Alaska Tribal Health System (ATHS), which is comprised of tribal health programs that serve all of the 229 tribes and over 177,000 Alaska Natives and American Indians (AN/AI) throughout the state. As the statewide tribal health advocacy organization, ANHB helps Alaska's tribes and tribal programs achieve effective consultation and communication with state and federal agencies on matters of mutual concern. We present the comments, recommendations, and questions below to encourage the Department to change the final regulations to better achieve the aims of the 1115 Behavioral Health Waiver and improve delivery of those new services in rural, Alaska Native communities. 1. Home-Based Family Treatment Services (All levels)[1] : a. There is a gap of 8 hours between all levels of service, i.e. between 40 and 48 between Levels I and II, and 48 and 56 between Levels II and III. While we understand the numbers represent maximums, we would appreciate clarity on how we determine if a person should be Level I or Level II if they need 44 hours, for instance, or if they are Level II and III if necessitating 51 hours and how that affects the need to request a service authorization for above these limits for each level.	Please see the department's previous response.

[1] Proposed Alaska Behavioral Health Providers Services Standards & Administrative Procedures for Behavioral Health Provider Services, pp. 6-12.

	2. Intensive Case Management Services[2]: a. We were glad to see that the Department deems Behavioral Health Aides (BHAs) to meet the requirements of a Behavioral Health Clinical Associate (CA) per 7 AAC 70.990 in its responses to submitted questions.[3] Additionally, we request that the Department remove the requirement that a Peer Support Specialist (PSS) cannot bill for the service because "…at least a behavioral health clinical associate" must facilitate the service for it to be reimbursable. There are properly trained PSSs who may provide the services of a BHA or CA. 3. Assertive Community Treatment[4]: a. We appreciate the addition of this service. We recognize some of the requirements for this service may be difficult depending on service area. With geographic barriers in some of our communities, we recommend the addition of telehealth as an option to meet the requirements and be written into the service descriptions. We believe we have seen the viability of telehealth-led services during the	Thank you for the comment and recommendation.

[2] Proposed Alaska Behavioral Health Providers Services Standards & Administrative Procedures for Behavioral Health Provider Services, pp. 15-17.
[3] Alaska Department of Health and Social Services, Division of Behavioral Health Medicaid 1115 Behavioral Health Waiver Services Emergency Regulations Aggregated Questions and Responses. Pp. 14, (https://aws.state.ak.us/OnlinePublicNotices/Notices/Attachment.aspx?id=123499).
[4] Proposed Alaska Behavioral Health Providers Services Standards & Administrative Procedures for Behavioral Health Provider Services, pp. 19-23.

	pandemic and believe they could be successful when employed under an ACT service. b. Providers may spend a lot of time assessing a person who would benefit from Assertive Community Treatment (ACT) services, and many resources are pulled together to be a part of the team for that particular person, and some interventions may be necessary as the Treatment Plan is being developed; that said, ACT services are only reimbursable when a Treatment Plan is in place. We request that documented preparation time be included as a reimbursable component of this service. 4. Peer-Based Crisis Services: a. We appreciate the Department's clarification in its responses to questions regarding the rendering of peer support specialist services that if any "rendering provider meets the qualification, they may render the 1115 Behavioral Health Medicaid Waiver service."[5] 5. 23 Hour Crisis Observation and Stabilization[6]: a. We believe the requirements of four check-ins within 15 days can be limiting. Sometimes, a	Thank you for the comment and recommendation. Thank you for the comment and recommendation. Thank you for the comment.

[5] Alaska Department of Health and Social Services, Division of Behavioral Health Medicaid 1115 Behavioral Health Waiver Services Emergency Regulations Aggregated Questions and Responses. Pp. 13, (https://aws.state.ak.us/OnlinePublicNotices/Notices/Attachment.aspx?id=123499).

[6] Proposed Alaska Behavioral Health Providers Services Standards & Administrative Procedures for Behavioral Health Provider Services, pp. 37-39.

	person is brought in by police who do not have any other location they can safely take the person, or the person may arrive by rescue squad with a crisis condition; if this occurs after four services have been implemented and it's the 12th day, we cannot and would not deny service and should be reimbursed for the intervention. If a Service Authorization (SA) remains as a requirement, that SA should be retroactive to the service. We do believe the SA confounds the need for intervention as a crisis is not defined in regulation; if an SA is denied, on what definition could a person from a distance determine that a person did not have a crisis?	
	6. Mobile Outreach and Crisis Response Services[7]: a. We request the requirement to follow-up within 48 hours should be a billable component of this service and defined under "call-out" as the Unit Value or be defined as a standalone for Unit Value.	Please see the department's previous response.
	7. General Questions/Statements: a. Contraindications are long and not always appropriate. If someone is receiving Intensive Outpatient Services, he/she might benefit from skills development that comes with "Community Recovery Support Services," a contraindicated service. By way of comparison to the 1115 SUD Waiver, these two services would be contraindicated. We request	Thank you for the comment and recommendation.

[7] Proposed Alaska Behavioral Health Providers Services Standards & Administrative Procedures for Behavioral Health Provider Services, pp. 39-41.

		revisiting the contraindications to ensure they are logical and accurate.	
	b.	We believe services in the home and other locations are important, and we greatly appreciate the ability to do so under the Waiver; however, with this MH Waiver offering services that allow for and demand home-based service delivery, we are concerned about the restrictions of the federal Four Walls requirement and whether home-based services will continue to be covered when CMS resumes enforcing the requirement after January 30, 2021. Additionally, we will not be able to provide all of the approved community-based services that are imperative to one's safety and treatment needs, if the Four Walls limitation applies to Waiver services. If it applies to Waiver services, the Four Walls restriction will prevent or greatly limit tribal health organizations from providing at least eight of the new 1115 Behavioral Health Waiver services. We request meetings with the Division and Department to address this requirement and ask that they advocate with CMS to relax or waive the requirement, due to the large number of people who will not be able to access services otherwise.	Thank you for the comment and recommendation.
	c.	The Medicaid flexibilities allowed in response to the current Novel Coronavirus pandemic have shown the viability of telehealth services, including those delivered by telephone or	Thank you for the comment. The department looks forward to coordinating a meeting to address the Four Walls restriction.

	other audio-only modalities. We request strong consideration and partnership with Tribal Health to cover these services permanently once the emergency regulations are lifted. d. The CMS approved 1115 Behavioral Health Waiver includes screeners and interventions based on risk determined by screeners. The 1115 included brief interventions, brief therapy and coordination to treatment based on the level of risk identified by the screener. We note that the Department indicated it had not yet developed new codes for brief therapy and coordination. Please confirm that the state intends to issue regulations for brief therapy and coordination to treatment with reimbursement for these services. 8. 1115 SUD Waiver: a. Ambulatory Withdrawal Management Level I – We request telehealth be added for these services as a delivery method as it would be appropriate for this service level. It is very plausible that an Addiction Medicine Specialist could safely deliver this service to a remote primary care clinic via telehealth to a community without the specialty provider. 9. 7 AAC 139.030 – Provision of Medicaid State Plan Services a. Per language in the emergency regulations at 7 AAC 139.030(b); concurrent state plan Behavioral Health clinical and rehabilitation services and 1115 Waiver services require	Thank you for the comment and recommendation. Please see the department's previous response. Thank you for the comments and recommendation.

	PRIOR AUTHORIZATION. The requirement to have Prior Authorization for concurrent outpatient services creates an administrative burden that deters from good clinical care. For example, if a person was receiving outpatient psychotherapy services for chronic PTSD, they may also need 1115 Waiver CRSS for case management support. Per the regulations, the provider would need to seek Prior Authorization to get reimbursed for common service needs of clients. It is of high likelihood that individuals could meet criteria for outpatient mental health clinic services (e.g., psychotherapy – child, family, group, individual) AND 1115 Waiver services (e.g., CRSS), but be under the threshold for Intensive Outpatient Services (both MH or SUD), Intensive Case Management, or ASAM Level 1.0 treatment. We recommend this provision in the regulations be removed; or, more explicit allowances for concurrent services be specified in the Standards and Procedures.	
	We again thank you for the opportunity to provide comment on these Emergency Regulations. If you have any questions regarding our comments, please contact ANHB at (907) 562-6006 or by email at anhb@anhb.org.	Thank you for the comments and recommendations.
	Sincerely, Andrew Jimmie, Tribally-Elected Leader of the Village of Minto Chairman	Thank you for the detailed comments and recommendations.

	Alaska Native Health Board	
Michael K. Abbott / *Alaska Mental Health Trust Authority*	Dear Ms. Wooden: The Trust strongly supports the implementation of the 1115 Behavioral Health Waiver Services, and believes the proposed regulations will dramatically improve services to Trust beneficiaries. These regulations will be strengthened, and will further improve access to quality care if: 1) new chapters for: 7 AAC 139 Behavioral Health 1115 Demonstration Waiver Services and 7 AAC 138.450 Crisis Response Services are added and 2) other focused changes are addressed as described later in these comments. The 1115 waiver represents one of the best opportunities to maintain and grow our behavioral health service infrastructure in Alaska. It is also essential to work the Trust is engaged in with the Department in strengthening Alaska's psychiatric crisis continuum of care, and will support system accountability and cost containment. The Trust has contributed millions of dollars to support the department's work to bring the 1115 process this far. Further, we agree with the Department that this 1115 waiver is critical to attain many of the jointly developed goals in the Department's Comprehensive Mental Health Program Plan. In particular, the 1115 Waiver is critical to the development of Alaska's behavioral health crisis response system. Making more crisis services eligible for Medicaid reimbursement is a significant element in sustainably implementing a Crisis Now model in Alaska. For the Crisis Now model to be effectively implemented, proposed reimbursement rates need to better reflect anticipated costs. We look forward to leveraging these	

	waiver services to advance our coordinated efforts to improve the continuum of care for Trust beneficiaries experiencing a mental health crisis. General Recommendations: During COVID-19 telemedicine has greatly expanded access to care across all service modalities and intervention types. We recommend that all regulations and supplemental materials included in this public comment process be examined and expanded upon to allow for the continuation of telemedicine opportunities even after COVID-19 has resolved. Telemedicine is one of the greatest efficiencies that promotes access to a robust service array in a Trust beneficiary's home community. Allowing modern technology to support service modalities and interventions ensures efficiencies and cost savings that support beneficiaries receiving the right services at the right time for the right cost which in is often less expensive than delivering the services in a traditional "four wall" clinic setting. We also recommend continuing to intensely pursue Medicaid's Institutions for Mental Disease (IMD) Exclusion Waiver of "16 or fewer beds." Allowing providers to render and receive reimbursement for services in larger service settings beyond the 16-bed limitation will greatly improve access to care for Trust beneficiaries and will promote financial viability for service providers. We further recommend an analysis of existing regulations and proposed regulations (7 AAC 138.450(b)(1)) to be reviewed and mentions of the IMD exclusion to either be rescinded or modified and reenacted to allow for an expedient implementation of an approved IMD exclusion waiver. Please	The division continues to monitor the current flexibilities around telehealth and will consider extending those flexibilities as circumstances allow. Services under the 1115 Waiver can be provided via telehealth except in those areas that have specifically prohibited it. The state continues to work with the Centers for Medicare and Medicaid Services (CMS) regarding the addition of the SMI IMD exemption, in addition to the current SUD IMD exemption. However, the SMI IMD exemption has implications for Length of Stay and an impact to the state IMD DSH allotment, that must be analyzed carefully as the determination to move forward is made.

	see our comment related to 2) 7 AAC 138.450(b)(1) for additional information pertaining to this recommendation. As a final general recommendation, we urge the Department to be mindful as providers transition from State Plan services to 1115 Behavioral Health Waiver services to provide clear and concise guidance so providers can successfully navigate the differences between service types. We would like to note the following recommendations Medicaid 1115 Behavioral Health Waiver Services dated 5-20-2020: 1) 7 AAC 138.450(a)(1) We recommend removing the provider type of mental health professional clinician and replacing with any provider type identified in AS 08.01.010 or allow any qualified professional practicing within their experience, training, and/ or supervision to deliver the service. 2) 7 AAC 138.450(b)(1) We recommend removing reference to Medicaid's Institutions for Mental Disease (IMD) Exclusion of "16 or fewer beds" as this is already found in regulation (§1905(a)(30)(B) of the Social Security Act [SSA]). We understand that part of the 1115 Demonstration allows the State of Alaska to seek an IMD exclusion waiver which would allow the State to waive the "16 or fewer beds" requirement. If the IMD waiver is approved DHSS will need a secondary regulatory change to implement the IMD exclusion waiver. 3) 7 AAC 139.010 (3) We recommend expanding the recipient eligibility for adults to mirror the	The transition from the State Plan has been applied using a phased approach to allow providers the maximum amount of time to transition to the new services. The deleted services have been publicly noticed and publicly available since January 2018. The State also must be mindful of CMS compliance issues in addition to budget neutrality. Thank you for the comment and recommendation. Thank you for the comment. At this time, the State feels it clarifies services to reassert 16 beds or less. At such time that the State receives approval for the SMI IMD exemption, this can be revised in one of the technical fix regulation packages that will be ongoing throughout the life of the 1115 Waiver demonstration project.

		applicable sections related to youth under age 21. Please see the CMS 1115 Demonstration approval letter dated September 3, 2019, whereby CMS approves the extent and scope to "increase and make services more readily available for Medicaid beneficiaries, especially at-risk individuals and families, in order to support the healthy development of children and adults through increased outreach and prevention and early intervention supports." (pg.3) For example, we would recommend adding a modified expanded eligibility criterion from the youth eligibility section listed in (1). In the modified adult section we would add: i) is at risk of developing a mental health or substance use disorder based upon a screening conducted under 7 AAC 135.100; ii) an adult who has been booked or remanded to a jail or correctional facility; iii) is currently in the custody of the state (this could be both from a guardianship or probation/ parole perspective).	Thank you for this comment. The target populations are a part of the budget neutrality approved by CMS. Over the life of the 1115 Waiver demonstration project, stakeholders can revisit the construct of the populations.
	4)	7 AAC 139.030(b) We recommend replacing prior authorization with presumptive eligibility similar to other medical services. We believe prior authorizations may act a barrier for timely access to many of the services outlined in these regulations package especially crisis services.	Presumptive Eligibility requires a State Plan Amendment that would be administered through the Division of Public Assistance. At this time, Alaska Medicaid only allows presumptive eligibility to be filed by hospitals.
	5)	7 AAC 139.030(c) We recommend adding screenings under 7 AAC 135.100 for an eligible individual without prior authorization.	

	6)	7 AAC 139.150(a) We recommend providing clarification of how a provider determines and documents "effective or is deemed likely to not be effective" outpatient services. We would not want this to be a barrier for a beneficiary accessing care.	Screenings are currently available under the State Plan and not the 1115 Waiver.
	7)	7 AAC 139.150(a)(3) We recommend broadening to include discharged from "a jail or correctional facility." In some instances, youth may be charged as an adult and discharged from a jail or correctional facility. In addition, some communities may use their local jail for both youth and adults.	Thank you for the comment and recommendation.
	8)	7 AAC 139.150(e) We recommend allowing flexibility by adding language such as . . . arrange for another provider to provide those services "if recommended by family services plan or treatment plan, if the service is available in recipient's community." There is a concern that, if another provider does not exist in a rural community, level 2 and 3 cannot be provided unless the service provider provides one or more of the component services.	It is the intention of the State to make the entire suite of services available to eligible recipients. If this language proves to be a barrier to providing HBFT, then stakeholders and the State can revisit this over the life of the 1115 Waiver demonstration project.
	9)	7 AAC 139.200(b)(1) We recommend reducing 24-hours a day 7 days per week to 8-hours per day on weekends. In smaller rural communities the 24-hour a day requirement, especially on weekends, will likely be difficult to meet and could decrease smaller communities' ability to offer assertive community treatment services.	

	10)	7 AAC 139.250(a)(1) (A) We recommend clarifying or reducing "daily" scheduled treatment activities. Partial hospitalization indicates a higher level of medical acuity and the need for medical intervention(s) but the behavioral interventions are provided with the same frequency and duration of a standard outpatient (OP) or intensive outpatient treatment program (IOP). Typically, IOP services range between 12-15 hours of services per week, thus asking providers to staff and deliver additional behavioral health interventions on a "daily" basis would likely be more intensive than the American Society of Addiction Medicine (ASAM) recommendations for an outpatient level of care.	The division leaves it to the discretion of the provider to establish how (i.e. partnership, etc.) they will fulfil these requirements. Thank you for the comment. It is not the intent of the department to require services to be provided 7 days per week. However, when services are provided there must be a daily schedule of treatment activities.
	11)	7 AAC 139.250(a)(2)(A) We recommend clarifying or reducing "daily" scheduled treatment activities." Please see the explanation in 7 AAC 139.250(a) (1)(A).	Thank you for the comment. It is not the intent of the department to require services to be provided 7 days per week. However, when services are provided there must be a daily schedule of treatment activities.
	12)	7 AAC 139.250(b) We recommend replacing activities of daily living with functional impairments. Activities of daily living aligns better with programs for individuals experiencing a developmental or physical disability, whereas functional impairments are more in alignment with behavioral health conditions.	Please see the department's previous response.
	13)	7 AAC 139.300(b)(1) We recommend reducing the barrier for level 1 care by removing "a prior history of continuous high service needs." This	

		may be challenging for an individual needing this level of service but whom lives in rural area where a regular service provider does not exist and/ or documentation of "continuous high service needs" is not readily available or robust enough to meet this criterion.	Thank you for the comment and recommendation.
	14)	7 AAC 139.300(d) We recommend broadening the service settings to account for rural communities that may not have traditional infrastructure such as acute psychiatric hospitalization, psychiatric emergency services, or a correctional facility. For example, some rural communities have rural health clinics, tele-psychiatry, or repeated contact with village police, etc. By broadening the service settings, it will promote greater access to beneficiaries who live in rural communities.	Thank you for the comment and recommendation.
	15)	7 AAC 139.350(a) We recommend adding to "any appropriate community setting" to include use of or incorporation of a crisis call center (a component of the Crisis Now model) to complete the crisis continuum of care. We would further recommend ensuring that crisis call center services are explicitly mentioned as an allowable and reimbursable service setting that allows call centers to deliver services via text, chat, and peer-to-peer warm phone line services.	Thank you for the comment and recommendation.

