Proposed Changes on Medicaid Payment Rates for Community Behavioral Health & Mental Health Physician Clinic Services

Response to Public Comment Received August 26, 2024 – October 16, 2024

On August 26, 2024, the Department of Health (DOH) proposed changes to Medicaid Payment Rates for Community Behavioral Health & Mental Health Physician Clinic Services published via the Alaska Online Public Notice system under NOTICE OF PROPOSED CHANGES ON MEDICAID PAYMENT RATES FOR COMMUNITY BEHAVIORAL HEALTH & MENTAL HEALTH PHYSICIAN CLINIC SERVICES with an archive date of 10/17/2024. The notice was also published in the Anchorage Daily News. Public comment was available through multiple channels, including:
The Department of Health, Division of Behavioral Health (DBH) email box at doh.dbh.public.comment@alaska.gov;
By phone at 907-269-6549, the direct line for William Hurr, Project Coordinator 2, Division of Behavioral Health (DBH); and,
In writing with the mailing the address State of Alaska, Department of Health, Division of Behavioral Health, 3601 C Street, Suite 934, Anchorage, AK 99503.

An oral hearing was held on October 10, 2024, 12:00 p.m. to 1:00 p.m. to allow for oral presentation of comments. No public comment was received during the public hearing. The meeting was attended by four (4) people: Two staff from the Division of Behavioral Health and two people stating they were present to listen to public comment received during the meeting.

The public comment period closed at 5:00pm on October 16, 2024. This document contains the Department of Health's responses to those comments. Identical or substantively similar comments have been consolidated for purposes of response.

PUBLIC COMMENT	DEPARTMENT OF HEALTH RESPONSE
Public Comment #1: I am wondering if it was intentional to leave out some of the services that are impacted in the last attachment "Rate Inputs for CBH Rebase (Informational Purposes Only)." For example, the breakdown for the MH Intake Assessment and the Integrated Assessment are not included, etc. [via doh.dbh.public.comments@alaska.gov, 8/27/24, 10:29 a.m.]	*DOH Response #1:* Thank you for the technical question. The *Chart of Community Behavioral Health and Mental Health Physician Clinic Medicaid Covered Services Rates* include more than one rate type and each type is subject to a different rate methodology. Community Behavioral Health services are subject to a process where rates were reestablished or "re-based," under 7 AAC 145.580. The method was shared with the public through the Alaska Online Public Notice process. Attached are links for the announcements and slides that explained the process: 1. Medicaid Community Behavioral Health and Mental Health Physician Clinic Rate Setting Methodology, published 10/19/22. It includes the CBH Rebase Presentation 2022 FINAL. Discussion of Upper Payment Limit (UPL) considerations begin on slide 24.

