PUBLIC COMMENT RECEIVED - Behavioral Health Medicaid Services Transition
Proposed Regulations
7AAC 135, 7 AAC 138, 7AAC 139, 7 AAC 160

COMMENTER/ AGENCY	COMMENT RECEIVED	RESPONSE
Dustin Larna RYC CEO	RE: NOTICE OF PROPOSED CHANGES ON BEHAVIORAL HEALTH MEDICAID SERVICES TRANSITION IN THE REGULATIONS OF THE DEPARTMENT OF HEALTH & SOCIAIL SERVICES To whom it May Concern: My name is Dustin Larna, I serve as the Chief Executive Officer at Residential Youth Care, Inc. I am writing you today to express my appreciation to the Division of Behavioral Health. Thank you for involving the behavioral health providers from across the State of Alaska, allowing, all of us to work together, have conversations, and provide feedback in the process leading up to the revision of the eligibility criteria of Children's Mental Health Residential Treatment-Level 2. I want to voice my support for the changes made to the Children's Mental Health Residential Treatment-Level 2 eligibility criteria. The new version is much more inclusive and allows youth to be placed in the right level of care. I also support the change made to CRT-2 and the weekly treatment services requirements. Under CRT-2, Services Requirements Expectations state, "Weekly services must include: Minimum of 15 hours of treatment services per week." Revising the number of treatment service hours from a daily to a weekly requirement makes this service requirement more manageable for providers and is in line with other daily services. This revision will also allow provider to work with more clients and provide the right service to the right clients. I want to suggest two revision to Children's Mental Health Residential Treatment-Level 2: 1.Under the *Service Requirement Expectations*, it states, "Minimum of 3 hours of clinical services per week, including <u>one hour each</u> of family therapy, group therapy, and individual therapy, unless clinically contraindicated in which case, another clinical service may be substituted." Regard to the minimum number of clinical services per week, <u>I propose revising the *Service Requirement Expectation* verbiage to state, "one service each" or "one session each" instead of "one hours each."</u> In RYC's experience, sometimes family therapy, group therapy, and individual therapy sessions can run 30 or 45 minutes rather than on hour. 2. Under *Additional Information,* I believe the Division intended to <u>change the number of therapeutic interventions per day from five to one. The regulation has a typo and is unclear. It states, "at least five (1) therapeutic intervention per day."</u>	Thank you for the feedback. The Division will take this under consideration. The Division agrees with this change.

	I would also like to point out a discrepancy between Children's Mental Health Residential Treatment-Level 2 and Level 1, CRT-1, under *Target Population* it states, "Children/Adolescents ages 0-21, under *Target Population* its sates, "Children/Adolescents ages 0-20." Should the Target Populations be the same for both CRT-1 and CRT-2? Which one is correct? There are some concerns I still have around the rates, though I look forward to future conversations and working with the Division of Behavioral Health to ensure reimbursement rates for CRT-1 and CRT-2 appropriately support the cost to provide the service. Thank you Dustin Larna, RYC CEO	We appreciate the feedback. The ages will be updated We will take this under consideration.
Adryan Glasgow, PhD	Hello DHSS, VOA Alaska would like to express appreciation for the Department's continued efforts to improve behavioral healthcare in Alaska and to submit the following comments for proposal #2021200080: VOA is concerned about a new gap in services created by the removal of CCSS services. Under the state plan, our Permanent Supportive Housing has been able to use this code to provide pre-tenancy support and tenancy sustaining service to our clients who are unhoused or at risk of becoming houseless. While most houseless clients and clients housed for the first and second year may qualify for ICM services, there is no code at a sufficient reimbursement rate to provide these services for clients who have stabilized their MH and SUD conditions but require ongoing supportive services. Other states are using "Tenancy Support" service under the 1115 waiver with fee for service or setting unit rates. VOA asks that DBH consider adding similar services to the waiver demonstration to help BH providers expand their housing program capacity, meet the community needs, and reduce both the human and fiscal costs of houselessness. VOA would also like to thank DBH for not sunsetting Case Management in this set of regulations. For client who do not require the service frequency of intensive case management, we will continue offering case management according to the state plan. However, CM is a rehab code in the state plan and therefore requires a prior authorization before it can bill for a client receiving services under 1115. Until we have a replacement for lower-intensity case management under 1115, VOA asks that DBH consider adding CM to the list of rehab	We appreciate the feedback but this references topics outside the scope of this regulation change. We appreciate the feedback but this references topics outside the scope of this regulation change.