	We would like to note the following recommendations related to Chart of 1115 Medicaid Waiver Services, dated 5-20-2020: 16) We recommend allowing the public additional time, as well as a scoping meeting, to comment on the rate methodology used to determine the fees outlined in the chart and to provide feedback as to whether fees are adequate. To ensure long term success of the 1115 Waiver Demonstration project the reimbursement rates need to be financially sustainable and supportive of service delivery models across all types of community settings. This requires a heavy lift for providers to develop business Pro forma and fiscal projections that will likely take longer to develop and comment on than this public comment period allows. Thus, we would recommend offering providers an extended amount of time for comment though the use of a scoping meeting. 17) A preliminary review of rates for the 23-Hour Crisis Observation and Stabilization services indicates the proposed rate of $116 per hour may be sufficient only if the provider realizes an average length of stay of at least 17 hours, in the specific case of a new facility versus an existing service with shared staff and other services. This rate needs to be monitored and adjusted if average lengths of stay are less. 18) Similarly, preliminary review of rates for Mobile Outreach and Crisis Response (MOCRS)	The call center was not approved in the 1115 Waiver and is not in the scope of this regulation package.

	indicates that the $174.64 rate for MOCRS callouts is not sufficient to cover the costs of the program for a 24/7 operation, which is required. To provide staffing 24/7, an organization must increase its full-time equivalents to ensure enough individuals are available for all shifts. Cost modeling for MOCRS that are adjoined with another level of care, such as a 23 hour or short term stabilization unit should be conducted to determine if there are cost and staffing efficiencies that can be shared to make the service more feasible to operate. We also recommend that Mobile Crisis Services and 23 hour Crisis Observation be removed as contraindicated services from the Peer-based Crisis Services in order to facilitate peers working as part of Mobile Outreach teams, which is key part of effective mobile crisis response in states that have effectively implemented the Crisis Now model. If providers can bill separately for Peer-based Crisis Services, it will incentivize them to use peers in these roles and increase the feasibility of the Mobile Crisis Service. 19) Regarding Crisis Residential and Stabilization Services, we recommend Clarifying the type of care setting this service should be provided in (inpatient or residential) and expanding the service location if a residential setting is the intent. Crisis stabilization centers operating within the Crisis Now framework need to provide the necessary	Rates for 1115 Waiver services were set using a modeled methodology incorporating existing Medicaid rates for Medicaid provider types. Rates must be approved by CMS, and must meet budget neutrality. Over the course of the 1115 Waiver demonstration project there will be ongoing analysis around the efficacy of the rate structure. Rates for 1115 Waiver services were set using a modeled methodology incorporating existing Medicaid rates for Medicaid provider types. Rates must be approved by CMS, and must meet budget neutrality. Over the course of the 1115 Waiver demonstration project there will be ongoing analysis around the efficacy of the rate structure. Rates for 1115 Waiver services were set using a modeled methodology incorporating existing

		treatment and supports for the anticipated acuity of the clients that need this service. Additionally, financial modeling indicates that in order to support the staffing required to offer acute psychiatric care, to accept everyone into service and to eventually serve involuntary patients (which is the intent of the Crisis Now Model), the proposed daily rate is not sufficient to cover the cost of providing the service. A rate similar to the Alaska Psychiatric Institute (API) daily rate of $1,421 is closer to a break-even rate for this service. We would like to note the following recommendations related to Alaska Behavioral Health Providers Services Standards & Administrative Procedures for Behavioral Health Provider Services, dated 5-27-2020: 20) BH Provider Manual: G.) Assertive Community Treatment (ACT) Services: We recommend allowing a provider to bill a daily rate for this service type. The intent is for the service to be an intensive wraparound service. When the ACT program was first implemented, the plan at the time was to create a daily rate for the service however was never implemented. The proposed rates for ACT are only $2 per 15-minute increment higher than the proposed rate for ICM. The number of service units for each service is the same. The requirements to develop a program that maintains fidelity to the ACT model are much higher than those for ICM. The staff to client ratio is also lower and the clinical requirements for staffing are also higher. For these reasons, with the proposed	Medicaid rates for Medicaid provider types. Rates must be approved by CMS, and must meet budget neutrality. Over the course of the 1115 Waiver demonstration project there will be ongoing analysis around the efficacy of the rate structure. If the client or family member would benefit from additional services, any services **not** contraindicated may be provided concurrently.

	rates, there will be little incentive for providers to offer ACT services, which may result in a gap in care for those most likely to recidivate to higher levels of care. It is not clear if this service could be delivered by telehealth. This method may be preferable to some clients and would help with limiting transportation time, making the rates more feasible. 21) BH Provider Manual: N.) Mobile Outreach and Crisis Response Services. We recommend broadening the service location to allow call centers to deliver services via text, chat, and peer-to-peer warm phone line services. We would like to note the following recommendations related to CYW Adverse Childhood Experiences Questionnaire (ACE-Q), Center for Youth Wellness 2015: 22) Regarding Home-based Family Treatment, we are concerned that extremely acute clients with less than a "4" on the ACE-Q may be excluded. Other factors should be considered if the client is less than a "4" on the ACE-Q to determine eligibility for service. Thank you for this opportunity to comment on the proposed regulations, and for your consideration. We are supportive of any expansion effort to increase timely access to care for beneficiaries. We appreciate our continued collaborative efforts to improve the lives and circumstances of Alaskans experiencing mental illness, substance use disorders, and other behavioral health challenges	Rates for 1115 Waiver services were set using a modeled methodology incorporating existing Medicaid rates for Medicaid provider types. Rates must be approved by CMS, and must meet budget neutrality. Over the course of the 1115 Waiver demonstration project there will be ongoing analysis around the efficacy of the rate structure. Thank you for the comment and recommendation. Rates for 1115 Waiver services were set using a modeled methodology incorporating existing Medicaid rates for Medicaid provider types. Rates must be approved by CMS, and must meet budget neutrality. Over the course of the 1115 Waiver demonstration project there will be ongoing analysis around the efficacy of the rate structure.

	If you have any questions, please contact Autumn Vea 269-3492 or Michael Baldwin 269-7969. Michael K. Abbott, CEO	No, telehealth outreach will not be considered in the community for the 75% requirement. In the absence of the expanded flexibilities under the declaration of emergency, telehealth has not been identified as an option for service code H0039 V2. Telehealth remains an option for other modalities. The call center was not approved in the 1115 Waiver and is not in the scope of this regulation package.
Agnew::Beck Consulting, Inc.	1. Background & Scope of Comments This report summarizes public comments by Agnew::Beck Consulting, Inc. on the Medicaid 1115 Behavioral Health Waiver Services (1115 waiver) released for public review on May 20, 2020. Funding for this report is provided by the Alaska Mental Health Trust Authority and the Rasmussen	Thank you for your public comment.

	Foundation. These comments are not intended to be a comprehensive review of all facets of the proposed 1115 waiver services and rates but reflect three key areas: 1. How will the 1115 waiver services help fill in the gaps for service provision related to Anchorages homelessness response system? 2. How will the 1115 waiver rates improve financial feasibility for necessary behavioral health services, and specifically for behavioral health crisis services? Please note that Agnew::Beck relied on existing feasibility studies to inform this analysis and did not create new financial modeling for this effort. 3. Other observations To prepare these public comments, we participated in the June 18, 2020 public hearing and listened to multiple behavioral health providers who shared detailed comments on the positive change that will come from the 1115 waiver, as well as suggestions for improving the service and rate structure. We met with behavioral health leaders to understand their feedback on the 1115 rates and services and reviewed two current projects for specific examples of where the 1115 services and rates could improve access to necessary services: the Anchorage Coalition to End Homelessness Gap Analysis and Priorities 2020-2021, and the initial business modeling for the Alaska Mental Health Trust Authority's implementation support for the Crisis Now model. Overview The State of Alaska Department of Health and Social Services (DHSS) has been working with partners since 2016 to develop the application and gain CMS approval for an 1115 Medicaid waiver to improve Alaska's behavioral health service array. As	Thank you for the question. Homelessness is a complex problem requiring a variety of collaborative solutions. The 1115 Demonstration Project is a Medicaid initiative limited to the Medicaid population using the Alaska Medicaid eligibility groups. The overarching goals of the 1115 Waiver demonstration project focuses on establishing an enhanced set of services allowing vulnerable Alaskans access to care at the mild to moderate level, with step up or step down care if acute care is medically necessary. Expanded services availability are only one component of that solution.

	stated in the Alaska's Medicaid Section 1115 Behavioral Health Demonstration Application from January 31, 2018: The goal of the Alaska Medicaid Section 1115 Behavioral Health Demonstration is to create a data-driven, integrated behavioral health system of care for Alaskans with serious mental illness, severe emotional disturbance, and/or substance use disorders. Because behavioral health challenges often stem from childhood trauma and other adverse experiences and have downstream effects on entire families that translate to higher costs associated with subsequent acute care and chronic health needs, this proposal also aims to establish networks of support for individuals and family members. The state will achieve these goals by creating a more robust continuum of behavioral health care services with emphasis on early interventions, community-based outpatient services, inpatient residential treatment when appropriate, and enhanced peer recovery supports.1 1 State of Alaska Department of Health and Social Services Medicaid Section 1115, Behavioral Health Demonstration Application, January 31, 2018, page 3. Emphasis added. On May 20, 2020, DHSS adopted changes to Title 7 of the Alaska Administrative Code related to the Medicaid 1115 behavioral health waiver services. This change was made through an emergency regulation, 1 State of Alaska Department of Health and Social Services Medicaid Section 1115, Behavioral Health Demonstration Application, January 31, 2018, page 3. Emphasis added. 1. Amend the following sections of the Alaska Administrative Code (AAC) a. 7 AAC 70. Behavioral Health Services	

	b. 7 AAC 136. Alaska Substance Use Disorder and Behavioral Health Program 1115 Demonstration Waiver c. 7 AAC 160.900. Medicaid, Gen. Provisions. 2. Add the following to the Alaska Administrative Code (AAC) a. A new section, 7 AAC 138.450. Crisis response services. b. A new chapter, 7 AAC 139. Behavioral Health 1115 Demonstration Waiver Services. Goals and Objectives The goals and objectives for Alaska's 1115 waiver: • Create a data-driven, integrated behavioral health system of care for Alaskans with serious mental illness, severe emotional disturbance, and/or substance use disorders ○ Establish networks of support for individuals and family members ○ Create a more robust continuum of behavioral health care services ○ Emphasize early interventions, community-based outpatient services, inpatient residential treatment, when appropriate, and enhanced peer recovery supports. 2 Ibid. Summarized from paragraph quoted above. These goals and objectives can be used as criteria against which the proposed services and rates can be measured by asking: do the proposed services and rates help Alaska to achieve this goal and objectives? Specifically, we can ask the following:	Thank you for the comment and recommendation.

	• Will these services and rates facilitate integration of behavioral health into other health care systems? • Will they make data collection easier and facilitate using data to inform and improve service delivery more frequent? • Do they facilitate greater engagement of individuals and families with natural and community supports? • Will these services and rates fill gaps in the continuum of care to better meet community needs such as serving people with behavioral health issues experiencing homelessness, those involved in the criminal justice system, and those experiencing acute behavioral health crisis? • Do they facilitate earlier interventions with children and families to prevent trauma? • Do they facilitate care in the least restrictive settings? • Do they facilitate peers to take key roles in treatment teams? Using these as criteria, we offer the following overarching questions and comments: Facilitate Integration • Description and definition of medication services: Medication services, including continuity of medications, prescriptions and medication review, administration, and management is a service component of many of the 1115 services, including HBTS, TTHS, ACT, IOP, PHP. Will providers be expected to cover the cost of delivering medical services by a	

	qualified practitioner as part of the interdisciplinary team, or only ensure that this service is delivered? Because many provider organizations will not have medical staff in-house, and because many clients will want to continue to see their own medical providers, it would be better to require that providers coordinate medical care and ensure the child or adult receives necessary care but not require that it be paid for from the 1115 rate. Payment for medical services should be separated from daily rates. • Most behavioral health providers do not have the organizational capacity to hire a medical director or medical staff. These services may be available to behavioral health providers through contracts with individuals or physical health care organizations. More clarification is needed to advise how best to set up the interdisciplinary teams and to ensure adequate payment for all providers. ○ How many of the listed professionals are required? Are there staff ratios to maintain? ○ What does "at least a peer support specialist" mean? (This seems unintentionally derogatory to peer support specialists.) ○ Requiring all SUD treatment providers to be a QAP may unintentionally limit the availability of SUD treatment. • We recommend clarifying which services can be delivered via telehealth and be eligible for	Please see the department's previous response to this question. Thank you for the comments and recommendation. Thank you for the question. It is not the intent of the department to prescribe the makeup of an interdisciplinary team.

	reimbursement. Allowing telehealth services is necessary during the current pandemic and provides increased confidentiality for service provision, which increases engagement. ○ We would further recommend ensuring that crisis call center services are explicitly mentioned as an allowable and reimbursable service setting that allows a call centers to deliver services via text, chat, and peer-to-peer warm phone line services. Crisis call centers staffed by health professional clinicians could provide clinical services to provide crisis intervention and stabilization. Allowing this as a service would increase feasibility of crisis call centers in Alaska and greatly increase access to crisis stabilization services across the state. These call centers could be paired with dispatch of Mobile Outreach and Crisis Response Services, which would help optimize staffing and increase the feasibility of both services. Improve Data Collection and Use • Adding the use of Z codes will increase the ability to track social determinants of health and housing status in relation to behavioral health conditions. Analyzing this data will inform the development of appropriate services to improve overall well-being.	Please see the department's previous response to this question. Thank you for the comments. Each service listed in the Alaska Behavioral Health Providers Services Standards & Administrative Procedures for Behavioral Health Provider Services and the Alaska Behavioral Health Providers Services Standards & Administrative Procedures for SUD Provider Services identifies a service code. Any service code with a GT modifiers indicates the service can be provide via telehealth. Thank you for the comment and recommendation.

	Increase Engagement with Natural and Community Supports • The addition of ICM and ACT are critical for connecting individuals and families with natural and community supports. For these to be effective, providers must be able to develop these new services and bring them to scale to adequately meet community need. The rates do not appear to be adequate to support standing up these new services. We recommend completing a rate study to determine feasibility and potentially funding some pilot programs to identify costs and adequate rate structures. • Including the use of Z codes for secondary or tertiary diagnosis is an innovative step towards addressing social determinants of health and will help with data collection and analysis on the links between behavioral health conditions and social determinants. We recommend allowing or guiding providers to collaborate with social service providers to address social determinants and identifying payment opportunities for this coordination of supports. • Fill Critical Gaps in Continuum of Care • Clarity is needed about how the 1115 services and rates relate to other behavioral health services currently in the State Plan, and which of these will continue to be available during the 5-year 1115 demonstration period. Without this clarity, providers will likely not be able to develop dependable business models to launch and sustain new services that are necessary to fill gaps in the continuum of care.	Thank you for the comment and recommendation. Over the course of the 1115 Waiver demonstration project there will be ongoing analysis around the efficacy of the rate structure. Thank you for the comment and recommendation.