	2. Additionally, there were a series of Medicaid Community Behavioral Health and Mental Health Physician Clinic Rate Setting Methodology Meetings (Alaska Online Public notice on 6/14/2023) in June and July of 2023. The slide deck for the June 27, 2023, Meeting #1 Clinic and Daily Substance Use provides significant discussion about Clinical rates and the Upper Payment Limit process. The two services and related rates mentioned in the comment are Clinic rates subject to Upper Payment Limit and its rate calculation method.
Public Comment #2: I have been reviewing the proposed changes to the Medicaid payment rates and saw one glaring thing that I request clarification on. The new proposed rate sheet divides residential substance use disorder treatment into three categories - low, medium, and high intensity. These differentiations are incongruent with ASAM levels of care, and incongruent with how they are currently reimbursed. ASAM has clinically managed a low intensity level of care (LOC 3.1) and a clinically managed high intensity level of care (LOC 3.5). The current low intensity reimbursement rate is $418.87. On the new rate chart the low intensity rate is $233.72. Can someone help me understand why this drastic reduction is recommended? We are barely making it work on the current rate and will most certainly have to close our doors if the rate is cut nearly in half. According to the American Society of Addiction Medicine, there are not three levels of intensity in residential substance use treatment. Can you provide me with the information on what differentiates low, medium, and high intensity that will decide which of these rates we can bill? Also, the 3.5 treatment programs in the state are already struggling to make things work and some are closing down. We have tried to come up with a sustainable way to open one, but the current rate structure is just not in the feasibility range. The new rates only marginally increase this amount, and I would anticipate more residential sud programs will need to close if there is not a more substantial increase to the high intensity rates. [via doh.dbh.public.comments@alaska.gov, 8/28/24, 8:32 a.m.]	*DOH Response #2:* Thank you for the comment and expressed concern regarding rates for substance use disorder treatment (SUD) services. The Department is working diligently to expand the array of SUD services available to Alaskans and to develop a robust SUD treatment infrastructure across the state. The current mechanism for this work is the Behavioral Health Reform 1115 Medicaid Waiver Services. Under the 1115 Waiver, Alaska continues to reshape the SUD service array in a way that supports the levels of care set out in *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-occurring Conditions*. Discussion of this process can be found in *The Centers for Medicare and Medicaid Services (CMS) approval to extend "Behavioral Health Reform" in Accordance with Section 1115(a) of the Social Security Act, March 26, 2024* under Attachment D, the SUD Implementation Plan Protocol. As SUD services are developed, added to the array, and transition takes place, allowances are made to ensure providers of SUD services are supported as old service codes sunset and new services are established. The three SUD service codes mentioned in the comment for low, medium, and high intensity SUD residential treatment services on the Community Behavioral Health & Mental Health Physician Clinic (CBH & MHPC) rate chart are a remnant in the transition of these services from the Medicaid State Plan services to 1115 Waiver services. Only a few providers continue to bill under these CBH & MHPC SUD service codes. Comparable services listed on the current *Chart of 1115 Medicaid Waiver Services, effective 2/2/24* have reimbursement rates substantially higher than the CBH & MHPC rate chart. Additionally, a 4.5% increase in rates for these services goes into effect on 11/8/24 with adoption of the *Chart of Behavioral Health Reform 1115 Medicaid Services Rates* into regulation under 7 AAC 160.900. Although the three SUD residential treatment

	codes on the CBH & MHPC rate chart were not included in the rate rebasing process. They received a 3.2% inflationary increase effective 7/1/24. Services under the 1115 Waiver more closely reflect the levels of care in the ASAM than services listed on the CBH & MHPC rate chart, which are slated to be sunset. The Department is not authorizing use of the three SUD residential services codes on the CBH & MHPC rate sheet beyond the handful of agencies that continue to bill under those codes. All other agencies are currently billing under the 1115 Waiver, where newly enrolled SUD providers will also be directed.
Public Comment #3: The changes continue to note at the bottom the GT modifier for telehealth services. I thought GT had been eliminated in need of modifier 95 for audio and video or FQ for audio only telehealth services; more specific modifiers. Can you please clarify this when finalizing rate changes. [via doh.dbh.public.comments@alaska.gov, 8/28/24, 6:12 p.m.]	*DOH Response #3:* Thank you for the technical question regarding the rate chart. Although the Department is transitioning away from the "GT" modifier, it is still technically valid until the transition to the new codes is complete. A revision will be made so the finalized rate chart notes section reflects modifiers for telehealth include "95" for audio and video or "FQ" for audio only.
Public Comment #4: I am struggling to understand the way upper payment limits for Medicaid are determined, despite having found your excellent presentation from 2023. Would you have a few minutes sometime to talk by phone to help me wrap my head around it? I think I'm getting lost by the term "in aggregate"; exactly what I aggregated, and how that allows for some flexibility with payment rates within a set of codes. [via doh.dbh.public.comments@alaska.gov, 9/11/24, 4:06 p.m.]	*DOH Response #4:* Thank you for the technical question. The Department appreciates how difficult it can be to navigate Medicaid questions given their complexity, including the question regarding Upper Payment Limits (UPL) and other rate methodologies. Unfortunately, the question is related to the proposed regulation changes that were in the public comment period for Proposed Changes on *Medicaid Payment Rates for Community Behavioral Health & Mental Health Physician Clinic Services*. Given the general nature of the question, it is difficult to provide a response in addition to the technical assistance tools described in *DOH Response #1,* above. If you need more direct technical assistance in understanding UPL, please contact the Department after the regulation process is completed. Thank you for your patience with the requirements of public process.