	services that can be provided along with 1115 services without a prior authorization. Finally, VOA is concerned about the implications of repealing 7 AAC 138.030 while retaining 7 AAC 139.030. These mirrored regulations allow for the billing of state plan services concurrently with 1115 services as well as establish the requirement of prior authorizations. While we have received training on how to interpret and comply with 139.030, the proposed removal of 138.030 would obscure our ability to bill for state plan services concurrently with 1115 SUD waiver services. Thank you for all you do, **Adryan Glasgow, PhD (she/her)** | Compliance and QA Manager	The division agrees with this, both regulations will be repealed.
Gerald Moses, Vice President Intergovernmental Affairs	**RE**: Proposed Regulations: 7 AAC 135. Medicaid Coverage; Behavioral Health Services. 7 AAC 138. 1115 Substance Use Disorder Waiver Services; 7 AAC 139. Behavioral Health 1115 Waiver Services; 7 AAC 160. Medicaid Program; General Provisions, Dear Ms. Weeks, The Alaska Native Tribal Health Consortium (ANTHC) is a statewide tribal health organization serving 229 tribes and all Alaska Native and American Indian (AN/AI) individuals in Alaska. ANTHC and Southcentral Foundation co-manage the Alaska Native Medical Center, the tertiary care hospital for all AN/AI people in Alaska. ANTHC also provides a wide range of statewide public health, community health, environmental health and other programs and services for Alaska Native people and their communities. I am writing to you about the proposed behavioral health regulations referenced above. As a general matter, we are supportive of the proposed regulation changes and thank the Department for listening to provider recommendations to improve the regulations around Children's Residential Treatment (CRT) Services; and to the Behavioral Health Providers Services Standards & Administrative Procedures accompanying the regulations. These changes eliminate barriers to care and provide flexibility to improve and provide services to youth. We believe the proposed regulations can be strengthened to support the delivery of services to our children who need	

	behavioral health residential services by amending the language in proposed 7 AAC 139.325(b)(2), and which should also be applied to 7 AAC 139.325(b)(1). We recommend the phrase "medical personnel" be changed to more inclusive phrasing, such as "interdisciplinary treatment team." The use of the phrase "medical personnel" may not include a host of health care professionals that are important and may assist in the intensive treatment of residential patients. We recommend a more inclusive phrase to include all members of a treatment team can help fix a narrow and unintentional application of the current terms. In the Standards & Administrative Procedures, page 22, concerning the requirement that, "CRT programs may employ a multidisciplinary team of professionals to work in their programs; however, at least five (1) therapeutic intervention per day, must be documented and be provided by a qualified staff to be eligible to draw down the daily rate" [Emphasis added]. We recommend the Department revise the value "five" and replace it with the value "one" to better reflect the minimum service requirements from daily to weekly found in the "Service Requirements Expectations" on page 21 for CRT 2. It appears the Level 1 "Additional Information" was adjusted to reflect these changes, and believe it was the States intent in this section as well. We thank you for the opportunity to provide our comment and recommendations on the proposed behavioral health regulations. If you should have any questions, do not hesitate to contact me. Sincerely, Gerald Moses, Vice President Intergovernmental Affairs	The Division agrees with this change. The Division agrees with this change.
John Solomon MA, CPHQ, CDCI	Hi Allison It was great to meet you via zoom. I appreciate your willingness to work with us. **Children's Mental Health Residential Treatment level 1 (CRT) and Level 2 (CRT)** Proposed Regulation changes:7 AAC 139.325(b) Behavioral residential treatment services for children must be provided by an interdisciplinary treatment team for an individual under 7 AAC 139.010(1) according to the following criteria: (1) level 1: for children and adolescents in need of stabilization and assessment who do not require the intensive services of medical personnel and who have not responded to outpatient treatment; and	Thank you for the feedback, The Division is aware this is being discussed at the Director level with collaborative partners.