	• One of the largest gaps in the current continuum is appropriate response to behavioral health crisis. The Trust is supporting implementation of the Crisis Now framework in Alaska; this model includes 100% acceptance as a best practice, similar to the policies of hospital emergency departments. In a hospital setting, Medicaid allows presumptive eligibility so that a person who is likely eligible for Medicaid but not yet enrolled can still receive services and the provider can still be reimbursed for the services once enrollment is complete. Will presumptive eligibility be allowed for any providers offering any of the 1115 services? Particularly for behavioral health crisis care, this policy as well as the various stipulations about service limits and service authorizations will have a strong impact on whether these services will meet community need, or not. • See comments below in relation to the need to optimize the use of psychiatric inpatient, jails, and emergency departments by increasing access to supports in community and home settings. • Has DBH completed any rate testing to determine feasibility of new services? If not, we recommend allowing the public additional time to comment on the rate methodology. To ensure long term success of the 1115 waiver demonstration project, the reimbursement rates need to be financially sustainable and supportive of service delivery models across all types of community settings. This requires a	Thank you for the question. No, presumptive eligibility will not be allowed. Please refer to 7ACC 139.010 for recipient eligibility requirements.

	heavy lift for providers to develop business pro forma and fiscal projections that will likely take longer to develop and comment on than this public comment period allows. Thus, we would recommend offering providers an extended amount of time for comment on the rates or a commitment to reviewing and revising the rates on a regular basis. ○ Specifically, rate testing is needed to ensure that home and community-based services such as ACT, ICM and CRSS, will be feasible to make them broadly available to make transitions from higher levels of care, such as Adult Residential Mental Health Treatment, successful. Without these lower-level services to help individuals and families maintain housing and community supports, recidivism to higher, more expensive levels of care is expected. ○ The proposed rates for ACT are only $2 per 15-minute increment higher than the proposed rate for ICM. The number of service units allowed for each service is the same. The requirements to develop a program that maintains fidelity to the ACT model are much higher than those for ICM. The staff to client ratio is also lower and the clinical requirements for staffing are higher. For these reasons, at the proposed rates, there will be little incentive for providers to offer ACT services, which may	Thank you for the comment and recommendation.

	result in a gap in care for those most likely to recidivate to higher levels of care. Facilitate Early Intervention • Clarity is needed on which of the 1115 services can be provided without a treatment plan. In order to respond in a crisis, provide early intervention, or to engage individuals who are resistant to treatment, providers must perform outreach and provide some services prior to the client agreeing to engage in the full treatment planning process. To develop dependable business models and to expand the number of individuals receiving services, providers require clarity on which reimbursement and other funding is available to support this work. ○ Specifically, ICM and ACT require a significant amount of clinical care to engage clients in the service. The regulations currently only allow for reimbursement post treatment plan, which creates a significant barrier to the success of these services. We recommend allowing some reimbursement of this service prior to developing a treatment plan. • The State of Alaska's ALCAN Link project identified homelessness as the factor associated with the greatest increase in ACE score for children before the age of 3.3 Ensuring that Home-based Family Treatment services, and other supportive services such as Intensive Case Management and Assertive Community Treatment, that have been shown to	Thank you for the comment and recommendation. Over the course of the 1115 Waiver demonstration project there will be ongoing analysis around the efficacy of the rate structure. Thank you for the comment and question. The only non-crisis service they may be provided without a treatment plan is Home Based Family Treatment Level I, please refer to the Alaska Behavioral Health Providers Services Standards &

	increase retention of housing for people with high vulnerability, are widely available will improve outcomes, reduce out-of-home placement, and reduce costs of care in other settings. • We recommend that Home-based Family Treatment level 1 be available to families at time of conception to provide very early interventions, especially those with risk of prenatal substance-exposure or other preventable conditions. Care in Least Restrictive Setting • Individuals experiencing behavioral health crisis often end up in the highest levels of care: psychiatric institutions, jails, and hospital emergency departments. Improved response to crisis is needed to reduce recidivism to these higher levels of care and improve outcomes. We recommend making it easy to use the crisis services included in the 1115 by removing service limits and identifying feasible rates that will allow providers to launch these new services. Allowing presumptive eligibility will also help providers make 24/7 services feasible. • Rates for the Crisis Residential and Stabilization service are $665.15 per day for a maximum of seven days, with extensions allowed if medically necessary. Initial financial modeling indicates that if the service is offered with appropriate staffing, the daily rate is not sufficient to cover the cost of providing the service. The Alaska Psychiatric Institute (API) daily Medicaid	Administrative Procedures for Behavioral Health Provider Services for specific documentation requirements. Thank you for the comment and recommendation. This service is tied to a youth, but this service starts at age 0. Thank you for the comment and recommendation.

	rate of $1,421 comes closer to a breakeven rate for this service; a daily rate of $1,700 provides a breakeven, based on initial modeling of this service. This rate is still well below the daily Medicaid hospital inpatient rate for care in a hospital setting. We recommend adjusting this rate to allow this service to operate feasibly and to reduce costs to the State for inpatient care. Given the expected level of care and acuity of the clients who will benefit from this service, we recommend revising the rate to allow providers to staff and equip facilities to a close-to inpatient level of care to make this service available in the community, and reduce demand for inpatient and institutional care settings. • In order to help clients step-down from higher levels of care and to avoid escalation to institutional levels of care, early intervention and community-based services such as those included in the 1115 are critical; however, the rates must cover the cost of delivering the services and ensure sustainability. The rates proposed for ICM and ACT, at first analysis, appear to cover the costs of delivering those services, especially in non-urban areas where volume of clients will be lower and travel time longer. Consider a per member per month or daily rate for these services. • Many of the 1115 services can be delivered in community locations. This will greatly enhance accessibility and flexibility to meet the client where they are. Some of these, however, should be clarified	Thank you for the comment and recommendation.

	and modified. We address these under each service category in the next section of this report. In general, ensure that clients experiencing homelessness are not inadvertently excluded from receiving services. For example, Home-Based Family Treatment Services can be delivered in '12-Home' only, which excludes families living in a homeless shelter, or families whose home environment may not be suitable for delivering services. • Permanent Supportive Housing is a best practice for reducing chronic homelessness and reducing recidivism to crisis services and jails. To help individuals retain housing, many need access to ICM or ACT. At first analysis, the 1115 rate structure will not be adequate to develop these new services. Without access to these services, we may see continued recidivism to higher levels of care that will cost the system more over time. We recommend reevaluating the rates for these services in relation to the expected savings for reducing recidivism to higher levels of care. Engage Peers • Adding Peer Support Specialists to the allowed provider types is an excellent addition. • The phrase "at least a peer support specialist" is unintentionally derogatory and its meaning is not clear.	Thank you for the comment and recommendation. Thank you for the comment. The department agrees and will consider your recommendation. Thank you for the comment and recommendation. Over the course of the 1115 Waiver demonstration project there will be ongoing analysis around the efficacy of the rate structure.

	• Peer-Based Crisis Services should be reimbursed to any listed provider that meets the criteria, for example, a Behavioral Health Aide. 2. Public Comment by Behavioral Health 1115 Demonstration Waiver Service Home-Based Family Treatment Services Home-based Family Treatment (all three levels) • Learning and using new skills for coping and managing the needs of at-risk children takes education, practice, and reinforcement. Over a course of six weeks a parent may be able to learn these skills and perhaps use them in low-stress situations. Long term guidance and reinforcement are a critical part of being able to use these skills in stressful or crisis situations that are often typical in families where a child may be at risk of an out-of-home placement. Additional barriers exist if parents are addressing their own mental health or substance use disorders. Longer-term support over the course of 6 months to a year may be less of a barrier for clients and families. • Service location: Providing services in a home setting only may present a barrier because some families that could benefit from this service will be experiencing homelessness while others have home environments that may not be well suited to receive services. Suggest opening the service location to include more than the home, such as a homeless shelter, community setting, and a program office.	Thank you for the comment and recommendation. It was not the intention of the department to refer to Peer Support Specialist in a derogatory manner. Thank you for the comments.

	• Including the use of Z codes for secondary or tertiary diagnosis is an innovative step towards addressing social determinants of health and will help with data collection and analysis on the links between behavioral health conditions and social determinants. We recommend allowing or guiding providers to collaborate with social service providers to address social determinants as part of the family services plan and identifying payment opportunities for this coordination of supports. • What is the definition of an interdisciplinary team? What is required? What does "at least a peer support specialist" mean? • Description (and definition) of medication services: Medication services, including continuity of medications, prescriptions and medication review, administration, and management is considered a service component of HBFT services. The HBFT service code doesn't provide enough funding for medication services to be provided by a qualified practitioner as part of the interdisciplinary team. Clarify that that this should occur under separate billing codes. Align medication plan with family treatment plan. • Addressing gaps in continuum of care: This service will help facilitate step-down from residential care and provide early intervention to prevent escalation to residential care. • The ability during the pandemic to use telehealth for current providers of these services is proving to be a	Thank you for the comments and recommendation. Thank you for the comments and recommendation. Thank you. HBFT is designed to be a short-term early intervention. If services are needed for a longer duration, the individual can be referred to a higher level of treatment.

	useful way for providers to connect with families. Staff have increased productivity and would be useful in the future in combination with home visits. Additionally, telehealth could be used to connect with rural families and provide services in rural areas. • Case management is not included in the service package and Intensive Case Management is contraindicated. We recommend making some form of case management available during the delivery of this service, and to assist with transitions in care at the beginning and end of service. Home-based Family Treatment Level 1 • How is the family services plan defined? The family services plan focuses on risk factors which may stigmatize families. What about focusing on protective factors or strengths of the family to look toward solutions? • We recommend that this service be available to families at time of conception to provide very early interventions with families, especially those where there is risk of prenatal substance-exposure or other preventable conditions. Home-based Family Treatment Level 2 • Target population: Extremely acute clients with less than a "4" on the ACE-Q may be excluded. Other factors should be considered if client is less than a "4" on the ACE-Q. Use of this tool does not account for	Home-Based Family Treatment is meant to occur in the "home" or "home-like setting". Thank you for the comment and recommendation. The division leaves it to the discretion of the provider to establish how providers will collaborate across services sectors.

	resilience measures. Also, the different ACE categories carry different weight so a simple counting of ACEs may not be an effective way to determine eligibility. Recommend adding a caveat that allows for an ACE-Q (or other) score less than 4 with authorization from the ASO. • ACEs are identified according to an individual's personal history and do not account for collective and intergenerational trauma. Using ACEs to determine eligibility also does not account for resilience measures that can counteract the negative effects of ACEs. Consider using Indigenous protective factors as part of the screening process. The "Child and Youth Resilience Measure" has proven validity with Canadian Aboriginal youth and Indigenous Australian students. This article provides a review of instruments to measure resilience in Indigenous adolescents: https://www.frontiersin.org/articles/10.3389/fpubh.2019.00194/full Home-based Family Treatment Level 3 No additional comments. Therapeutic Treatment Home Services • Medical or psychiatric care should be billed separately from the daily rate especially because children would be seeing a regular physician outside of the services supported by the behavioral health provider. This is not clear in the service components section. • The reimbursement rate appears adequate if it applies to the services provided by the foster parent in the	It is not the intent of the division to require that services must be staffed by an interdisciplinary team. If a rendering provider meets the qualification, they may render the 1115 Behavioral Health Medicaid Waiver service. The division will edit the manual adding clarity for medication service criteria. Home-Based Family Treatment is designed to be an early intervention service. Service components are written to allow providers flexibility to establish a relationship with the family and to gather the information necessary to create a formal treatment plan. If the client or family member would benefit from additional services, any services not contraindicated may be provided concurrently.

	foster home, with other medical and therapeutic services billed separately. To determine if the rate is feasible, we recommend completing a per member per month cost analysis. Intensive Case Management (ICM) Services • This is an excellent addition to the behavioral health service array; there is significant community need for this service to help individuals retain housing and maintain themselves in community settings. To be effective, it will need to be available at a broad scale. The rate does not appear adequate to launch this at the level needed. We recommend completing a rate study to determine feasibility and potentially funding some pilot programs to identify costs and adequate rate structures. • ICM and ACT require a significant amount of clinical care to engage clients in the service. The regulations currently only allow for reimbursement post treatment plan, which creates a significant barrier to the success of these services. We recommend allowing some reimbursement of this service prior to developing a treatment plan. • Many services for ICM require transportation costs both to the client and to the agency, which are not adequately covered in the billable rates and covered services. This will limit feasibility of this service, especially in non-urban communities.	Please refer to the service requirements and expectations in Alaska Behavioral Health Providers Services Standards & Administrative Procedures for Behavioral Health Services. The department did not seek approval under the 1115 Waiver to add eligibility groups. Pregnant Women remain an eligibility category, and individuals under the age of 21 remain eligible for services. If a pregnant woman qualifies for services through the State Plan, or under the categories of population 2 or 3, then those support services will be covered by Medicaid. Thank you for the comment and recommendation.

	• At the proposed rate, it will be difficult to maintain the client ratios recommended to make this intensive level of service effective. • We recommend allowing a provider to bill a daily rate for this service type. • Services are required to be facilitated by a behavioral health clinician. To make this service available and effective in limiting recidivism to higher levels of care, for a social service organization to offer this service, it will either need to hire a behavioral health clinician or contract with an individual or agency to offer this service. This may limit the availability of this service. • It is not clear if this service could be delivered by telehealth. This method may be preferable to some clients and would help with limiting transportation time, making the rate more feasible. Community Recovery Support Services (CRSS) This service will be very useful for providing supports in the community and in a wide range of settings; it also will increase access to peer-provided services. It may be a useful complement for supportive housing to enable individuals to better retain housing. Assertive Community Treatment (ACT) Services • This service is needed to step-down from the Adult Mental Health Residential Treatment service that is available for a maximum of 9 months. That service is available at an adequate daily rate. ACT is a helpful service to support individuals with high vulnerability in maintaining housing and reduce recidivism to higher	Thank you for the comment and the article. Thank you for the comment and recommendation. If the client or family member would benefit from additional services, any services not contraindicated may be provided concurrently. There is ongoing cost analysis in three ways; through ongoing budget neutrality monitoring and reporting between the State and CMS, through the outside evaluator for efficacy of the project, and through the ASO quality improvement structure. This is in addition to the division's ongoing and regular practice of tribal consultation and regularly scheduled meetings, and ongoing stakeholder engagement across the life of the project.

	levels of care. This will only be possible if ACT is available at a competitive rate for providers to launch it as a new service, and to deliver it at the necessary scale to meet community need. • The proposed rates for ACT are only $2 per 15-minute increment higher than the proposed rate for ICM. The number of service units for each service is the same. The requirements to develop a program that maintains fidelity to the ACT model are much higher than those for ICM. The staff to client ratio is also lower and the clinical requirements for staffing are also higher. For these reasons, wat the proposed rates, there will be little incentive for providers to offer ACT services, which may result in a gap in care for those most likely to recidivate to higher levels of care. • It is not clear if this service could be delivered by telehealth. This method may be preferable to some clients and would help with limiting transportation time, making the rate more feasible. • We recommend allowing a provider to bill a daily rate for this service type. • ICM and ACT require a significant amount of clinical care to engage clients in the service. The regulations currently only allow for reimbursement post treatment plan, which creates a significant barrier to the success of these services. We recommend allowing some reimbursement of this service prior to developing a treatment plan.	Rates for 1115 Waiver services were set using a modeled methodology incorporating existing Medicaid rates for Medicaid provider types. Rates must be approved by CMS, and must meet budget neutrality. Over the course of the 1115 Waiver demonstration project there will be ongoing analysis around the efficacy of the rate structure. Billing is limited to services covered in the Alaska Behavioral Health Providers Services Standards & Administrative Procedures for Behavioral Health Provider Services. At this time, engagement phase services for ACT are not covered by Medicaid. Payment for transportation is available when medically necessary under the State Plan. Daily rates are highly scrutinized by CMS, even under an 1115 Waiver. Rates for 1115 Waiver services were set using a modeled methodology incorporating existing Medicaid rates for Medicaid provider types. Rates must be approved by CMS, and must meet budget neutrality. Over the course of the 1115 Waiver

	Intensive Outpatient Services • We recommend allowing service to be delivered in a Homeless Shelter (04) or Appropriate Community location (99) to facilitate psychoeducational and other life skill building, and linkages to social supports. • Clarify what is meant by telehealth units in the statement "Services may be combined with telehealth units at which point a service authorization is required". The phrase 'telehealth units' is not used elsewhere in the document Partial Hospitalization Program Compared to previous financial modeling for other providers, the new 1115 Waiver daily rate ($500/day) for partial hospitalization is an increase in reimbursement for this service. In previous modeling, we developed a clinical model and utilized fee-for-service State Plan rates to include screening, status reviews, SBIRT, assessments, pharmacological management, group and individual psychotherapy, and comprehensive community support services. In this model the estimated billable revenue was roughly $300 per day per client and was not enough to cover staff expenses. This modeling did not account for any additional medical or psychiatric support that may be needed for some clients. The new 1115 daily rate provides additional reimbursement for this service. Adult Mental Health Residential Treatment • This service could support a step-down from institutional level of care, which is a significant gap in Alaska's continuum of care and could reduce recidivism to institutions.	demonstration project there will be ongoing analysis around the efficacy of the rate structure. The division leaves it to the discretion of the provider to establish how providers will collaborate across services sectors. Thank you for your comments. Please refer to service code descriptor for ICM found in the Alaska Behavioral Health Providers Services Standards & Administrative Procedures for Behavioral Health Provider Services and note the telehealth code.

	• The daily rate appears adequate for the 9 months covered by the two levels of care in this service. • For this to be successful, individuals will need to step-down to a home or community-based setting after the 9-month period. This could be permanent supportive housing for some, or assisted living. Neither of these services operate sustainably in the current continuum for people with complex needs. Without a viable step-down there will be significant recidivism to this level of care, and/or significant cost to the State due to lack of ability to discharge from this level of care. See comments related to ICM and ACT regarding the need to make these services broadly available in order to reduce recidivism to higher levels of care. Peer-Based Crisis Services • Peer-based Crisis Services is an excellent addition to Alaska's behavioral health service array. • To incentivize the use of peers in order to grow and develop this part of the behavioral health workforce, we recommend that Mobile Crisis Services and 23-hour Crisis Observation be removed as contraindicated services. If providers can bill separately for Peer-based Crisis Services, it will incentivize them to use peers in these roles and increase the feasibility of the Mobile Crisis Service. • The call-back requirement that is included in the Mobile Crisis Service should be removed from that service and added as a service that Peers can bill for.	Rates for 1115 Waiver services were set using a modeled methodology incorporating existing Medicaid rates for Medicaid provider types. Rates must be approved by CMS, and must meet budget neutrality. Over the course of the 1115 Waiver demonstration project there will be ongoing analysis around the efficacy of the rate structure. In the absence of the expanded flexibilities under the declaration of emergency, telehealth has not been identified as an option for service code H0039 V2. Telehealth remains an option for other modalities. Rates for 1115 Waiver services were set using a modeled methodology incorporating existing Medicaid rates for Medicaid provider types. Rates must be approved by CMS, and must meet budget neutrality. Over the course of the 1115 Waiver demonstration project there will be ongoing analysis around the efficacy of the rate structure. Billing is limited to services covered in the Alaska Behavioral Health Providers Services Standards & Administrative Procedures for Behavioral Health Provider Services. At this time, engagement phase services for ACT are not covered by Medicaid. Thank you for the comment and recommendation.