Public Comment #5: Background/Context: Alaska is in the midst of a behavioral health crisis that providers have seen coming for some time. Despite expressing repeated concerns and at times warnings to State leadership, we are reaching a breaking point and the collapse of our system is imminent. Providers cannot afford to deliver care. Costs of doing business have skyrocketed, workforce shortages persist as valuable providers move on to higher paying, less burdensome roles elsewhere, and administrative burdens encroach on every aspect of care delivery. In the meantime, the Medicaid reimbursement rates are continually inadequate. We are now facing alarming trends: a 45% increase in overdose rates in the past year (while other states have seen declines), federal investigations into our state's ability to provide adequate community services to our youth, and one of the nation's highest suicide rates. These are clear signs of an inadequate system. While states across the country have invested in behavioral healthcare systems, Alaska continues to expect providers to do more with fewer and fewer resources. Alaskan behavioral health providers waited four years – while also navigating the COVID-19 pandemic – for new Medicaid rate adjustments, which are required every four years. Despite starting the comprehensive two-year study after the deadline, the study went on to reveal that the costs of delivering care far exceed reimbursement rates. The newly proposed rates provide only a modest increase and are years past the deadline set by the State. In fact, the information used to reach these rates is now years out of date. While we acknowledge the incredible workload placed on State employees and commend them for their efforts under such difficult circumstances, we must emphasize that these rates provide, at best, only a temporary reprieve before the behavioral health system of care collapses. We are adamant that reimbursement rates are well below the steady growth of costs and will only lead to further decline if not adjusted. We are grateful that the State completed a rate rebase and urge immediate action to begin preparations for the next one, as these proposed rates are based on outdated data. Recommendations:	*DOH Response to #5, #6, and #7:* The Department values the perspectives and concerns raised regarding the challenges behavioral health providers are facing in Alaska, as well as the resulting impacts on patient care and, ultimately, on our communities. The Department acknowledges these concerns as Alaska addresses the ongoing social and economic challenges of the post-pandemic era. We recognize the strain caused by rising care costs, workforce shortages, and the growing demand for behavioral health services, and remain committed to meeting the needs of those we serve. Adoption of the proposed CBH & MHPC rate chart will complete the rate rebasing process started in 2022 for community behavioral health rates. The purpose of rate reestablishment under 7 AAC 145.580(b) for Community Behavioral Health & Mental Health Physician Clinic services rates being every four years is to help ensure rate reimbursements keep up with the cost of services. Additionally, subsection (c) provides for an annual inflationary adjustment using the most current health market information. Within current regulation and budget constraints, CBH & MHPC rates were increased three times since July 1, 2021. This included 3.9% on July 1, 2022, and the 3.2% increase on July 1, 2024, both inflationary increases. A rate increase of 3.7% was implemented effective July 1, 2023, while work on the rebase continued. The delay allowed the Department to analyze an additional year of service utilization data and incorporate a rate increase for clinic rates subject to the Upper Payment Limit (UPL). Clinic rates would not have received an additional increase without the additional time and data given limited room in the UPL gap at the time. The proposed CBH & MHPC rate chart increases clinic rates an additional 3.8% and implements Community Behavioral Health rate increases based on the rate methodology. The effective rate increase for clinic rates from July 1, 2021, to the proposed rate chart is just over 15.3%. The effective rate increase from July 1, 2021, for CBH rates through July 1, 2024, is just over 11.2% based on inflationary increases. Given the rate methodology for CBH rates, the rate for each service is adjusted based on available data, including data from provider surveys. The rate is intended to reflect the most current costs associated with a given service. For two rates, the change was over 100%, including behavioral health screen at 184% and day treatment for children at 111%. Withdrawal services remained the same and treatment plan review for methadone recipients is