	These service definitions do not meet the needs of Putyuk Emergency Shelter formerly BRS Services for children. Although there is currently a collaborative effort being made that includes Office of Children's Services and DBH Director's Office and Maniilaq Association Putyuk Children's Home, we believe the outcome should meet the regulatory requirements for Chapter 50 Community Licensing regulations and be a way to address the behavioral health needs for a child in an Emergency Shelter. There are children in Putyuk Children's Home who have not had previous services, to address their needs would require us to put the onus of the need for emergency shelter on their own behavior which is not clinically appropriate for the needs of the community and the children, as many of these children are experiencing severe trauma caused by the fact that they have been removed from their homes or from previously unsafe environments. There are children under the age of 6 who are currently paid by the DBH general fund operating budget and are not billed through a claim and do not have a BH assessment and treatment plan but are tracked through documentation based on Chapter 50 Community Licensing regulations and the BRS Handbook 7 AAC 160.900 (26) (which is slated for termination but has not been identified as ending in the current proposed changes.) Switching to the service details of a level 1 CRT would require behavioral health documentation requirements for daily services and would require us to significantly change the staffing and oversight of the Putyuk program and would leave us with an even larger burden when attempting to provide care. Currently Putyuk continues to operate even while maintaining a budget deficit at the direction of the board in order to provide these services. If the regulations take effect, we would no longer be able to operate Putyuk with the staff we have, and as we are severely understaffed in our behavioral health department already, we would likely be forced to shut down the program for all children over the age of 6. Thank you for your interest in our situation and I hope we can find a way to keep the kids in our region. ***John Solomon MA, CPHQ, CDC I*** (he/him)	

Beverly Schoonover, Executive Director	Dear Ms. Weeks: The Advisory Board on Alcoholism and Drug Abuse (ABADA) and the Alaska Mental Health Board (AMHB) are statutorily charged with advising, planning, and coordinating behavioral health services and programs funded by the State of Alaska. The Boards are also tasked with evaluating federal and state laws concerning mental health, alcohol, and other drug and substance misuse prevention and treatment services (A.S. 47.30.661, A.S. 44.29.100). We thank the Alaska Division of Behavioral Health (DBH) for their tireless efforts to establish 1115 Medicaid waiver services for the Alaskans we serve and for allowing additional time for providers to continue to offer state-funded behavioral health rehabilitation services during this transition. We understand the bulk of these proposed regulation changes are to comply with guidance from the Centers for Medicare & Medicaid Services (CMS) for the repeal of certain Medicaid State Plan services and transition to the 1115 Waiver. Below are some general comments based on review of the regulations and discussions with board members and our stakeholders. 1. In order to continue supporting a continuum of care that is responsive to the clinical needs of the Alaskans we serve, we advise that DBH: a. Continue to find creative solutions to fund rehabilitation services currently provided through the state plan but not specifically covered in the new 1115 waiver billable services. b. Partner with the Office of Children's Services, current grantees, and child placement agencies to ensure a strong lower level of care infrastructure exists, including investments in recruiting new foster and kinship homes and in-home and out-of-home caregiver training and support. This will support feasibility of service limitations outlined in these regulations. c. Provide support to providers regarding the components of the new 1115 Waiver services, including providing examples of evidence-based and promising practices, and offering additional opportunities for technical assistance and guidance to help stand up services. This would be especially useful for smaller provider agencies with limited administrative capacity. d. Connect with Division of Senior and Disabilities Services-Infant Learning Program (ILP) providers to assist them in understanding how they can support families through the 1115 Waiver.	Thank you for the feedback and comments, the Division will take these actions under consideration.

	2. We thank DBH for meeting with children's residential providers and incorporating their feedback into these proposed changes. There remains a concern from children's residential treatment providers regarding equitable and reasonable service rates as compared to adult residential treatment rates. We encourage DBH to collaborate with providers and the Office of Rate Review to come to an agreement on an equitable payment rate for all residential services. 3. We note that there appears to be discrepancy on Page 20 of the Service Standards & Administrative Procedures manual, in the Children's Residential Treatment Level 2 Service Description. It reads, "CRT 2 is for Children/adolescents who have a history in the past calendar year…or other structured treatment in the last 12-month period." 4. We are unable to locate a public version of the state's corrective action plan with CMS as referred to in the notice of proposed regulation changes and respectfully request a copy for our records. In conclusion, we continue to encourage the Department of Health and Social Services and DBH leadership to prioritize meaningful engagement with behavioral health providers and stakeholders that allows them to be included in the planning and decision-making process as the 1115 Waiver moves forward. This partnership will be a key factor in the success of the desired outcomes of our ongoing behavioral health reform efforts and development of the behavioral health continuum of care. Thank you for conducting this public comment period on these proposed regulation changes and we greatly appreciate the hard work and dedication of DBH staff. Respectfully, Beverly Schoonover Executive Director	The Division agrees with this comment, the description has been corrected.
Randee Shafer, LCSW	Dear Allison, The Alaska Association of Homes for Children (AAHC) welcomes the opportunity to provide comment on the notice of proposed changes-Behavioral Health Medicaid Services Transition for the 1115 Waiver Services noticed by the Department on March 12, 2021. AAHC provides behavioral healthcare to Alaska's most at-risk children and adolescents throughout the state, is comprised of 16 member organizations, employs over thousands of Alaskans and serves	