	This will make tracking the service simpler and incentivize the use of peers in these roles. • Peer-Based Crisis Services should be reimbursed to any listed provider that meets the criteria, for example, a Behavioral Health Aide. 23-Hour Crisis Observation and Stabilization • Staff qualifications do not list "Mental health professional clinicians, 7 AAC 70.990 (28)" as a provider type for this service. Master's level clinicians will be an important part of the clinical team for this service and should be included. • Rates. Rates for this service are $116 per hour up to 23 hours and 59 minutes. Initial financial modeling as part of the Alaska Mental Health Trust Authority's Crisis Now project, indicates that this rate may be sufficient only if the provider realizes an average length of the stay (ALOS) of at least 17 hours; this would be for a facility without shared staff for other services. This may not be a realistic ALOS and is something to monitor as this service and rate structure is implemented. We recommend monitoring the average length of stay in 23-hour crisis observation and stabilization to determine whether revenues are enough to cover costs for this service. • Indian Health Service Medicaid Outpatient Rate. Under current regulations, it's likely that Tribal providers who opt to provide 23-Hour Crisis Observation and Stabilization under the Medicaid 1115 Waiver, will be	Thank you for the question. Unit value is described in the Alaska Behavioral Health Providers Services Standards & Administrative Procedures for Behavioral Health Provider Services for each service. A "unit" for this service is 15 minutes regardless of modality. Once the aggregate of all units is met, regardless of modality, a service authorization to extend the limit is required. Thank you for the comment and recommendation. Thank you for the comment and recommendation. Over the course of the 1115 Waiver demonstration project there will be

	reimbursed using the Indian Health Service Medicaid Outpatient rate (currently $710 per encounter/day). The 1115 Waiver rate for 23-Hour Crisis Observation and Stabilization will reimburse at a higher rate for those who stay longer than seven hours, when compared to the IHS outpatient encounter rate. • Service limits. Currently, there is a limit of 4 check-ins within a 15 days per client each year; additional check-ins require service authorization. The nature of a service provided in a crisis situation reduces the feasibility of service authorizations. Including presumptive eligibility for these services will increase their adoption and feasibility and be more successful in reducing the need for higher levels of care. We recommend eliminating the service limitation of 4 check-ins within a 15-day period per client per year. • Location of service. Service locations for 23-Hour Crisis Observation and Stabilization include IHS and Tribal 638 free-standing facilities and provider-based facilities, community mental health centers, as well as hospitals (including psychiatric), mental health physician clinics and crisis stabilization centers. How will crisis stabilization centers be licensed? Mobile Outreach and Crisis Response Services • This is an excellent addition to the behavioral health continuum. In other states, mobile teams are dispatched by a Crisis Call Center. We recommend adding a crisis call center (a component of the Crisis	ongoing analysis around the efficacy of the rate structure. Thank you for the comments and recommendation. Thank you for the comments. Thank you for the comments. Thank you for the comments and recommendations.

	Now model) to complete the crisis continuum of care. We would further recommend ensuring that crisis call center services are explicitly mentioned as an allowable and reimbursable service setting that allows a call centers to deliver services via text, chat, and peer-to-peer warm phone line services. • Mobile Outreach and Crisis Response Services (MOCRS) is reimbursed at $175.64 per callout. Initial financial modeling related to the Crisis Now project, indicates that the rates for MOCRS are not sufficient to cover the costs of the program. Reasons why the rates are insufficient are listed below. ○ Rates and 24/7 staffing requirements. Providers who are reimbursed under MOCRS are required to be provide the service 24/7. This means that providers must staff up for 24/7 response into the community, which requires "staffing for coverage" as opposed to "staffing for demand" only. To provide staffing 24/7, an organization must increase its full-time equivalents (FTEs) to ensure enough individuals are available for all shifts. An example shift calculator shows that to have two mobile response team members available 24/7, you must have at least eight FTE to cover all the shifts, unless you can integrate part-time employees, which is challenging to do as individuals often prefer full time, or close to full time, positions. Initial results from the	Thank you for the comment and recommendation. Thank you for the comment. The department will consider the recommendation. Thank you for the comment and recommendation.

	financial modeling indicate that the rate structure is not sufficient to cover the costs for staffing and benefits even if the service is not provided 24/7; with 24/7 coverage the gap between revenue and expenses will be larger. ○ Inefficiencies in transportation and non-billable time. A mobile response team that operates 24/7 requires time for transport to crisis episodes, operations and administrative responsibilities. This limits the average number of responses that can be reasonably assumed for each team; thereby limiting the potential revenue necessary to cover expenses. • We recommend that Mobile Crisis Services and 23-hour Crisis Observation be removed as contraindicated services from the Peer-based Crisis Services in order to facilitate peers working as part of Mobile Outreach teams. If providers can bill separately for Peer-based Crisis Services, it will incentivize them to use peers in these roles and increase the feasibility of the Mobile Crisis Service. • We recommend that the call-back requirement that is included in the Mobile Crisis Service should be removed from this service and added as a service under Peer-based Crisis Services. This will make tracking the service simpler and incentivize the use of peers in these roles. • Consider increasing the callout rate or adjusting the rate structure to a daily rate with performance	Over the course of the 1115 Waiver demonstration project there will be ongoing analysis around the efficacy of the rate structure. Thank you for your comment. The encounter rate is published by the federal government in the Code of Federal Regulations. Thank you for the comment. The department intends to license 23-Hour Crisis Observation and Stabilization centers as outpatient. The call center was not authorized under the 1115 Waiver authority.

	measures for number of crisis episodes responded to do on a quarterly basis, for example. • Consider eliminating the provision that services be provided 24/7 in urban areas, not just in rural areas. We have heard from providers that they prefer to provide these services 24/7. However, we recommend that the rate structure not preclude less than 24/7 coverage. For example, there may be opportunities for organizations to partner in such as ways as to provide 24/7 coverage together but if each provider must provide 24/7 coverage in order to be reimbursed, this would not be feasible. • Service limits. Currently, there is a limit of 12 calls per SFY with a service authorization bypass. The nature of a service provided in a crisis situation reduces the feasibility of service authorizations. Including presumptive eligibility for these services will increase their adoption and feasibility and be more successful in reducing the need for higher levels of care. We recommend eliminating the service limitation of 12 calls per SFY. Crisis Residential and Stabilization Services • Lack of clarity around type of service. The intent of this service is to provide, "a medically monitored, short-term, residential program in an approved facility that provides 24/7 psychiatric stabilization."5 Other characteristics related to this service include:	Over the course of the 1115 Waiver demonstration project there will be ongoing analysis around the efficacy of the rate structure. Thank you for the comment and recommendation.

	○ Must be provided in a facility with no more than 16 beds; considered short-term (no more than 7 days) and residential. ○ Service components include an assessment, crisis intervention, and stabilization when the client does not require inpatient hospitalization, stabilization of withdrawal symptoms, psychiatric evaluation services, nursing, medication services, as well as treatment plan development and referrals out for treatment. ○ Services must be offered 24/7. ○ Clients must be seen by a physician, physician assistant, and psychiatrist or advanced nurse practitioner within 24 hours of admission. ○ Service locations include IHS and Tribal 638 free-standing facilities and provider-based facilities, community mental health centers, as well as hospitals (including psychiatric), mental health physician clinics and crisis stabilization units. The mix of characteristics reflecting Crisis Residential and Stabilization Services is confusing. For example, can the service be provided as an inpatient setting as part of a hospital? The description suggests the service should be in a residential setting and that it is applicable to clients who do not need psychiatric inpatient care. This indicates that this service is not an inpatient service. However, service locations include hospitals. Service locations do not offer residential housing or supportive housing as an option for service provision. It would be helpful to clarify whether the intent of	Thank you for the comment. Thank you for the comment and recommendation. If the client or family member would benefit from additional services, any services **not** contraindicated may be provided concurrently. Thank you for the comment and recommendation. Thank you for the comment and recommendation.

	this service is for inpatient care for a more residential setting while recognizing that this is a short-term stay and that residential level of care likely will not provide the necessary treatment and supports for the acuity of the clients that need this service. • Rates for this service are $665.15 per day for a maximum of seven days, with extensions allowed if medically necessary. Initial financial modeling indicates that if the service is offered with appropriate staffing, the daily rate is not sufficient to cover the cost of providing the service. The Alaska Psychiatric Institute (API) daily Medicaid rate of $1,421 comes closer to a breakeven rate for this service; a daily rate of $1,700 provides a breakeven, based on initial modeling of this service. This rate is still well below the daily Medicaid hospital inpatient rate for care in a hospital setting. We recommend adjusting this rate to allow this service to operate feasibly and to reduce costs to the State for inpatient care. • Given the expected level of care and acuity of the clients who will benefit from this service, we recommend revising the rate to allow providers to staff and equip the facilities to a close-to inpatient level of care to make this service available in the community, and reduce demand for inpatient and institutional care settings. Treatment Plan Development Review No comments on this service.	Over the course of the 1115 Waiver demonstration project there will be ongoing analysis around the efficacy of the rate structure. Please see the department's previous response to this question. Thank you for the comment and recommendation. Over the course of the 1115 Waiver demonstration project there will be ongoing analysis around the efficacy of the rate structure.

	Footnotes 1. State of Alaska Department of Health and Social Services Medicaid Section 1115, Behavioral Health Demonstration Application, January 31, 2018, page 3. Emphasis added. 2. Ibid. Summarized from paragraph quoted above. 3. http://dhss.alaska.gov/dph/wcfh/Documents/mchepi/ALCANLink_Brief_Overview.pdf 4. As stated on page 40 of the Alaska Behavioral Health Providers Services Standards & Administrative Procedures for Behavioral Health Provider Services,"MOCR programs must be available 24/7 (i.e. 24 hours a day, 7 days of the week)…" 5. As stated on page 41 of the Alaska Behavioral Health Providers Services Standards & Administrative Procedures for Behavioral Health Provider Services Prepared by Agnew::Beck Consulting, Inc. www.agnewbeck.com	Thank you for the question, crisis residential and stabilization services are not an inpatient service, they are a residential service. Please reference 139.350. Thank you for the detailed comments and questions.

Edward Leach / *Board Member*	I am a board member of a behavior health care provider, but I am not an expert on the particulars of care. However, I do not understand how these proposed changes can be done under emergency regulations. AS 44.62.260 puts a 120 day limit on the period of emergency regulations. Since these were issued 20 May 20, they expire on 17 Sep 20. The providers spent significant funds to convert computer systems to follow the Medicaid requirements. I have been told that these changes have significant overlap with other state Medicaid programs that are not being changed in this time frame. If the providers spend more funds to quickly convert computer systems to implement these regulations, and then the emergency regulations expire because they prove to be insufficient to provide the necessary care to the patients, do the providers revert back to the previous requirements? If so, who pays for these costs? Since the Alaska waivers were authorized by the CMS to begin 3 Sep 19 and run until 31 Dec 23, I do not understand the hurry to implement a complex set of new regulations that have not been reviewed for sufficiency to achieve the desired outcomes for the patients.	Thank you for the comments. Thank you for the question. If the regulations are not made permanent all services promulgated under the emergency regulations expire. All services authorized are optional and made available to providers to increase access to care and to open up new revenue lines, but not required.

	The chances for adverse outcomes for the patients under these conditions seems significant. Edward Leach	Thank you for the comments. Thank you for the detailed comments and questions.
ERICA LONG / *Kenaitze Indian Tribe's Behavioral Health Department*	Alysa, On behalf of the Kenaitze Indian Tribe's Behavioral Health Department, we stand in support with the comments made by ABHA and the other Tribal Behavioral Health Directors (TBHD's) in regards to the 1115 Behavioral Health Services. There are many questions as we navigate this new season of Behavioral Health services within Alaska, and particularly so within the time of Covid-19. We welcome ongoing discussions as we voice concerns about potential gaps in services and/or re-organized plans of delivery. I believe the need for behavioral health services will only continue to increase as our communities, state, country and world seem in a state of disarray, confusion and peril. Of specific concern to our community and those we serve within Kenaitze regarding these proposed services, are the Therapeutic Behavioral Health Services delivered both individually as well as groups provided within the schools and/or community. These services have been particularly valuable to our un'ina (those who come to us), their families, and for the future well-being of our community. Those TBHS services promote skill-building, positive modeling, healthy peer interactions, and many other positive outcomes for youth struggling to function appropriately within a school-	Thank you for the detailed comments regarding the sunsetting services, specifically TBHS. The department intends to hold a series of listening sessions to ensure we properly understand the challenges facing providers.

	based or community setting. Our hope is these services may continue and even expanded to ensure youth and/or adults can be supported in the least-restrictive setting. We are hopeful about the future of our great state of Alaska and our wonderful Kenai Peninsula and thank you for considering the concerns addressed by ABHA, TBHD's, and directly within the Kenaitze Indian Tribe. **ERICA LONG, MS, LPC** Interim Behavioral Health Director	
Katherine Gotlieb / *Southcentral Foundation*	July 7, 2020 Alyssa Wooden Division of Behavioral Health Alaska Department of Health & Social Services 3601 C Street, Suite 878 Anchorage, AK 99503 Re: Proposed Regulatory 1115 Changes Dear Ms. Wooden, Southcentral Foundation provides these comments in response to the emergency regulations released May 20, 2020. Southcentral Foundation is the Alaska Native tribal health organization designated by Cook Inlet Region, Inc. and eleven Federally- Recognized Tribes - the Aleut Community of St. Paul Island, lgiugig, lliamna, Kokhanok, McGrath, Newhalen, Nikolai, Nondalton, Pedro Bay, Telida, and Takotna - to provide	

	healthcare services to beneficiaries of Indian Health Service pursuant to a compact with the United States government under the authority of P.L 93-638, as amended, the Indian Self Determination and Education Assistance Act. Southcentral Foundation provides services to more than 65,000 Alaska Native and American Indian people living in the Municipality of Anchorage, the Matanuska-Susitna Borough and 55 rural Alaskan villages. Services provided by Southcentral Foundation include outpatient medical care, home health care, dentistry, optometry, psychiatry, and mental health counseling, and substance abuse treatment, residential treatment facilities for adolescents and for women, suicide prevention and domestic violence prevention. We employ numerous staff, all of whom work in harmony to treat patients for the best access to quality care. SCF provides comments below on the following topics: 1. Home and Family Based Treatment Level 1 2. Family Recipient Eligibility- Behavioral Health 1115 Waiver Services 3. Screening, Brief Intervention and Brief Therapy 4. Crisis Response Services 5. Service rates, limits, and authorization 6. Assertive Community Treatment (ACT) Services 7. Intensive Outpatient Mental Health 8. Partial Hospitalization 9. Recipient Eligibility 10. Services facilitated by "At Least" 11. Service Components **12.** Intensive Case Management 13. Community Recovery Support Services **14.** Intensive Outpatient -Service Components	

	15. Service Location 16. Peer-Based Crisis Services 17. 23 Hour Crisis Observation and Stabilization **18.** Mobile Outreach and Crisis Response Services 19. Treatment Plan Review **20. QAP** **21.** SUD Interim Services **22.** ASAM 1.0 Service Frequency and Limits **23. SUD-Codes** **24.** Outpatient SUD Treatment 25. SUD Care Coordination 26. Adult Partial Hospitalization **1.** Home and Family Based Treatment Level **1** One issue that we are grateful for is the inclusion of Home Based Family Treatment. We would however like to highlight some challenges the regulations present in planning for operationalizing HBFT. a) Level 1: a. The six-week timeframe for the 240-unit service limit does not have clinical logic. We recommend that the current 240 allowable units remain without the six week cap. b. This service is based on family risk factors. With that information in mind, we would like this service to be available at the time of conception. We see great benefit to providing HBFT level 1 to high risk families during pregnancy. b) All Levels: We are excited for the option to provide these services in the home. We would like to note that this is not always a viable location. At times, the home may not be a safe environment and or the family may not be willing to receive services in the home. We also believe there would be value in providing this service in community, for example when a child	

	is struggling at daycare, or soccer, or in other community locations. We recommend that the department include other appropriate community settings in the service location section of the Alaska Behavioral Health Providers Services Standards & Administrative Procedures for Behavioral Health Provider Services. **2.** Family Recipient Eligibility - Behavioral Health **1115** Waiver Services Source Document Department of Health & Social Services Emergency Regulations Proposed Changes to Regulations Medicaid 1115 Behavioral Health Waiver Services Text **7AAC 139 010** Concerns a) Although the Special Terms and Conditions clearly state that family members are eligible to receive Group 1 services if a child or youth in the family is eligible, this is not stated in the regulations. Recommendations a) If a youth becomes eligible based on 7 AAC 139.010 behavioral health services should be authorized for youth and family members 3. Screening, Brief Intervention and Brief Therapy Source Document Department of Health & Social Services Emergency Regulations Proposed Changes to Regulations Medicaid 1115 Behavioral Health Waiver Services	Thank you for the comment. The department agrees and will consider your recommendation. Thank you for the comment. The department addressed services for the family unit through the inclusion of Home Based Family Treatment Level I/III. Please refer to the components of service.