Respectfully, we request a comprehensive reassessment of how behavioral health providers are compensated, whether through cost-based reimbursement models, encounter or prospective payment systems, or simply contributing funds above the upper payment limit outside the federal match as other states have done. More substantial action is required. The State of Alaska must seek out all possible solutions to this crisis. This includes increasing grants, providing one-time bridge funding, and significantly reducing the administrative burden of delivering Medicaid care. We are also concerned with the proposed allocation of increases; for example, prioritizing the increase of screening costs rather than treatment costs such as psychotherapy, which received only a minimal 4% increase. This perpetuates a rate system focused on administrative processes over direct patient care. Furthermore, there are inconsistencies in the rate structure that reinforce an overall lack of clinical vision. The state plan case management rate now exceeds the rate for 1115 Waiver "intensive" case management, highlighting the inadequacies of 1115 Waiver rates in comparison. Conclusion: We recognize the importance of the proposed rate changes and appreciate the State's efforts thus far. However, we ask for a cohesive clinical vision for Medicaid behavioral health that prioritizes all components needed for positive treatment outcomes. We cannot wait; without immediate reform, Alaska's Medicaid behavioral health system faces a complete breakdown. [via doh.dbh.public.comments@alaska.gov, 10/15/24, 10:55 a.m.]	down about 1%. Ultimately, reestablishing rates through the rate methodology process has been successful as rates more closely reflect the cost of those services. Limits on what Medicaid will pay for at the federal level will continue to limit federal reimbursement to match the cost of services. Limits in current rate methodology is also a factor. Consequently, the Department is initiating a rate methodology contract for quality improvement to support a more robust process for data-driven decision-making. Division of Behavioral Health rates are a priority in the rate methodology contract and include Behavioral Health Reform 1115 Medicaid Services Rates. For 1115 services there is not currently a mechanism in regulation to reestablish rates or provide inflationary increases that lead to the "inconsistencies" in rates noted in public comment. The Department is looking forward to deliverables through the rate methodology contract that will assist the Office of Rate Review and the Division of Behavioral Health as the Department continues to work with providers and communities to build a stronger continuum of behavioral health services for Alaska. The Department understands the strength of Alaska's behavioral health system is in the knowledge, skills, and experience of those providing services in our communities. We welcome the conversations and work ahead related to resources, reducing barriers to care, and further developing the continuum of services in ways that respond to the needs of all Alaskans, urban and rural.
Public Comment #6: We consistently hear from providers across Alaska that current Medicaid rates are insufficient to support essential services, which is leading to closures. As one provider explained during our youth services assessment in Ketchikan in October, "When you look at residential beds, in 4 years…we've lost 80 beds in Southeast. We've lost essentially all of Juneau Youth Services… They (Bartlett's adolescent unit) were 6 months in…they're closing. But we've lost Crossings, Raven's Way moved to Juneau and instead of 15 beds is operating at like 12 or something…But the reason they're being squeezed out is this administrative burden."	*See consolidated DOH response to public comments #5, #6, and #7 above.*