	approximately 1850 children, families and Trust beneficiaries a year. AAHC would like to offer feedback for the 1115 regulations and rates: AAHC is pleased to see the eligibility requirements amended for children in 7 AAC 139.325 (b) (2) and want to thank you for your partnership. We would suggest that the language stating, "for children and adolescents who need treatment and recovery require the intensive services of **Medical Personal** "be changed to "for children and adolescents who need treatment and recovery require the intensive services of **multi-disciplinary treatment team"** The term medical personal can be prescriptive for a one type of provider rather than allowing flexibility in care delivery. Alaska Behavioral Health Providers Services Standards & Administrative Procedures for Behavioral Health Provider Services. AAHC would like to thank the State for modifying the recommended hours of service provided for each day for both children's level 1 & 2. <u>We believe there is a typo on page 22 and the word five should be deleted See below</u>. CRT programs may employ a multidisciplinary team of professionals to work in their programs; however, at least **five** 1 therapeutic intervention per day, must be documented and provided a qualified staff to be eligible to draw down the daily rate. We also believe that there may be a typo on Children' s regulation related to the age range. <u>It would make sense that both levels of care would be for ages 0-21, however, the level 2 only goes up to age 20.</u> Lastly, we would like to recommend that the State <u>re-evaluate the rates for both children's residential level 1 & 2.</u> We believe these rates do not allow financial sustainability of the programs, ensuring clinical excellence. These rates do not cover the higher staffing ratios required in regulation and are lower than the adult residential rates that have lower staffing ratios. We recommend that the rates at least mirror the adult residential rates. Appropriate rates ensure our families have access to this care throughout the state of Alaska. As president of the Alaska Association of Homes for Children, I want to thank for your consideration and your efforts to partner.	The Division agree with this change. The Division agrees with this change. We appreciate the feedback. The ages will be updated.

	Randee Shafer, LCSW	
Andrew Jimmie Tribally elected Minto Village	Dear Ms. Weeks The Alaska Native Health Board (ANHB) is writing to comment on the proposed regulatory changes on Behavioral Health Medicaid Services Transition. ANHB writes in support of comments provided by Southcentral Foundation on these proposed regulations First, ANHB would like to thank the Department for listening to providers' feedback and incorporating changes recommended around Children's Residential Treatment (CRT) Services in the proposed regulations as well as the Behavioral Health Providers Services Standards & Administrative Procedures ("Standards & Procedures") accompanying these proposed regulations. Particularly, we would like to thank the Department for: 1. The changes made to CRT eligibility criteria for Level 2 services. This change allows programs more flexibility to admit youth to programs based on clinical needand removes barriers to care. 2. The changes the Department has proposed in the Standards & Procedures to service requirements for CRT Levels 1 and 2, changing minimum treatment requirements from daily to weekly minimums. This change allows programs moreflexibility to schedule visits, while still meeting the needs of patients. As we all work together to improve behavioral health care for Alaskans, our continued dialogue will help us achieve the best outcomes for our Alaska Native people and all Alaskans. We do wish to provide comments to help improved the proposed regulations and documents that we believe will clarify and strengthen delivery of services to our children who need behavioral health residential services. 1. The changes proposed for CRT Services eligibility criteria for Level 2 care are positive. We support this change, but we do wish to recommend a change to the language in proposed 7 AAC 139.325(b)(2), and which should also be applied to 7 AAC 139.325(b)(1).<u>We recommend the phrase "medical personnel" be changed to more inclusive phrasing, such as "interdisciplinary treatment</u>	The Division agrees with the requested change.

	team." The use of the phrase "medical personnel" in the regulations may not include a host of health care professionals, including behavioral, mental, and medical, that may assist in the intensive treatment of residential patients, and we believe a more inclusive phrase can help cure this narrower regulatory phrase currentlyused. 2. Under CRT 2 in the Standards & Procedures on page 22, "at least five (1) therapeutic interventions per day". We recommend the Department remove a word "five" in "Additional Information" and replace it with "one" to better reflect the minimum service requirements from daily to weekly found in the "Service Requirements Expectations" found on page 21 for CRT 2. It appears the Level 1 "Additional Information" was adjustedto reflect these changes, and believe it was the Department's intent in this section as well. 3. We recommend that the Department revisit the current payment rate for CRT 1 and 2 services. While Tribal health providers of these services would receive the IHS all- inclusive rate for these services, the current Fee-for-Service rate is too low for many providers of these services to remain in business. Losing providers of CRT services would impact the entire Alaska Behavioral Health System, putting more demand on fewer slots available at remaining facilities. It is already difficult with the current number of CRT service providers to find enough placements for patients that need treatment and losing providers would exacerbate this difficulty for the Tribal system.	The Division agrees with this change. Thank you for the feedback, the Division will take this under consideration.