	Text 7 AAC 138.200 Concerns a) The choice of screeners is narrow. It is important to seek the input of providers in choosing appropriate screeners for the populations they serve. We would like to see provider specific recommendations incorporated into the choice of available screeners. b) The 1115 intends that screeners result in brief intervention and therapy. We do not see in the proposed emergency regulations the ability to deliver and be reimbursed for therapy and brief intervention following completion of the screeners. Brief intervention and therapy would be most easily delivered without a diagnosis and treatment plan. Recommendations a) We recommend that the department provide opportunities for community providers to provide input into screeners. b) We recommend that the department add codes for brief intervention and therapy. c) We recommend that documentation for brief intervention and brief therapy follow the requirements in 7 AAC 105.230. 4. Crisis Response Services Source Document Department of Health & Social Services Emergency Regulations Proposed Changes to Regulations Medicaid 1115 Behavioral Health Waiver Services Text 7 AAC 138.450 Concerns a) In most cases, 23 hours is a sufficient time to resolve a short-term crisis. However, we are concerned that a 23-hour	Thank you for the comment. The division anticipates hosting a series of workgroups with behavioral health providers to identify a list of suggested screening tools. Thank you for the question. The department will assess over time what additional services may be added as data from the 1115 waiver demonstration becomes available.

	time limit will interfere with clinical needs when a recipient needs a bit more time for crisis resolution or is waiting for an appropriate subsequent placement. Having visited programs in other states, we have observed that it is not uncommon to provide care beyond 23 hours. This could be especially true in the early years of the 1115 before adequate step down and step up services are launched. Recommendations a) We recommend the language be changed to allow for reimbursement after 24 hours when needed. 5. Service rates, limits, and authorization Source Document Department of Health & Social Services Emergency Regulations Proposed Changes to Regulations Medicaid 1115 Behavioral Health Waiver Services Text 7 AAC 139.040 (c) (d) Concerns a) We are concerned that this regulation, 7 AAC 136.020 to which it refers, and the Alaska Behavioral Health and Providers Service Standards and Administrative Procedures have conflicting information. 7 AAC 139.040 (c) 7 AAC 139.040 (c) requires that a provider request prior approval for services beyond the service limits stated in the manual. 7AAC 136.020 states that a provider meeting its requirements may furnish any behavioral health 1115 waiver service without prior authorization. However, one of the requirements is to comply with the Alaska Behavioral Health Providers Service Standards and Administrative Procedures, adopted by reference in 7	Thank you for the comment and recommendation.

	AAC 160.900. The manual contains service limits beyond which a prior authorization is needed. Recommendations a) We recommend that requirements for prior authorization be removed from the regulations and the manual. 6. Assertive Community Treatment (ACT) Services Source Document Alaska Behavioral Health Providers Services Standards & Administrative Procedures for Behavioral Health Provider Services Text ACT Pages 19-23 Concerns a) There is significant clinical care provided during the engagement stage of an ACT service. The engagement stage is prior to completion of a treatment plan. Reimbursement for clinical care during the engagement stage is essential for these services to work. Recommendations a) Include reimbursement for clinical care delivered prior to treatment plan development with reference to 7AAC105.230 for documentation. b) We note this service has both behavioral health and medical components. The tribal provider reimbursement structure should include the opportunity for both a behavioral health encounter payment and a medical encounter payment if both services are furnished on the same day. 7. Intensive Outpatient Mental Health Source Document Department of Health & Social Services Emergency Regulations Proposed Changes to	Thank you for the comment and recommendation. Billing is limited to services covered in the Alaska Behavioral Health Providers Services Standards & Administrative Procedures for Behavioral Health Provider Services. At this time, engagement phase services for ACT are not covered by Medicaid. Thank you for the comment. The tribal provider reimbursement structure, both behavioral health encounter payment and a medical encounter payment, are not impacted by 1115 Waiver services.

	Regulations Medicaid 1115 Behavioral Health Waiver Services Text 7 **AAC 139.250 (b)** Concerns a) (b) lists activities of daily living. This list appears to be based on a medical model, such as a skilled nursing facility. These ADLs do not fit within typical outcomes associated with **IOP.** Inclusion of ADLs in the regulations suggests outcomes that are inconsistent with IOP services. The functional outcomes described in this service are sufficient without the addition of the ADLs Recommendations a) We recommend striking (b) (ADLs) completely from the regulations. 8. Partial Hospitalization Source Document Department of Health & Social Services Emergency Regulations Proposed Changes to Regulations Medicaid 1115 Behavioral Health Waiver Services Text 139.250 (1) (A) and (2) (A) be provided in a therapeutic environment that maintains daily scheduled treatment activities by providers qualified to treat individuals with significant mental health and co-occurring disorders; Concerns a) The language in this section is open to interpretation and it is unclear if it is intended that the facilities operate 7 days/week. Recommendations	Thank you for the comment. The department agrees with the recommendation and acknowledges a revision will be made. Thank you for the comment, the department acknowledges the confusion. The PHP services

	a) We recommend that the department change the language to read "provided as a therapeutic outpatient program that provides weekly scheduled activities" or similar language. 9. Recipient Eligibility Source Document Alaska Behavioral Health Providers Services Standards & Administrative Procedures for Behavioral Health Provider Services Text II. Background A. Recipient Eligibility Page 3 Concerns a) For Medicaid recipients between the age of 18 and 21 the type of services should be based on the clinical needs of the recipient. All Medicaid recipients over the age of 18 should be eligible to receive adult waiver services if clinically appropriate. Recommendations a) We recommend this section be deleted from the manual. 1 o. Services facilitated by "At Least" Source Document Various sections within Alaska Behavioral Health Providers Services Standards & Administrative Procedures for Behavioral Health Provider Services Text Additional Information Concerns a) The phrasing "services must be facilitated by AT LEAST" (emphasis added) is confusing as no clear hierarchy is included in the manuals or other documents provided. It is	can be provided up to 7 days per week if a provider chooses to do so. Thank you for the comment. The department agrees and will consider your recommendation. Thank you for the comment.

	unclear to us which providers are "above" or "below" others in the hierarchy. Recommendations a) We recommend that the language in this section be changed to read "Any eligible provider type may draw down the rate" 11. Service Components Source Document Alaska Behavioral Health Providers Services Standards & Administrative Procedures for Behavioral Health Provider Services Text Service Components sections in each service Concerns a) The service component sections could be interpreted to mean that the provider must furnish every service component listed. For example, HBFTI has a long list of service components. It is a great list, but it would not be possible (or appropriate) to deliver every listed component to every family. Please confirm that individual service components may be delivered as part of a service if and when it is clinically appropriate. Recommendations a) We would like the department to state that individual service components may (not must) be delivered as part of a service if and when clinically appropriate. 12. Intensive Case Management Source Document Alaska Behavioral Health Providers Services Standards & Administrative Procedures for Behavioral Health Provider Services	Thank you for the comment and recommendation. Thank you for the comment. Service components can be delivered as part of the service as clinically appropriate.

	Text Intensive Case Management Concerns a) ICM services include a significant amount of clinical care delivery during the engagement stage. The engagement stage occurs prior to completion of a treatment plan. Reimbursement for clinical care during the engagement stage is essential for these services to work. Please include a reference to 7AAC105.230 to allow reimbursement for care delivered prior to the treatment plan. b) As written the service description requires client interaction at least 2-3 times a day and once every two weeks. Recommendations a) Include reimbursement for clinical care delivered prior to treatment plan development with reference to 7AAC 105.230 for documentation. b) Delete reference to interactions 2-3 times per day. Care will be delivered as clinically needed. 13. Community Recovery Support Services Source Document Alaska Behavioral Health Providers Services Standards & Administrative Procedures for Behavioral Health Providers - Community Recovery Support Services (CRSS) Text Service Frequency/Limits Concerns a) The service limit is 140 15-minute units of individual CRSS. It is not clear why the service limit for "Behavioral Health" CRSS should be less than the service limit for "SUD" CRSS.	Billing is limited to services covered in the Alaska Behavioral Health Providers Services Standards & Administrative Procedures for Behavioral Health Provider Services. At this time, engagement phase services for ICM are not covered by Medicaid. Thank you for the comment and recommendation.

	There is no clinical reason that a recipient of Behavioral Health 1115 waiver services would need less CRSS service than a recipient of SUD 1115 waiver services. Recommendations a) We recommend that the department change the services limit to 280 15-minute units of individual CRSS to match SUD CRSS limits. 14. Intensive Outpatient -Service Components Source Document Alaska Behavioral Health Providers Services Standards & Administrative Procedures for Behavioral Health Providers - Intensive Outpatient and other services Text Service Components Concerns a) The services components include "therapies". Thank you for clarifying in response to submitted questions that psychotherapy is a state plan service and can be reimbursed in addition to 1115 services. Per this clarification, therapy should be removed from the list of service components. Recommendations a) Remove 'therapy' from the list of service components. 15. Service Location Source Document Alaska Behavioral Health Providers Services Standards & Administrative Procedures for Behavioral Health Providers -Adult Mental Health Residential Services Level 1 Text	Thank you, the department acknowledges the oversight and will correct the error. Thank you for the comment and recommendation.

	Service Location section for each 1115 service Concerns a) The service locations do not consistently include tribal facilities. b) The description for location code 99 includes a page reference that is not relevant. Recommendations a) We recommend that the department add the following service locations: 05- I.H.S. Free standing facility 06-1.H.S. Provider-based facility 07-Tribal 638 Free standing facility 08-Tribal 38 Provider-based facility. Remove the reference to Page 22 after **99-** 16. Peer-Based Crisis Services Source Document Alaska Behavioral Health Providers Services Standards & Administrative Procedures for Behavioral Health Providers-Peer-Based Crisis Services Text Service Documentation Concerns a) The requirement to document according to 7 AAC 135.130, which requires a treatment plan, is not consistent with the provision of crisis services, particularly by a peer support specialist. Recommendations a) Change the documentation requirement to conform to 7 AAC 105.230. 17. 23 Hour Crisis Observation and Stabilization Source Document	Thank you for the comment and recommendation. Thank you for the comment and recommendation.

	Alaska Behavioral Health Providers Services Standards & Administrative Procedures for Behavioral Health Providers - 23-Hour Crisis Observation and Stabilization Text Service limits Additional information Concerns a) By nature, a crisis service needs to be delivered when needed without the barrier of a service authorization if a recipient has already had 4 check-ins in a 15-day period. b) Physicians or medical providers may provide services via telehealth in 23-hours crisis programs. c) Clinicians should be able to "draw down" the service rate following the initial psych eval. d) Staff qualifications include a "bachelor's behavioral health clinical associate" Recommendations a) Remove the requirement for prior authorization for this service. b) We recommend that the department state that medical providers may be accessed via telehealth support. c) Any qualified provider should be able to "draw down" payment for this service. d) We recommend striking the word "bachelor's" from the phrase "bachelor's behavioral health clinical associate". 18. Mobile Outreach and Crisis Response Services Source Document Alaska Behavioral Health Providers Services Standards & Administrative Procedures for	Thank you for the comment. The department agrees the check-in limit is a barrier and acknowledges a revision will be made. Thank you for the comment and recommendation.

	Behavioral Health Providers-Mobile Outreach and Crisis Response Services Text Mobile Outreach and Crisis Response Services Concerns a) The follow up call as part of this service is a valuable part of the intervention helping to ensure continued stability and transition to care. These follow up calls will prevent future crisis services and escalation to higher levels of care. It is imperative that these follow up calls be eligible for reimbursement. b) We are grateful that the department pays for each call out. It will be common that a "call out" cannot be completed because the person in crisis has left, refuses the intervention or the situation escalates, and police intervention is needed. When this happens, it is not explicitly clear that the cost for the "call out" can still be covered because this service is paid per "call out" rather than based on care delivered. c) Crisis intervention triage by telephonic means is not mentioned. It is not always possible or safe to meet with a recipient experiencing a crisis. Starting the crisis intervention process by phone may allow faster service delivery or may be the only way of delivering the service at all. Recommendations a} We recommend that the department add a unit of service and payment for the follow-up call. b} We recommend that the department provide clarification that a call out described above would be considered reimbursable by the department	Thank you for the comment and recommendation.

	c} We recommend that the department add video and telephone to methods of Mobile Crisis Team service delivery. 19. Treatment Plan Review Source Document Alaska Behavioral Health Providers Services Standards & Administrative Procedures for SUD Provider Services - Treatment Plan Review Alaska Behavioral Health Providers Services Standards & Administrative Procedures for Behavioral Health Provider Services Text The treatment plan review is to be documented in a progress note. Concerns a) A treatment plan (and its review} are standalone documents. A progress note is duplicative and redundant. Recommendations a} We recommend that the department remove the requirement to document a treatment plan review with a progress note. 20. QAP Source Document Alaska Behavioral Health Providers Services Standards & Administrative Procedures for SUD Provider Services Text Qualified Addition Professional Requirements Concerns a} The QAP is a significant barrier to providing 1115 services. We strongly advice using this opportunity to reconsider the	Thank you for the comment and recommendation. Thank you for the comment and recommendation.

	QAP. In the months since the QAP was rolled out, we have seen CDCs become extremely difficult to fill. Vacancies for CDC positions are open for recruitment almost indefinitely. We have begun reclassifying CDC positions to Clinicians. This change (hiring Clinicians to fill CDC positions) will create a drastic workforce shortage and hinder the ability for ALL 1115 services to thrive. The old model (which allowed for a mix of Clinicians, CDCs and Clinical Associates) allowed providers to grow services while ensuring quality through accreditation. While well intended, the new QAP requirement has proven to be detrimental to the success of the 1115 waiver. Recommendations a) We strongly urge the department to eliminate the QAP requirement and replace it with "Behavioral Health Aide, Clinical Associate and/or Substance Use Disorder Counselor." b) Barring elimination, we recommend increasing the time period to four years for a provisional QAP to obtain final QAP status c) Barring elimination, we recommend that the four-year time period reset with each new hire date. 21. SUD Interim Services Source Document Alaska Behavioral Health Providers Services Standards & Administrative Procedures for SUD Provider Services - services in general Text Service Requirements Concerns a) We note that several SUD service requirements include interim services. Interim services are good harm reduction interventions that would help keep acuity steady and allow	Thank you for the comment and recommendation.

	for less costly interventions when access is available, however they can only be provided if there is reimbursement. b) Providers are expected to furnish interim services to persons waiting for admission. However, there is no mechanism for reimbursement. Recommendations a) We recommend that the department add reimbursement codes and rates to pay for SUD interim services. 22. ASAM 1.0 Service Frequency and Limits Source Document Alaska Behavioral Health Providers Services Standards & Administrative Procedures for SUD Provider Services - ASAM 1.0 Services Text Service Frequency/Limits Concerns a) Telehealth should be a normal route of delivery with no authorization required. Recommendations a) Change language to allow delivery of services both face to face and by telehealth, combining the units of services against a single service limit. 23. SUD - Codes Source Document Alaska Behavioral Health Provider Services Standards & Administrative Services Manual for SUD Provider Services, Chart of 1115 Medicaid Waiver Services Text	Thank you for the comment and recommendation. Thank you for the comment and recommendation.

	No text to reference as there are no codes for SUD crisis services Concerns a) 7 AAC 138.450 specifically adds crisis services (Peer-Based Crisis Services, Mobile Outreach and Crisis Response Services, and 23 Hour Crisis Stabilization services to the "substance abuse" chapter of the 1115 waiver regulations. However, there are no corresponding services and codes in the Alaska Behavioral Health Provider Services Standards & Administrative Services Manual for SUD Provider Services or the Chart of 1115 Medicaid Waiver Services. For other services described in both 7 AAC 138 and 7 AAC 139, there are service descriptions and codes in both the Alaska Behavioral Health Provider Services Standards & Administrative Services Manual for SUD Provider Services and the Alaska Behavioral Health Provider Services Standards & Administrative Services Manual for Behavioral Health Provider Services manual (Intensive Outpatient, Intensive Case Management, Community and Recovery Support Services, Partial Hospitalization, Intensive Outpatient, and Treatment Plan review). b) How will a provider of 1115 SUD waiver services or a recipient of 1115 SUD waiver services from a SUD provider access these services in a prompt and efficient way? Recommendations a) Either provide codes for "SUD" crisis services or clarify how these services can be accessed by recipients and providers of SUD 1115 waiver services. 24. Outpatient SUD Treatment Source Document	Thank you for the comment and recommendation.

	Alaska Behavioral Health Providers Services Standards & Administrative Procedures for SUD Provider Services Outpatient SUD Treatment Text Target Population 2.1 2. Individuals experiencing a mental disorder, as defined under 139.010, and significant functional impairment that interferes with the individual's ability to participate in one or more life domains, including home, work, school, and community. Concern a) This language excludes adults who do not have a mental health diagnosis. It may be true that many recipients of this service have a co-occurring mental health diagnosis but this shouldn't be a requirement for receiving this service. Recommendations a) We recommend that the department delete reference to mental health diagnosis. 25. SUD Care Coordination Source Document Alaska Behavioral Health Providers Services Standards & Administrative Procedures for SUD Provider Services - SUD Care Coordination Text Additional Information/Service Location Concern a) Medication Assisted Treatment is often furnished in a primary care setting, and the primary care case management staff who would provide this service are not Qualified Addiction Professionals and do not work under Behavioral Health treatment plans.	Thank you for the comment and recommendation.