The situation in Southeast Alaska reflects a broader issue across the state, where many youth service providers have been forced to shut down due to the administrative burdens associated with Medicaid billing and insufficient reimbursement rates. This loss of services comes at a time when Alaska is already struggling to meet the behavioral health needs of its youth, with many being sent away from their home communities—or even out of state—to receive the care they need. While the Boards commend the Department of Health for proposing rate increases, we encourage further action to ensure rates fully reflect the cost of care, particularly in rural and underserved areas. Prioritizing rates for services that have the greatest impact on long-term recovery will help ensure that providers can continue delivering critical interventions. Without adequate funding, Alaska's continuum of care remains at risk of further reductions and closures, which will severely limit access to services. As the Department prepares for the upcoming rate methodology study, we urge the adoption of strong data governance practices rooted in data sovereignty. Transparent, accurate data collection and stakeholder input will be critical to setting fair and effective rates. Any data project within Alaska must recognize the historical trauma that many underserved communities, particularly Alaska Native communities, have experienced when data has been collected and used to make decisions without their input. We urge the state to be conscientious of the collective trauma from state entities gathering data from Indigenous and rural communities and feedback. Although the Department has made tremendous and commendable efforts to gather input from communities, providers continue to report to the Boards that they feel their input isn't gathered in shaping outcomes from their own reports. This opinion was expressed strongly during our recent youth services assessment, with one provider stating, "I do feel like they've done a great job, especially this last year, reaching out and getting the voice. But then it's kind of like they get our opinion… and then (we) don't hear anything and then there's a decision or a new regulation." It is imperative that this dynamic change. Transparent, accurate data collection and ongoing stakeholder input must be at the core of setting fair and effective rates. Decisions made from this data must be done in true partnership with the communities most affected. Data-driven approaches that respect community ownership will ensure Medicaid rates reflect the true	

needs of our providers and the people they serve, leading to more equitable and sustainable outcomes. [via doh.dbh.public.comments@alaska.gov, 10/16/24, 3:58 p.m.]	
Public Comment #7: We sincerely appreciate the efforts of the Department of Health to move toward developing a system of care within the State of Alaska that will allow for all residents to gain access to and engage in needed behavioral health treatment services within the communities that they reside. We acknowledge the arduous and delicate process of elevating the rates associated with behavioral health services and we very much appreciate the elevations to the services outlined within this notice. In the fall of 2023, The Office of Rate Review hosted several meetings for the provider group during which an extensive review of the rate rebasing methodology that has been in use for the last several years is implemented to determine the appropriate rate for all of the various services that are contained within the Alaska Medicaid State Plan. This series of educational trainings occurred secondary to the completion of a cost survey requested by The Office of Rate Review of behavioral health providers. During these trainings, we learned a great deal about the rate rebasement methodology and about the cost survey results. The provider group became well educated on what is federally known as the Upper Payment Limit (UPL). According to our understanding, state plan rates cannot exceed the UPL in the aggregate across all services provided. That is to say, there is some room that the state has to adjust rates within the state plan up or down so long as the total ask for CMS matching is not greater than the UPL. We learned through this series of trainings that after a review of the cost surveys provided, the increase to rates overall would have to be somewhere in the 14-15% increase, but that to do so right now would clearly take us past the UPL and thus the state would not be able to provide the increase that would be needed to match the cost of the services as experienced by the provider group. It was expressed that the division would be able to do something close to a 7% increase to rates, which was then broken down into a smaller inflationary adjustment and now the rates	*See consolidated DOH response to public comments #5, #6, and #7 above.*

currently being prosed here. Though the increases outlined within this notice are very much needed and greatly appreciated, it does not appear that they truly cover the cost of the services in most cases. Understanding that there are some barriers regarding the UPL set by federal CMS, I am wondering if it is at all possible to exceed the UPL with the state assuming the responsibility to come up with the difference. I am aware that there are other states that have done so and have experienced some success with their provision of services as a result. I would recommend that the state strongly consider this as a possibility and for the rates to be elevated minimally to the level that was calculated in the last provided cost survey. Again, we very much would like to acknowledge the efforts that the State is using to evaluate and elevate the system of healthcare within Alaska. We acknowledge that the state has contracted with experts to evaluate the rebasement methodology used to determine what the rates will be in the future. We express concern though that the results of the contract to do so will be a protracted process and it will delay they already regulatorily out of compliance re basement in rates which was to be implemented in July of 2023. We are hopeful that we can continue to move forward in partnership with The State, the Department of Health, and the Division of Behavioral Health for the betterment of all Alaskan's. [via doh.dbh.public.comments@alaska.gov, 10/16/24, 4:02 p.m.]	