	In closing, we are supportive of the changes being made to CRT services in these proposed regulations to transition to 1115 waiver services. We believe some small changes can be made to improve the clarity of these proposed regulations and improve access to CRT services for all Alaskans, especially our most vulnerable children. We thank the Department for the opportunity to comment on these proposed regulatory changes. If the Department has any comments or questions regarding the recommendations, you can reach ANHB at anhb@anhb.org or via telephone at (907) 231-1266. Sincerely Andrew Jimmie, Tribally Elected Leader of the Village of Minto. Chairman Alaska Native Health Board	
April Kyle, MBA Interim CEO	Dear Ms. Weeks, Thank you for the opportunity for Southcentral Foundation to provide these comments in response to the proposed changes to the Behavioral health Medicaid Services Transition released March 11, 2021. 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, Iliamna, Kokhanok, McGrath, Newhalen, Nikolai, Nondalton, Pedro Bay, Telida, and Takotna-to provide healthcare services to beneficiaries of the 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 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, substance abuse treatment,	

	residential treatment facilities for adolescents and for women, suicide prevention and domestic violence prevention. Southcentral Foundation offers the following comments: The first is the 1115 Regulations section: 7 AAC 139.325 (b)(2)- Southcentral Foundation appreciates the State listening to provider concerns around Children's Residential Level 2 Eligibility Criteria and removing the requirement that children have more than three placements in a less restrictive setting prior to qualifying for level 2 treatment services. Allowing programs to continue to provide this service while the regulations are amended is a positive start. SCF is supportive of the proposed regulation changes as it allows more flexibility based on the child's clinical need and removes barriers to care. SCF has one recommendation in this section: 1) 7 AAC 139.325 (b)(2) Level 2: for children and adolescents who need treatment and recovery, require the intensive services of medical personnel, **SCF Recommendation**: Broadly define "medical personnel" or change to **"interdisciplinary treatment team"** The use of the phrase "medical personnel" in the regulations may not include a host of health care professionals, including behavioral, mental, and medical providers that may assist in the intensive treatment of residential patients, and we believe a more inclusive phrase can help cure this narrower regulatory phrase currently used. **Alaska behavioral health Providers Services Standards & Administrative Procedures for Behavioral Health Provider Services** The State made changes to regulatory language around "required hours of service per day" in both the Children's Residential Level 1 and 2 Service Requirements Expectation(s). The change for Level 1 from a minimum of three hours of treatment services per day to a minimum of 10 hours of treatment services per week, and the change for Level 2 from 5 hours per day to 15 hours per week are good changes that allow program to provide the required house of services while	The Division agrees with the recommended change.

	considering the child/adolescent needs that may arise during treatment. SCF has two recommendations in this section: **Level 2 Additional information-**CRT programs may employ a multi-disciplinary team of professionals to work in their programs: however, at least five (1) therapeutic intervention per day, must be documented. **SCF Recommendation:** change the "five" to "one" as this is what the state intended. **Payment Rate –** We urge the State to review and change the payment rate for Children's Residential 1 and 2. While Tribal Health providers of those services would receive the Indian Health Service all-inclusive rate for these services, the current fee-for-service rate is too low for many providers of these services to remain in business or to develop new service options under the 1115 Waiver. The staffing requirements for children's residential services exceed that of adult residential services yet they are expected to be paid significantly less. This barrier would pose a significant risk to our delivery system reducing the number of beds that the state has for residential placements and placing a burden on the OCS & DJJ systems to find placement s for children without a developed continuum of services. **SCF recommendation:** Pay Children's Residential at least the same rate as Adult Residential Level 1 and 2 respectively. Southcentral Foundation appreciates the opportunity to comment on the proposed regulations. If you have any questions about our comments, please contact Vice President of Behavioral Services, Michelle Baker at mbaker@scf.cc or at (907) 729-4907 Sincerely April Kyle Interim CEO	The Division agrees with the correction. We will take this under consideration.