	Restricting the service from these settings will materially decrease access to the service. Recommendations a) Change the documentation requirements to 7 AAC 105.230 and add primary care clinic staff to the list of qualified providers. 26. Adult Partial Hospitalization Source Document Alaska Behavioral Health Provider Service Standards & Administrative Procedures For SUD Provider Services- ASAM 2.5 Partial hospitalization Text Adult Partial Hospitalization Additional Information Concerns a) SCF recognizes that EBPs are a good way to learn about effective clinical models. While EBPs are a good way to learn about effective clinical models, requiring conformance to a specific EPB is concerning. Our first concern is the cultural appropriateness of EBPs across cultures. Our second concern is that the EPB might have been tested only in urban settings. Our final concern is that the EBP might require provider types that are scarce or not possible across Alaskan communities. We support learning about EBPs, but we would not want to limit care by requiring compliance with a specific EBP. Recommendations a) Change the language to be clear that while providers are encouraged to learn about EBPs they are not limited to compliance with specific set of EBPs.	Thank you for the comment and recommendation.

	Southcentral Foundation appreciates the opportunity to comment on the proposed regulations. If you have any questions about our comments, please contact April Kyle at (907) 729-4981 or akyle@scf.cc. Sincerely, **SOUTHCENTRAL FOUNDATION** Katherine Gotlieb, MBA, DPS, LHD President/CEO	Thank you for the comment and recommendation. The department has not mandated the use of any EBP's at this time.
Public Comments from the Oral Hearing: 6/18/2020, 1-4PM		
LANCE JOHNSON	LANCE JOHNSON: Thank you. This is Lance again. I first want to start by thanking you, Director Moreau-Johnson and your team, for really picking up the ball on this when it could have been left on the field and not gotten anywhere. So I really acknowledge the hard work that you and your team have put into this to make these different layers come across. I want to stress that I appreciate that you don't have to, but you provide the opportunity for these public comments; and I want to ensure you that it's not simply just about how we can help each other through improving things, but it's also about	

	praises. So I'd like to start off by thanking you for recognizing and adding these home-based family treatment services at three levels. I think they are fantastic to include the whole family, and it's just gotten such great accessibility to it. So we thank you. One of our points, just for clarification for the record, is that we know that certain authorization has to be required for more than 40 units per week for more than six weeks and that's for a level 1. There appears to be a gap between level 1 and level 2 of eight hours -- or 8 units, and then there's a gap of 8 units between level 2 and level 3. So we're hoping that there can be clarification on when the service authorization is needed if we go over the 40 hours on level 1, but not quite 48 to level 2, and why that gap exists. Thank you. LANCE JOHNSON: Hi, this is Lance again. Thank you for including assertive community treatment. I think that's absolutely wonderful. People have been doing it in bits and pieces, but it's good to see it as a recognized service. We're hoping, since there are some requirements to making sure that we're in the community 75 percent of the time, that there is one-and-a-half hours of contact and three hours of services a week. Because our geography is very different across the state, we're hoping that telehealth is being considered as part of making that contacts and meeting those requirements. We also are hoping that there might be some consideration. While we understand that reimbursable services are allowed for ACT, once there is a treatment plan in place, there's a lot of startup work that occurs. It's putting together the team. It's really assessing the person in their community and the situation. So there might be some	Thank you for the comment. The department acknowledges the gap and a revision will be made.

	consideration on how that might be a reimbursable service because that could be many, many hours. Thank you. LANCE JOHNSON: This is Lance again. Again, very thankful for the mobile outreach in crisis response services. A couple questions for clarification. The requirement to follow up within 48 hours. It doesn't indicate whether or not that is a reimbursable activity. So we are seeking clarification on that. We're also hoping for clarification on -- since this is billed as the units are call-outs, if we are called out or a provider is called out and the crisis is already stabilized, whether or not that actual activity of going out to the crisis is a reimbursable service. Then we also are just seeking clarity on the service authorization required for a service beyond 12 calls. Certainly we will always tend to a crisis situation; but we are hoping if an SA is required after those 12 calls and somebody's on their 13th, that that can be a retro service authorization so we can provide the service and still seek reimbursement. Thank you. We just have a few more comments. LANCE JOHNSON: This is Lance Johnson again. Just a couple more. Just some clarification might be helpful and it might seem something little, but I think it would help. There are location codes and in some of them there is home as a service location. Then there is a 99 code for homelike setting. So sometimes that 99 code is specific to certain locations. Sometimes it's left open. Looking for clarity on what "another" is and what a "homelike setting" is in comparison to a home setting.	Thank you for the comment and recommendation. Thank you for the comment. The department agrees the confusion and acknowledges a revision will be made. Thank you for the question- https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set

	LANCE JOHNSON: Thank you, Alysa. Appreciate it. We just have two quick things. Four walls, which affects the tribal health organizations. There are wonderful home-based services within the 1115 mental health array. Should four walls continue to go forward for Indian Health Service agencies, we will not be able to provide those in-home services. So a dialogue around that with the Division will be very helpful as we progress through this. I appreciate that. LANCE JOHNSON: This is Lance. On behalf of the Tribal Behavioral Health Directors, thank you for the time and thank you for all the work. LANCE JOHNSON: Hi. This is Lance Johnson, L-a-n-c-e J-o-h-n-s-o-n. LANCE JOHNSON: Thank you. I wanted to reemphasize a general comment that was made by Tribal Behavioral Health Directors regarding the four walls limitations that may be imposed by Indian Health Services on tribal health organizations. I reemphasize it again because in looking at the services in the mental health waiver, if a service has to be provided within the four walls of a clinic, as classically defined, eight of those services are immediately eliminated from tribal health behavioral health being able to offer them. So while it's a federal concern, it's an accessibility concern and a service concern that I would like to reemphasize, and I would hope that the Division and tribal behavioral health can sit down together and strategize around advocacy and what that means because it will affect many clients who will not be able to receive services in their region. Thank you.	Thank you for the comment. Thank you for the comment.

VICTORIA KILDAL	VICTORIA KILDAL: Good afternoon, this is Victoria Kildal with Tanana Chiefs Conference, and I'm the vice chair for the Tribal Behavioral Health Directors. VICTORIA KILDAL: Hello, this is Victoria again. In reference to intensive case management services, we had a comment on a peer support specialist being listed as a provider type, but presumably cannot bill for the service because it must be provided or must be facilitated by at least a behavioral health clinical assistant. So we were a little confused about that. We also were hoping for a clarification of the meaning of "facilitated". Does facilitated mean provided? Certainly a clarification would be appreciated. VICTORIA KILDAL: This is Victoria again. In reference to the 23-hour crisis observation stabilization, we were wondering under staff qualifications why a Bachelor's Behavioral Health Clinical Associate's is required. I'm wondering if that possibly could be a typo. I also have some concerns a little bit about the four check-ins within the 15-day limitation. Obviously if a person is brought in by police, who have no other option to take that person, if it occurs after four services have been implemented and it's on the twelfth day, we're not going to deny the service. So we can run into limitations there. Still wondering about the state plan crisis intervention services, if that's going to be sun setting in the face of this 23-hour crisis observation and stabilization. Thank you.	Thank you for the question. Please see the department's previous response to this question. Thank you for the comment. The department agrees and acknowledges a revision will be made.

	VICTORIA KILDAL: Thank you. Again, this is Victor Kildal. We had a general question about psychotherapy and whether it will remain in the state plan services since it was not included in the waiver. Thank you.	Thank you for the question. Psychotherapy will remain a State Plan service.
CODY CHIPP	CODY CHIPP: A question about peer-based crisis services. The service requirement says that it should be delivered by a peer support specialist, while under the additional information within that service description that says that each unit of service must be provided by a peer support specialist. So we're just, again, seeking clarification on that requirement versus optional. Also, much like the prior question about what is the definition of facilitated: Can a different provider type provide a reimbursable service if that is coordinated by a peer support specialist? So seeking clarification for that service. Thank you. CODY CHIPP: Hi. This is Cody again. We have some -- again, we appreciate the service array in the waiver, the SUD component of the waiver and the mental health component of the waiver, provides to providers. We did have some questions about contraindications on intensive health patient treatment services. Sometimes it reads that -- well, specifically for the mental health outpatient intensive outpatient service, community recovery support services is contraindicated, but we can see that being a valuable service if somebody, for example, is experiencing a co-occurring issue that they're getting intensive outpatient treatment for their mental health related concern, but could use community	Thank you for the comment. The department acknowledges the confusion and a revision for clarity will be made.

	recovery support services for substance use disorder concerns. There are some questions about how that could be contraindicated and kind of conversely in the 1115 waiver SUD manual CRSS is not contraindicated for outpatient treatment, for SUD outpatient treatment. So I think we're seeking some clarification on that and really with the advocacy of trying to support ancillary services even if somebody is in outpatient treatment. I will stop there.	Thank you for the question any service not contraindicated can be provided. Please refer to 7AAC 139.030 for clarity on the provision of State Plan services.
	CODY CHIPP: Just to follow up on the four walls, too. It's not only in-home, but any community-based services. So services delivered outside of the four walls of a clinic, which has some implications around mobile crisis response, ACT teams, et cetera. So we really are seeking support from the State of Alaska's Division of Behavioral Health and health care services to help with our federal advocacy around the four walls rule. Additionally, also ask for continued support around telehealth services and flexibility. We're seeing a tremendous amount of service utilization and stabilization of services, and with our rural areas that don't have access to broadband Internet, the telephonic services or what is available, we ask for continued support and flexibility being able to deliver telehealth services via telephonic means to help improve social equity and health equity across our entire system of care. Lastly, within the 1115 SUD waiver, the manual seems to have ambulatory withdraw management, but that is not available via telehealth. Strongly encourage that that service be offered via telehealth. Outside of the context of a pandemic there's a lot of good clinical care pathways. That service could be delivered via telehealth. Thank you.	Thank you for the comment. Thank you for the comment.

	CODY CHIPP: This is Cody Chipp again on behalf of the Tribal Behavioral Health Directors. Again, that's C-o-d-y C-h-i-p-p. I just have a comment regarding the level 1.0 outpatient treatment that is in the revised 1115 SUD Waiver Standards and Procedure manuals. My comment is in regard to the section on service frequency and limits. As I read it, it appears that a provider who's providing outpatient treatment is required -- it doesn't actually say this. The question is: Are providers required to do a minimum of individual and group treatment, or could a provider strictly do individual treatment or strictly do group treatment? Within that there are requirements on minimums of each of those service categories. It also reads -- where it says combine of telehealth units, at which point a service authorization is required, I assume that means that across individual and group settings, be it in person or telehealth, once you hit your service max, then you need to do a service authorization. I just want to confirm that that is in fact the case, versus if you do some in-person and some telehealth, that any time you enter in telehealth with an in-person session within that period, that you are required to have a service authorization. So it's a clarification that might just need a little bit of language cleanup on that. Again, the comment regarding – I guess I would recommend that providers have flexibility in how they provide outpatient care, be it individual or group settings, either one or both, but in line with the provider and client choice based on the necessary treatment plan. Thank you. CODY CHIPP: Hi. This is Cody Chipp again with another public comment regarding ASAM level 1 outpatient treatment.	Thank you for the question. The department has not mandated the use of group or individual treatment exclusively, the choice is at the discretion of the provider. Thank you for the comment.

	Again, C-o-d-y C-h-i-p-p, on behalf of the Tribal Behavioral Health Directors. A question is: Upon assessment, if someone meets criteria for level 1 outpatient treatment, and let's say that service is delivered and that service is submitted for reimbursement based on the codes identified in the revised service payment, so the H007, B1, et cetera. What's unclear to me is if somebody let's say coming out of residential treatment and they enter in a level one outpatient for after care. Maybe it's determined they've successfully completed level 1, but still necessitate -- or it would be helpful for them to have some type of after-care service to help maintain their recovery pathway. Is that then when the other services that are subsumed under a level 1 outpatient can be utilized independent of that code. So, for example, they come out of treatment, goes into outpatient care for after-care. They do really well, and then they kind of step down from those minimums identified in the level one outpatient service frequency and limits. Is that then when you can utilize the CRSS in individual group formats for those that -- otherwise, it's unclear when you would use ASAM level 1 versus when you'd use a CRSS or clinic psychotherapy or spot psychotherapy to maintain after-care services. I think some clarity around those clinical pathways would be helpful or clarity around it's up to the provider and client's discretion based on clinical need. Thank you. CODY CHIPP: Hi. This is Cody Chipp on behalf of the Tribal Behavioral Health Directors. Again, C-o-d-y C-h-i-p-p. I just want to echo comments made by a prior caller regarding the prior authorization for clinic services if services are delivered in conjunction with 1115 waiver service. It is actually not	Thank you for the question. Please refer to the ASAM level of care definition for 1.0.

	uncommon to be delivering outpatient mental health clinic psychotherapy or family psychotherapy service and the client also need some type of rehab service like the CRSS, particularly for case management support, and they may not quite meet the full criteria for intensive case management, but they certainly need support that would fall within the realm of the CRSS. So, again, recommend that prior authorization for both state plan services and 1115 services – recommend having that omitted as that could become a barrier to care and serving clients as best as possible. Thank you.	Thank you for the comment and recommendation.
RENEE RAFFERTY	RENEE RAFFERTY: This is Renee Rafferty from Providence Health and Services Alaska. I wanted to take the opportunity to thank you so much for the opportunity to provide a new array of services. I think there are some really great additions including being able to treat people that are at risk of developing disorders. So I want to say again, I really appreciate this opportunity and that you guys have done a great job. Two things I wanted to mention. I echo what the Tribal Leaders mentioned and validate that those are concerns and questions that I had as well. I want to add just one comment about -- to start the crisis residential stabilization. I just would like to say that I think residential is a confusing term and does not describe the service well in terms of the way providers view it as well as accreditation. Joint Commission uses residential in a much different way, and those regulations are quite intense and very different and prevent low-barrier services from being successful.	Thank you for the comments.

	RENEE RAFFERTY: The other thing that I wanted to mention is page 15, addressing daily living. This appears to be an error in regulations that look to be more related to like home health or something not necessarily related to behavioral health. I wanted to make sure that was mentioned. And then for partial hospitalization, I wanted to mention that I think requiring 24 hours/seven days a week could put a burden and prevent the service from being lifted. We provide partial hospitalization, but we do it five days a week, and I think with the requirement you can do that successfully within five days, not seven. Then I wanted to also mention that I think telephonic services for mobile outreach and crisis response services would be really helpful in launching this services. Many times in the Crisis Now model what you see is stabilization in the field, the latest to telephonic intervention. So I think that would be helpful in making sure that we can bill for this service successfully. Also, we're curious about screeners being able to be billed for. That would allow for the services, early intervention to be attained. Then I think my last comment would just be to clarify. If a comprehensive family assessment is required for the level one home-based family treatment, curious about that being the timeline of that given that you may engage families and they may not stay engaged in care in that level one. And when you develop those early interventions, it may be challenging to do a comprehensive assessment and just being thoughtful about when that -- if you're providing that crisis intervention stabilization initially, I think that would be important. I echo my tribal partners as well in the sense of maybe expanding the time frame for that service, a home-based level 1, being	Thank you for the comment. Please see the department's previous response to this question. Thank you for the comment.

	really short and could we make that longer over a period of time just to prevent -- it's a very intensive service. I think it's amazing and a great opportunity, but I think it would be better to be expanded over a longer period of time rather than in a shorter six-week stay. RENEE RAFFERTY: Hi. This is Renee Rafferty from Providence Health and Services. R-e-n-e-e R-a-f-f-e-r-t-y. I just wanted to add to one comment about including provider services within bundled payment. I think one solution could be that we look for a continuity of care exclusion. So I think several providers have mentioned that the shortage of providers is challenging, but I think that also the other piece is that when you think about youth that are receiving medication services and then require home-based services, we just want to make sure that they don't have to break with their provider because that service is already provided within, that they can receive those outpatient services. That may already be in the process and it may just be a clarification that's allowed in the state plan services. But I think that clarity and that conversation with providers so we make sure that we don't sunset codes, whether they're crisis codes or they're other types of billing practices until we really see the impact of the 1115 and really have good dialogue and partnership that I know the state is already really focused on doing. So I just wanted to clarify that. Thank you. RENEE RAFFERTY: Hi. This is Renee Rafferty from Providence Health and Services, R-e-n-e-e R-a-f-f-e-r-t-y. I wanted to address the mobile outreach and crisis class services, acknowledging that the 24-hour/seven days a week	Thank you for the comments and recommendations.

	requirement would be challenging in some areas and it could be maybe, just for clarification, that we could have a partnership between other programs that were able to use some components of that service and just allow for modifications based on capacity and setting.	Thank you for the comment and recommendation.
TOMMY GLANTON	TOMMY GLANTON: Hi, this is Tommy Glanton, and I'm with SeaView Community Services. TOMMY GLANTON: Yes. We would also like to just express our gratitude to the Division for kind of this new service array that's being offered. We really feel like it's going to enhance our ability to meet the needs of the community and appreciate all the work that went into it. We do have some concerns about the potential implications of 7 AAC 139.030. On page 9 under B it says that behavioral health clinic services and rehabilitation services can only be provided concurrently with waiver services if the provider first obtains an authorization and with kind of individual therapy and some other really critical services being included in that. We just want to make sure we have the ability to meet the needs of the clients. With specifically the mobile outreach and crisis response really echoing what all of the other providers have	

	already shared. But just being concerned about the fee schedule being per call-out. If we have to spend an extended period of time stabilizing a crisis, that that fee structure would not support the service implementation and the staffing cost. In response to ACT team services. The provider standards that are in the manual don't address smaller communities that might have an ACT team serving fewer than 45 to 50 clients. So seeking more clarity there on smaller-size teams serving smaller client loads in different communities. Underneath adults mental health residential level one, we appreciate that there are two levels there that kind of recognize the different service needs of clients that may have greater acuity. But on that highest service level there's criteria for specific events having happened in order to get that person qualified for that level of care. We're concerned that it's more event-based episodes to being kind of clinical criteria. So we would like for that to be considered, that someone may not have had that much interaction, but still requires that level of care clinically. Those are our main questions at this time and appreciate the opportunity to comment.	Thank you for the comment and recommendation.
PAUL INGRAM	PAUL INGRAM: This is Paul Ingram with Hope Community Resources. We've got a couple of questions that kind of span throughout the regulatory language here, and just some concerns with what looked like they may be either contradictions or uncertainties as we go through. Specifically I'll start with the home-based family treatment services. All three levels here indicate that the clinical services are called service components there. It references clinical assessment and treatment plan and individual family group psychotherapies as well. Our understanding, though, was	

	that clinical services were going to be remaining underneath the state plan. So we have some questions about how will billing work if, say, a patient really does look like they need those home-based family services, but they can also benefit from individual or group psychotherapy outside of that location. So that's one question that we have here. Also, looking for some clarity on what it means to have medication services be a component part of the services that are outlined in the 1115. So several different places it references both medication services, the continuity of medications, prescriptions, medication review, administration and management as a component piece. So just looking to see what exactly does that look like, or what is the indication or intent behind that. Is that individual providers, say, have a medication prescriber on hand, or is it ensuring that some kind of linkage to a medication provider, if needed, is there. So just looking for some clarity on that. Got another concern about contraindicated services kind of across the regulations here, across the different service types. Looking at what truly does it mean to be contraindicated? Does that mean disallowed? Does that mean doesn't sound like a good idea or clinically unwarranted? Specifically kind of look at, like some of the other providers have already referenced, community recovery support services in those home-based family treatments, which could be a wonderful therapeutic adjunct to a family who was at risk of having a child go to residential treatment. So just looking for some clarity on how kind of that makes sense going forward, that that would be a disallowed service. I mimic Lance with Norton Sound with regards to the location of there being an identified home-based location, No. 12, and then another 99, which references	Thank you for the question. Please refer to the department's previous response to this question. Thank you for the question. Please refer to the department's previous response to this question.

	a home could be involved. Specifically there I look at those CRSS services as having a 12 identified, and then who makes the distinction there as to whether or not the home would be a good place for that service to be provided. Is that a clinical decision that the assessing directing clinician makes, or is that a kind of essay process where we have to kind of apply and see what the reviewers...So looking for clarity there. And then finally I've got some concerns about staff qualifications. Many of the service types referenced that they must be staffed by an interdisciplinary team, and then it references kind of the whole gamut, from licensed physicians all the way down to peer support specialists. So the question there is: What is to be required and what is going to meet interdisciplinary team? Is the expectation then that there are directing physicians that provider agencies have on staff that are actively involved in daily, weekly, monthly interaction with teams about specific patients, or what exactly is the requirement there? So I know that's a whole bunch of stuff, and I really do appreciate everything contained within the 1115. We appreciate the Division of Behavioral Health moving us forward, constructing the 1115, and having these very needed services fill in gaps where people have missed time and time again for ages. So I think it's going to be really good for everybody, but just some questions about kind of how do we move forward responsibly. Thank you. I yield the rest of my time. PAUL INGRAM: This is Paul Ingram with Hope Community Resources again. That's P-a-u-l I-n-g-r-a-m. I've got just a couple more comments here. One is related to the therapeutic treatment home services, referencing, again like	Thank you for the question. Please refer to the department's previous response to this question. Thank you for the question. Please refer to the department's previous response to this question.

	some of the other providers have mentioned, the recommendations for clinicians to provide, quote, clinical supervision. I'm looking for some clarity on exactly what does that mean "clinical supervision". When you talk about our licensed clinicians here, clinical supervision has a whole lot of connotations that go with it that's contained within professional licensure regulations specifically for licensed professional counselors. So looking to see what exactly does that mean, or what is the state intending that to be as we go forward here. Then another one -- or another comment that I have is regarding the treatment plan development service limits that says specifically they can be -- it's a billable service, I think, every 90 days with a service limit of four times per year. That would put us right on the line of having to do exactly every 90 days with a leeway of about five days. My recommendation, I think, is that we increase those service limits to maybe six a year to allow for a review to happen prior to 90 days, so maybe every 60 days. Thank you.	Thank you for the detailed comments and questions. It is not the intent of the division to require formal supervision. Thank you for the comment and recommendation.
DUSTIN LARNA	DUSTIN LARNA: Good afternoon. This is Dustin Larna with residential youth care. DUSTIN LARNA: I would like to definitely echo that it's nice to see some new creative ways to be able to meet the needs of folks in our communities. So I appreciate the access to new services. As I've been listening to some of the public comments, there's definitely questions seeking clarity or -- which I think can sometimes end up in more definition, which will actually restrict flexibility. So I think what I would like to comment on is as we move forward, it's clear that there's	

	some things that are somewhat vague, but allow for some flexibility depending on community need. I think that we should, moving forward, attempt to balance that out, not get things so defined that now they become restricted. I think there's been a lot of work put into allowing these services to be flexible depending on where you're at in the state and what kind of would like that to be kept in mind as we make adjustments. One area that I would like to comment on that has been brought up already is how medication services are defined. That is one area that I think, as you flip through the different service descriptions, it's described differently. So home-based services describes it as a service component being medication services, including continuity of medications, prescriptions, medication review, administration and management. It's a pretty extensive description. When you look under other levels of care, it's described differently. I am not asking that that be described more thoroughly or accurately. I'm asking that that be removed as a service component because it is going to lead to some youth not receiving medication services that should. If that's a service component that's required to be provided under the rate, then that would put a provider in a position of: If I want to have a youth assessed for medical need for meds, I'm going to have to pay to have that done. Medical services should be covered outside of this behavioral health service description. So I would urge that to be looked at very carefully. The new service codes do not provide enough funding to require that medication services from a qualified practitioner are provided included in those rates. So I think it would be appropriate to require that that service occur, but just make it clear that it's	Thank you for the detailed comments and recommendations.

	not required to be covered under the proposed rates. I think that's all I have. Thank you.	
ANNE DENNIS-CHOI	ANNE DENNIS-CHOI: Hello. This is Anne Dennis-Choi with Alaska Child and Family. ANNE DENNIS-CHOI: Thank you. I appreciate the opportunity to provide public comment, and I appreciate all the work that's gone into the 1115 waiver. I know it's a multi-year task. I wanted to say that we are definitely on board with all of you in improving access, wanting to reduce operational barriers, and reduce the administrative burden to improve Alaska's behavioral health system. I think our chief clinical officer is going to provide some additional detail in later testimony. Just echoing what others have said, I agree with a lot of the testimony that's already been provided. Some of the portions of the 1115 emergency regs seem as though they may reduce consumer choice or impede access to certain levels of care, so we're concerned about that. Other portions of the 1115 may not adequately take into consideration workforce shortages, and some areas may reduce the ability of providers to provide individualized care because it's very prescribed. I want to talk, though, about two of the areas in a little bit more detail, which other people have already touched on. The first one is medical provider shortages. We all know there's significant medical provider shortages within our state. When we're looking at some of these rates, some of the bundles, daily and unit rates, I have questions about continuity of care and consumer choice. So we often serve clients that come into our services that already have a well-established relationship	

	with their medical provider. So we want to ensure that they are able to have a choice in who they see and don't experience disruption in continuity of services. But it's really not clear in these regs whether these can be billed outside of the bundled rate and they stay with their old provider, or as Dustin was just speaking about, if this is part of the bundled rate and providers would be then obligated to figure out how to pay for those services. If so, the rates are not adequate to cover that. Another area that I wanted to talk about is lack of clarity in some of the sections and some of the discrepancies which other people have already touched on. For example, in the home-based family treatment services it states that it must be staffed by an interdisciplinary team, and then later it talks about an interdisciplinary team may be employed. There's also reference to services needing to be facilitated by at least a peer support specialist, and if that peer support specialist is not a part of the team, then the unit rate cannot be drawn down. Again, I have some concern about workforce challenges. This could preclude people from being able to participate in this level of service if their interdisciplinary team does not include a peer support specialist. The other question we had was whether or not somebody else could provide those peer support specialist services if they have the qualifications. I guess the last question would be: How is life experience defined for purposes of these regulations? That's all I was going to say. Again, thanks to everyone for your hard work. I'm really hoping we can all move forward with the collaborative process so that we can provide innovative services for the good of all Alaskans.	Thank you for the detailed comments and recommendations. Thank you for the question, please refer to 138.400 for a definition of lived experience.

	ANNE DENNIS-CHOI: This is Anne Dennis-Choi again from AK Child and Family. Anne with an E, D-e-n-n-i-s C-h-o-i. I really do appreciate the opportunity to testify and for many of us to be able to say more than one comment. So I'm very appreciative of that. I think that good feedback has been provided. My hope is that as we move forward, you know, again when I look at the original goals of the 1115, it was to improve access. I'm hoping -- back to some of April's and others' comments that the 1115 regulations can include more flexibility without some of the rigid criteria that's in there now for some of the categories and some of the eligibility criteria. Because I think for the most part they do make sense, I agree, but I think there will be exceptions. If providers are obligated to follow those to the letter of the law, it will actually decrease access versus improve access. I also echo what Rachel just said about minimizing administrative burden. As I go through these regulations, I'm not seeing a lot of areas that actually reduce administrative burden, which was one of the original goals of the 1115 waiver. I would just encourage all of us to keep that in mind as one of the goals as well as reducing operational barriers. Again, thank you. Thank you for your time. I appreciate all the hard work everyone's doing.	Thank you for the detailed comments and recommendations.
RACHEL COOPER	RACHEL COOPER: This is Rachel Cooper with Alaska Child and Family.	

	RACHEL COOPER: Yes. Rachel, R-a-c-h-e-l C-o-o-p-e-r. I am our chief clinical officer at Alaska Child and Family, and I'm going to provide some more specific feedback. One specific question we are hoping to get clarity on is what state codes are going to sunset and when are those projected dates. This is important for providers to know when our state codes we have been billing under may go away so we can do adequate planning transitioning our services over. So we hope to get clarity around that in the near future from the state. The second point I want to make is related to the home-based family treatment services level 1. This speaks to having a family service plan, but it also speaks to needing a treatment plan related to providing clinical services. So clarity around what family service plan means, and if our treatment plan would be sufficient if we were also then clinic services. Others have spoken to using clinic services with home-based family treatment. So while we don't want more restrictive regulations, as Dustin talked about, let's keep things flexible. Having clarity around what some of these definitions mean will be helpful as we prepare to start providing a new service. Another piece to touch on is related to the home-based family treatment level, all three of them. The service location is 12. Others have already spoken to service location questions; 12 is just for home, and that's the only approved service location for the home-based family treatment services. There is concern that home may not be the most appropriate place to provide services. While it is an intensive family service, we do want to be able to meet the family's needs, and it may be more appropriate to have them come into a clinic where they maybe have more materials, other options to engage in therapeutic skill building than they could have in their own	

	home setting. Their home may be not conducive to provide services if they're living with multiple older people. There's a number of factors where limiting that billable service just to home may not be in the client's best interest. So we encourage that home setting to be brought into community locations also. Then I have a couple more points. For intensive outpatient services the state references significant functional impairment for clients who qualify for the service. Then it references regulation 7 AAC 139.250(b). In that regulation it talks about -- the definition relates to activities of daily living as the requirement to define functional impairment. We're encouraging the state to not just focus functional impairment on ADLs, or activities of daily living, and encourage the functional impairment to be a broader scope. So we're not limited to only focus on assessing how clients do with eating, drinking, walking, dressing, activities of daily living. The last comment I would like to make is related to intensive case management. This service component is confusing. Again, we don't want to make our regulations more restrictive. We want the flexibility to be able to take care of our clients and meet their needs. Again, it's supposed to be individualized treatment. The confusing piece about this one speaks to capacity to furnish and what is the intent of the language around capacity to furnish services up to two to three times a day. Some clients, especially children, may not need that intensity for kids, their family system, their schools; other partners may need more frequent intensity, but the clients to two to three times a day. So clarity around what the state expects for capacity to furnish, especially knowing auditors will hold us to these standards, and making sure	Thank you for the detailed comments and recommendations.

	we're in compliance with expectations. Thank you. That is what I wanted to share. RACHEL COOPER: Hi. This is Rachel Cooper with Alaska Child and Family. RACHEL COOPER: Yes. It is Rachel, R-a-c-h-e-l C-o-o-p-e-r. Again, I already testified, but like April I have additional questions as it seems we have time and ability to provide them. One question piece about the therapeutic treatment school services is that it is unclear when it speaks to recommendations to have a clinician meet with the youth and child twice a month, but it's not clear if it's billable or not. We are highly encouraging or requesting that these clinic services are recommended be billable clinical services under the state plan to be able to support the family and youth in the home. Additionally, what April shared about home-based family services and how to structure that time, especially the one over a longer period of time versus a condensed six weeks. Six weeks is a very quick period of time to provide very intensive services to actually produce lasting change to avoid higher level of service. Having the same number of units over a longer period of time may produce the change needed that the state is hoping to produce to avoid higher level access. Additionally, for our youth and families, when we're looking at intensive case management, we request that intensive case management be billable with our therapeutic treatment home service parents. It is important for us to be able to provide this level of support to the parents themselves as we're providing the service for youth. They do need additional support at times to help maintain placements and	Thank you for the question, clinic services remain billable under the State Plan.

	without a billable revenue stream for an agency to provide that service above and beyond the normal standard rate, it is challenging for agencies to maintain youth at home if we cannot be compensated for that extra work we do with families to avoid a crisis stabilization point for a kid or youth. So at times choices have to be made to hospitalize the youth versus maintaining them in the home because they don't have the billable streams to cover the cost of the additional support for the family. So we request that intensive case management be billable with our therapeutic treatment home. Thank you. That is my additional comments. RACHEL COOPER: Hi. This is Rachel Cooper with Alaska Child and Family. Rachel, R-a-c-h-e-l, Cooper, C-o-o-p-e-r. My additional comment that I wanted to share for testimony is that for treatment planning, our hope is that the state will reduce administrative burden for treatment plans and documentation requirements. One use could be in more than one program. We appreciate the state allowing services to overlap and they're not all contraindicated of each other. So, for example, a youth can be in home-based family treatment for some level two and potentially in an intensive case management program as those aren't contraindicated services; but then our hope and request is the state allows us to use one treatment plan for both of those different programs to be able to meet our youth needs. Thank you. That was my testimony.	Thank you for the detailed comments and recommendations. Thank you for the detailed comments and recommendations.
KATY SMITH	KATY SMITH: Hi. This is Katy Smith, K-a-t-y, and Smith, S-m-i-t-h. I'm the director of community programs with Alaska Child	

	and Family. I just had an additional point to add to Rachel Cooper and Anne Dennis-Choi's testimony related to the community recovery support services. Our question is the family work that is listed in those service components. That is a part of that billing code; there doesn't appear to a billable code for the family work, including family education. I'm referencing page 18 and 19 the Provider Service Standards and Administrative Procedures Manual. So I wanted to pull that out. There appears to be a lack of clarity around the required service, but not a billing method for it.	Thank you for the question, "family work" is a service component and billable under the service code.
JEANNIE FANNING	JEANNIE FANNING: Hello. This is Jeannie Fanning, also with Alaska Child and Family. I was hoping to contribute to the conversation. My name is spelled J-e-a-n-n-i-e F-a-n-n-i-n-g. JEANNIE FANNING: Thank you. I wanted to speak to the use of ACEs scoring to determine access levels to HBF 1, 2 and 3. Adverse childhood experiences are being increasingly recognized as an important predictor of mental health outcome. While that's true that ACEs can predict poor outcomes in general, this does not mean that each individual carries equivalent weight. High ACE scores determine a likelihood of a negative outcome, but not the severity of response to any individual ACE category. So ACEs covers a wide range of experiences, whether they be mental, physical, sexual abuse, neglect, exposure to domestic violence, living with household members who are mentally ill, incarceration, feeling bullied, et cetera. By determining levels of care based on a predetermined number of ACEs, example being a 4 or higher of ACEs due to access to HBF 2 services while no like	

	measure is required for one or three as opposed to determining the level of care based on severity of response to the adverse childhood experience. It could negatively impact the consumer's access to the right service to the right person at the right time. Requiring four ACEs is unnecessarily limiting and primary responses cannot be 100 percent predicted based on the outcome of the standardized tests. ACEs is intended to determine the likelihood of a negative response to trauma, but that does not necessarily identify or consider resiliency factors, the severity of the response, or the intervention needed for any individual ACE exposure. As an example for this, under this criteria it could be possible that a child who is exposed to multiple sexual abuse episodes over their lifetime to score 1 on an ACEs measure if no other areas of their life was impacted. But at the same time a child's exposure to a divorce, having a parent pass away, felt unloved at home, and bullied at school even one time could score a 4. Both of those children may benefit from the services highlighted under HBF 2, but under the current criteria only the child with a 4 score on ACEs would be considered. Without considering the child's resiliency factors, the success and struggle in various life domains, determining a child with high risk and eligible for HBF 2 services based on an arbitrary number on a screening tool could potentially fail to provide the right service to the right person at the right time. Thank you for your time.	Thank you for the detailed comments and recommendations.

APRIL KYLE	APRIL KYLE: Good afternoon. This is April Kyle with Southcentral Foundation. A-p-r-i-l, last name, K-y-l-e. APRIL KYLE: Thank you very much. First of all, just echo all the praise from other providers. When you look at these services and imagine them existing at population size across Alaska, it's really exciting. This is a big step. Appreciate you listening to providers. I think all of us want to see the regulations result in kind of real action towards launching these programs. We'll have more written comments, but just in the brief time I have some specifics. One, I wanted to talk about screeners. The 1115 intended to require screeners and then based on the risk factor of kind of a low risk, a medium, or a high risk, there would be a brief intervention, kind of a shorter longitudinal intervention or referral to treatment. I know we delayed implementing that when just the SUD portion was approved, but I don't see that in these regs. So I'm just curious if that's going to be yet another reg package that gets to the screener and brief intervention and brief therapy processes. Second, I want to echo what other providers have said about the current crisis billing codes that are in the state plan. As we review the crisis services in the new regulations, I'm assuming that those crisis services continue. If I'm wrong about that, it would really make me rethink how I'm reading the crisis. Specially for peer-based crisis services, there's a nice long list of eligible provider types, but it seems to read	Thank you for the question. Please refer to the department's previous response to this question.

	that you can only bill if the service is delivered by a peer. I just want to mention that with so many eligible provider types, I would hope you could bill for the service if any of those provider types delivered it. I use peer-based crisis services as an example, but I think that makes sense to be true across all of the regulations and would point out that in some communities SDS might have a behavioral health aide in the community, but we just don't have to volume to have a behavioral health aide and a peer and another provider type and another provider type. So we might have a single provider type that delivers a variety of services. Also, the peer-based service documentation is 135.130, which seemed to be treatment plans based, and would be better tied to 105.230. I want to comment briefly on the new use-based risk eligibility. I think it's really exciting to see us moving in that direction. I do worry that the only intervention that I see that you're eligible for based on that risk base is the home-based family treatment level 1, which is a pretty intensive service. I sure would like to see us being able to provide less intensive service if that's what the family needs. I want to agree with another provider who commented that while we may often do this in the home setting, we may want to do it in other community-based settings, in shelters, potentially in schools. There may be times we're trying to engage families in clinic-based services and so delivering that in clinic would make sense. Just a little bit of time left. In several of the descriptions it says you have to bill for at least X provider, and it's unclear to me what the hierarchy of providers are. So, for example, if it says you have to bill for at least a clinical associate, I'm not clear how a behavioral health aide falls in comparison to a clinical associate. Is that more than a clinical	Thank you for the question. Please refer to the department's previous response to this question.

	associate or less than a clinical associate? I think it would be much more clear if we could say: Must be billed by any of the listed eligible provider types. I want to echo around ACT services. I think it's really exciting if we could see more ACT services. We know in delivering that care there's a lot of work that's involved in the engagement stage, and it appears that you could only bill after you've completed the engagement stage, done the assessment and are working under a treatment plan and would encourage some amount of service that could be delivered during that engagement stage for the ACT services. One more comment about mental health residential treatment where it requires a high needs service, which is based on three or more of certain utilizations of other things in our system, and concern that there may be clinical need even if someone hasn't had three of those. That may be particularly a barrier for somebody who's not living in an urban hub where they have easy access to those services. One comment about crisis services. I'm really excited about the conversations state. Lots of energy around the Crisis Now model. One of the components of that is a first immediate telephonic crisis service delivered by a master's level clinician. I can't see in the regs where it would be possible to deliver that service. I think the best place to do that is MOCRS as long as that can be delivered brief intervention crisis immediate telephonic. Lastly, because I know I'm out of time, since we've opened comment about the SUD portion of the 1115, I wonder if we could think about the experience providers are having with the QAP and the time that it takes for us to help an employee reach that QAP from provisional to meeting the qualification and whether that three-year timeline is really possible. If we could change that to be	Thank you for the question. Please refer to the department's previous response to this question. Thank you for the comment and recommendation.

	either four or five years and that the clock starts when the employee begins with the employer rather than the first time that they see provisional. I think I'll end there. Thank you so much for the time and all the work on the regulations. APRIL KYLE: This is April Kyle with Southcentral Foundation. I stopped due to time; I wonder if I could say a few more since we have a bit of silence right now. Would that be all right? APRIL KYLE: Okay. Perfect. A-p-r-i-l K-y-l-e. So I'm excited about the mobile crisis response. I've gone to several states and looked at that service in other places. One concern I have is that it allows for 12 calls a year and to seek authorization after 12. What I worry about is, as a crisis response, after you've delivered 12, I'm not sure you know that somebody is going to need the 13th. So do you seek an authorization just every time someone hits 12 or when somebody needs a crisis intervention and they're on the corner of Spenard and it's the 13th time, just saying no and submit the service authorization. I just don't think that these limits specifically for crisis interventions make sense operationally and would recommend removing that service limit. One other thing I wanted to comment on is the new CRSS service. I think it's going to cover a fair bit of the sunsetting services. So I'm excited about that. But I was surprised to see that the service limit for the mental health regulations are half that of the service limits for the SUD regulations, and that doesn't make logical sense to me. So I would recommend increasing the service limits in the new regs for mental health such that they match the SUD limits. I might pause there just to leave time and space for others.	Thank you for the comments and recommendations. Thank you for the comment and recommendation. Thank you for the comment and recommendation.

	APRIL KYLE: This is April Kyle with Southcentral Foundation, A-p-r-i-l K-y-l-e. I just have two more comments just trying to create space for others by not taking up too much time before I did. One is on the new home-based family treatment level 1 where the service limit is ten hours a week for six weeks. I wonder if it would be possible to just say that you could have 240 units per state plan year. That might allow a provider to either deliver a super-intensive six-week intervention based on risk factors or have a little bit less intensive, but with more longevity or with more follow-up care at the same cost. The other comment I'll make about that service is that as we think about family then risk factors and Z codes, we've began that conversation at time of conception. I would really like to see family eligibility for a child be possible at the moment when family gets pregnant. It's such an opportunity for a family to think about life and behavior change in order to create a healthy start for baby and family. I would love to see this intervention be able to be delivered for high-risk families based on Z codes at time of conception and then following through that prenatal care and after baby is born. Thank you. APRIL KYLE: This is April Kyle with Southcentral Foundation. A-p-r-i-l K-y-l-e. I have a couple more on my list that I'd like to share. One is, I mentioned that we were anticipating regs related to reimbursement for screeners and then the care that's delivered as a result of those screeners. And we've had conversation about including provider voice in what screeners can be used. So some of us who have been sort of trying and facilitating screeners and developing interventions for a decade or more have really played with screeners and would	Thank you for the comment and recommendation. Thank you for the comment and recommendation.

	like to recommend which screeners can count in that requirement so including provider voice in that. I want to echo what another provider said about intensive outpatient mental health services. I think that the description around functional impairment makes really good sense, but later it talks about daily activities of living and it does feel out of place in a behavioral health setting. Things like bed mobility, toileting, and walking aren't the goals of SDS intensive outpatient mental health. I think if you just eliminate those daily activities and leave the functional impairment description, which is listed above, you end up with a nicely described service. I wanted to talk a little bit about mobile crisis response. First, the documentation standard referenced for mobile crisis response seems to be under our normal assessment treatment plan model, but you wouldn't be delivering a mobile crisis response under a treatment plan. So it seems like that should tie instead to the medical documentation standard. Then I wonder if the code is the same for the followup care that you would provide on a different day. I like the idea that includes followup care and support to transition of care, but I don't know if the intention is just to bill that same code again or if there's a different code that should be used for that. Thank you. APRIL KYLE: This is April Kyle with Southcentral Foundation, A-p-r-i-l K-y-l-e. I want to support a comment that was made a couple of callers ago around if you're providing both a state plan service and an 1115 service. I'll reference 7 AAC 139.030(c). It seems to say that if you want to provide a state plan service and an 1115 service at the same time, you must	Thank you for the comment and recommendation. Thank you for the comment and recommendation.

	get authorization. I'm not sure I'm reading that correctly. But if it does, that would mean that if you're delivering a regular mental health outpatient psychotherapy service, which is not an 1115 service, but you want to add to that treatment plan a rehab service, the rehab service would be the 1115 CRSS code. So you'd have a state plan service and an 1115 service at the same time. That doesn't always happen with outpatient therapy, but it's common enough that it would be a significant burden to providers to seek a state plan service and an 1115 service. In my mind, as we move forward with the 1115, they all become services whether they're state plan or 1115. So creating kind of barriers to delivering those, I think, I would recommend eliminating. Thank you. APRIL KYLE: This is April Kyle with Southcentral Foundation, A-p-r-i-l K-y-l-e. I wanted to make a comment about 23-hour crisis stabilization. I'm excited about this service. I think it's very much needed. I've traveled out of state and looked and spent time in other places that have 23-hour crisis stabilization in their service line, you know, three or four different states. But one concern I have is that the service limit seems odd. So it says four check-ins in 15 days. I think practically that makes sense, but it wouldn't be impossible for somebody to need that service greater than four times in 15 days. One aspect of the Crisis Now model, which is getting a lot of support right now, is that if you have somebody in the community experiencing a behavioral health crisis, that they could be brought to the crisis stabilization center in lieu of being arrested and brought to jail. If we want that to be the case every time, with quick dropoff by police officers, we need to make sure that we don't create a limit barrier so that	Thank you for the comment and recommendation. Thank you for the comment and recommendation. Thank you for the comment and recommendation.

	if somebody is showing up for the fifth time, we aren't asking them to please wait in the lobby while we seek some sort of authorization for them to enter crisis stabilization. So I think service limits for crisis stabilization are problematic considering the nature of that work, and I would recommend eliminating that service frequency barrier. Thank you. APRIL KYLE: This is April Kyle again, A-p-r-i-l K-y-l-e. Part of the regulations open for public comment are the SUD services, and I think we have focused on 1.0 because it's the new service, but if you go line by line, there are changes to the other services, many of which are really great changes that I think the state made based on provider feedback. My comment is it's really hard to find and see those. So it would be helpful to this process if a track-changes version were available or some document that referenced the changes from the currently published regulations -- I suppose the emergency regulations are currently published. The prior regulations to the changed regulations is what I meant to say. Thank you. APRIL KYLE: Surprise, this is April Southcentral Foundation, A-p-r-i-l K-y-l-e. I think this might be the last one on my list. I just want to say related to the high-needs service definition in the mental health residential treatment section where it requires psychiatric hospitalization, psychiatric emergency services, and/or criminal justice interaction three or more times in the past calendar year in order to be eligible. It does seem likely that an adult might have experienced that and have a clinical need for mental health residential, but I'd hate to require a specific utilization pattern in order to be eligible for a clinical	Thank you for the comment and recommendation. Thank you for the comments and recommendations. Thank you for the comments and recommendations.

	service. I'm particularly concerned given the access problems we've had with API in our state. I want to point out that in rural settings, while we do provide emergency services, our emergency rooms don't bill as emergency rooms. They count as clinic visits. In our villages sometimes our communities go years without any local law enforcement or public safety. This means that Alaskans who live in rural settings might not have had eligibility or the ability -- excuse me -- to access those types of services that then become required to get the clinically needed mental health residential treatment. Creating these utilization requirements as a barrier to access could have an adverse impact on Alaskans who live in a rural setting and don't have access to those services. I suggest changing the language to say that it is likely that somebody may have had three or more of those utilization experiences, but I do not think it should be a prerequisite and instead people should be eligible based on clinical need alone and would prefer to see that utilization reference removed from the regulation. Thank you.	Thank you for the comments and recommendations.
BRANDY STRATMAN	BRANDY STRATMAN: My name's Brandy Stratman from the Providence Adolescent Residential Treatment program with Providence Health and Services. May I speak? BRANDY STRATMAN: Thank you for the opportunity to provide comment today. The first comment that I would like to make is just that the state wait in sunsetting the codes until we can evaluate the usage of those codes and ensure that the 1115 waiver has been effectively implemented. The other	

	request is that the state consider not limiting residential to clients who have had a history in an outpatient setting, but instead have that criteria be based on acuity and clinical assessment. The third is that medication management to be excluded from the bundling of home-based services and to allow for that to be billed separately. That's all the comments I have.	Thank you for the comments and recommendations.
JULIA LUEY	JULIA LUEY: This is Julia Luey, J-u-l-i-a L-u-e-y, with Volunteers of America Alaska. JULIA LUEY: I have a couple of comments and items for clarification echoing a lot of what other providers have mentioned on today's call. On the home-based family services, it's a short, intensive timeline. So I'm hoping that we can spread those units across the fiscal year so that we can individualize services with respect to that person and family's needs. A suggestion of allowing more locations within home-based family services to allow more services outside of the home, such as parks, school, office, clinic settings. The biopsychosocial assessment is listed as a component service, so it's outpatient level one. And so more clarity around when to bill state plan services and when it is covered under the waiver because it seems like there are differences between each level and how those component services line up with one another. An additional area that would be helpful for clarification purposes includes a list of what services sunset in January. There's still some clarity needed around when and how we can bill for waiver services and state services for the same client. We're hoping for more information when it	Thank you for the comments and recommendations.

	comes to the requirements for the family services plan in addition to definitions of activities of daily living. When it comes to criteria for intensive outpatient that are experiencing significant functions of an impairment, one or more life domains, including home, work, school, and community, that the client's able to maintain nutrition and hygiene, but they may still struggle. The requirement to do a progress note after we do a treatment plan development is redundant, and so this would require double entry of information to go into the treatment plan and then into an individual progress note. That's it. JULIA LUEY: Hi. This is Julia Luey again with Volunteers of America Alaska. JULIA LUEY: J-u-l-i-a L-u-e-y. I just wanted to echo what a coupleother providers have referenced today as far as the psychiatric evaluation and pharm medication management being included as component services in certain levels of care and services. With this being integrated in at a much lower rate than what it costs us to provide will dramatically impact services for our clients especially those that receive medication-assisted treatment. That's it.	Thank you for the comments and recommendations. Thank you for the comment.
JERRY JENKINS	JERRY JENKINS: Alysa, this is Jerry Jenkins, J-e-r-r-y, Jenkins, J-e-n-k-i-n-s. I have two comments. One is about the definition of the high service needs where they're using a combination of three or more in the past calendar year. Having been around behavioral health for many years, you will have individuals who either spend the majority of the year in DOC	

	or API, and they only have one episode, but it's intent and related to a serious mental illness. They're high risk, high needs. That may not have the three that you're looking for. So recommending some ability for special consideration in those cases. The other comment that I will make is in regards to the mobile crisis and the service description -- the mobile outreach and crisis service description. It's paid per call-out. Having experience with having multiple mobile crisis teams before, my average call-out was three hours and that was portal to portal. That means from the time we got the call until we made the location. These are averages; some are shorter, some are longer based upon where the intervention is and how challenging it is. So I'm concerned about the payment rate. It's per call-out, and recognizing that I understand I can bill that plus my peer support, but still if I've got someone in the field for three-plus hours and all of the expense, I'm concerned about the rate there. Thank you for this opportunity. JERRY JENKINS: This is Jerry Jenkins. Can I do two more comments? JERRY JENKINS: J-e-r-r-y, Jenkins, J-e-n-k-i-n-s. I know we have about 45 more minutes. Page 8 where it talks about individuals, particularly adults who qualify, it says: An adult who is experiencing a mental disorder, and it references the DSM. My request is clarification, if that's all diagnoses within the DSM are qualifying, regardless of length of illness -- I know in this area of mental illness, there's a definition that includes a length of time. So just clarify whether all DSM diagnoses count. Also, on page 15 where we talk about behavioral	Thank you for the comments and recommendations.

	health residential treatment services, there's reference to a facility with 16 or fewer beds. Is that 16 or fewer beds in the facility, or can it be designated beds within a multiple-use facility? So if we could get some clarification on that. Thank you very much.	Thank you for the comments and recommendations.
TOM CHARD	TOM CHARD: This is Tom Chard with the Alaska Behavioral Health Association. That's T-o-m C-h-a-r-d. I appreciate you folks staying online to the bitter end here. You know, based on the comments we've received this afternoon alone, I think you'll agree that providing proper notice to allow for stakeholder comment isn't just a requirement beneficial to this process. We're making some significant changes to our system of care with these regulations. While we understand that we're facing extraordinary challenges, we're also concerned that providers don't have the best opportunity to implement new services correctly and improve our collective efforts through meaningful comment when the state exercises this emergency regulatory authority. It's confusing to implement new services without the full support of the Division and Department and they're limited in what they can offer while the proposed regulations are out for comment. Another aspect of this process we'd like to draw attention to is that providers are offering their comments without a complete picture of what our system of care will look like. The 1115 waiver services we're commenting on today, in part, replace state plan services that are scheduled to be phased out, which state plan are scheduled to be phased out and exactly when isn't clear. Similarly, regulations for children's waiver services are expected after the comment period on regulations we're discussing today closes. So it's difficult for	

	providers to offer comment with this incomplete information. Finally, I'd like to point out that the 1115 waivers are time-limited demonstration projects. We're certainly hoping that the 1115 waivers will be renewed after their initial five-year period, and there's a lot of evidence out there to suggest that they will be. But getting rid of some state plan services, cutting grants or significant changes to Alaska's Medicaid program at either the state or federal level makes our focused reliance on the 1115 waivers risky. There's a lot of benefits to people in the state of Alaska included in these regulations. You've repeatedly heard that today and I've repeatedly heard that in discussions I've been involved with on the changes. This was no small list and ABHA sincerely appreciates DBH's hard work and dedication to get us all to this point. We know that the goal is for the 1115 waiver to create a solid continuum of behavioral health services for Alaskans, and ABHA stands ready to continue partnership with the state to help accomplish that goal. Those are my comments for today on behalf of the Behavioral Health Association. We'll be submitting written comments prior to the close of the comment period.	Thank you for the comments and recommendations.